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DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 905

[Docket No. FV02–905–3 FIR]

Oranges, Grapefruit, Tangerines, and Tangelos Grown in Florida; Removing Dancy and Robinson Tangerine Varieties From the Rules and Regulations

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 that removed the Dancy and Robinson varieties of tangerines from the regulated varieties of Florida citrus prescribed under the marketing order covering oranges, grapefruit, tangerines, and tangelos grown in Florida (order). The order is administered locally by the Citrus Administrative Committee (committee). This rule also continues in effect the removal of a section of the rules and regulations dealing with handling procedures for Dancy and Robinson tangerines. Production of these varieties has declined and is expected to continue to decline. Removing these varieties will not have a significant impact on the tangerine market.

EFFECTIVE DATE: December 2, 2002.

FOR FURTHER INFORMATION CONTACT: William G. Pimental, Southeast Marketing Field Office, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 799 Overlook Drive, Suite A, Winter Haven, Florida 33884–1671; telephone: (863) 324–3375, Fax: (863) 325–8793; or George Kelhart, Technical Advisor, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20250–0237; 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, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20250–0237; 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. 84 and Marketing Order No. 905, both as amended (7 CFR part 905), regulating the handling of oranges, grapefruit, tangerines, and tangelos grown in Florida, 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.''

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

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. This rule is not intended to have retroactive effect. 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. A 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.

The order provides for the establishment of grade and size requirements for Florida citrus, with the concurrence of USDA. These grade and size requirements are designed to provide fresh markets with citrus fruit of acceptable quality and size. This helps create buyer confidence and contributes to stable marketing conditions. This is in the interest of growers, handlers, and consumers, and is designed to increase returns to Florida citrus growers.

This rule continues in effect the removal of Dancy and Robinson tangerines from the regulated varieties of Florida citrus fruit prescribed under the marketing order covering oranges, grapefruit, tangerines, and tangelos grown in Florida. Production of these varieties has declined, and it is expected that production will continue to decline. Removing these varieties from the minimum grade and size requirements will not have a significant impact on the overall quality of tangerines. This action was unanimously recommended by the committee at its meeting on May 22, 2002.

Section 905.52 of the order, in part, authorizes the committee to recommend minimum grade and size regulations to USDA. Section 905.306 of the order's rules and regulations specifies the regulation period and the minimum grade and size requirements for different varieties of fresh Florida citrus. Such requirements for domestic shipments are specified in § 905.306 in Table I of paragraph (a), and for export shipments in Table II of paragraph (b).

This rule continues to modify § 905.306 by deleting Dancy tangerines and Robinson tangerines from the list of entries in Table I of paragraph (a), and in Table II of paragraph (b). In its deliberations, the committee realized that Dancy tangerines and Robinson tangerines no longer significantly impact the citrus market. During the 2001–02 season, total shipments of Dancy tangerines were 12,798 cartons. Florida Department of Agriculture statistics show that in 2000–01, 23,000 cartons were shipped. This is down from 94,000 cartons shipped during the 1997–98 season. During 2001–02, only 124,249 cartons of Robinson tangerines were shipped. Florida Department of Agriculture statistics show that in 2000–01, 165,000 cartons were shipped. This is down from 262,000 cartons shipped in 1997–98. Production of these varieties has declined as newer varieties

have been developed and planted. The decline is expected to continue. Shipments of these varieties represented less than 3 percent of fresh shipments of early tangerines during the 2001–02 season. Consequently, the committee believes that the current market share and shipment levels justify removal of minimum grade and size requirements for these varieties.

Section 905.152 sets forth procedures for determining handlers' permitted quantities of Dancy and Robinson tangerine varieties when a portion of the 210 size of these varieties was restricted. Because Dancy and Robinson tangerines no longer have to meet size requirements, § 905.152 is unnecessary and the removal of this section is continued.

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 action 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 11,000 producers of Florida citrus in the production area and approximately 75 tangerine 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.

Based on industry and committee data, the average annual F.O.B. price for fresh early Florida tangerines during the 2000–01 season was around $10.00 per 4/5-bushel carton, and total fresh shipments of early tangerines for the 2001–02 season were approximately 5.2 million cartons.

Approximately 20 percent of all handlers handled 77 percent of Florida tangerine shipments. Using tangerine shipments and the average F.O.B. prices, it can be determined that the majority of Florida tangerine handlers could be considered small businesses under SBA's definition. In addition, the majority of Florida citrus growers may be classified as small entities.

This rule continues in effect the removal of Dancy and Robinson tangerines from the varieties of citrus regulated under the order. These varieties are no longer required to meet the minimum grade and size requirements. Production of these varieties has declined and it is expected that production will continue to decline. Removing these varieties from the list of regulated varieties will not have a significant impact on the tangerine market.

Section 905.52 of the order, in part, authorizes the committee to recommend minimum grade and size regulations to the USDA. Section 905.306 of the order's rules and regulations specifies the regulation period and the minimum grade and size requirements for different varieties of fresh Florida citrus. This rule continues in effect modifications to § 905.306 of the rules and regulations concerning covered varieties and minimum grade and size requirements, respectively. This rule also continues to remove § 905.152.

This rule is expected to have a positive impact on affected entities because these varieties are being removed from the handling requirements. Because this rule continues to relax the handling requirements by removing two varieties from the list of varieties regulated, handlers will be able to market these varieties free from the order's requirements. There are no additional costs imposed on growers and handlers with this rule.

Only a total of approximately 137,000 cartons of these tangerines were shipped during the 2001–02 season. Florida Department of Agriculture statistics show that in 2000–01, a total of 188,000 cartons of these varieties were shipped. This is down from a total of 356,000 cartons of Dancy and Robinson tangerines shipped during the 1997–98 season. Shipments of these varieties accounted for less than 3 percent of the overall 5.2 million cartons of early Florida tangerines shipped during the 2001–02 season. Production of these varieties has declined as newer varieties have been developed and planted. The decline in production of these varieties is expected to continue. Most producers have already discontinued growing these varieties and handlers find it easier to sell the newer varieties that have been developed. The benefits derived from this change are expected to benefit both large and small entities equally.

One alternative discussed was to make no change to the order's handling regulations. The committee saw this alternative as being of no benefit to the industry because of the declining production and minimal market share of these varieties. The committee believes these varieties have no significant impact on the tangerine market and agreed that action should be taken to remove these varieties from the handling regulations, so this alternative was rejected.

Another alternative was to also remove the Ambersweet variety from the regulations. However, the committee determined that annual shipments of this variety are at a level that impacts the market and, therefore, this alternative was rejected.

This rule will not impose any additional reporting or recordkeeping requirements on either small or large Florida tangerine 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. In addition, as noted in the initial regulatory flexibility analysis, USDA has not identified any relevant Federal rules that duplicate, overlap or conflict with this rule.

Further, the committee's meeting was widely publicized throughout the citrus industry and all interested persons were invited to attend the meeting and participate in the committee's deliberations. Like all committee meetings, the May 22, 2002, meeting was a public meeting and all entities, both large and small, were able to express their views on this issue.

An interim final rule concerning this action was published in the **Federal Register** on July 23, 2002. Copies of the rule were mailed or sent via facsimile to all Committee members and handlers. In addition, the rule was made available through the Internet by the Office of the Federal Register and USDA. That rule provided for a 60-day comment period which ended September 23, 2002. 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 committee's recommendation, and other information, it is found that finalizing the interim final rule, without change, as published in the **Federal Register** (67

FR 48015, July 23, 2002) will tend to effectuate the declared policy of the Act.

List of Subjects in 7 CFR Part 905

Grapefruit, Marketing agreements, Oranges, Reporting and recordkeeping requirements, Tangelos, Tangerines.

PART 905—ORANGES, GRAPEFRUIT, TANGERINES, AND TANGELOS GROWN IN FLORIDA

Accordingly, the interim final rule amending 7 CFR part 905 which was published at 67 FR 48015 on July 23, 2002, is adopted as a final rule without change.

Dated: October 28, 2002.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 02–27764 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Parts 945 and 980

[Docket No. FV00–945–2 FR]

Irish Potatoes Grown in Certain Designated Counties in Idaho, and Malheur County, Oregon, and Irish Potatoes Imported Into the United States; Modification of Handling and Import Regulations

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: This rule removes the reference to Norgold variety potatoes from the handling regulation issued under the marketing order for Idaho-Eastern Oregon potatoes. The Norgold variety was specifically referenced to establish less restrictive maturity requirements for early season shipments. However, Norgold variety potatoes are no longer produced in the production area covered under the marketing order and the less restrictive requirements are not needed. As required under section 608e of the Agricultural Marketing Agreement Act of 1937, the maturity requirements for potato imports are changed accordingly.

EFFECTIVE DATE: This final rule becomes effective December 2, 2002.

FOR FURTHER INFORMATION CONTACT: Robert Curry, Northwest Marketing Field Office, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1220 SW Third Avenue, suite 385, Portland, Oregon 97204; telephone: (503) 326–2724, Fax: (503) 326–7440; or George Kelhart, Technical Advisor, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, room 2525–S, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20250–0237; telephone: (202) 720–2491, Fax: (202) 720–5698.

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, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20250–0237; telephone: (202) 720–2491, Fax: (202) 720–5698, or e-mail: *Jay.Guerber@usda.gov.*

SUPPLEMENTARY INFORMATION: This final rule is issued under Marketing Agreement No. 98 and Marketing Order No. 945, both as amended (7 CFR part 945), regulating the handling of Irish potatoes grown in certain designated counties in Idaho, and Malheur 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.''

This rule also is issued under section 608e of the Act, which provides that whenever certain specified commodities, including potatoes, are regulated under a Federal marketing order, imports of these commodities into the United States are prohibited unless they meet the same or comparable grade, size, quality, or maturity requirements as those in effect for the domestically produced commodities.

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. This action is not intended to have retroactive effect. 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. A 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.

There are no administrative procedures which must be exhausted prior to any judicial challenge to the provisions of import regulations issued under section 608e of the Act.

Sections 945.51 and 945.52 of the order provide authority for the establishment and modification of regulations applicable to the handling of potatoes. Section 945.341 establishes minimum maturity and pack requirements for potatoes handled subject to the order. Requirements in effect prior to this final rule provided, in part, that all potatoes packed in cartons were to be inspected and certified as meeting U.S. No. 1 grade or better. All varieties were to meet the maturity requirement of slightly skinned (except the Norgold variety from August 1–15, and the White Rose and red skinned varieties from August 1–December 31 were allowed to be moderately skinned). During other periods of the year, the White Rose and red skinned varieties are not subject to maturity requirements. Size is to be conspicuously marked on all cartons (except when used as a master container). The grade requirements are based on the U.S. Standards for Grades of Potatoes (7 CFR 51.1540–51.1566), and the size must be marked consistent with section 51.1545 of these standards.

The Idaho-Eastern Oregon Potato Committee (Committee), the agency responsible for local administration of the order, met on November 9, 1999, and unanimously recommended the removal of reference to Norgold variety potatoes from the handling regulations.

Prior to this final rule, the Norgold variety of potatoes was specifically referenced in the handling regulations so a less restrictive maturity requirement (moderately skinned) could be applied during a 15-day period (August 1–August 15) at the beginning of each shipping season. This rule removes the reference to Norgold potatoes as a separate variety from the minimum maturity requirements of the handling regulations. As required under section 608e of the Act, the maturity requirements for potato imports are changed accordingly. This rule also removes outdated language and makes other conforming changes to the handling and import regulations. The Committee recommended this change in the regulations because Norgold variety

potatoes are no longer produced in the production area.

Production of this long type variety was discontinued due in part to the Norgold variety's inherent propensity to have lighter, thinner skin early in the season compared to the varieties produced today. Newer replacement varieties are less prone to early season maturity problems, which enables the industry to maintain a consistent maturity level throughout the entire shipping season.

In addition, buyers are accustomed to long type potatoes having a higher maturity level than this minimum requirement allowed. To meet buyer expectations, all varieties of long type potatoes currently produced are required to be of a higher maturity level (slightly skinned) throughout the marketing year. The degree of skinning or maturity is differentiated by the amount of loss of the outer surface or skin layer. ''Slightly skinned'' means that up to 10 percent of the potatoes in any inspected lot can have one-fourth of the outer skin missing, while ''moderately skinned'' potatoes can have one-half of the skin missing.

This change will not have any economic impact upon producers or handlers, as it simply updates the handling regulations to recognize that the Norgold variety is no longer being produced within the production area.

As mentioned earlier, section 608e of the Act requires that when certain domestically produced commodities, including Irish potatoes, are regulated under a Federal marketing order, imports of that commodity must meet the same or comparable grade, size, quality, or maturity requirements. Section 608e also provides that whenever two or more marketing orders regulating the same commodity produced in different areas of the United States are concurrently in effect, a determination must be made as to which of the areas produces the commodity in most direct competition with the imported commodity. Imports must then meet the minimum requirements established for that particular area.

Grade, size, quality, and maturity regulations have been issued regularly under the order since it was established. The import regulation in § 980.1 specifies that import requirements for long type potatoes be based on those in effect for potatoes grown in certain designated counties in Idaho, and Malheur County, Oregon, during each month of the marketing year. This rule removes reference to Norgold variety potatoes from the maturity requirements of the handling regulation.

While no changes are required in the language of § 980.1, any potential imports of long type potatoes, including the Norgold variety, during the period from August 1–15 will be required to meet the modified maturity requirement of ''slightly skinned.''

This rule is not expected to have any economic impact upon importers. Nearly all potato imports come from Canada, and representatives of USDA's Market News Service have indicated that their contacts in Canada have reported that Norgold variety potatoes are no longer commercially produced in Canada.

This rule also removes § 945.130 of the rules and regulations which is obsolete, and revises and updates language in § 980.1, Import regulations; Irish potatoes. Sections 945.22 and 945.23 of the order, regarding committee membership districts within the production area and redistricting and committee reapportionment, were amended on June 5, 1995 (60 FR 29724), and § 945.130 is no longer needed. In addition, this rule removes references in the potato import regulation to the terminated marketing orders for Red River Valley and Maine potatoes, removes outdated language regarding import regulations in effect during 1970 and 1971, updates the list and addresses of inspection offices for imports, and updates the references in the import regulation to government agencies.

Final Regulatory Flexibility Analysis

Pursuant to the requirements set forth in the Regulatory Flexibility Act (RFA), the Agricultural Marketing Service (AMS) has considered the economic impact of this action 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 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. Import regulations issued under the Act are based on those established under Federal marketing orders.

There are approximately 63 handlers of Idaho-Eastern Oregon potatoes subject to regulation under the order and about 1,600 potato producers in the regulated area. There are approximately 161 importers of potatoes. Small agricultural service firms, which include potato handlers and importers, are defined by the Small Business Administration (13 CFR 121.201) as those having annual receipts of less than $5,000,000, and small agricultural producers are defined as those whose annual receipts are less than $750,000. A majority of these handlers, importers, and producers may be classified as small entities.

This rule removes the reference to Norgold variety potatoes from the maturity requirements in the handling regulation. The Norgold variety was specifically referenced to establish less restrictive maturity requirements for early season shipments. However, Norgold variety potatoes are no longer produced in the production area covered under the marketing order. As required under section 608e of the Act, the maturity requirements for potato imports are also changed.

The Committee met on November 9, 1999, and unanimously recommended the removal of the reference to Norgold variety potatoes from the handling regulations.

Prior to this final rule, the Norgold variety of potatoes was specifically referenced in the handling regulations so a less restrictive maturity requirement (moderately skinned) could be applied during a 15-day period (August 1–15) at the beginning of each shipping season. This final rule removes the reference to Norgold potatoes as a separate variety from the minimum maturity requirements of the handling regulations. As earlier stated, the Committee recommended this change in the regulations because Norgold variety potatoes are no longer produced in the production area. In addition, buyers have become accustomed to long type potatoes (such as Norgold variety potatoes) having a higher maturity level than this minimum requirement allowed. To meet buyer expectations, all varieties of long type potatoes currently produced are required to be of a higher maturity level (slightly skinned) throughout the marketing year. ''Slightly skinned'' means that up to 10 percent of the potatoes in any inspected lot can have one-fourth of the outer skin missing, while ''moderately skinned'' potatoes can have one-half of the skin missing. This change will not have any economic impact upon producers or handlers, as it simply updates the handling regulations to recognize that the Norgold variety is no longer being produced within the production area.

As mentioned earlier, section 608e of the Act requires that when certain domestically produced commodities, including Irish potatoes, are regulated under a Federal marketing order, imports of that commodity must meet

the same or comparable grade, size, quality, or maturity requirements. The current import regulation specifies that import requirements for long type potatoes be based on those in effect for potatoes grown in certain designated counties in Idaho, and Malheur County, Oregon, during each month of the marketing year. This rule removes reference to Norgold variety potatoes from the maturity requirements of the handling regulation. While no changes are required in the language of § 980.1, all potential imports of long type potatoes, including the Norgold variety, during the period from August 1–15 would be required to meet the modified maturity requirement of ''slightly skinned.''

This rule is not expected to have an economic impact upon importers as there are currently no potato imports during the period of August 1–15. In addition, representatives of the USDA Market News Service have indicated that their contacts in Canada have reported that Norgold variety potatoes are no longer commercially produced in Canada. Nearly all potato imports come from Canada, but there are no shipments until the latter part of September.

The removal of the references to Norgold variety potatoes is not expected to impose any additional costs on handlers, importers, or producers.

As an alternative to this rule, the Committee discussed leaving the handling regulations unchanged. The Committee rejected this idea because it would have left outdated language in the rules and regulations.

This rule does not impose any additional reporting or recordkeeping requirements on either small or large potato handlers and importers. As with all Federal marketing order programs, reports and forms are periodically reviewed to reduce information requirements and duplication by industry and public sectors. USDA has not identified any relevant Federal rules that duplicate, overlap, or conflict with this final rule.

Further, the Committee's meeting was widely publicized throughout the potato industry, and all interested persons were invited to attend the meeting and participate in Committee deliberations. Like all Committee meetings, the November 9, 1999, meeting was a public meeting and all entities, both large and small, were able to express their views on this issue.

A proposed rule concerning this action was published in the **Federal Register** on July 23, 2002 (67 FR 48051). A copy of the rule was mailed to the Committee's manager who in turn provided copes to all Committee members. The proposed rule was also made available through the Internet by the Office of the Federal Register and USDA. A 60-day comment period ending September 23, 2002, was provided to allow interested persons the opportunity to respond to the proposal as well as to submit information on the regulatory and informational impacts of the action on small businesses. No comments were received.

A small business guide on complying with fruit, vegetable, and specialty crop marketing agreements and orders may be viewed at the following Web site: *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 matter 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.

In accordance with section 608e of the Act, the United States Trade Representative has concurred with the issuance of this rule.

List of Subjects

7 CFR Part 945

Marketing agreements, Potatoes, Reporting and recordkeeping requirements.

7 CFR Part 980

Food grades and standards, Imports, Marketing agreements, Onions, Potatoes, Tomatoes.

For the reasons set forth above, 7 CFR parts 945 and 980 are amended as follows:

1. The authority citation for 7 CFR parts 945 and 980 continues to read as follows:

Authority: 7 U.S.C. 601–674.

PART 945—IRISH POTATOES GROWN IN CERTAIN DESIGNATED COUNTIES IN IDAHO, AND MALHEUR COUNTY, OREGON

§ 945.130 [Removed]

2. Section 945.130 is removed.

§ 945.341 [Amended]

3. In § 945.341, paragraph (b)(2) is removed, and paragraphs (b)(3) and (b)(4) are redesignated as paragraphs (b)(2) and (b)(3), respectively.

PART 980—VEGETABLES; IMPORT REGULATIONS

4. Section 980.1 is amended as follows:

a. Revise paragraphs (a)(1)(i), (a)(2)(ii), (b)(2), (e), (f), and (g)(1)(ii).

b. Redesignate paragraph (i) as paragraph (j).

c. Redesignate paragraphs (h)(1) and (h)(2) as paragraphs (i)(1) and (i)(2) and revise newly designated paragraphs (i)(1) and (i)(2). The revisions read as follows:

§ 980.1 Import regulations; Irish potatoes.

* * * * *

(a) * * *

(1) * * *

(i) Grade, size, quality, and maturity regulations have been issued from time to time pursuant to the following marketing orders: No. 945 (part 945 of this chapter), No. 948 (part 948 of this chapter), No. 947 (part 947 of this chapter), No. 946 (part 946 of this chapter), and No. 953 (part 953 of this chapter).

* * * * *

(2) * * *

(ii) Imports of all other round type potatoes during the period June 5 through July 31 are in most direct competition with the marketing of the same type of potatoes produced in the Southeastern States covered by Order No. 953 (part 953 of this chapter); and during the period of August 1 through June 4 of the following year they are in most direct competition with all other round type potatoes produced in Area No. 3, Colorado (Northern Colorado) covered by Marketing Order No. 948, as amended (part 948 of this chapter).

* * * * *

(b) * * *

(2) During the period June 5 through July 31 of each marketing year, the grade, size, quality, and maturity requirements of Marketing Order No. 953 (part 953 of this chapter) applicable to potatoes of the round type shall be the respective grade, size, quality, and maturity requirements for imports of other round type potatoes; and during the period August 1 through the following June 4 of each year the grade, size, quality, and maturity requirements of Area No. 3, Colorado (Northern Colorado) covered by Marketing Order No. 948, as amended (part 948 of this chapter) shall be the respective grade, size, quality, and maturity requirements for imports of all other round type potatoes.

* * * * *

(e) *Certified seed.* Certified seed potatoes shall include only those

potatoes which are officially certified and tagged as seed potatoes by the Plant Health and Production Division, Plant Products Directorate, Canadian Food Inspection Agency, and which are subsequently used as seed.

(f) *Designation of governmental inspection services.* The Federal or Federal-State Inspection Service, Fruit and Vegetable Programs, Agricultural Marketing Service, U.S. Department of Agriculture and the Food of Plant Origin Division, Plant Products Directorate, Canadian Food Inspection Agency, are hereby designated as governmental inspection services for the purpose of certifying the grade, size, quality, and maturity of Irish potatoes that are imported, or to be imported, into the United States under the provisions of § 608e of the Act.

(g) * * *

(1) * * *

(ii) Since inspectors may not be stationed in the immediate vicinity of a port, or point of entry, an importer of uninspected and uncertified Irish potatoes should make advance arrangements for inspection. Each importer should give at least the specified advance notice to one of the following applicable inspection offices prior to the time the Irish potatoes will be imported.

Ports and points	Inspection offices	Advance notice (days)
All Maine ports and points of entry	In-Charge, Post Office Box 1058, Presque Isle, ME 04767 (PH 207–764–2100)	1
Port of Boston, MA	In-Charge, Boston Market Terminal Building, Room 1, 34 Market Street, Everett, MA 02149 (PH 617–389–2480).	1
Port of New York, NY	In-Charge, 465B New York City Terminal Market, Bronx, NY 10474 (PH 718–991–7665).	1
Port of Philadelphia, PA	In-Charge, 210 Produce Building, 3301 South Galloway Street, Philadelphia, PA 19148 (PH 215–336–0845.	1
All other ports and points of entry	Head, Field Operations Section, Fresh Products Branch, Fruit and Vegetable Programs, AMS, USDA, Washington, DC 20250–0240 (PH 1–800–811–2373).	3

* * * * *

(i) *Definitions.* (1) For the purpose of this part potatoes meeting the requirements of Canada No. 1 grade and Canada No. 2 grade shall be deemed to comply with the requirements of the U.S. No. 1 grade and U.S. No. 2 grade, respectively, and the tolerances for size, as set forth in the U.S. Standards for Grades of Potatoes (§§ 51.1540 to 51.1556, inclusive of this title) may be used.

(2) *Importation* means release from the custody of the U.S. Customs Service.

* * * * *

Dated: October 28, 2002.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 02–27767 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

8 CFR Parts 100, 103, 236, 245a, 274a and 299

[INS No. 2115–01; AG Order No. 2588–2002]

RIN 1115–AG06

Adjustment of Status Under Legal Immigration Family Equity (LIFE) Act Legalization Provisions and LIFE Act Amendments Family Unity Provisions; Corrections

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Final rule: Corrections.

SUMMARY: The Department of Justice published in the **Federal Register** of June 4, 2002 (67 FR 38341), a final rule which amended the Immigration and Naturalization Service (Service) regulations to provide definitive regulations for all applicants under section 1104 the Legal Immigration Family Equity (LIFE) Act, and section 1504 of the LIFE Act Amendments. The final rule contains technical errors that are corrected in this document.

EFFECTIVE DATES: November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Elizabeth N. Lee or Suzy Nguyen, Assistant Directors, Residence and Status Branch, Office of Adjudications, Immigration and Naturalization Service, 425 I Street NW., Room 3040, Washington, DC 20536, telephone (202) 514–3228.

SUPPLEMENTARY INFORMATION:

Need for Correction

As published in the **Federal Register** on June 4, 2002 (67 FR 38341), the final rule amending parts 100, 103, 236, 245a, 274a and 299 contains technical errors that are in need of correction.

Correction of Publication

Accordingly, the publication on June 4, 2002 (67 FR 38341), of the final rule that was the subject of FR Doc. 02–13918 is corrected as follows:

PART 245a—ADJUSTMENT OF STATUS TO THAT OF PERSONS ADMITTED FOR LAWFUL TEMPORARY OR PERMANENT RESIDENT STATUS UNDER SECTION 245A OF THE IMMIGRATION AND NATIONALITY ACT

§ 245a.10 [Corrected]

1. On page 38350, in the second column, amendment 3a should be revised to read: ''Revising the introductory text for the definition 'eligible alien'; and by''

PART 299—IMMIGRATION FORMS

§ 299.1 [Corrected]

2. On page 38352, in the third column, in the table for § 299.1 the edition date for Form I–485 Supplement D should read: ''06–05–02''

Dated: October 21, 2002.

James W. Ziglar,

Commissioner, Immigration and Naturalization Service.

[FR Doc. 02–27798 Filed 10–31–02; 8:45 am]

BILLING CODE 4410–10–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 94

[Docket No. 02–072–2]

Change in Disease Status of Israel Because of BSE

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Affirmation of interim rule as final rule.

SUMMARY: We are adopting as a final rule, without change, an interim rule that amended the regulations by adding Israel to the list of regions where bovine spongiform encephalopathy exists because the disease had been detected in a native-born animal in that region. The effect of the interim rule was a restriction on the importation of ruminants, meat, meat products, and certain other products of ruminants that had been in Israel. The interim rule was necessary to help prevent the introduction of bovine spongiform encephalopathy into the United States.

EFFECTIVE DATE: The interim rule became effective on June 4, 2002.

FOR FURTHER INFORMATION CONTACT: Dr. Gary Colgrove, Chief Staff Veterinarian, Sanitary Trade Issues Team, National Center for Import and Export, VS, APHIS, 4700 River Road Unit 38, Riverdale, MD 20737–1231; (301) 734–4356.

SUPPLEMENTARY INFORMATION:

Background

The regulations in 9 CFR parts 93, 94, 95, and 96 (referred to below as the regulations) govern the importation of certain animals, birds, poultry, meat, other animal products and byproducts, hay, and straw into the United States in order to prevent the introduction of various animal diseases, including bovine spongiform encephalopathy (BSE).

In an interim rule effective June 4, 2002, and published in the **Federal Register** on July 18, 2002 (67 FR 47243–47244, Docket No. 02–072–1), we amended the regulations in § 94.18 (a)(1) by adding Israel to the list of regions where BSE exists due to the detection of BSE in a native-born animal in that region.

Comments on the interim rule were required to be received on or before September 16, 2002. We did not receive any comments. Therefore, for the reasons given in the interim rule, we are adopting the interim rule as a final rule.

This action also affirms the information contained in the interim rule concerning Executive Orders 12866 and 12988 and the Paperwork Reduction Act.

Further, for this action, the Office of Management and Budget has waived its review under Executive Order 12866.

Regulatory Flexibility Act

This action affirms an interim rule that amended the regulations by adding Israel to the list of regions where BSE exists. The effect of the interim rule was a restriction on the importation of ruminants, meat, meat products, and certain other products of ruminants that had been in Israel. The interim rule was necessary to help prevent the introduction of BSE into the United States.

The following analysis addresses the economic effects of the interim rule on small entities, as required by the Regulatory Flexibility Act.

The interim rule's restrictions on the importation of ruminants and ruminant products and byproducts from Israel are not expected to have a significant impact on a substantial number of small entities due to the fact that the restricted items are either not imported from Israel or are imported in very small amounts. There are three categories of imports that may be affected, but Israel's share of U.S. imports is small in each case.

The first category of affected imported commodities is ''Meat and edible meat offal, salted in brine, dried or smoked; edible flours and meals of meat or meat offal.'' Average total yearly imports of these products by the United States over the 3-year period 1999–2001 were valued at $24.6 million. Imports from Israel in 1999 were valued at $26,000. No imports of these products from Israel were reported for 2000 or 2001.

The second category of affected commodities is ''Preparations of a kind used in animal feeding.'' Average total yearly imports of these products, 1999–2001, were valued at $93.5 million. Imports from Israel had an average yearly value over this period of about $76,000.

The final category of affected commodities is ''Other prepared or preserved meat, meat offal or blood.'' Average yearly imports of these products, 1999–2001, were valued at $101.2 million. Imports from Israel had an average yearly value over this period of about $2.7 million.

It is apparent that Israel is a minor supplier to the United States of the ruminant products and byproducts affected by the BSE-related restrictions resulting from the interim rule. Therefore, we do not expect that the interim rule's restrictions on ruminants and ruminant products and byproducts from Israel will substantially affect any U.S. importers, large or small, of those commodities.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 9 CFR Part 94

Animal diseases, Imports, Livestock, Meat and meat products, Milk, Poultry and poultry products, Reporting and recordkeeping requirements.

PART 94—RINDERPEST, FOOT-AND-MOUTH DISEASE, FOWL PEST (FOWL PLAGUE), EXOTIC NEWCASTLE DISEASE, AFRICAN SWINE FEVER, HOG CHOLERA, AND BOVINE SPONGIFORM ENCEPHALOPATHY: PROHIBITED AND RESTRICTED IMPORTATIONS

Accordingly, we are adopting as a final rule, without change, the interim rule that amended 9 CFR part 94 and that was published at 67 FR 47243–47244 on July 18, 2002.

Authority: 7 U.S.C. 450, 7711–7714, 7751, 7754, 8303, 8306, 8308, 8310, 8311, and 8315; 21 U.S.C 136 and 136a; 31 U.S.C. 9701; 42 U.S.C. 4331 and 4332; 7 CFR 2.22, 2.80, and 371.4.

Done in Washington, DC, this 28th day of October, 2002.

Bobby R. Acord,

Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 02–27812 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Federal Housing Enterprise Oversight

12 CFR Part 1750

RIN 2550–AA26

Risk-Based Capital; Technical Amendment

AGENCY: Office of Federal Housing Enterprise Oversight, HUD.

ACTION: Final rule.

SUMMARY: The Office of Federal Housing Enterprise Oversight (OFHEO) is adopting technical amendments to Appendix A to Subpart B of 12 CFR part 1750 Risk-Based Capital. The amendments are intended to enhance the accuracy of the calculation of the

risk-based capital requirement for the Enterprises.

EFFECTIVE DATE: November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Jeannine Schroeder, Manager of Operations, Office of Risk Analysis and Model Development, telephone (202) 414–8881 or Jamie Schwing, Associate General Counsel, telephone (202) 414–3787 (not toll free numbers), Office of Federal Housing Enterprise Oversight, Fourth Floor, 1700 G Street, NW., Washington, DC 20552. The telephone number for the Telecommunications Device for the Deaf is (800) 877–8339.

SUPPLEMENTARY INFORMATION:

Background

OFHEO published a final regulation setting forth a risk-based capital stress test on September 13, 2001, 12 CFR part 1750 (the Rule), which formed the basis for determining the risk-based capital requirement for the federally sponsored housing enterprises—Federal National Mortgage Association (Fannie Mae) and Federal Home Loan Mortgage Corporation (Freddie Mac) (collectively, the Enterprises).[1]

On September 12, 2002, OFHEO published a notice of proposed rulemaking (NPRM), 67 FR 57760, which proposed twelve technical and corrective amendments to the Rule. One commenter, Freddie Mac, expressed concern regarding the appropriate effective date for a proposed technical amendment that corrected a table that utilized original loan-to-value ratios rather than amortized original loan-to-value ratios (amendment number eight in the list of 12 amendments in the preamble of the NPRM). Freddie Mac also requested a delay in the effective date for two amendments relating to the implementation of Financial Accounting Standard 133 (FAS 133) in the Rule (amendments numbered 11 and 12 in the list of 12 amendments in the preamble of the NPRM).[2] OFHEO also received comments requesting additional time to comment upon these two amendments. Subsequently, OFHEO reopened and extended the comment period regarding the two FAS 133-related proposed amendments, noting that it might move to final action on any of the other ten.[3] OFHEO is also reviewing, and will delay action on, a proposed technical amendment regarding the definition of ''unamortized balance'' (amendment number seven in the list of 12 amendments in the preamble of the NPRM). OFHEO has determined to adopt as final immediately, the following eight proposed amendments as to which there were no issues remaining and to defer final action on the other four proposed amendments until after the extended comment period closes on October 29, 2002.

(1) Provisions relating to new activities are updated to cross-reference the Prompt Supervisory Response and Corrective Action regulation, 12 CFR part 1777, in paragraph 3.11.3[c] and to correct a typographical error in paragraph 3.11.2[a];

(2) Out-of-date third party sources of information related to interest rate indexes (*e.g.* 30-year CMT, Bloomberg Tickers) are updated to reflect currently available indexes and to update the Rule to incorporate a reference to the applicable U.S. Treasury Department methodology. Specifically, the 30-year constant maturity yield is no longer reported by the Federal Reserve in the H.15 Release. In its place, the U.S. Treasury Department has developed a methodology using its ''Long-Term Average Rate'' and ''Extrapolation Factors'' designed to generate a substitute for the 30-year CMT yield series discontinued in February 2002. Similarly, the Bloomberg tickers for the Federal Agency Cost of Funds are being updated. Table 3–18 and paragraphs 3.3.1[b] and 3.3.2 are amended to reflect these changes;

(3) Credit Ratings in Table 3–30 are updated to include certain credit ratings used in the marketplace that were not listed in the original table. Specifically, Moody's assigns an additional rating from VMIG1 through VMIG3 to quantify the risks of the demand feature of variable-rate demand obligations and Standard & Poor's rates short term issuances as SP–1+, SP–1, SP–2, and SP–3;

(4) Paragraph 3.6.3.4.3.1 [a] 3. a. on single family default and prepayment explanatory variables is replaced in full, including equations, to correct the parenthetical (q= -7, -6,...0, 1,...40);

(5) Table 3–35, in which the explanatory variable categories for Relative Spread (RS_q) in the explanatory variable column were identified incorrectly, is replaced and a typographical error in paragraph 3.6.3.6.3.3[a]1. is corrected;

(6) The equation related to mortgage credit enhancement procedures at paragraph 3.6.3.6.4.3 is corrected to reflect the fact that in extreme circumstances (*i.e.*, when defaults are zero), an equation in section 3.6.3.6.4.3 Mortgage Credit Enhancement Procedures produces ''divide by zero'' errors in the computer code;

(7) A typographical error in the equation in 3.7.3.1[g]2. for calculating haircuts for mortgage backed securities is corrected by changing a specified addition sign (+) to a multiplication sign (×); and

(8) Table 3–68 is revised to reflect that the Table relates to long caps and floors.

In order to make these eight adjustments applicable to the first fully enforceable risk-based capital calculation for each Enterprise, OFHEO has determined that the amendments shall be effective immediately and shall apply to any data submissions from the Enterprises received after the effective date. Waiver of the normal 30-day delay in effective date is in the public interest because these changes rectify errors in the code and in the language of the rule that could mislead the public if left unamended. In some cases they simply reflect changes that have already been implemented in the computer software used to implement the stress test and are necessary for the stress test to be operational. Moreover, both Enterprises have participated in data and software validation processes with OFHEO for the past year and have been aware of the pendency of these technical changes, which have no material impact on capital requirements, for many months.

Regulatory Impact

Executive Order 12866, Regulatory Planning and Review

This document contains amendments to the Rule, which was designated a major rule by the Office of Management and Budget (OMB). The amendments address provisions of the Rule that are out-of-date, incorrect or contain typographical errors. OFHEO has determined that the amendments to the Rule are not economically significant for purposes of Executive Order 12866. Further, they implement technical changes and do not involve novel policy issues. Therefore, these amendments are not a ''significant rule'' under Executive Order 12866.

Paperwork Reduction Act

These amendments do not contain any information collection requirements that require the approval of the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires that a

[1] Risk-based Capital, 66 FR 47730 (September 13, 2001), 12 CFR part 1750, *as amended*, 67 FR 11850 (March 15, 2002), 67 FR 19321 (April 19, 2002).

[2] Financial Account Standards Board Statement of Financial Accounting Standard 133, ''Accounting for Derivative Instruments and Hedging Activities,'' June 1998.

[3] Risk-Based Capital, 67 FR 61300 (September 20, 2002).

regulation that has a significant economic impact on a substantial number of small entities, small businesses, or small organizations must include an initial regulatory flexibility analysis describing the regulation's impact on small entities. Such an analysis need not be undertaken if the agency has certified that the regulation does not have a significant economic impact on a substantial number of small entities. 5 U.S.C. 605(b). OFHEO has considered the impact of the regulation under the Regulatory Flexibility Act. The General Counsel of OFHEO certifies that this regulation is not likely to have a significant economic impact on a substantial number of small business entities because the regulation is applicable only to the Enterprises, which are not small entities for purposes of the Regulatory Flexibility Act.

List of Subjects in 12 CFR Part 1750

Capital classification, Mortgages, Risk-based capital.

Accordingly, for the reasons stated in the preamble, OFHEO amends 12 CFR part 1750 as follows:

PART 1750—CAPITAL

1. The authority citation for part 1750 continues to read as follows:

Authority: 12 U.S.C. 4513, 4514, 4611, 4612, 4614, 4615, 4618.

2. Amend Appendix A to subpart B of part 1750 as follows:

a. Revise Table 3–18 in paragraph 3.1.3.1[c];

b. Revise paragraph 3.3.1[b];

c. In paragraph 3.3.2, add the following sentence after the word ''Appendix.'': ''Inputs for the 30-year CMT yield after February 15, 2002 are estimated according to the Department of Treasury methodology using long-term average rates and extrapolation factors.''

d. Revise Table 3–30 in paragraph 3.5.3[a]2.a.;

e. Revise paragraph 3.6.3.4.3.1[a]3.a.;

f. Revise Table 3–35 in paragraph 3.6.3.4.3.2[a]1.;

g. In paragraph 3.6.3.6.3.3[a]1., remove the term ''GL_m'' both places it appears and replace it with the term ''GLS_m'';

h. In paragraph 3.6.3.6.4.3[a]5., after the words ''Defaulted UPB:'' and before the equation, add the following equation:

$$\text{If } DEF_m = 0, \text{then } ALPD_m^{DCC} = 0$$

i. Revise paragraph 3.7.3.1[g]2.;

j. Revise Table 3–68 in paragraph 3.8.3.6.1[e]2.;

k. In paragraph 3.11.2[a], remove the cross-reference ''1750.2(c)'' and replace it with the cross-reference ''1750.12(c)''; and

l. Revise paragraph 3.11.3[c].

The revisions and additions read as follows:

Appendix A to Subpart B of Part 1750—Risk-Based Capital Test Methodology and Specifications

* * * * *

3.1.3.1 * * *

[c] * * *

TABLE 3–18—INTEREST RATE AND INDEX INPUTS

Interest Rate Index	Description	Source
1 MO Treasury Bill	One-month Treasury bill yield, monthly simple average of daily rate, quoted as actual/360	Bloomberg Generic 1 Month U.S. Treasury bill Ticker: GB1M (index).
3 MO CMT	Three-month constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
6 MO CMT	Six-month constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
1 YR CMT	One-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
2 YR CMT	Two-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
3 YR CMT	Three-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
5 YR CMT	Five-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
10 YR CMT	Ten-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.
20 YR CMT	Twenty-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield	Federal Reserve H.15 Release.

TABLE 3–18—INTEREST RATE AND INDEX INPUTS—Continued

Interest Rate Index	Description	Source
30 YR CMT	Thirty-year constant maturity Treasury yield, monthly simple average of daily rate, quoted as bond equivalent yield; after February 15, 2002, estimated according to the Department of Treasury methodology using long-term average rates and extrapolation factors as referenced in OFHEO guideline 402	Federal Reserve H.15 Release, Extrapolation Factors used for estimation, U.S. Dept. of Treasury.
Overnight Fed Funds (Effective)	Overnight effective Federal Funds rate, monthly simple average of daily rate	Federal Reserve H.15 Release.
1 Week Federal Funds	1 week Federal Funds rate, monthly simple average of daily rates	Bloomberg Term Fed Funds U.S. Domestic Ticker: GFED01W(index).
6 Month Fed Funds	6 month Federal Funds rate, monthly simple average of daily rates	Bloomberg Term Fed Funds U.S. Domestic Ticker: GFED06M(index).
Conventional Mortgage Rate	FHLMC (Freddie Mac) contract interest rates for 30 YR fixed-rate mortgage commitments, monthly average of weekly rates	Federal Reserve H.15 Release.
FHLB 11th District COF	11th District (San Francisco) weighted average cost of funds for savings and loans, monthly	Bloomberg Cost of Funds for the 11th District Ticker: COF11 (index).
1 MO LIBOR	One-month London Interbank Offered Rate, average of bid and asked, monthly simple average of daily rates, quoted as actual/360	British Bankers Association. Bloomberg Ticker: US0001M (index).
3 MO LIBOR	Three-month London Interbank Offered Rate, average of bid and asked, monthly simple average of daily rates, quoted as actual/360	British Bankers Association. Bloomberg Ticker: US0003M (index).
6 MO LIBOR	Six-month London Interbank Offered Rate, average of bid and asked, monthly simple average of daily rates, quoted as actual/360	British Bankers Association. Bloomberg Ticker: US0006M (index).
12 MO LIBOR	One-year London Interbank Offered Rate, average of bid and asked, monthly simple average of daily rates, quoted as actual/360	British Bankers Association. Bloomberg Ticker: US0012M (index).
Prime Rate	Prevailing rate as quoted, monthly average of daily rates	Federal Reserve H.15 Release.
1 MO Federal Agency COF	One-month Federal Agency Cost of Funds, monthly simple average of daily rates, quoted as actual/360	Bloomberg Generic 1 Month Agency Discount Note Yield. Ticker: AGDN030Y (index).
3 MO Federal Agency COF	Three-month Federal Agency Cost of Funds, monthly simple average of daily rates, quoted as actual/360	Bloomberg Generic 3 Month Agency Discount Note Yield. Ticker: AGDN090Y (index).
6 MO Federal Agency COF	Six-month Federal Agency Cost of Funds, monthly simple average of daily rates, quoted as actual/360	Bloomberg Generic 6 Month Agency Discount Note Yield. Ticker: AGDN180Y (index).
1 YR Federal Agency COF	One-year Federal Agency Cost of Funds, monthly simple average of daily rates, quoted as actual/360	Bloomberg Generic 12 Month Agency Discount Note Yield. Ticker: AGDN360Y (index).
2 YR Federal Agency COF	Two-year Federal Agency Fair Market Yield, monthly simple average of daily rates	Bloomberg Generic 2 Year Agency Fair Market Yield. Ticker: CO842Y (index).
3 YR Federal Agency COF	Three-year Federal Agency Fair Market Yield, monthly simple average of daily rates	Bloomberg Generic 3 Year Agency Fair Market Yield. Ticker: CO843Y (index).
5 YR Federal Agency COF	Five-year Federal Agency Fair Market Yield, monthly simple average of daily rates	Bloomberg Generic 5 Year Agency Fair Market Yield. Ticker: CO845Y (index).

TABLE 3–18—INTEREST RATE AND INDEX INPUTS—Continued

Interest Rate Index	Description	Source
10 YR Federal Agency COF	Ten-year Federal Agency Fair Market Yield, monthly simple average of daily rates	Bloomberg Generic 10 Year Agency Fair Market Yield. Ticker: CO8410Y (index).
30 YR Federal Agency COF	Thirty-year Federal Agency Fair Market Yield, monthly simple average of daily rates	Bloomberg Generic 30 Year Agency Fair Market Yield. Ticker: CO8430Y (index).
15 YR fixed-rate mortgage	FHLMC (Freddie Mac) contract interest rates for 15 YR fixed-rate mortgage commitments, monthly average of FHLMC (Freddie Mac) contract interest rates for 15 YR	Bloomberg FHLMC 15 YR, 10 day commitment rate. Ticker: FHCR1510 (index).
7-year balloon mortgage rate	Seven-year balloon mortgage, equal to the Conventional Mortgage Rate less 50 basis points	Computed.

* * * * *

3.3.1 * * *

[b] The process for determining Interest Rates is as follows: first, identify the values for the necessary Interest Rates at time zero; second, project the ten-year CMT for each month of the Stress Period as specified in the 1992 Act; third, project the 1-month Treasury yield, the 3-month, 6-month, 1-, 2-, 3-, 5-, 20-year, and 30-year CMTs; fourth, project non-treasury Interest Rates, including the Federal Agency Cost of Funds Index; and fifth, project the Enterprises Cost of Funds Index, which provides borrowing rates for the Enterprises during the Stress Period, by increasing the Agency Cost of Funds Index by 10 basis points for the last 108 months of the Stress Test. Guidance in determining interest rates is available under OFHEO Guideline No. 402, ''Risk Based Capital Process for Capturing and Utilizing Interest Rates Files,'' which is available on OFHEO's Web site, *http://www.OFHEO.Gov.*

* * * * *

3.5.3 * * *

[a] * * *

2. * * *

a. * * *

TABLE 3–30—RATING AGENCIES MAPPINGS TO OFHEO RATINGS CATEGORIES

OFHEO Ratings Category	AAA	AA	A	BBB	Below BBB and Unrated
Standard & Poor's Long-Term	AAA	AA	A	BBB	Below BBB and Unrated
Fitch Long-Term	AAA	AA	A	BBB	Below BBB and Unrated
Moody's Long-Term	Aaa	Aa	A	Baa	Below Baa and Unrated
Standard & Poor's Short-Term	A–1+ SP–1+	A–1 SP–1	A–2 SP–2	A–3	SP–3, B or Below and Unrated
Fitch Short-Term	F–1+	F–1	F–2	F–3	B and Below and Unrated
Moody's [1]	Prime-1 MIG1 VMIG1	Prime-1 MIG1 VMIG1	Prime-2 MIG2 VMIG2	Prime-3 MIG3 VMIG3	Not Prime, SG and Unrated
Fitch Bank Individual Ratings	A	B A/B	C B/C	D C/D	E D/E
Moody's Bank Financial Strength Rating	A	B	C	D	E

[1] Any rating that appears in more than one OFHEO category column is assigned the lower OFHEO rating category.

* * * * *

3.6.3.4.3.1 * * *

[a] * * *

3. * * *

a. Compare mortgage rates for each quarter of the Stress Test and for the eight quarters prior to the start of the stress test (q = −7, −6,...0, 1,...40):

$$b_q = 1 \text{ if } MCON_m + 0.02 \leq MIR_m \text{ for all three months in quarter q (i.e., m = } 3q-2,\ 3q-1,\ 3q),$$

$$b_q = 0 \text{ otherwise}$$

Note: For this purpose, $MCON_m$ is required for the 24 months (eight quarters) prior to the start of the Stress Test. Also, $MIR_m = MIR_0$ for $m < 0$.

* * * * *

3.6.3.4.3.2. * * *

[a] * * *

1. * * *

TABLE 3–35—COEFFICIENTS FOR SINGLE FAMILY DEFAULT AND PREPAYMENT EXPLANATORY VARIABLE

Explanatory Variable (V)	30-Year Fixed-Rate Loans		Adjustable-Rate Loans (ARMs)		Other Fixed-Rate Loans	
	Default Weight (β_v)	Prepayment Weight (γ_v)	Default Weight (β_v)	Prepayment Weight (γ_v)	Default Weight (β_v)	Prepayment Weight (γ_v)
A_q						
$0 \leq A_q \leq 4$	−0.6276	−0.6122	−0.7046	−0.5033	−0.7721	−0.6400
$5 \leq A_q \leq 8$	−0.1676	0.1972	−0.2259	0.1798	−0.2738	0.1721
$9 \leq A_q \leq 12$	−0.05872	0.2668	0.01504	0.2744	−0.09809	0.2317
$13 \leq A_q \leq 16$	0.07447	0.2151	0.2253	0.2473	0.1311	0.1884
$17 \leq A_q \leq 20$	0.2395	0.1723	0.3522	0.1421	0.3229	0.1900
$21 \leq A_q \leq 24$	0.2773	0.2340	0.4369	0.1276	0.3203	0.2356
$25 \leq A_q \leq 36$	0.2740	0.1646	0.2954	0.1098	0.3005	0.1493
$37 \leq A_q \leq 48$	0.1908	−0.2318	0.06902	−0.1462	0.2306	−0.2357
$49 \leq A_q$	−0.2022	−0.4059	−0.4634	−0.4314	−0.1614	−0.2914
LTV_{ORIG}						
$LTV_{ORIG} \leq 60$	−1.150	0.04787	−1.303	0.08871	−1.280	0.02309
$60 < LTV_{ORIG} \leq 70$	−0.1035	−0.03131	−0.1275	−0.005619	−0.06929	−0.02668
$70 < LTV_{ORIG} \leq 75$	0.5969	−0.09885	0.4853	−0.09852	0.6013	−0.05446
$75 < LTV_{ORIG} \leq 80$	0.2237	−0.04071	0.1343	−0.03099	0.2375	−0.03835
$80 < LTV_{ORIG} \leq 90$	0.2000	−0.004698	0.2576	0.004226	0.2421	−0.01433
$90 < LTV_{ORIG}$	0.2329	0.1277	0.5528	0.04220	0.2680	0.1107
$PNEQ_q$						
$0 < PNEQ_q \leq 0.05$	−1.603	0.5910	−1.1961	0.4607	−1.620	0.5483
$0.05 < PNEQ_q \leq 0.1$	−0.5241	0.3696	−0.3816	0.2325	−0.5055	0.3515
$0.1 < PNEQ_q \leq 0.15$	−0.1805	0.2286	−0.1431	0.1276	−0.1249	0.2178
$0.15 < PNEQ_q \leq 0.2$	0.07961	−0.02000	−0.04819	0.03003	0.07964	−0.02137
$0.2 < PNEQ_q \leq 0.25$	0.2553	−0.1658	0.2320	−0.1037	0.2851	−0.1540
$0.25 < PNEQ_q \leq 0.3$	0.5154	−0.2459	0.2630	−0.1829	0.4953	−0.2723
$0.3 < PNEQ_q \leq 0.35$	0.6518	−0.2938	0.5372	−0.2075	0.5979	−0.2714
$0.35 < PNEQ_q$	0.8058	−0.4636	0.7368	−0.3567	0.7923	−0.3986
B_q	1.303	−0.3331	0.8835	−0.2083	1.253	−0.3244
RLS						
$0 < RLS_{ORIG} \leq 0.4$	.....	−0.5130	.....	−0.4765	.....	−0.4344
$0.4 < RLS_{ORIG} \leq 0.6$	.....	−0.3264	.....	−0.2970	.....	−0.2852
$0.6 < RLS_{ORIG} \leq 0.75$	.....	−0.1378	.....	−0.1216	.....	−0.1348
$0.75 < RLS_{ORIG} \leq 1.0$	.....	0.03495	.....	0.04045	.....	0.01686
$1.0 < RLS_{ORIG} \leq 1.25$	.....	0.1888	.....	0.1742	.....	0.1597
$1.25 < RLS_{ORIG} \leq 1.5$	.....	0.3136	.....	0.2755	.....	0.2733
$1.5 < RLS_{ORIG}$	.....	0.4399	.....	0.4049	.....	0.4045

TABLE 3–35—COEFFICIENTS FOR SINGLE FAMILY DEFAULT AND PREPAYMENT EXPLANATORY VARIABLE—Continued

Explanatory Variable (V)	30-Year Fixed-Rate Loans		Adjustable-Rate Loans (ARMs)		Other Fixed-Rate Loans	
	Default Weight (β_v)	Prepayment Weight (γ_v)	Default Weight (β_v)	Prepayment Weight (γ_v)	Default Weight (β_v)	Prepayment Weight (γ_v)
IF	0.4133	−0.3084	0.6419	−0.3261	0.4259	−0.3035
RS_q						
$RS_q \leq -0.20$	.....	−1.368	.....	−0.5463	.....	−1.195
$-0.20 < RS_q \leq -0.10$	.....	−1.023	.....	−0.4560	.....	−0.9741
$-0.10 < RS_q \leq 0$	.....	−0.8078	.....	−0.4566	.....	−0.7679
$0 < RS_q \leq 0.10$	.....	−0.3296	.....	−0.3024	.....	−0.2783
$0.10 < RS_q \leq 0.20$	.....	0.8045	.....	0.3631	.....	0.7270
$0.20 < RS_q \leq 0.30$	.....	1.346	.....	0.7158	.....	1.229
$0.30 < RS_q$	.....	1.377	.....	0.6824	.....	1.259
PS_q						
$PS_q \leq -0.20$	.....	.....	0.08490	0.6613	.....	.....
$-0.20 < PS_q \leq -0.10$	.....	.....	0.3736	0.4370	.....	.....
$-0.10 < PS_q \leq 0$	.....	.....	0.2816	0.2476	.....	.....
$0 < PS_q \leq 0.10$	.....	.....	0.1381	0.1073	.....	.....
$0.10 < PS_q \leq 0.20$	.....	.....	−0.1433	−0.3516	.....	.....
$0.20 < PS_q \leq 0.30$	.....	.....	−0.2869	−0.5649	.....	.....
$0.30 < PS_q$	.....	.....	−0.4481	−0.5366	.....	.....
YCS_q						
$YCS_q < 1.0$	.....	−0.2582	.....	−0.2947	.....	−0.2917
$1.0 \leq YCS_q < 1.2$	.....	−0.02735	.....	−0.1996	.....	−0.01395
$1.2 \leq YCS_q < 1.5$	.....	−0.04099	.....	0.03356	.....	−0.03796
$1.5 \leq YCS_q$	.....	0.3265	.....	0.4608	.....	0.3436
$IREF_q$	.....	.....	0.1084	−0.01382	.....	.....
PROD						
ARMs	.....	.....	0.8151	0.2453	.....	.....
Balloon Loans	.....	.....	.....	.....	1.253	0.9483
15 − Year FRMs	.....	.....	.....	.....	−1.104	0.07990
20 − Year FRMs	.....	.....	.....	.....	−0.5834	0.06780
Government Loans	.....	.....	.....	.....	0.9125	−0.5660
$BCal_{LTV}$						
$LTV_{ORIG} \leq 60$	2.045	.....	2.045	.....	2.045	.....
$60 < LTV_{ORIG} \leq 70$	0.3051	.....	0.3051	.....	0.3051	.....
$70 < LTV_{ORIG} \leq 75$	−0.07900	.....	−0.07900	.....	−0.07900	.....
$75 < LTV_{ORIG} \leq 80$	−0.05519	.....	−0.05519	.....	−0.05519	.....
$80 < LTV_{ORIG} \leq 90$	−0.1838	.....	−0.1838	.....	−0.1838	.....
$90 < LTV_{ORIG}$	0.2913	.....	0.2913	.....	0.2913	.....
Intercept (β_0, γ_0)	−6.516	−4.033	−6.602	−3.965	−6.513	−3.949

* * * * *

3.7.3.1 * * *

[g] * * *

2. Compute:

$$HctAmt_m = (TPR_m + TIR_m) \times HctFac_m$$

* * * * *

3.8.3.6.1 * * *

[e] * * *

2. * * *

TABLE 3–68—CALCULATION OF MONTHLY CASH FLOWS FOR LONG CAPS AND FLOORS

Instrument	Cash Flows
Cap	$(I - K) \times N \times D$ if $I > K$; O if $I \leq K$
Floor	$(K - I) \times N \times D$ if $I < K$; O if $I \geq K$

* * * * *

3.11.3 * * *

[c] OFHEO will provide the Enterprise with its estimate of the capital treatment as soon as possible after receiving notice of the New Activity. In any event, the Enterprise will be notified of the capital treatment in accordance with the notice of proposed capital classification provided for in § 1777.21 of this chapter.

* * * * *

Dated: October 17, 2002.

Armando Falcon, Jr.

Director, Office of Federal Housing Enterprise Oversight.

[FR Doc. 02–26863 Filed 10–31–02; 8:45 am]

BILLING CODE 4220–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 99–CE–71–AD; Amendment 39–12925; AD 2002–22–01]

RIN 2120–AA64

Airworthiness Directives; MORAVAN a.s. Models Z–143L and Z–242L Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to certain MORAVAN a.s. (Moravan) Models Z–143L and Z–242L airplanes. This AD requires you to modify the engine secondary vent line. This AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for the Czech Republic. The actions specified by this AD are intended to prevent the engine crankcase ventilation lines from freezing during flight in cold weather (winter) conditions, which could result in oil leaking from the engine. Such a condition could lead to engine failure.

DATES: This AD becomes effective on December 13, 2002.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of December 13, 2002.

ADDRESSES: You may get the service information referenced in this AD from Moravan, Inc., 765 81 Otrokovice, Czech Republic; telephone: +420 67 767 3940; facsimile: +420 67 792 2103. You may view this information at the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 99–CE–71–AD, 901 Locust, Room 506, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

What Events Have Caused This AD?

The Civil Aviation Authority (CAA), which is the airworthiness authority for the Czech Republic, notified FAA that an unsafe condition may exist on certain Moravan Models Z–143L and Z–242L airplanes. The CAA reports that during a production delivery flight of a Model Z–242L airplane, smoke accumulated in the cockpit of the airplane, and engine oil pressure dropped significantly. As a result of this situation, the pilot was forced to make an emergency landing.

Investigation analysis revealed that the engine crankcase ventilation lines became frozen while flying in low ambient air temperature (winter) conditions. When the engine crankcase ventilation lines freeze, the front crankcase seal ring slips out, which allows oil to leak from the engine.

What Is the Potential Impact if FAA Took No Action?

This condition, if not corrected, could result in the engine crankcase ventilation lines freezing during flight in cold weather (winter) conditions. Such a condition could lead to engine failure.

Has FAA Taken Any Action to This Point?

We issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to certain Moravan Models Z–143L and Z–242L airplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on August 14, 2002 (67 FR 52899). The NPRM proposed to require you to modify the engine secondary vent line.

Was the Public Invited To Comment?

The FAA encouraged interested persons to participate in the making of this amendment. We did not receive any comments on the proposed rule or on our determination of the cost to the public.

FAA's Determination

What Is FAA's Final Determination on This Issue?

After careful review of all available information related to the subject presented above, we have determined that air safety and the public interest require the adoption of the rule as proposed except for minor editorial corrections. We have determined that these minor corrections:

—Provide the intent that was proposed in the NPRM for correcting the unsafe condition; and

—Do not add any additional burden upon the public than was already proposed in the NPRM.

Cost Impact

How Many Airplanes Does This AD Impact?

We estimate that this AD affects 39 airplanes in the U.S. registry.

What Is the Cost Impact of This AD on Owners/Operators of the Affected Airplanes?

We estimate the following costs to accomplish the modification:

Labor cost	Parts cost	Total cost per airplane	Total cost on U.S. operators
1 workhour × $60 per hour = $60	No parts required	$60	$60 × 39 = $2,340.

Regulatory Impact

Does This AD Impact Various Entities?

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.

Does This AD Involve a Significant Rule or Regulatory Action?

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 copy of the final evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting 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, under 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. FAA amends § 39.13 by adding a new AD to read as follows:

2002–22 01 Moravan A.S.: Amendment 39–12925; Docket No. 99–CE–71-AD.

(a) *What airplanes are affected by this AD?* This AD affects the following airplane models and serial numbers that are certificated in any category:

Model	Serial Nos.
Z–143L	All serial numbers up to and including 0029, except 0025 and 0027.
Z–242L	All serial numbers up to and including 0733.

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the airplanes identified in paragraph (a) of this AD must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to prevent the engine crankcase ventilation lines from freezing during flight in cold weather (winter) conditions, which could result in oil leaking from the engine. Such a condition could lead to engine failure.

(d) *What actions must I accomplish to address this problem?* To address this problem, you must accomplish the following:

Actions	Compliance	Procedures
Modify the engine vent lines	Within the next 100 hours time-in-service after December 13, 2002 (the effective date of this AD).	In accordance with Moravan Mandatory Service Bulletin Z 242L/19a—Rev. 3, Z 143L/20a, dated April 30, 1999.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Manager, Small Airplane Directorate, approves your alternative. Submit your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Small Airplane Directorate.

Note 1: This AD applies to each airplane identified in paragraph (a) of this AD, 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 (e) 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 you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

(g) *What if I need to fly the airplane to another location to comply with this AD?* The FAA can issue a special flight permit under § § 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your airplane to a location where you can accomplish the requirements of this AD.

(h) *Are any service bulletins incorporated into this AD by reference?* Actions required by this AD must be done in accordance with Moravan Inc. Mandatory Service Bulletin Z 242L/19a—Rev. 3, Z 143L/20a, dated April 30, 1999. The Director of the Federal Register approved this incorporation by reference under 5 U.S.C. 552(a) and 1 CFR part 51. You may get copies from Moravan, Inc., 765 81 Otrokovice, Czech Republic; telephone: +420 67 767 3940; facsimile: +420 67 792 2103. You may view copies at the FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri, or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Note 2: The subject of this AD is addressed in Czech Republic AD Number CAA–AD–042/1999, August 18, 1999.

(i) *When does this amendment become effective?* This amendment becomes effective on December 13, 2002.

Issued in Kansas City, Missouri, on October 18, 2002.

Michael Gallagher,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 02–27201 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–CE–28–AD; Amendment 39–12927; AD 2002–22–03]

RIN 2120–AA64

Airworthiness Directives; PILATUS Aircraft Ltd. Model PC–7 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to certain PILATUS Aircraft Ltd. (Pilatus) Model PC–7 airplanes. This AD requires you to repetitively inspect the main landing gear front attachment brackets for cracks, and, if cracks are found, install improved-design brackets. Installing the improved-design brackets terminates the required inspections. This AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Switzerland. The actions specified by this AD are intended to detect and correct cracks in the main landing gear front attachment brackets,

which could result in failure of the brackets. Such failure could lead to the main landing gear leg detaching from the wing main spar.

DATES: This AD becomes effective on December 20, 2002.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of December 20, 2002.

ADDRESSES: You may get the service information referenced in this AD from Pilatus Aircraft Ltd., Customer Liaison Manager, CH–6371 Stans, Switzerland; telephone: +41 41 619 63 19; facsimile: +41 41 619 6224; or from Pilatus Business Aircraft Ltd., Product Support Department, 11755 Airport Way, Broomfield, Colorado 80021; telephone: (303) 465–9099; facsimile: (303) 465–6040. You may view this information at the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, *Attention:* Rules Docket No. 2002–CE–28–AD, 901 Locust, Room 506, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW., Suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

What Events Have Caused This AD?

The Federal Office for Civil Aviation (FOCA), which is the airworthiness authority for Switzerland, recently notified FAA that an unsafe condition may exist on certain Pilatus Model PC–7 airplanes. The FOCA reports that an operator of a similar aircraft type design, which uses identical main landing gear support brackets, reported a single crack in one bracket. A fleet inspection of the operator's aircraft revealed stress corrosion cracking in more than 20 aircraft.

What Is the Potential Impact if FAA Took No Action?

Cracks in the main landing gear front attachment brackets could result in failure of the brackets. Such failure could lead to the main landing gear leg detaching from the wing main spar.

Has FAA Taken Any Action to This Point?

We issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to certain Pilatus Model PC–7 airplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on August 9, 2002 (67 FR 51794). The NPRM proposed to repetitively inspect the main landing gear front attachment brackets for cracks, and, if cracks are found, install improved-design brackets. Installing the improved-design brackets terminates the required inspections.

Was the Public Invited To Comment?

The FAA encouraged interested persons to participate in the making of this amendment. We did not receive any comments on the proposed rule or on our determination of the cost to the public.

FAA's Determination

What Is FAA's Final Determination on This Issue?

After careful review of all available information related to the subject presented above, we have determined that air safety and the public interest require the adoption of the rule as proposed except for minor editorial corrections. We have determined that these minor corrections:

—Provide the intent that was proposed in the NPRM for correcting the unsafe condition; and

—Do not add any additional burden upon the public than was already proposed in the NPRM.

Cost Impact

How Many Airplanes Does This AD Impact?

We estimate that this AD affects 14 airplanes in the U.S. registry.

What Is the Cost Impact of This AD on Owners/Operators of the Affected Airplanes?

We estimate the following costs to accomplish the inspection:

Labor cost	Parts cost	Total cost per airplane	Total cost on U.S. operator
4 workhours × $60 = $240	No parts required	$240	$240 × 14 = $3,360.

The FAA has no method of determining the number of repetitive inspections each owner/operator would incur over the life of each of the affected airplanes so the cost impact is based on the initial inspection.

We estimate the following costs to accomplish any necessary replacements that would be required based on the results of the inspection. We have no way of determining the number of airplanes that may need such replacement:

Labor cost	Parts cost	Total cost per airplane
80 workhours × $60 = $4,800 per side	$2,500 per side	$4,800 + $2,500 = $7,300 per side.

Regulatory Impact

Does This AD Impact Various Entities?

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.

Does This AD Involve a Significant Rule or Regulatory Action?

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 copy of the final evaluation prepared for this action is contained in the Rules Docket. A copy

of it may be obtained by contacting 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, under 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. FAA amends § 39.13 by adding a new AD to read as follows:

2002–22–03 Pilatus Aircraft LTD.: Amendment 39–12927; Docket No. 2002–CE–28–AD.

(a) *What airplanes are affected by this AD?* This AD affects Model PC–7 airplanes, serial numbers 101 through 618, that are certificated in any category.

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the airplanes identified in paragraph (a) of this AD must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to detect and correct cracks in the main landing gear front attachment brackets, which could result in failure of the brackets. Such failure could lead to the main landing gear leg detaching from the wing main spar.

(d) *What actions must I accomplish to address this problem?* To address this problem, you must accomplish the following:

Compliance	Actions	Procedures
(1) *Initial Inspection:* At whichever of the following occurs later, unless already accomplished: (i) Upon the accumulation of 3,000 hours time-in-service (TIS) on the attachment brackets or 10 years after installation of the brackets, whichever occurs first; or (ii) within 90 days after December 20, 2002 (the effective date of this AD).	Inspect, using the Impedance-Plane Eddy-Current Inspection, both main landing gear front attachment brackets, part number (P/N) 111.34.07.105 and P/N 111.34.07.106 for cracks.	In accordance with the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–004, Revision No. 1, dated June 17, 2002; the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–005, dated September 10, 2001; and Pilatus PC–7 Maintenance Manual, Temporary Revision No. 05–10, dated September 10, 2001.
(2) *Repetitive Inspections:* Within 12 calendar months after the initial inspection required in paragraph (d)(1) of this AD and thereafter at intervals not to exceed 12 calendar months.	Inspection, using the Impedance-Plane Eddy-Current Inspection, both main landing gear front attachment brackets, P/N 111.34.07.105 and P/N 111.34.07.106 for cracks.	In accordance with the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–004, Revision No. 1, dated June 17, 2002; the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–005, dated September 10, 2001; and Pilatus PC–7 Maintenance Manual, Temporary Revision No. 05–10, dated September 10, 2001.
(3) Prior to further flight after the inspection in which the damage was found.	If a crack is found in any main landing gear front attachment bracket during any inspection required in this AD, replace with an improved bracket, P/N 557.10.09.045, P/N 557.10.09.046, or FAA-approved equivalent P/N. Repetitive inspections are still required on any P/N 111.34.07.105 and P/N 111.34.07.106 for cracks.	In accordance with the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–005, dated September 10, 2001.
(4) At any time as terminating action for the repetitive inspections. However, you must replace prior to further flight if you find cracks during any inspections required by this AD.	You may terminate the inspections required in paragraphs (d)(1) and (d)(2) of this AD when improved design main landing gear front attachment brackets, P/N 557.10.09.045, P/N 557.10.09.046, or FAA-approved equivalent P/Ns, are installed on both sides of the airplane.	In accordance with the ACCOMPLISHMENT INSTRUCTIONS section of Pilatus PC–7 Service Bulletin No. 57–005, dated September 10, 2001.
(5) As of December 20, 2002 (the effective date of this AD).	Only install main landing gear brackets that are P/N 557.10.09.045, P/N 557.10.09.046, or FAA-approved equivalent P/Ns.	Not Applicable.

Note 1: If you find cracks on one side only, you are only required to replace the damaged side with the new improved-design bracket and continue the repetitive inspections required by paragraph (d)(2) of this AD. Repetitive inspections are still required on any installed bracket with either P/N 111.34.07.105 or P/N 111.34.07.106.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Standards Office Manager, Small Airplane Directorate, approves your alternative. Submit your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Standards Office Manager.

Note 2: This AD applies to each airplane identified in paragraph (a) of this AD, 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 (e) 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 you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Doug Rudolph, Aerospace Engineer, FAA, Small Airplane

Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

(g) *What if I need to fly the airplane to another location to comply with this AD?* The FAA can issue a special flight permit under §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your airplane to a location where you can accomplish the requirements of this AD.

(h) *Are any service bulletins incorporated into this AD by reference?* Actions required by this AD must be done in accordance with Pilatus PC–7 Service Bulletin No. 57–004, Revision No. 1, dated June 17, 2002; Pilatus PC–7 Service Bulletin No. 57–005, dated September 10, 2001; and Pilatus PC–7 Maintenance Manual, Temporary Revision No. 05–10, dated September 10, 2001. The Director of the Federal Register approved this incorporation by reference under 5 U.S.C. 552(a) and 1 CFR part 51. You may get copies from Pilatus Aircraft Ltd., Customer Liaison Manager, CH–6371 Stans, Switzerland; telephone: +41 41 619 63 19; facsimile: +41 41 619 6224; or from Pilatus Business Aircraft Ltd., Product Support Department, 11755 Airport Way, Broomfield, Colorado 80021; telephone: (303) 465–9099; facsimile: (303) 465–6040. You may view copies at the FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri, 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 Swiss AD HB 2002–270, dated June 24, 2002.

(i) *When does this amendment become effective* ? This amendment becomes effective on December 20, 2002.

Issued in Kansas City, Missouri, on October 22, 2002.

David R. Showers,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 02–27418 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–CE–21–AD; Amendment 39–12926; AD 2002–22–02]

RIN 2120–AA64

Airworthiness Directives; Pilatus Britten-Norman Limited BN–2, BN–2A, BN–2B, BN–2T, and BN2A MK. III Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to all Pilatus Britten-Norman Limited (Pilatus Britten-Norman) BN–2, BN–2A, BN–2B, BN–2T, and BN2A MK. III series airplanes. This AD requires you to repetitively inspect the bottom corner of the engine mount bracket for cracks and replace any cracked bracket with a new one. This AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for the United Kingdom. The actions specified by this AD are intended to detect and correct cracks in the engine mount bracket. Such a condition could cause the engine mount assembly to fail, which could result in the engine separating from the airplane and lead to loss of control of the airplane.

DATES: This AD becomes effective on December 20, 2002.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of December 20, 2002.

ADDRESSES: You may get the service information referenced in this AD from B–N Group Limited, Bembridge, Isle of Wight, United Kingdom PO35 5PR; telephone: +44 (0) 1983 872511; facsimile: +44 (0) 1983 873246. You may view this information at the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 2002–CE–21–AD, 901 Locust, Room 506, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

What Events Have Caused This AD?

The Civil Aviation Authority (CAA), which is the airworthiness authority for the United Kingdom, recently notified FAA that an unsafe condition may exist on all Pilatus Britten-Norman BN–2, BN–2A, BN–2B, BN–2T, and BN2A MK. III series airplanes. The CAA reports two occurrences of extensive cracks being found on the bottom corner of the engine mount bracket between the attachment flange and the main bracket. The cracks were found during regular scheduled maintenance.

The manufacturer has determined that this condition is a result of the reinforcing doubler being too close to the flange.

What Is the Potential Impact if FAA Took No Action?

This condition, if not detected and corrected, could result in failure of the engine mount. Such failure could result in the engine separating from the airplane and lead to loss of control of the airplane.

Has FAA Taken Any Action to This Point?

We issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to all Pilatus Britten-Norman BN–2, BN–2A, BN–2B, BN–2T, and BN2A MK. III series airplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on August 22, 2002 (67 FR 54384). The NPRM proposed to require you to repetitively inspect the bottom corner of the engine mount bracket for cracks, replace any cracked bracket, return the removed bracket(s) to Pilatus Britten-Norman, and report the return to FAA.

Are There Differences Between This AD, the Service Information, and the CAA AD?

The CAA AD and the service information allow continued flight if cracks are found in the engine mount bracket that do not exceed certain limits. The applicable service bulletin specifies replacement of the engine mount bracket only if cracks are found exceeding this limit, as does CAA AD 005–11–2001. This AD does not allow continued flight if any crack is found. FAA policy is to disallow airplane operation when known cracks exist in primary structure, unless the ability to sustain ultimate load with these cracks is proven. The engine mount bracket is considered primary structure, and the FAA has not received any analysis to prove that ultimate load can be sustained with cracks in this area.

Is There a Modification I Can Incorporate Instead of Repetitively Inspecting the Engine Mount Brackets?

The FAA has determined that long-term continued operational safety will be better assured by design changes that remove the source of the problem rather than by performing repetitive inspections. With this in mind, we will continue to work with Pilatus Britten-Norman in collecting information to determine whether a future design change may be necessary.

Was the Public Invited To Comment?

The FAA encouraged interested persons to participate in the making of this amendment. We did not receive any

comments on the proposed rule or on our determination of the cost to the public.

FAA's Determination

What is FAA's Final Determination on This Issue?

After careful review of all available information related to the subject presented above, we have determined that air safety and the public interest require the adoption of the rule as proposed except for minor editorial corrections. We have determined that these minor corrections:

—Provide the intent that was proposed in the NPRM for correcting the unsafe condition; and

—Do not add any additional burden upon the public than was already proposed in the NPRM.

Cost Impact

How Many Airplanes Does This AD Impact?

We estimate that this AD affects 126 airplanes in the U.S. registry.

What Is the Cost Impact of This AD on Owners/Operators of the Affected Airplanes?

We estimate the following costs to accomplish the inspection for BN–2, BN–2A, BN–2B, and BN2A MK. III series airplanes:

Labor cost	Parts cost	Total cost per airplane
4 workhours × $60 per hour = $240	$10	$250

We estimate the following costs to accomplish the inspection for BN–2T series airplanes:

Labor cost	Parts cost	Total cost per airplane
8 workhours × $60 per hour = $480	$10	$490

We estimate the following costs to accomplish any necessary replacements for BN–2, BN–2A, BN–2B, and BN–2T series airplanes that will be required based on the results of the inspection. We have no way of determining the number of airplanes that may need such replacement:

Labor cost	Parts cost per bracket	Total cost per bracket
48 workhours × $60 per hour = $2,880 per bracket (2 brackets per engine, 2 engines per airplane).	$1,295	$2,880 + $1,295 = $4,175.

We estimate the following costs to accomplish any necessary replacements for BN2A MK. III series airplanes that will be required based on the results of the inspection. We have no way of determining the number of airplanes that may need such replacement:

Labor cost	Parts cost per bracket	Total cost per bracket
48 workhours × $60 per hour = $2,880 per bracket (2 brackets per engine, 2 engines per airplane).	$714	$2,880 + $714 = $3,594.

What Is the Compliance Time of This AD?

The compliance time of this AD is ''within the next 500 hours time-in-service (TIS) or within the next 24 calendar months after the effective date of this AD, whichever occurs first.''

Why Is The Compliance Time of This AD Presented in Both Hours TIS and Calendar Time?

We have established the compliance time of this AD in both hours TIS and calendar time. The unsafe condition is dependent upon repetitive airplane operation. However, the recommended maintenance program specifies other actions in this area at intervals not to exceed 2 years. Therefore, the compliance time will ensure that high-time airplanes are inspected within a certain amount of hours TIS and the lower time airplanes would be inspected at the next maintenance event in the affected area. We have determined that this compliance time:

—Will ensure that the unsafe condition is addressed in a timely manner on all affected airplanes; and

—Will not inadvertently ground any of the affected airplanes.

Regulatory Impact

Does This AD Impact Various Entities?

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.

Does This AD Involve a Significant Rule or Regulatory Action?

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 copy of the final

evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting 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, under 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. FAA amends § 39.13 by adding a new AD to read as follows:

2002–22–02 Pilatus Britten-Norman Limited: Amendment 39–12926; Docket No. 2002–CE–21–AD.

(a) *What airplanes are affected by this AD?* This AD affects the following airplane models, all serial numbers, that are certificated in any category:

Models

BN–2, BN–2A, BN–2A–2, BN–2A–3, BN–2A–6, BN–2A–8, BN–2A–9, BN–2A–20, BN–2A–21, BN–2A–26, BN–2A–27, BN–2B–20, BN–2B–21, BN–2B–26, BN–2B–27, BN–2T, BN–2T–4R, BN2A MK. III, BN2A MK. III–2, BN2A MK. III–3

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the airplanes identified in paragraph (a) of this AD must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to detect and correct cracks in the engine mount bracket. Such a condition could cause the engine mount assembly to fail, which could result in the engine separating from the airplane and lead to loss of control of the airplane.

(d) *What actions must I accomplish to address this problem?* To address this problem, you must accomplish the following:

Actions	Compliance	Procedures
(1) Inspect the bottom corner of the engine mount bracket between the attachment flange and the main part of the bracket for cracks: (i) If cracks are found during any inspections, replace the bracket with a new bracket and continue with the repetitive inspection requirements of this AD; (ii) If no cracks are found during any inspection, continue with the repetitive inspection requirements of this AD.	Initially inspect within the next 500 hours time-in-service (TIS) or within the next 24 calendar months after December 20, 2002 (the effective date of this AD), whichever occurs first, and repetitively inspect thereafter at intervals not-to-exceed 500 hours TIS or 1,000 landings, whichever occurs first. Replace cracked bracket prior to further flight after the inspection in which the crack is found.	In accordance with Pilatus Britten Norman Service Bulletin SB 275, Issue 1, dated November 30, 2001.
(2) Send the removed brackets to the Engineering and Design Authority, B–N Group Ltd. and report the return to FAA. The Office of Management and Budget (OMB) approved the information collection requirements contained in this regulation under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*) and assigned OMB Control Number 2120–0056.	Within 10 days after removing the bracket or within 10 days after December 20, 2002 (the effective date of this AD), whichever occurs later.	Send the removed brackets to B–N Group Limited, Bembridge, Isle of Wight, United Kingdom P035 5PR, and report the return to Doug Rudolph, FAA, at the address in paragraph (f) of this AD.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Standards Office Manager, Small Airplane Directorate, approves your alternative. Submit your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Standards Office Manager.

Note 1: This AD applies to each airplane identified in paragraph (a) of this AD, 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 (e) 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 you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; facsimile: (816) 329–4090.

(g) *What if I need to fly the airplane to another location to comply with this AD?* The FAA can issue a special flight permit under §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your airplane to a location where you can accomplish the requirements of this AD.

(h) *Are any service bulletins incorporated into this AD by reference?* Actions required by this AD must be done in accordance with Pilatus Britten Norman Service Bulletin SB 275, Issue 1, dated November 30, 2001. The Director of the Federal Register approved this incorporation by reference under 5 U.S.C. 552(a) and 1 CFR part 51. You may get copies from B–N Group Limited, Bembridge, Isle of Wight, United Kingdom PO35 5PR; telephone: +44 (0) 1983 872511; facsimile: +44 (0) 1983 873246. You may view copies at the FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri, or at the Office of the Federal Register, 800 North Capitol Street, NW, suite 700, Washington, DC.

Note 2: The subject of this AD is addressed in the United Kingdom CAA–AD Number 005–11–2001, not dated.

(i) *When does this amendment become effective?* This amendment becomes effective on December 20, 2002.

Issued in Kansas City, Missouri, on October 22, 2002.

David R. Showers,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 02–27419 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–CE–29–AD; Amendment 39–12928; AD 2002–22–04]

RIN 2120–AA64

Airworthiness Directives; Stemme GmbH & Co. KG Model S10–VT Sailplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to certain Stemme GmbH & Co. KG (Stemme) Model S10–VT sailplanes. This AD requires you to modify the engine compartment fuel and oil system and firewall. This AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Germany. The actions specified by this AD are intended to reduce the potential for a fire to ignite in the engine compartment and increase the containment of an engine fire in the engine compartment. A fire in the engine compartment could lead to loss of control of the sailplane.

DATES: This AD becomes effective on December 20, 2002.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of December 20, 2002.

ADDRESSES: You may get the service information referenced in this AD from Stemme GmbH & Co. KG, Gustav-Meyer-Allee 25, D–13355 Berlin, Germany; telephone: 49.33.41.31.11.70; facsimile: 49.33.41.31.11.73. You may view this information at the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 2002–CE–29–AD, 901 Locust, Room 506, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mike Kiesov, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4144; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

What events have caused this AD? The Luftfahrt-Bundesamt (LBA), which is the airworthiness authority for Germany, recently notified FAA that an unsafe condition may exist on certain Stemme Model sailplanes. The LBA reports an incident of an in-flight fire on a Model sailplane. The accident investigation revealed that the fire was not contained in the engine compartment. The manufacturer conducted a design review and determined that modifications to the fuel and oil system and the firewall design will significantly reduce the potential for a fire to ignite in the engine compartment and increase the containment of an engine fire in the engine compartment.

What is the potential impact if FAA took no action? If this condition is not corrected, there is potential for a fire to ignite in the engine compartment and spread into the cockpit. Such a condition could lead to loss of control of the sailplane.

Has FAA taken any action to this point? We issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to certain Stemme Model sailplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on August 2, 2002 (67 FR 50383). The NPRM proposed to require you to modify the engine compartment fuel and oil system and modify the firewall by sealing all gaps.

Was the public invited to comment? The FAA encouraged interested persons to participate in the making of this amendment. We did not receive any comments on the proposed rule or on our determination of the cost to the public.

FAA's Determination

What is FAA's final determination on this issue? After careful review of all available information related to the subject presented above, we have determined that air safety and the public interest require the adoption of the rule as proposed except for minor editorial corrections. *We have determined that these minor corrections:*

—Provide the intent that was proposed in the NPRM for correcting the unsafe condition; and

—Do not add any additional burden upon the public than was already proposed in the NPRM.

Cost Impact

How many sailplanes does this AD impact? We estimate that this AD affects 41 sailplanes in the U.S. registry.

What is the cost impact of this AD on owners/operators of the affected sailplanes? We estimate the following costs to accomplish the modifications:

Labor cost	Parts cost	Total cost per sailplane	Total cost on U.S. operators
10 workhours × $60 per hour = $600	$620	$1,220	$1,220 × 41 = $50,020.

Compliance Time of This AD

What will be the compliance time of this AD? The compliance time of this AD is ''within the next 50 hours time-in-service (TIS) or 3 months after the effective date of this AD, whichever occurs first.''

Why is the compliance time of this AD presented in both hours TIS and calendar time? The unsafe condition on these sailplanes is not a result of the number of times the sailplane is operated. Sailplane operation varies among operators. For example, one operator may operate the sailplane 50 hours TIS in 3 months while it may take another operator 12 months or more to accumulate 50 hours TIS. For this reason, the FAA has determined that the compliance time of this AD should be specified in both hours time-in-service (TIS) and calendar time in order to ensure this condition is not allowed to go uncorrected over time.

Regulatory Impact

Does this AD impact various entities? 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.

Does this AD involve a significant rule or regulatory action? 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 copy of the final evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting 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, under 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. FAA amends § 39.13 by adding a new AD to read as follows:

2002–22–04 Stemme GmbH & Co. KG: Amendment 39–12928; Docket No. 2002–CE–29–AD.

(a) *What sailplanes are affected by this AD?* This AD affects Model S10–VT sailplanes, serial numbers 11–002 through 11–072, that are certificated in any category.

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the sailplanes identified in paragraph (a) of this AD must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to reduce the potential for a fire to ignite in the engine compartment and increase the containment of an engine fire in the engine compartment. A fire in the engine compartment could lead to loss of control of the sailplane.

(d) *What actions must I accomplish to address this problem?* To address this problem, you must accomplish the following:

Actions	Compliance	Procedures
Modify the firewall by sealing all gaps and modify the fuel and oil lines in the engine compartment.	Within the next 50 hours time-in-service (TIS) or 3 months after December 20, 2002 (the effective date of this AD), whichever occurs first.	Modify the firewall in accordance with Stemme Service Bulletin A31–10–057, dated June 7, 2001, as specified in Stemme Service Bulletin A31–10–061, dated April 22, 2002. Modify the fuel oil lines in accordance with Stemme Service Bulletin A31–10–061, dated April 22, 2002, and Stemme Installation Instruction A34–10–061E, dated April 22, 2002.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Manager, Standards Office, Small Airplane Directorate, approves your alternative. Submit your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Standards Office.

Note 1: This AD applies to each sailplane identified in paragraph (a) of this AD, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For sailplanes 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 (e) 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 you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Mike Kiesov, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4144; facsimile: (816) 329–4090.

(g) *What if I need to fly the sailplane to another location to comply with this AD?* The FAA can issue a special flight permit under sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your sailplane to a location where you can accomplish the requirements of this AD.

(h) *Are any service bulletins incorporated into this AD by reference?* Actions required by this AD must be done in accordance with Stemme Service Bulletin A31–10–057, dated June 7, 2001, Stemme Service Bulletin A31–10–061, dated April 22, 2002, and Stemme Installation Instruction A34–10–061E, dated April 22, 2002. The Director of the Federal Register approved this incorporation by reference under 5 U.S.C. 552(a) and 1 CFR part 51. You may get copies from Stemme GmbH & Co. KG, Gustav-Meyer-Allee 25, D–13355 Berlin, Germany; telephone: 49.33.41.31.11.70; facsimile: 49.33.41.31.11.73. You may view copies at the FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri, or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Note 2: The subject of this AD is addressed in German AD 2002–156, dated June 13, 2002.

(i) *When does this amendment become effective?* This amendment becomes effective on December 20, 2002.

Issued in Kansas City, Missouri, on October 22, 2002.

David R. Showers,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 02–27420 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NE–21–AD; Amendment 39–12931; AD 2002–22–06]

RIN 2120–AA64

Airworthiness Directives; Honeywell International, Inc., (Formerly AlliedSignal, Inc. and Textron Lycoming) LF507 and ALF502R Series Turbofan Engines

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that is applicable to Honeywell International, Inc., (formerly AlliedSignal, Inc. and Textron Lycoming) LF507 and ALF502R series turbofan engines with combustion chamber liner assembly part number (P/N) 2–131–520–03 installed. This action requires initial and repetitive borescope inspections of the combustion chamber liner assembly to determine if the combustion liner assembly condition is acceptable for continued operation, requires the removal from service of certain serial number (SN) combustion chamber liner assemblies, and provides an optional terminating action to the

repetitive borescope inspections. This amendment is prompted by three reports of separation of the combustor dome baffle from the combustion chamber liner assembly resulting in engine combustion chamber liner assembly burn through. The actions specified in this AD are intended to prevent separation of the combustor dome baffle from the combustion chamber liner assembly and the flow of hot combustor gases on oil and fuel lines which could result in engine fire, in-flight shutdown, and damage to the airplane.

DATES: Effective November 18, 2002. The incorporation by reference of certain publications listed in the rule is approved by the Director of the Federal Register as of November 18, 2002.

Comments for inclusion in the Rules Docket must be received on or before December 31, 2002.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), New England Region, Office of the Regional Counsel, *Attention:* Rules Docket No. 2002–NE–21–AD, 12 New England Executive Park, Burlington, MA 01803–5299. Comments may be inspected at this location, by appointment, between 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays. Comments may also be sent via the Internet using the following address: *''9-ane-adcomment@faa.gov''.* Comments sent via the Internet must contain the docket number in the subject line.

The service information referenced in this AD may be obtained from Honeywell International, Inc. (formerly AlliedSignal, Inc. and Textron Lycoming), *Attn:* Data Distribution, M/S 64–3/2101–201, PO Box 29003, Phoenix, AZ 85038–9003, *telephone:* (602) 365–2493; fax: (602) 365–5577. This information may be examined, by appointment, at the FAA, New England Region, Office of the Regional Counsel, 12 New England Executive Park, Burlington, MA; or at the *Office of the Federal Register,* 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Robert Baitoo, Aerospace Engineer, Los Angeles Aircraft Certification Office (LAACO), FAA, Transport Airplane Directorate, 3960 Paramount Blvd., Lakewood, CA 90712–4137; telephone (562) 627–5245; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION: The FAA has received three reports of combustion liner assemblies that have been found with burned and missing material. One combustion chamber liner assembly that burned through was found at routine maintenance, one manifested itself as a low thrust condition, and one resulted in an engine in-flight shutdown. Some combustion liner assemblies may have inferior baffle attachment welds. To date, there have been no in-flight engine fires due to separation of the combustor dome baffle from the combustion chamber liner assembly. However, the FAA has determined that LF507 and ALF502R series turbofan engines with combustion chamber liner assembly part number (P/N) 2–131–520–03 installed could experience burn through due to separation of the combustor dome baffle and the flow of hot combustor gases on oil and fuel lines. This condition, if not corrected, could result in engine fire, in-flight shutdown, and damage to the airplane.

Manufacturer's Service Information

The FAA has reviewed and approved the technical contents of Honeywell International, Inc., (formerly AlliedSignal, Inc. and Textron Lycoming) alert service bulletin (ASB).

- ALF/LF A72–1076, Revision 1, dated August 30, 2002. That ASB describes initial and repetitive borescope inspection procedures of the combustion chamber liner assembly part number (P/N) 2–131–520–03. That ASB also lists combustion chamber liner assembly SN's that require removal within 250 cycles from date of receipt of that service bulletin revision (Revision 1).

FAA's Determination of an Unsafe Condition and Required Actions

Since an unsafe condition has been identified that is likely to exist or develop on other Honeywell International, Inc., (formerly AlliedSignal, Inc. and Textron Lycoming) LF507 and ALF502R series turbofan engines of the same type design, this AD is being issued to prevent separation of the combustor dome baffle from the combustion chamber liner assembly and the flow of hot combustor gases on oil and fuel lines which could result in an engine fire, an in-flight shutdown, and damage to the airplane. The actions are required to be done in accordance with the alert service bulletin described previously.

Immediate Adoption of This AD

Since a situation exists that requires the immediate adoption of this regulation, it is found that notice and opportunity for prior public comment hereon are impracticable, and that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

Although this action is in the form of a final rule that involves requirements affecting flight safety and, thus, was not preceded by notice and an opportunity for public comment, comments are invited on this rule. Interested persons are invited to comment on this rule by submitting such written data, views, or arguments as they may desire. Communications should identify the Rules Docket number and be submitted in triplicate to the address specified under the caption **ADDRESSES.** All communications received on or before the closing date for comments will be considered, and this rule may be amended in light of the comments received. Factual information that supports the commenter's ideas and suggestions is extremely helpful in evaluating the effectiveness of the AD action and determining whether additional rulemaking action would be needed.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the rule that might suggest a need to modify the rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report that summarizes each FAA-public contact concerned with the substance of this AD will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this action must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket Number 2002–NE–21–AD.'' The postcard will be date stamped and returned to the commenter.

Regulatory Analysis

This final rule does not have federalism implications, as defined in Executive Order 13132, because it would 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. Accordingly, the FAA has not consulted with state authorities prior to publication of this final rule.

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and is not a ''significant regulatory action'' under Executive Order 12866. It has been determined further that this action involves an emergency regulation

under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket. A copy of it, if filed, 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:

2002–22–06 Honeywell International, Inc., (formerly AlliedSignal, Inc. and Textron Lycoming): Amendment 39–12931. Docket No. 2002–NE–21–AD.

Applicability: This airworthiness directive (AD) is applicable to Honeywell International, Inc., (formerly AlliedSignal, Inc. and Textron Lycoming) LF507 and ALF502R series turbofan engines with combustion chamber liner assembly part number (P/N) 2–131–520–03 installed. These engines are installed on, but not limited to, BAE Systems Avro 146 and BAE 146 series aircraft.

Note 1: This AD applies to each engine 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 engines 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 (e) 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: Compliance with this AD is required as indicated, unless already done.

To prevent separation of the combustor dome baffle from the combustion chamber liner assembly and the flow of hot combustor gases on oil and fuel lines which could result in an engine fire, an in-flight shutdown, and damage to the airplane, do the following:

Removal Requirements

(a) Within 250 cycles-in-service (CIS) after the effective date of this AD, remove from service engines that have combustion chamber liner assemblies, P/N 2–131–520–03, listed by serial number (SN) in Table 1 of this AD. Replace that SN combustion chamber liner assembly with a serviceable part. Table 1 follows:

TABLE 1.—AFFECTED COMBUSTION CHAMBER LINER ASSEMBLIES

Serial Nos. to be removed from service
990992700016.
990992700018 thru 990992700028.
990992700077 thru 990992700078.
990992700081.
990992700083.
990992700085 thru 990992700090.

Initial and Repetitive Inspections

(b) On engines that have combustion chamber liner assemblies with more than 2,000 CIS on the effective date of this AD, perform an initial borescope inspection of combustion chamber liner assembly P/N 2–131–520–03 within 500 CIS after the effective date of this AD in accordance with paragraphs 2(A)(1) through 2(A)(8) of the Accomplishment Instructions of Honeywell alert service bulletin (ASB) ALF/LF A72–1076, Revision 1, dated August 30, 2002.

(c) Thereafter, at each successive 500 CIS, perform a borescope inspection of combustion chamber liner assembly P/N 2–131–520–03 in accordance with paragraphs 2(A)(1) through 2(A)(8) of the Accomplishment Instructions of Honeywell ASB ALF/LF A72–1076, Revision 1, dated August 30, 2002.

Optional Terminating Action

(d) Replacement of combustion chamber liner assembly, P/N 2–131–520–03, with the new improved durability combustion chamber liner assembly, P/N 2–131–520–04, constitutes terminating action to the borescope inspection requirements of paragraph (c) of this AD. Information regarding the replacement of combustion chamber liner assembly P/N 2–131–520–03 with P/N 2–131–520–04 can be found in Honeywell service bulletin ALF/LF 72–1078, dated June 28, 2002.

Alternative Methods of Compliance

(e) 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 (LAACO). Operators must submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, LAACO.

Note 2: Information concerning the existence of approved alternative methods of compliance with this airworthiness directive, if any, may be obtained from the LAACO.

Special Flight Permits

(f) Special flight permits may be issued in accordance with §§ 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 done.

Documents That Have Been Incorporated by Reference

(g) The initial and repetitive borescope inspections of combustion chamber liner assembly, PN 2–131–520–03, must be done in accordance with the Honeywell International, Inc. ASB ALF/LF A72–1076, Revision 1, dated August 30, 2002. 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 Honeywell International, Inc. (formerly AlliedSignal, Inc. and Textron Lycoming), *Attn:* Data Distribution, M/S 64–3/2101–201, P.O. Box 29003, Phoenix, AZ 85038–9003, telephone: (602) 365–2493; fax: (602) 365–5577. Copies may be inspected at the FAA, New England Region, Office of the Regional Counsel, 12 New England Executive Park, Burlington, MA; or at the Office of the Federal Register, 800 North Capitol Street, NW, suite 700, Washington, DC.

Effective Date

(h) This amendment becomes effective on November 18, 2002.

Issued in Burlington, Massachusetts, on October 22, 2002.

Francis A. Favara,

Acting Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 02–27433 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

CONSUMER PRODUCT SAFETY COMMISSION

16 CFR Part 1700

Poison Prevention Packaging Requirements; Exemption of Hormone Replacement Therapy Products

AGENCY: Consumer Product Safety Commission.

ACTION: Final rule.

SUMMARY: The Commission is amending its child-resistant packaging requirements to exempt hormone replacement therapy (''HRT'') products containing one or more progestogen or estrogen substances. Current exemptions cover some HRT products, but not others. This rule would uniformly exempt from child resistant packaging requirements all HRT products that rely solely on the activity of one or more progestogen or estrogen substances.

DATES: The rule is effective November 1, 2002, and applies to products packaged on or after that date.

FOR FURTHER INFORMATION CONTACT: Geri Smith, Office of Compliance and Enforcement, Consumer Product Safety Commission, Washington, DC 20207; telephone (301) 504–0608 ext. 1160.

SUPPLEMENTARY INFORMATION:

A. Background

The Poison Prevention Packaging Act of 1970 (''PPPA''), 15 U.S.C. 1471–1476, authorizes the Commission to issue standards for the special packaging of household substances, such as drugs, when (1) Child resistant packaging is necessary to protect children from serious personal injury or illness due to the substance and (2) the special packaging is technically feasible, practicable, and appropriate for the substance. Accordingly, a Commission rule requires that oral prescription drugs be in child resistant (''CR'') packaging. 16 CFR 1700.14(a)(10).

The Commission's regulations allow exemptions from this requirement for substances that have low acute toxicity. 16 CFR 1702.1(b) and 1702.7. Current regulations provide four PPPA exemptions for sex hormones: (1) Oral contraceptives in mnemonic packages containing one or more progestogen or estrogen substances; (2) conjugated estrogen tablets in mnemonic packages; (3) norethindrone acetate tablets in mnemonic packaging; and (4) medroxyprogesterone acetate tablets. 16 CFR 1700.14(a)(10)(iv), (xvii), (xviii) and (xix). Some HRT products fall within these exemptions, but because of the way these exemptions are written, other HRT products currently require CR packaging.

On February 19, 2002, the Commission published a notice of proposed rulemaking (''NPR'') proposing to exempt from the special packaging requirements HRT products containing one or more progestogen or estrogen substances. 67 FR 7319. This rule will make the exemption of HRT products more uniform by exempting all HRT products that rely solely on the activity of one or more progestogen or estrogen substances.[1]

B. HRT Products

HRT is used to replace the estrogen and progesterone that normally decline following menopause (the cessation of menstruation). Women may experience a range of menopausal symptoms. Additionally, menopause accelerates bone depletion that commonly occurs with aging, leading to osteoporosis.

HRT has been used to relieve a number of menopausal symptoms and help to prevent osteoporosis. HRT consists of using estrogen alone or various combinations of estrogens and progestins, similar to oral contraceptives. Some are natural hormones (*e.g.*, estradiol) and others are semi-synthetic or synthetic (*e.g.*, norgestimate). Since available HRT products contain estrogen/progestin combinations similar to oral contraceptives, it is reasonable and consistent to exempt them similarly.

Recently, studies have raised questions about the health effects of HRT. A Women's Health Initiative study indicated that women treated for about 5 years with a combination of estrogen and progestin had an increased risk of breast cancer, heart disease, stroke and blood clots compared to placebo. While this study suggests that HRT may not be indicated for long term use, it did not examine different doses, different estrogen or progestins or alternative formulations. It is likely that physicians may consider prescribing short term hormone therapy for menopausal symptoms after evaluating the risks and benefits for individual patients. Because the acute toxicity of HRT is low and its use is likely to continue even with the questions raised about its long term use, the Commission believes that a rule uniformly exempting HRT products from CR packaging requirements is appropriate.

C. Toxicity Data

Human toxic doses for estrogens or progestins have not been defined. Exposure summaries in the Poisindex® for estrogens, progestins, and oral contraceptives state that acute toxicity is unlikely following overdosage. Gastrointestinal effects (*e.g.*, nausea, vomiting, abdominal cramps) may occur after an acute overdose, but typically no treatment is necessary.

The medical literature provides little information concerning acute overdosage of progestins or estrogens. One case mentioned in the NPR showed that a single dose of 160 mg estradiol valerate (80 tablets/2 mg each), ingested by a 19-year-old woman in a suicide attempt, produced little toxicity. The woman slept easily during the night of the ingestion and the next evening presented in the emergency clinic in generally good condition with nausea and a headache.

For the NPR, the staff reviewed poisoning data from the American Association of Poison Control Centers (''AAPCC'') Toxic Exposure Surveillance System (''TESS'') showing acute exposures in children less than five years old to estrogens, progestins, and oral contraceptives from 1993 to 1998. There were no deaths and most of the exposures were non-toxic.

For this final rule, the staff reviewed available AAPCC data since the NPR was published, and found no major outcomes or deaths in any of the hormone categories in 1999 and 2000 (the most recent data available).

D. Public Comment on the NPR

The Commission received one comment in response to the NPR. It came from Berlex Laboratories, which wrote that it currently markets estrogen replacement therapy, long-acting contraception, and oral contraception products and plans to market an oral HRT product in the near future. Berlex states that the proposed exemption is ''beneficial in terms of cost and efficiency'' and provides ''drug producers greater flexibility in meeting the needs of the HRT patient population.''

E. Effective Date

With this rule, the Commission issues an exemption from the child-resistant packaging requirements generally applicable to oral prescription drugs. Thus, the rule imposes no new requirements, but lifts requirements currently in existence for some HRT products (some HRT products are already exempt from CR packaging requirements). Under these circumstances the Commission believes it is appropriate for the rule to become effective on the date it is published in the **Federal Register**.

F. Impact on Small Business

As discussed in the NPR, the Commission preliminarily concluded that the proposed amendment exempting HRT products from special packaging requirements would not have a significant impact on a substantial number of small businesses or other small entities. This conclusion was based on the fact that the exemption would actually increase the packaging options for manufacturers because it would allow them to package the affected HRT products in non-CR packages. Thus, the exemption is not likely to have a significant impact on a substantial number of companies, regardless of size.

G. Environmental Considerations

In the NPR, the Commission also discussed possible impact on the environment as required by the National

[1] Commissioner Thomas H. Moore issued a statement, which is on file in the Commission's Office of the Secretary, Room 501, 4330 East-West Highway, Bethesda, Maryland 20814.

Environmental Policy Act, and in accordance with the Council on Environmental Quality regulations and CPSC procedures for environmental review. The Commission found that, because the rule would have no adverse effect on the environment, neither an environmental assessment nor an environmental impact statement is required.

H. Executive Orders

According to Executive Order 12988 (February 5, 1996), agencies must state in clear language the preemptive effect, if any, of new regulations.

The PPPA provides that, generally, when a special packaging standard issued under the PPPA is in effect, ''no State or political subdivision thereof shall have any authority either to establish or continue in effect, with respect to such household substance, any standard for special packaging (and any exemption therefrom and requirement related thereto) which is not identical to the [PPPA] standard.'' 15 U.S.C. 1476(a). A State or local standard may be excepted from this preemptive effect if (1) the State or local standard provides a higher degree of protection from the risk of injury or illness than the PPPA standard; and (2) the State or political subdivision applies to the Commission for an exemption from the PPPA's preemption clause and the Commission grants the exemption through a process specified at 16 CFR part 1061. 15 U.S.C. 1476(c)(1). In addition, the Federal government, or a State or local government, may establish and continue in effect a non-identical special packaging requirement that provides a higher degree of protection than the PPPA requirement for a household substance for the Federal, State or local government's own use. 15 U.S.C. 1476(b).

Accordingly, with the exceptions noted above, the rule exempting HRT products from special packaging requirements would preempt non-identical state or local special packaging standards for those products.

The Commission has also evaluated the rule in light of the principles stated in Executive Order 13132 concerning federalism, even though that Order does not apply to independent regulatory agencies such as CPSC. The Commission does not expect that the rule will have any substantial direct effects on the States, the relationship between the national government and the States, or the distribution of power and responsibilities among various levels of government.

List of Subjects in 16 CFR Part 1700

Consumer protection, Drugs, Infants and children, Packaging and containers, Poison prevention, Toxic substances.

For the reasons given above, the Commission amends 16 CFR part 1700 as follows:

PART 1700—[AMENDED]

1. The authority citation for part 1700 continues to read as follows:

Authority: Pub. L. 91–601, secs. 1–9, 84 Stat. 1670–74, 15 U.S.C. 1471–76. Secs 1700.1 and 1700.14 also issued under Pub. L. 92–573, sec. 30(a), 88 Stat. 1231. 15 U.S.C. 2079(a).

2. The introductory text of paragraphs (a) and (a)(10) is republished. Section 1700.14 is amended by adding new paragraph (a)(10)(xxi) to read as follows:

§ 1700.14 Substances requiring special packaging.

(a) *Substances.* The Commission has determined that the degree or nature of the hazard to children in the availability of the following substances, by reason of their packaging, is such that special packaging meeting the requirements of § 1700.20(a) is required to protect children from serious personal injury or serious illness resulting from handling, using, or ingesting such substances, and the special packaging herein required is technically feasible, practicable, and appropriate for these substances:

* * * * *

(10) *Prescription Drugs.* Any drug for human use that is in a dosage form intended for oral administration and that is required by Federal law to be dispensed only by or upon an oral or written prescription of a practitioner licensed by law to administer such drug shall be packaged in accordance with the provisions of § 1700.15(a),(b), and (c), except for the following:

* * * * *

(xxi) Hormone Replacement Therapy Products that rely solely upon the activity of one or more progestogen or estrogen substances.

* * * * *

Dated: October 28, 2002.

Todd Stevenson,

Secretary, Consumer Product Safety Commission.

List of Relevant Documents

1. Briefing memorandum from Jacqueline Ferrante, Ph.D., Directorate for Health Sciences, to the Commission, ''Final Rule to Exempt Hormone Replacement Therapy Products from the Special Packaging Requirements of the Poison Prevention Packaging Act,'' October 9, 2002.

2. Memorandum from Robert Franklin, Directorate for Economic Analysis, to Jacqueline Ferrante, Ph.D., Project Manager, ''Small Business and Environmental Considerations Related to Exempting HRT Products from PPPA Requirements,'' September 9, 2002.

[FR Doc. 02–27745 Filed 10–31–02; 8:45 am]

BILLING CODE 6355–01–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD01–02–118]

Drawbridge Operation Regulations: Danvers River, MA

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 Kernwood Bridge, mile 1.0, across the Danvers River in Massachusetts. This temporary deviation will allow the bridge to remain in the closed position from 7 a.m. on November 12, 2002 through 8 p.m. on November 14, 2002. This temporary deviation is necessary to facilitate structural repairs at the bridge.

DATES: This deviation is effective from November 12, 2002 through November 14, 2002.

FOR FURTHER INFORMATION CONTACT: John McDonald, Project Officer, First Coast Guard District, at (617) 223–8364.

SUPPLEMENTARY INFORMATION: The Kernwood Bridge has a vertical clearance in the closed position of 8 feet at mean high water and 17 feet at mean low water. The existing regulations are listed at 33 CFR 117.595.

The bridge owner, Massachusetts Highway Department, requested a temporary deviation from the drawbridge operating regulations to facilitate structural maintenance, replacement of the pinion bearing and support frame, at the bridge. The bridge must remain closed during these repairs. The bridge opening records indicate this bridge has received few requests to open during the requested closure time during past years.

This deviation from the drawbridge operation regulations will allow the bridge to remain in the closed position from 7 a.m. on November 12, 2002 through 8 p.m. on November 14, 2002.

This deviation from the drawbridge operation 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: October 23, 2002.

V.S. Crea,

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

[FR Doc. 02–27851 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD01–02–100]

RIN 2115–AE47

Drawbridge Operation Regulations: Connecticut River, CT

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary final rule governing the operation of the Route 82 Bridge, at mile 16.8, across the Connecticut River at East Haddam, Connecticut. This temporary final rule allows the bridge to operate on fixed opening schedule from November 1, 2002 through October 31, 2003. This action is necessary to facilitate major rehabilitation of the bridge.

DATES: This temporary final rule is effective from November 1, 2002 through October 31, 2003.

ADDRESSES: Material received from the public, as well as documents indicated in this preamble as being available in the docket, are part of docket (CGD01–02–100) and are available for inspection or copying at the First Coast Guard District, Bridge Branch Office, 408 Atlantic Avenue, Boston, Massachusetts 02110, 6:30 a.m. to 3 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Joseph Schmied, Project Officer, First Coast Guard District, (212) 668–7165.

SUPPLEMENTARY INFORMATION:

Regulatory Information

On September 10, 2002, we published a notice of proposed rulemaking (NPRM) entitled Drawbridge Operation Regulations; Connecticut River, Connecticut, in the **Federal Register** (67 FR 57355). We received no comments in response to the notice of proposed rulemaking. No public hearing was requested and none was held.

Pursuant to 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this final rule effective in less than 30 days after publication in the **Federal Register**. Any delay encountered in this regulation's effective date would be unnecessary and contrary to the public interest because the rehabilitation construction is necessary in order to assure continued reliable operation of the bridge.

Background and Purpose

The Route 82 Bridge has a vertical clearance of 22 feet at mean high water, and 25 feet at mean low water in the closed position. The existing drawbridge operating regulations listed at 33 CFR 117.205(c), require the bridge to open on signal at all times; except that, from May 15 to October 31, 9 a.m. to 9 p.m., the bridge is required to open for recreational vessels on the hour and half hour only. The bridge is required to open on signal at all times for commercial vessels.

The Route 82 Bridge was scheduled for major repairs in the summer of 2001, but due to a funding shortfall the work was delayed. Subsequent to that, the bridge has continued to deteriorate. Funding has now been made available and the necessary repairs should be performed with due speed to assure safe reliable continued operation of the bridge.

The bridge owner, Connecticut Department of Transportation, has requested a temporary final rule to allow the bridge to open for recreational and commercial vessels at specific times; however, commercial vessels may obtain unscheduled openings at any time provided they give a twenty-four hour notice with a two-hour confirmation to the bridge tender.

The bridge owner has also requested one seven day bridge closure, two eight-hour closures and one twenty-four hour bridge closure required to facilitate the bridge repairs. The exact dates for the above closures are not known at this time. The Coast Guard plans to publish the exact times and dates in the Local Notice to Mariners at least thirty-days in advance of the anticipated occurrence to assist mariners in their planning.

The operating schedule that would be in effect at the Route 82 Bridge from November 1, 2002 through October 31, 2003, is as follows:

From November 1 through July 6, the draw shall open on signal at 5:30 a.m., 1:30 p.m., and 8 p.m., daily.

From July 7 through October 31 the draw shall open on signal Monday through Thursday at 6:30 a.m., 1:30 p.m., and 8 p.m., with one additional opening on Friday at 11:30 p.m., three additional openings on Saturday at 9:30 a.m., 4 p.m., and 11:30 p.m., two additional openings on Sunday at 9:30 a.m. and 4 p.m.

The draw shall open on signal at any time for Commercial vessels provided a twenty-four hour notice with a two-hour confirmation is given to the drawtender at the bridge.

The Coast Guard and the bridge owner have successfully coordinated the above temporary operating schedule with the mariners. The Coast Guard believes this temporary final rule is reasonable as a result of the above information.

Discussion of Comments and Changes

We received no comments in response to the notice of proposed rulemaking.

The effective dates of this temporary final rule have been changed to be effective from November 1, 2002 through October 31, 2003. The notice of proposed rulemaking listed the effective dates as October 15, 2002 through April 30, 2004.

We changed the effective dates of this temporary final rule because the new dates depict the actual time period that the operating schedule of the bridge will be changed.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3), of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979).

This conclusion is based on the fact that vessel traffic will not be prevented from transiting the bridge as a result of this temporary final rule.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we 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 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 conclusion is based on the fact that vessel traffic will not be prevented

from transiting the bridge as a result of this temporary final rule.

Collection of Information

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

Federalism

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

Unfunded Mandates Reform Act

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

Taking of Private Property

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

Civil Justice Reform

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

Protection of Children

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

Indian Tribal Governments

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

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a ''significant energy action'' under that order because it is not a ''significant regulatory action'' under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. 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.

Environment

We have considered the environmental impact of this rule and concluded that under figure 2–1, paragraph (32)(e), of Commandant Instruction M16475.1D, this rule is categorically excluded from further environmental documentation because promulgation of changes to drawbridge regulations have been found to not have a significant effect on the environment. A ''Categorical Exclusion Determination'' is available in the docket for inspection or copying where indicated under **ADDRESSES.**

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

For the reasons set out in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

2. From November 1, 2002 through October 31, 2003, § 117.205 is temporarily amended by suspending paragraph (c) and adding a new paragraph (d) to read as follows:

§ 117.205 Connecticut River.

* * * * *

(d) The draw of the Route 82 Bridge, mile 16.8, shall operate as follows:

(1) From November 1 through July 6 the draw shall open on signal at 5:30 a.m., 1:30 p.m., and 8 p.m., daily.

(2) From July 7 through October 31, Monday through Thursday, the draw shall open on signal at 6:30 a.m., 1:30 p.m., and 8 p.m., with one additional opening on Friday at 11:30 p.m., three additional openings on Saturday at 9:30 a.m., 4 p.m., and 11:30 p.m., and two additional openings on Sunday at 9:30 a.m., and 4 p.m.

(3) The draw shall open on signal for commercial vessels at all times provided a twenty-four hour advance notice with a two-hour confirmation is given.

Dated: October 24, 2002.

V.S. Crea,

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

[FR Doc. 02–27850 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AK89

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document affirms amendments to VA's medical regulations to extend CHAMPVA eligibility to persons age 65 and over who would have otherwise lost their CHAMPVA eligibility due to attainment of entitlement to hospital insurance benefits under Medicare Part A, implement coverage of physical examinations required in connection with school enrollment for beneficiaries through age 17, and reduce the catastrophic cap for CHAMPVA dependents and survivors (per family) from $7,500 to $3,000 for each calendar year. These amendments were made by an interim final rule and were necessary to implement provisions of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 and the Veterans' Survivor Benefits Improvements Act of 2001.

DATES: *Effective Date:* This document is effective on November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Susan Schmetzer, Chief, Policy & Compliance Division, VA Health Administration Center, P.O. Box 65020, Denver, CO 80206–9020, telephone (303) 331–7552.

SUPPLEMENTARY INFORMATION: An interim final rule amending VA's medical regulations to extend CHAMPVA eligibility to persons age 65 and over who would have otherwise lost their CHAMPVA eligibility due to attainment of entitlement to hospital insurance benefits under Medicare Part A, implement coverage of physical examinations required in connection with school enrollment for beneficiaries through age 17, and reduce the catastrophic cap for CHAMPVA dependents and survivors (per family) from $7,500 to $3,000 for each calendar year was published in the **Federal Register** on January 30, 2002 (67 FR 4357). A correction to the interim final rule was published in the **Federal Register** on February 14, 2002 (67 FR 6874).

We provided a 60-day comment period that ended April 1, 2002. No comments have been received. Based on the rationale set forth in the interim final rule, we now affirm as a final rule the changes made by the interim final rule.

Administrative Procedure Act

The changes made by this final rule in large part reflect statutory changes. Moreover, we have found good cause to dispense with the notice-and-comment and delayed effective date provisions of the Administrative Procedure Act (5 U.S.C. 553). Compliance with such provisions would be impracticable, unnecessary, and contrary to the public interest. To avoid significant administrative confusion, it was in the public's interest to provide these benefits within approximately the same period as similar benefits were provided to DoD's TRICARE beneficiaries.

Unfunded Mandates

The Unfunded Mandates Reform Act requires at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Paperwork Reduction Act

This final rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511).

Regulatory Flexibility Act

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (RFA), 5 U.S.C. 601–612. Based on a more recent projection, the number of potential beneficiaries over age 65 has increased from 89,500 as estimated in the interim final rule to approximately 135,209 potential beneficiaries that will use the benefit of coverage secondary to Medicare. The interim final rule estimates of approximately 2,000 beneficiaries impacted by the inclusion of school-required physical examination benefit and approximately 2,500 families benefiting from the reduction of the catastrophic cap remain unchanged. Since these beneficiaries are widely geographically diverse, the health care provided to them would not have a significant impact on any small businesses. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

There are no Catalog of Federal Domestic Assistance program numbers for the programs affected by this document.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: September 25, 2002.

Anthony J. Principi,

Secretary of Veterans Affairs.

PART 17—MEDICAL

Accordingly, the interim final rule amending 38 CFR part 17 that was published at 67 FR 4357 on January 30, 2002, and corrected at 67 FR 6874 on February 14, 2002, is adopted as a final rule without change.

[FR Doc. 02–27877 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[Docket # WA–01–006; FRL–7267–8]

Approval and Promulgation of Air Quality Implementation Plans; State of Washington; Yakima Carbon Monoxide Redesignation to Attainment and Designation of Areas for Air Quality Planning Purposes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: On September 26, 2001, the State of Washington requested EPA to redesignate the Yakima ''not classified'' carbon monoxide (CO) nonattainment area to attainment for the CO National Ambient Air Quality Standard (NAAQS) and submitted a CO maintenance plan for Yakima. In this action, EPA is approving the maintenance plan and redesignating the Yakima CO nonattainment area to attainment.

DATES: This direct final rule will be effective December 31, 2002, unless EPA receives adverse comments by December 2, 2002. If relevant 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: Written comments may be mailed to: Steve Body, State and Tribal Programs Unit, Office of Air Quality, EPA Region 10, 1200 Sixth Avenue, Seattle, WA 98101.

Copies of the documents relevant to this action are available for public inspection during normal business hours at the United States Environmental Protection Agency, Region 10, Office of Air Quality, 1200 Sixth Avenue, Seattle WA.

FOR FURTHER INFORMATION CONTACT: Steve Body, State and Tribal Programs Unit, Office of Air Quality, EPA Region 10, 1200 Sixth Avenue, Seattle WA, Telephone number: (206) 553–0782.

SUPPLEMENTARY INFORMATION:

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I. What Is the Purpose of This Action?

EPA is redesignating the Yakima ''not classified'' CO nonattainment area from nonattainment to attainment and approving the maintenance plan that will keep the area in attainment for the next 10 years.

EPA originally designated the Yakima area as nonattainment for CO under the provisions of the 1977 Clean Air Act (CAA) Amendments (see 43 FR 8962, March 3, 1978). On November 15, 1990, the Clean Air Act Amendments of 1990 were enacted (Pub. L. 101–549, 104 Stat. 2399, codified at 42 U.S.C. 7401–7671q). Under section 107(d)(1)(C) of the CAA, the Yakima area was designated nonattainment for CO by operation of law because the area had been designated as nonattainment before November 15, 1990. The Yakima area is classified as an unclassified, or ''not classified'' CO nonattainment area.

Nonattainment areas can be redesignated to attainment after the area has measured air quality data showing it has attained the NAAQS and when certain planning requirements are met. Section 107(d)(3)(E) of the CAA provides the requirements for redesignation. These are:

(i) The Administrator determines that the area has attained the national ambient air quality standard;

(ii) The Administrator has fully approved the applicable implementation plan for the area under section 110(k) of the Act;

(iii) The Administrator determines that the improvement in air quality is due to permanent and enforceable reductions in emissions resulting from implementation of the applicable implementation plan, applicable Federal air pollution control regulations, and other permanent and enforceable reductions;

(iv) The Administrator has fully approved a maintenance plan for the area as meeting the requirements of CAA section 175A; and,

(v) The State containing the area has met all requirements applicable to the area under section 110 and part D of the CAA.

Before an area can be redesignated to attainment, all applicable State Implementation Plan (SIP) elements must be fully approved.

II. What Is the State's Process To Submit These materials to EPA?

The CAA requires States to follow certain procedural requirements for submitting SIP revisions to EPA. Section 110(a)(2) of the CAA requires that each SIP revision be adopted by the State after reasonable notice and public hearing. The State then submits the SIP revision to EPA for approval.

The Yakima Regional Clean Air Authority (YRCAA), which has regulatory authority for sources of air pollution in the Yakima CO nonattainment area, developed the CO maintenance plan. They released the draft maintenance plan for public review on August 21, 2000. On February 14, 2001, the Board of Directors for the YRCAA adopted the *Yakima Carbon Monoxide Nonattainment Area Limited Maintenance Plan and Redesignation Request.* On July 11, 2001, the State of Washington held a public hearing on the plan. On October 3, 2001, the State of Washington adopted the plan. On September 26, 2001, the State submitted the SIP to EPA. EPA has evaluated the State's submittal and determined that the State met the requirements for reasonable notice and public hearing under section 110(a)(2) of the CAA.

III. EPA's Evaluation of the Redesignation Request and Maintenance Plan

EPA has reviewed the State's maintenance plan and redesignation request and is approving the maintenance plan and redesignating the area to attainment consistent with the requirements of CAA section 107(d)(3)(E). The following is a summary of EPAs evaluation and a description of how each requirement is met.

(a) The Area Must Have Attained the Carbon Monoxide NAAQS

Section 107(d)(3)(E)(i) requires that the Administrator determine that the area has attained the applicable NAAQS. The primary NAAQS for CO is 9 parts per million (10 milligrams per cubic meter) for an 8-hour average, not to be exceeded more than once per year. CO in the ambient air is measured by a reference method based on 40 CFR part 50, Appendix C. EPA considers an area as attaining the CO NAAQS when all of the CO monitors in the area have one or less exceedance of the CO standard each calendar year over a two calendar year period. (See 40 CFR 50.8 and 40 CFR part 50, Appendix C.) EPA's interpretation of this requirement is that an area seeking redesignation to attainment must show attainment of the CO NAAQS for at least two consecutive calendar years (September 4, 1992, John Calcagni policy memorandum ''Procedures for Processing Requests to Redesignate Areas to Attainment'' (''Calcagni Memorandum'')). In addition, the area must continue to show attainment through the date that EPA promulgates redesignation to attainment.

Washington's CO redesignation request for the Yakima area is based on valid ambient air quality data. Ambient air quality monitoring data for calendar years 1988 through 2001 show a measured exceedance rate of the CO NAAQS of 1.0 or less per year at all monitoring sites. These data were collected and analyzed as required by EPA (see 40 CFR 50.8 and 40 CFR part 50, Appendix C) and have been stored in EPA's Aerometric Information and Retrieval System (AIRS). These data have met minimum quality assurance requirements and have been certified by the State as being valid before being included in AIRS. Further information on CO monitoring is presented in Section 2.3 and 2.4 of the Yakima maintenance plan. EPA has analyzed the ambient air quality data and determined that the Yakima area has not violated the CO standard since January 1988 and continues to attain through 2001.

(b) The Area Must Have Met All Applicable Requirements Under Section 110 and Part D

Section 107(d)(3)(E)(v) requires that an area must meet all applicable requirements under section 110 and part D of the CAA. EPA interprets this requirement to mean the State must meet all requirements that applied to the area prior to, or at the time of, the submission of a complete redesignation request.

1. CAA Section 110 Requirements

On May 31, 1972, EPA approved the original Washington SIP as meeting the requirements of section 110(a)(2) of the CAA (see 37 FR 10900). Although section 110 of the CAA was amended in 1990, the changes to the implementation plan requirements of section 110(a)(2) were not substantial. Thus, EPA has determined that the SIP revisions

approved in 1972 along with subsequent revisions that were previously approved, continue to satisfy the requirements of section 110(a)(2) of the CAA. EPA has analyzed the SIP elements that are being approved as part of this action and has determined they comply with the requirements of section 110(a)(2) of the CAA and that the area meets all applicable requirements under section 110 of the CAA.

2. Part D Requirements

The Yakima area was originally designated as nonattainment for CO on March 3, 1978 (see 43 FR 8962). On May 20, 1983, (48 FR 22716) EPA approved an extension of the attainment date to December 31, 1982. Washington's original CAA Part D plan for the Yakima CO nonattainment area was submitted and approved by EPA on June 5, 1980.

Prior to the 1990 CAA Amendments, EPA had begun development of its post-1987 policy for carbon monoxide; however, EPA did not finalize the post-1987 policy for CO because the Clean Air Act (CAA) was amended on November 15, 1990. Under section 107(d)(1)(C) of the CAA, the Yakima area was by operation of law designated nonattainment for CO because the area had been previously designated nonattainment before November 15, 1990. In the November 6, 1991, **Federal Register**, (56 FR 56694) the Yakima area was classified as a ''not classified'' CO nonattainment area as the area had not violated the CO NAAQS in 1988 or 1989.

Before the Yakima ''not classified'' CO nonattainment area may be redesignated to attainment, the State must have fulfilled the applicable requirements of part D. Under part D, an area's classification indicates the requirements to which it will be subject. Subpart 1 of part D sets forth the basic nonattainment requirements applicable to all nonattainment areas, whether classified or nonclassifiable.

The relevant Subpart 1 requirements are contained in sections 172(c) and 176. The April 16, 1992, General Preamble for the Implementation of Title I of the Clean Air Act Amendments of 1990 (see 57 FR 13498) (''General Preamble of April 16, 1992'') provides EPAs interpretation of the CAA requirements for not classified CO areas (see specifically 57 FR 13535). The General Preamble reads, ''Although it seems clear that the CO-specific requirements of subpart 3 of part D do not apply to CO ''not classified'' areas, the 1990 CAAA are silent as to how the requirements of subpart 1 of part D, which contains general SIP planning requirements for all designated nonattainment areas, should be interpreted for such CO areas. Nevertheless, because these areas are designated nonattainment, some aspects of subpart 1 necessarily apply.''

Under section 172(b), the applicable section 172(c) requirements, as determined by the Administrator, were due no later than three years after an area was designated as nonattainment under section 107(d) of the amended CAA (see 56 FR 56694, November 6, 1991). In the case of the Yakima area, the due date was November 15, 1993. Since the Yakima CO redesignation request and maintenance plan were not submitted by Washington until September 26, 2001, the General Preamble of April 16, 1992, provides that the applicable requirements of CAA section 172 are: 172(c)(3) (emissions inventory), 172(c)(5)(new source review permitting program), and 172(c)(7)(the section 110(a)(2) air quality monitoring requirements)). See 57 FR 13535, April 16, 1992.

EPA has determined that the Part D requirements for Reasonably Available Control Measures (RACM), an attainment demonstration, reasonable further progress (RFP), and contingency measures (CAA section 172(c)(9)) are not applicable to ''not classified'' CO nonattainment areas. See 57 FR 13535, April 16, 1992. EPA has also interpreted the requirements of sections 172(c)(1) (reasonably available control measures—RACM), 172(c)(2) (reasonable further progress—RFP), 172(c)(6) (other measures), and 172(c)(9) (contingency measures) as being irrelevant to a redesignation request because they only have meaning for an area that is not attaining the standard. See the General Preamble of April 16, 1992, and the Calcagni Memorandum. Finally, the State has not sought to exercise the options that would trigger sections 172(c)(4) (identification of certain emissions increases) and 172(c)(8) (equivalent techniques). Thus, these provisions are also not relevant to this redesignation request.

Section 176 of the CAA contains requirements related to conformity. Although federal regulations (see 40 CFR 51.396) require that states adopt transportation conformity provisions in their SIPs for areas designated nonattainment or that are subject to a federally approved maintenance plan, EPA has decided that a transportation conformity SIP is not an applicable requirement for purposes of evaluating a redesignation request under section 107(d) of the CAA. This decision is reflected in the 1996 approval of the Boston carbon monoxide redesignation. (See 61 FR 2918, January 30, 1996.)

The remaining applicable requirements of CAA section 172 are discussed below.

A. Section 172(c)(3)—Emissions Inventory

Section 172(c)(3) of the CAA requires a comprehensive, accurate, current inventory of all actual emissions from all sources in the Yakima CO nonattainment area. The emission inventory requirement for ''not classified'' CO nonattainment areas is detailed in the General Preamble of April 16, 1992. EPA has determined that an emissions inventory is required by CAA section 172(c)(3) regardless of air quality levels. An emissions inventory must be included as a revision to the SIP and was due three years from the time of the area's designation. For ''not classified'' CO areas, this date is November 15, 1993. To address the section 172(c)(3) requirement for a ''current'' inventory, EPA interpreted ''current'' to mean calendar year 1990 (see 57 FR 13502, April 16, 1992).

On March 4, 1994, Washington submitted a 1992 emission inventory for the Yakima CO nonattainment area. EPA deferred action on that inventory pending submittal of a maintenance plan. A 1996 emission inventory was prepared by YRCAA but it was never submitted to EPA. A new 1999 emission inventory was prepared for the CO maintenance plan. EPA believes this 1999 inventory meets the emission inventory obligation. EPA has reviewed the emission inventory and determined it is current, accurate, and comprehensive at the time and it continues to represent emissions in the area that provide for attainment with a 1998–1999 design value of 5.1 ppm CO.

B. Section 172(c)(5)—New Source Review (NSR)

The CAA requires all nonattainment areas to meet several requirements regarding NSR. The State must have an approved NSR program that meets the requirements of section 172(c)(5) of the Act. The State of Washington has an approved NSR program (see 60 FR 28726, June 2, 1995) that is applicable in Yakima CO nonattainment area. The requirements of the Part D, NSR program will be replaced by the Prevention of Significant Deterioration (PSD) program upon the effective date of this redesignation. The Federal PSD regulations found at 40 CFR 52.21 are the PSD rules in effect in Washington.

C. Section 172(c)(7)—Compliance With CAA Section 110(a)(2): Air Quality Monitoring Requirements

According to the General Preamble of April 16, 1992, ''not classified'' CO nonattainment areas should meet the ''applicable'' air quality monitoring requirements of section 110(a)(2) of the CAA. The State of Washington has operated a CO monitor in the Yakima area since the early 1970's. EPA previously approved the SIP for monitoring on April 15, 1981 (46 FR 21994). This SIP revision does not change that monitoring provision and it remains approved and in effect.

(c) The Area Must Have A Fully Approved SIP Under Section 110(k) of the CAA

Section 107(d)(3)(E)(ii) of the CAA states that for an area to be redesignated to attainment, it must be determined that the Administrator has fully approved the applicable implementation plan for the area under section 110(k).

Based on the approval into the SIP of provisions under the pre-1990 CAA, EPA's prior approval of a SIP revision required under the 1990 amendments to the CAA, and it's approval of the State's commitment to maintain an adequate monitoring network, EPA has determined that, as of the date of this action, Washington has a fully approved CO SIP under section 110(k) for the Yakima CO nonattainment area.

(d) The Area Must Show the Improvement in Air Quality Is Due to Permanent and Enforceable Emission Reductions

Section 107(d)(3)(E)(iii) of the CAA provides that for an area to be redesignated to attainment, the Administrator must determine that the improvement in air quality is due to permanent and enforceable reductions in emissions resulting from implementation of the applicable implementation plan, implementation of applicable Federal air pollutant control regulations, and other permanent and enforceable reductions.

The CO emissions reductions for the Yakima area were achieved through a number of control measures. The primary emission reductions are the result of the Federal Motor Vehicle Emission Standards and fleet turnover. These reductions will continue into the maintenance period for the Yakima area. In addition, there is a State requirement for commute trip reduction within the city of Yakima. The Yakima CO nonattainment area is a geographic area contained within the City boundary. This measure covers six employers in the nonattainment area and six additional employers within the City of Yakima, but outside the nonattainment area. And lastly there are three local measures that reduce CO emissions in the area: control of outdoor and agricultural burning, prohibition of installation of uncertified wood stoves, and wood stove curtailment program. While these local control measures are aimed at controlling particulate matter emissions, they concurrently reduce CO emissions especially during wintertime inversion conditions that are conducive to both PM and CO pollutant build-up. These local control measures have previously been approved by EPA in the PM–10 SIP for Yakima.

EPA has evaluated the various State and Federal control measures, and the 1999 emission inventory, and have concluded that the improvement in air quality in the Yakima nonattainment area has resulted from emission reductions that are permanent and enforceable.

(e) The Area Must Have A Fully Approved Maintenance Plan Under CAA Section 175A

Section 107(d)(3)(E)(iv) of the CAA provides that for an area to be redesignated to attainment, the Administrator must have fully approved a maintenance plan for the area meeting the requirements of section 175A of the CAA.

Section 175A of the CAA sets forth the elements of a maintenance plan for areas seeking redesignation from nonattainment to attainment. For areas such as Yakima that are utilizing EPA's limited maintenance plan approach, as detailed in the EPA guidance memorandum, ''Limited Maintenance Plan Option for Nonclassifiable CO Nonattainment Areas'' from Joseph Paisie, Group Leader, Integrated Policy and Strategies Group, Office of Air Quality and Planning Standards, dated October 6, 1995 (''Paisie Memorandum''), the maintenance plan demonstration requirement is considered to be satisfied for ''not classified'' areas if the monitoring data show the design value is at or below 7.65 ppm, or 85% of the level of the 8 hour CO NAAQS. The design value must be based on the 8 consecutive quarters of data. There is no requirement to project emissions or air quality over the maintenance period. EPA believes if the area begins the maintenance period at, or below, 85 percent of the level of the CO 8 hour NAAQS, the applicability of PSD requirements, the control measures already in the SIP, and Federal measures, should provide adequate assurance of maintenance over the initial 10-year maintenance period. In addition, the design value for the area must continue to be at or below 7.65 ppm until the time of final EPA action on the redesignation. The method for calculating the design value is presented in the June 18, 1990, EPA guidance memorandum entitled ''Ozone and Carbon Monoxide Design Value Calculations'', from William G. Laxton, Director of the OAQPS Technical Support Division, to Regional Air Directors (hereafter referred to as the ''Laxton Memorandum''.)

In the case of a ''not classified'' area applying for a limited maintenance plan, all the monitors must have a separate design value calculated and the highest design value must be at or below 7.65 ppm. Should the design value for the area exceed 7.65 ppm prior to final EPA action on the redesignation, then the area no longer qualifies for the limited maintenance plan and must instead submit a full maintenance plan as described in the Calcagni Memorandum.

Eight years after redesignation to attainment, the State must submit a revised maintenance plan that demonstrates continued maintenance of the CO NAAQS for an additional 10 years following the initial ten-year maintenance period. To address the possibility of future NAAQS violations, the maintenance plan must contain contingency measures, with a schedule for adoption and implementation, that are adequate to assure prompt correction of a violation. In this direct final rulemaking action, EPA is approving the limited maintenance plan for the Yakima nonattainment area because EPA has determined, as detailed below, that the State's maintenance plan submittal meets the requirements of section 175A of the CAA.

The analysis of the pertinent maintenance plan requirements follows:

1. Emissions Inventory—Attainment Year

The plan must contain an attainment year emissions inventory to identify the level of emissions in the area which is sufficient to attain the CO NAAQS. This inventory is to be consistent with EPA's most recent guidance on emissions inventories for nonattainment areas available at the time [1] and should

[1] The October 6, 1995, limited maintenance plan guidance memorandum states that current guidance on the preparation of emissions inventories for CO areas is contained in the following documents: ''Procedures for the Preparation of Emission Inventories for Carbon Monoxide and Precursors of

represent emissions during the time period associated with the monitoring data showing attainment. The Yakima CO maintenance plan contains an accurate, current, and comprehensive emission inventory for calendar year 1999 which coincides with the year that the design value of 5.1 ppm CO was calculated. Therefore the Yakima maintenance plan meets the emission inventory requirement.

2. Demonstration of Maintenance

As described in the October 6, 1995, limited maintenance plan guidance memorandum (Paisie Memorandum), the maintenance plan demonstration requirement is considered to be satisfied for ''not classified'' CO areas if the design value for the area is equal to, or less than 7.65 ppm. The CO design value for 1998–1999 period for the Yakima area is 5.1 ppm, which is below the limited maintenance plan requirement of 7.65 ppm. Therefore, the Yakima area has adequately demonstrated that it will maintain the CO NAAQS into the future.

3. Monitoring Network and Verification of Continued Attainment

Continued ambient monitoring of an area is required over the maintenance period. Sections 5.3 and 5.4 of the Yakima CO maintenance plan provide for continued ambient monitoring in the area.

4. Contingency Plan

Section 175A(d) of the CAA requires that a maintenance plan include contingency provisions. As discussed above, this requirement is not relevant to the redesignation request, but a contingency measure has been included in the plan. The plan contains a measure that requires the City of Yakima to change the timing of intersection stop lights in the downtown core to increase the speed of traffic on the heavily traveled streets. The change in speed is estimated to be from an average of 14 mph to 16 mph resulting in a 17% reduction in CO emissions. The City will adjust the stop light timing to achieve the reductions when CO levels reach 7.1 ppm and levels continue to increase.

IV. Conformity

Because Yakima submitted a limited maintenance plan, special conformity provisions apply. The transportation conformity rule (58 FR 62188; November 24, 1993) and the general conformity rule (58 FR 63214; November 30, 1993) apply to nonattainment areas and maintenance areas operating under maintenance plans. Under either rule, one means of demonstrating conformity of Federal actions is to indicate that expected emissions from planned actions are consistent with the emissions budget for the area. Emissions budgets in limited maintenance plan areas may be treated as essentially not constraining for the length of the initial maintenance period because there is no reason to expect that such an area will experience so much growth in that period that a violation of the CO NAAQS would result. In other words, emissions need not be capped for the maintenance period. Therefore, in areas with approved limited maintenance plans, Federal actions requiring conformity determination under the transportation conformity rule could be considered to satisfy the ''budget test'' required in sections 93.118, 93.119, and 93.120 of the rule. Similarly, in these areas, Federal actions subject to the general conformity rule could be considered to satisfy the ''budget test'' specified in section 93.158(a)(5)(i)(A) of the rule.''

V. Final Action

EPA approves the maintenance plan and request to redesignate the Yakima CO nonattainment area to attainment.

EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. However, in the proposed rules section of this **Federal Register** publication, EPA is publishing a separate document that will serve as the proposal to approve the SIP revision should adverse comments be filed. This rule will be effective December 31, 2002 without further notice unless the Agency receives adverse comments by December 2, 2002.

If EPA receives such comments, then EPA will publish a timely withdrawal of the direct final rule informing the public that the rule will not take effect. All public comments received will then be addressed in a subsequent final rule based on the proposed rule. The EPA will not institute a second comment period on this rule. Any parties interested in commenting on this rule should do so at this time. If no such comments are received, the public is advised that this rule will be effective on December 31, 2002 and no further action will be taken on the proposed rule.

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 (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

Ozone: Volume I'' (EPA–450/4–91–016), and ''Procedures for Emission Inventory Preparation: Volume IV, Mobile Sources'' (EPA–450/4–81–026d revised).

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 December 31, 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, Carbon Monoxide, Intergovernmental relations, Reporting and recordkeeping requirements.

40 CFR Part 81

Air pollution control, National parks, Wilderness areas.

Dated: August 13, 2002.

Ronald A. Kreizenbeck,

Acting Regional Administrator, Region 10.

Parts 52 and 81, chapter I, title 40 of the Code of Federal Regulations are 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 WW–Washington

2. Subpart WW is amended by adding § 52.2475 to read as follows:

§ 52.2475 Approval of plans.

(a) Carbon Monoxide.

(1) Yakima.

(i) EPA approves as a revision to the Washington State Implementation Plan, the Yakima Carbon Monoxide maintenance plan submitted by the State on August 31, 2001.

(ii) [Reserved]

(2) Spokane. [Reserved]

(b) Lead. [Reserved]

(c) Nitrogen Dioxide. [Reserved]

(d) Ozone. [Reserved]

(e) Particulate Matter. [Reserved]

(f) Sulfur dioxide. [Reserved]

PART 81—[AMENDED]

1. The authority citation for part 81 continues to read as follows:

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

2. In § 81.348, the table entitled ''Washington-Carbon Monoxide'' is amended by revising the entry for ''Yakima Area'' to read as follows:

§ 81.348 Washington.

* * * * *

WASHINGTON—CARBON MONOXIDE

Designated area	Designation		Classification	
	Date[1]	Type	Date[1]	Type
* * *	*	*	*	*
Yakima Area:				
Yakima County (part)	12–31–2002	[Attainment].		
Portion of the Central Business District Street intersections: S. 16th Ave. & W Mead Ave, S. 16th Ave & Hathaway Ave., E ''I'' St. & N 1st St., N 1st St & E ''G'' St., E ''G'' St & N 8th St., N 8th St. & Pitcher St., Pitcher St. & I–82 Interchange, Nob Hill Blvd & I–82 Interchange, Rudkin Rd & I–82 Interchange, S 1st St. & Old Town Rd., Old Town Rd & Main St., W Washington & S 1st St., E Mead Ave & S 1st St., S 16th Ave & W Mead Ave.				
* * *	*	*	*	*

[1] This date is November 15, 1990, unless otherwise noted.

* * * * *

[FR Doc. 02–27833 Filed 10–31–02; 8:45 am]
BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[OPP–2002–0298; FRL–7279–6]

Thiamethoxam; Pesticide Tolerance

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes a tolerance for combined residues of thiamethoxam and its metabolite in or on corn forage, corn stover and popcorn, corn grain and sweet corn (kernal and cob with husk removed). Syngenta Crop Protection, Inc. requested this tolerance under the Federal Food, Drug, and Cosmetic Act (FFDCA) , as amended by the Food Quality Protection Act of 1996 (FQPA).

DATES: This regulation is effective November 1, 2002. Objections and requests for hearings, identified by docket ID number OPP–2002–0298, must be received on or before December 31, 2002.

ADDRESSES: Written objections and hearing requests may be submitted electronically, by mail, or through hand delivery/courier. Follow the detailed instructions as provided in Unit VI. of the **SUPPLEMENTARY INFORMATION.**

FOR FURTHER INFORMATION CONTACT: Dani Daniel, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW.,Washington, DC 20460–0001; telephone number: 703 305–5409; e-mail address: daniel.dani@epa.gov.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does This Action Apply to Me?

You may be affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. Potentially affected categories and entities may include, but are not limited to:

Categories	NAICS	Examples of Potentially Affected Entities
Industry	111	Crop production
	112	Animal production
	311	Food manufacturing
	32532	Pesticide manufacturing

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in the table could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether or not this action might apply to certain entities. If you have questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

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

1. *Docket.* EPA has established an official public docket for this action under docket identification (ID) number OPP–2002–0298. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA. This docket facility is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The docket telephone number is (703) 305–5805.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the ''**Federal Register**'' listings at http://www.epa.gov/fedrgstr/. A frequently updated electronic version of 40 CFR part 180 is available at http://www.access.gpo.gov/nara/cfr/cfrhtml_00/Title_40/40cfr180_00.html, a beta site currently under development. To access the OPPTS Harmonized Guidelines referenced in this document, go directly to the guidelines at http://www.epa.gov/opptsfrs/home/guidelin.htm.

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at http://www.epa.gov/edocket/ to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B.1. Once in the system, select ''search,'' then key in the appropriate docket ID number.

II. Background and Statutory Findings

In the **Federal Register** of June 27, 2002 (67 FR 43310–43314) (FRL–7183–2), EPA issued a notice pursuant to section 408 of FFDCA, 21 U.S.C. 346a, as amended by FQPA (Public Law 104–170), announcing the filing of a pesticide petition (PP 0F6142) by Syngenta Crop Protection, Inc., P.O. Box 18300 Greensboro, NC 27419–8300. That notice included a summary of the petition prepared by Syngenta Crop Protection, Inc., the registrant. There were no comments received in response to the notice of filing.

The petition requested that 40 CFR 180.565 be amended by establishing tolerances for combined residues of the insecticide thiamethoxam, 3-[(2-chloro-5-thiazolyl)methyl] tetrahydro-5-methyl-*N*-nitro-4H-1,3,5-oxadiazin-4-imine and its metabolite (*N*-(2-chloro-thiazol-5-ylmethyl)-*N*′-methyl-*N*′-nitro-guanidine) in or on the raw agricultural commodities: field corn forage at 0.10 parts per million (ppm), sweet corn forage at 0.10 ppm, popcorn forage at 0.10 ppm, field corn stover at 0.05 ppm, sweet corn stover at 0.05 ppm, field corn grain at 0.07 ppm, popcorn grain at 0.02 ppm, and sweet corn (kernal and cob with husk removed) at 0.02 ppm.

Section 408(b)(2)(A)(i) of the FFDCA allows EPA to establish a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the tolerance is ''safe.'' Section 408(b)(2)(A)(ii) of the FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in residential settings, but does not include occupational exposure. Section 408(b)(2)(C) of the FFDCA requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue....''

EPA performs a number of analyses to determine the risks from aggregate exposure to pesticide residues. For further discussion of the regulatory requirements of section 408 of the FFDCA and a complete description of

the risk assessment process, see the final rule on Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997) (FRL–5754–7).

III. Aggregate Risk Assessment and Determination of Safety

Consistent with section 408(b)(2)(D) of the FFDCA, EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of and to make a determination on aggregate exposure, consistent with section 408(b)(2) of the FFDCA, for a tolerance for combined residues of thiamethoxam and its metabolite on field corn forage at 0.10 parts per million (ppm), sweet corn forage at 0.10 ppm, popcorn forage at 0.10 ppm, field corn stover at 0.05 ppm, sweet corn stover at 0.05 ppm, field corn grain at 0.07 ppm popcorn grain at 0.02 ppm, and sweet corn (kernal and cob with husk removed) at 0.02 parts per million (ppm). EPA's assessment of exposures and risks associated with establishing the tolerance follows.

A. Toxicological Profile

EPA has evaluated the available toxicity data and considered its validity, completeness, and reliability as well as the relationship of the results of the studies to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children. The nature of the toxic effects caused by thiamethoxam are discussed in Table 1 of this unit as well as the no-observed-adverse-effect-level (NOAEL) and the lowest-observed-adverse-effect-level (LOAEL) from the toxicity studies reviewed.

TABLE 1.—SUBCHRONIC, CHRONIC, AND OTHER TOXICITY

Guideline No.	Study Type	Results
870.3100	90–day oral toxicity - rat	NOAEL = 1.74 (males), 92.5 (females) mg/kg/day LOAEL = 17.64 (males), 182.1 (females) mg/kg/day based on increased incidence of hyaline change of renal tubular epithelium (males), fatty change in adrenal gland of females, liver changes in females, all at the LOAEL.
870.3100	90–Day oral toxicity-mouse	NOAEL = 1.41 (males), 19.2 (females) mg/kg/day LOAEL = 14.3 (males), 231 (females) mg/kg/day based on increased incidence of hepatocellular hypertrophy. At higher dose levels: decrease in bodyweight and bodyweight gain, necrosis of individual hepatocytes, pigmentation of Kupffer cells, and lymphocytic infiltration of the liver in both sexes; slight hematologic effects and decreased absolute and relative kidney weights in males; and ovarian atrophy, decreased ovary and spleen weights and increased liver weights in females.
870.3150	90– oral toxicity - dog	NOAEL = 8.23 (males), 9.27 (females) mg/kg/day LOAEL = 32.0 (males), 33.9 (females) mg/kg/day based on slightly prolonged prothrombin times and decreased plasma albumin and A/G ratio (both sexes); decreased calcium levels and ovary weights and delayed maturation in the ovaries (females); decreased cholesterol and phospholipid levels, testis weights, spermatogenesis, and spermatic giant cells in testes (males).
870.3200	28– dermal toxicity - rat	NOAEL = 250 (males), 60 (females) mg/kg/day LOAEL = 1,000 (males), 250 (females) mg/kg/day based on increased plasma glucose, triglyceride levels, and alkaline phosphatase activity and inflammatory cell infiltration in the liver and necrosis of single hepatocytes in females and hyaline change in renal tubules and a very slight reduction in body weight in males. At higher dose levels in females, chronic tubular lesions in the kidneys and inflammatory cell infiltration in the adrenal cortex were observed.
870.3700	Prenatal developmental - rat	Maternal NOAEL = 30 mg/kg/day LOAEL = 200 mg/kg/day based on decreased body weight, body weight gain, and food consumption. Developmental NOAEL = 200 mg/kg/day LOAEL = 750 mg/kg/day based on decreased fetal body weight and an increased incidence of skeletal anomalies.
870.3700	Prenatal developmental - rabbit	Maternal NOAEL = 50 mg/kg/day LOAEL = 150 mg/kg/day based on maternal deaths, hemorrhagic uterine contents and hemorrhagic discharge, decreased body weight and food intake during the dosing period. Developmental NOAEL = 50 mg/kg/day LOAEL = 150 mg/kg/day based on decreased fetal body weights, increased incidence of post-implantation loss and a slight increase in the incidence of a few skeletal anomalies/variations.

TABLE 1.—SUBCHRONIC, CHRONIC, AND OTHER TOXICITY—Continued

Guideline No.	Study Type	Results
870.3800	Reproduction and fertility effects - rat	Parental/Systemic NOAEL = 1.84 (males), 202.06 (females) mg/kg/day LOAEL = 61.25 (males), not determined (females) mg/kg/day based on increased incidence of hyaline change in renal tubules in F_0 and F_1 males. Reproductive NOAEL = 0.61 (males), 202.06 (females) mg/kg/day LOAEL = 1.84 (males), not determined (females) mg/kg/day based on increased incidence and severity of tubular atrophy observed in testes of the F_1 generation males. Offspring NOAEL = 61.25 (males), 79.20 (females) mg/kg/day LOAEL = 158.32 (males), 202.06 (females) mg/kg/day based on reduced body weight gain during the lactation period in all litters .
870.4100	Chronic toxicity - dog	NOAEL = 4.05 (males), 4.49 (females) mg/kg/day LOAEL = 21.0 (males), 24.6 (females) mg/kg/day based on increase in creatinine in both sexes, transient decrease in food consumption in females, and occasional increase in urea levels, decrease in ALT, and atrophy of seminiferous tubules in males.
870.4200	Carcinogenicity - mouse	NOAEL = 2.63 (males), 3.68 (females) mg/kg/day LOAEL = 63.8 (males), 87.6 (females) mg/kg/day based on hepatocyte hypertrophy, single cell necrosis, inflammatory cell infiltration, pigment deposition, foci of cellular alteration, hyperplasia of Kupffer cells and increased mitotic activity; also, an increase in the incidence of hepatocellular adenoma (both sexes). At higher doses, there was an increase in the incidence of hepatocellular adenocarcinoma (both sexes) and the number of animals with multiple tumors. evidence of carcinogenicity
870.4300	Combined chronic carcinogenicity - rat	NOAEL = 21.0 (males), 50.3 (females) mg/kg/day LOAEL = 63.0 (males), 155 (females) mg/kg/day based on increased incidence of lymphocytic infiltration of the renal pelvis and chronic nephropathy in males and decreased body weight gain, slight increase in the severity of hemosiderosis of the spleen, foci of cellular alteration in liver and chronic tubular lesions in kidney in females. no evidence of carcinogenicity
870.5100 870.5265	Gene mutation in *S. typhimurium* and *E. coli*	No evidence of gene mutation when tested up to 5,000 µg/plate. There was no evidence of cytotoxicity.
870.5265	Gene mutation in *S. typhimurium*	No evidence of gene mutation when tested up to 5,000 µg/plate. The S9 fraction was from non-induced mouse liver, Aroclor 1254 induced mouse liver, or thiamethoxam induced mouse liver, following dietary administration of thiamethoxam for 14 days at concentrations up to 2,500 ppm.
870.5300	Gene mutation in chinese hamster V79 cells at HGPRT locus	No evidence of gene mutation when tested up to solubility limit.
870.5375	CHO cell cytogenetics	No evidence of chromosomal aberrations when tested up to cytotoxic or solubility limit concentrations.
870.5395	*In vivo* mouse bone marrow micronucleus	Negative when tested up to levels of toxicity in whole animals; however no evidence of target cell cytotoxicity.
870. 5550	UDS assay	Negative when tested up to precipitating concentrations
870.6200	Acute neurotoxicity screening battery - rat	NOAEL = 100 mg/kg/day LOAEL = 500 mg/kg/day based on drooped palpebral closure, decrease in rectal temperature and locomotor activity and increase in forelimb grip strength (males only). At higher dose levels, mortality, abnormal body tone, ptosis, impaired respiration, tremors, longer latency to first step in the open field, crouched-over posture, gait impairment, hypo-arousal, decreased number of rears, uncoordinated landing during the righting reflex test, slight lacrimation (females only) and higher mean average input stimulus value in the auditory startle response test (males only).

TABLE 1.—SUBCHRONIC, CHRONIC, AND OTHER TOXICITY—Continued

Guideline No.	Study Type	Results
870.6200	Subchronic neurotoxicity screening battery - rat	NOAEL = 95.4 (males), 216.4 (females) mg/kg/day, both highest dose tested. LOAEL = not determined. No treatment-related observations at any dose level. LOAEL was not achieved. May not have been tested at sufficiently high dose levels; however, new study not required because the weight of the evidence from the other toxicity studies indicates no evidence of concern.
870.7485	Metabolism and pharmacokinetics - rat	Absorbed rapidly and extensively, widely distributed, followed by very rapid elimination, mostly in urine. Highest tissue concentrations in skeletal muscle: 10–15% of administered dose. Half life times from tissues ranged from 2–6 hours. Tissue residues after 7 days extremely low. Approximately 84–95% of administered dose excreted in urine and 2.5–6% excreted in feces within 24 hours. Greater than 0.2% detected in expired air. Most excreted as unchanged parent: 70–80% of dose. The major biotransformation reaction is cleavage of oxadiazine ring to corresponding nitroguanidine compound. Minor pathways: (1) cleavage of nitroguanidine group yielding guanidine derivative, (2) hydrolysis of guanidine group to corresponding urea, (3) demethylation of guanidine group, and (4) substitution of the chlorine of the thiazole ring by glutathione. Cleavage between thiazole- and oxadiazine ring occurs to a small extent. Glutathione derivatives prone to further degradation of the glutathione moiety resulting in various sulfur-containing metabolites (e.g. mercapturates, sulfides, and sulfoxides). Both the thiazole and oxadiazine moiety susceptible to oxidative attack. Small but measurable amounts exhaled, most probably as CO_2. Metabolites eliminated very rapidly. Enterohepatic circulation negligible.
870.7485	Metabolism and pharmacokinetics - mouse	Approximately 72% of administered dose excreted in the urine; 19% excreted in feces. Small but measurable amount detected in expired air (approximately 0.2% of dose). Predominant metabolites: unchanged parent (33–41% of administered dose; 2 other metabolites: 8–12% and 9–18% of administered dose. These are the same structures that were most commonly observed in rat excreta, however the proportions are quite different in mouse excreta. One additional significant metabolite (mouse R6) was isolated from feces samples. Between 30–60% of the administered dose was excreted as metabolites.
870.7600	Dermal penetration - rat	Estimates of dermal absorption were based on the sum of radioactivity in skin test site, urine, feces, blood, and carcass. Percentage dermal absorption is 27.0, highest mean dermal absorption value across all groups. This value is considered to represent the potential cumulative dermal absorption of test material that might occur after a 10 hour dermal exposure. As the study design did not permit analysis of the fate of skin bound residues, residues at skin site were included in determination of dermal absorption.
	Hepatic cell proliferation study - mouse	NOAEL = 16 (males), 20 (females) mg/kg/day LOAEL = 72 (males), 87 (females) mg/kg/day based on proliferative activity of hepatocytes. At higher dose levels, increases in absolute and relative liver wts, speckled liver, hepatocellular glycogenesis/fatty change, hepatocellular necrosis, apoptosis and pigmentation were observed.
	Replicative DNA synthesis in 28–day feeding study - male rat	NOAEL = 711 mg/kg/day (highest dose tested) LOAEL = not established. Immunohistochemical staining of liver sections from control and high-dose animals for proliferating cell nuclear antigen gave no indication for a treatment-related increase in the fraction of DNA synthesizing hepatocytes in S-phase. CGA 293343 did not stimulate hepatocyte cell proliferation in male rats.
	Special study to assess liver biochemistry in mouse	NOAEL = 17 (males), 20 (females) mg/kg/day LOAEL = 74 (males), 92 (females) mg/kg/day based on marginal to slight increases in absolute and relative liver weights, a slight increase in the microsomal protein content of the livers, moderate increases in the cytochrome P450 content, slight to moderate increases in the activity of several microsomal enzymes, slight to moderate induction of cytosolic glutathione S-transferase activity. Treatment did not affect peroxisomal fatty acid βoxidation.

B. Toxicological Endpoints

The dose at which no adverse effects are observed (the NOAEL) from the toxicology study identified as appropriate for use in risk assessment is used to estimate the toxicological level of concern (LOC). However, the lowest dose at which adverse effects of concern are identified (the LOAEL) is sometimes used for risk assessment if no NOAEL was achieved in the toxicology study selected. An uncertainty factor (UF) is applied to reflect uncertainties inherent in the extrapolation from laboratory animal data to humans and in the variations in sensitivity among members of the human population as well as other unknowns. An UF of 100 is routinely used, 10X to account for interspecies differences and 10X for intraspecies differences.

For dietary risk assessment (other than cancer) the Agency uses the UF to calculate an acute or chronic reference dose (acute RfD or chronic RfD) where the RfD is equal to the NOAEL divided by the appropriate UF (RfD = NOAEL/UF). Where an additional safety factors (SF) is retained due to concerns unique to the FQPA, this additional factor is applied to the RfD by dividing the RfD by such additional factor. The acute or chronic Population Adjusted Dose (aPAD or cPAD) is a modification of the RfD to accommodate this type of FQPA SF.

For non-dietary risk assessments (other than cancer) the UF is used to determine the LOC. For example, when 100 is the appropriate UF (10X to account for interspecies differences and 10X for intraspecies differences) the LOC is 100. To estimate risk, a ratio of the NOAEL to exposures (margin of exposure (MOE) = NOAEL/exposure) is calculated and compared to the LOC.

The linear default risk methodology (Q*) is the primary method currently used by the Agency to quantify carcinogenic risk. The Q* approach assumes that any amount of exposure will lead to some degree of cancer risk. A Q* is calculated and used to estimate risk which represents a probability of occurrence of additional cancer cases (e.g., risk is expressed as 1 x 10^{-6} or one in a million). Under certain specific circumstances, MOE calculations will be used for the carcinogenic risk assessment. In this non-linear approach, a ''point of departure'' is identified below which carcinogenic effects are not expected. The point of departure is typically a NOAEL based on an endpoint related to cancer effects though it may be a different value derived from the dose response curve. To estimate risk, a ratio of the point of departure to exposure (MOE_{cancer} = point of departure/exposures) is calculated. A summary of the toxicological endpoints for thiamethoxam used for human risk assessment is shown in Table 2 of this unit:

TABLE 2.—SUMMARY OF TOXICOLOGICAL DOSE AND ENDPOINTS FOR THIAMETHOXAM FOR USE IN HUMAN RISK ASSESSMENT

Exposure Scenario	Dose Used in Risk Assessment, UF	FQPA SF* and Level of Concern for Risk Assessment	Study and Toxicological Effects
Acute Dietarygeneral population including infants and children	NOAEL = 100 mg/kg/day UF = 100 Acute RfD = 1 mg/kg/day	FQPA SF = 10 aPAD = acute RfD/FQPA SF = 0.1 mg/kg/day	Acute mammalian neurotoxicity study in the rat LOAEL = 500 mg/kg/day based on treatment-related neurobehavioral effects observed in the FOB and LMA testing (drooped palpebral closure, decreased rectal temperature and locomotor activity, increased forelimb grip strength)
Chronic Dietary all populations	NOAEL= 0.6 mg/kg/day UF = 100 Chronic RfD = 0.006 mg/kg/day	FQPA SF = 10 cPAD = chronic RfD/FQPA SF = 0.0006 mg/kg/day	2-Generation reproduction study LOAEL = 1.8 mg/kg/day based on increased incidence and severity of tubular atrophy in testes of F1 generation males.
Oral Nondietary (all durations)	NOAEL= 0.6 mg/kg/day	LOC for MOE = 1,000 (Residential)	2-Generation reproduction study LOAEL = 1.8 mg/kg/day based on increased incidence and severity of tubular atrophy in testes of F1 generation males.
Dermal (all durations)(Residential)	Oral study NOAEL= 0.6 mg/kg/day(dermal absorption rate = 27%)	LOC for MOE = 1,000 (Residential) LOC for MOE = 100 (Occupational)	2-Generation reproduction study LOAEL = 1.8 mg/kg/day based on increased incidence and severity of tubular atrophy in testes of F_1 generation males.
Inhalation (all durations)(Residential)	Oral study NOAEL= 0.6 mg/kg/day (inhalation absorption rate = 100%)	LOC for MOE = 1,000 (Residential) LOC for MOE = 100 (Occupational)	2-Generation reproduction study LOAEL = 1.8 mg/kg/day based on increased incidence and severity of tubular atrophy in testes of F1 generation males.
Cancer (oral, dermal, inhalation)	Likely carcinogen for humans based on increased incidence of hepatocellular adenomas and carcinomas in male and female mice. Quantification of risk based on most potent unit risk: male mouse liver adenoma and/or carcinoma combined tumor rate. The upper bound estimate of unit risk, Q1* $(mg/kg/day)^{-1}$ is 3.77 x 10^{-2} in human equivalents.		

*The reference to the FQPA SF refers to any additional SF retained due to concerns unique to the FQPA.

C. Exposure Assessment

1. *Dietary exposure from food and feed uses.* Tolerances have been established (40 CFR 180.565) for the combined residues of thiamethoxam and its metabolite, in or on a variety of raw agricultural commodities. The following raw agricultural commodities have established tolerances: barley, canola, cotton, sorghum, wheat, tuberous and corm vegetables crop subgroup, fruiting vegetables, crop group, tomato paste, cucurbit vegetables crop group, pome fruits crop group,

milk and the meat and meat by products of cattle, goats, horses, and sheep. Risk assessments were conducted by EPA to assess dietary exposures from thiamethoxam in food as follows:

i. *Acute exposure*. Acute dietary risk assessments are performed for a food-use pesticide if a toxicological study has indicated the possibility of an effect of concern occurring as a result of a one day or single exposure. The Dietary Exposure Evaluation Model (DEEM®) analysis evaluated the individual food consumption as reported by respondents in the USDA 1994–1996 nationwide Continuing Surveys of Food Intake by Individuals (CSFII) and accumulated exposure to the chemical for each commodity. The following assumptions were made for the acute exposure assessments: tolerence level residues and 100% crop treated.

ii. *Chronic exposure*.In conducting this chronic dietary risk assessment the Dietary Exposure Evaluation Model (DEEM®) analysis evaluated the individual food consumption as reported by respondents in the USDA 1994–1996 nationwide Continuing Surveys of Food Intake by Individuals (CSFII) and accumulated exposure to the chemical for each commodity. The following assumptions were made for the chronic exposure assessments: percent crop treated (based on projected market shares) and anticipated residues (tier 3).

iii. *Cancer*. The dietary exposure for determining cancer risk is based on the chronic exposure explained in the previous paragraph using the same assumptions.

Section 408(b)(2)(E) of the FFDCA authorizes EPA to use available data and information on the anticipated residue levels of pesticide residues in food and the actual levels of pesticide chemicals that have been measured in food. If EPA relies on such information, EPA must require that data be provided 5 years after the tolerance is established, modified, or left in effect, demonstrating that the levels in food are not above the levels anticipated. Following the initial data submission, EPA is authorized to require similar data on a time frame it deems appropriate. As required by section 408(b)(2)(E) of the FFDCA, EPA will issue a data call-in for information relating to anticipated residues to be submitted no later than 5 years from the date of issuance of this tolerance.

Section 408(b)(2)(F) of the FFDCA states that the Agency may use data on the actual percent of food treated for assessing chronic dietary risk only if the Agency can make the following findings: Condition 1, that the data used are reliable and provide a valid basis to show what percentage of the food derived from such crop is likely to contain such pesticide residue; Condition 2, that the exposure estimate does not underestimate exposure for any significant subpopulation group; and Condition 3, if data are available on pesticide use and food consumption in a particular area, the exposure estimate does not understate exposure for the population in such area. In addition, the Agency must provide for periodic evaluation of any estimates used. To provide for the periodic evaluation of the estimate of PCT as required by section 408(b)(2)(F) of the FFDCA, EPA may require registrants to submit data on PCT.

The Agency used percent crop treated (PCT) information as follows in Table 3.

TABLE 3.—THIAMETHOXAM USES AND ESTIMATES OF PERCENT CROP TREATED

Crop	Percent Crop Treated
Tuberous and Corm Vegetables - Crop Subgroup 1 C	9
Fruiting Vegetables (Except Cucurbits - Crop Group 8	15
Cucumbers	5
Melons	13
Casabas	44
Crenshaws	44
Squash	44
Pumpkin	44
Apples	5
Crabapples	53
Pears	9
Quinces	53
Loquats	53
Field, corn	6
Pop, sweet corn	100

Since the May 23, 2001 Final Rule establishing tolerances for thiamethoxam, the Agency has updated the percent crop-treated value for apples. The registrant is voluntarily restricting use of thiamethoxam on apples to only three states, Michigan, New York and Pennsylvania. These three states account for 28% of the U.S. apple production (122,000 out of 430,200 bearing acres). After consultation with experts in the field, EPA believes that no more than 10% of the apple acreage in these states will be treated with thiamethoxam. Thus, using a percent crop-treated value of 5% for the U.S. apple acreage is expected to be an over-estimate of the acres which will actually be treated with thiamethoxam.

The Agency used 6% CT for field corn since this is the percent crop-treated value for the market leader. Sweet corn exposure estimates, which currently make up the bulk of the exposure for the cereal grains, assume 100% crop treated.

As to Conditions 2 and 3, regional consumption information and consumption information for significant subpopulations is taken into account through EPA's computer-based model for evaluating the exposure of significant subpopulations including several regional groups. Use of this consumption information in EPA's risk assessment process ensures that EPA's exposure estimate does not understate exposure for any significant subpopulation group and regional populations.

2. *Dietary exposure from drinking water*. The Agency lacks sufficient monitoring exposure data to complete a comprehensive dietary exposure analysis and risk assessment for thiamethoxam in drinking water. Because the Agency does not have comprehensive monitoring data, drinking water concentration estimates are made by reliance on simulation or modeling taking into account data on the physical characteristics of thiamethoxam.

The Agency uses the Generic Estimated Environmental Concentration (GENEEC) or the Pesticide Root Zone/Exposure Analysis Modeling System (PRZM/EXAMS) to estimate pesticide concentrations in surface water and SCI-GROW, which predicts pesticide concentrations in groundwater. In general, EPA will use GENEEC (a tier 1 model) before using PRZM/EXAMS (a tier 2 model) for a screening-level assessment for surface water. The GENEEC model is a subset of the PRZM/EXAMS model that uses a specific high-end runoff scenario for pesticides. GENEEC incorporates a farm pond scenario, while PRZM/EXAMS incorporate an index reservoir environment in place of the previous pond scenario. The PRZM/EXAMS model includes a percent crop area factor as an adjustment to account for the maximum percent crop coverage within a watershed or drainage basin.

None of these models include consideration of the impact processing (mixing, dilution, or treatment) of raw

water for distribution as drinking water would likely have on the removal of pesticides from the source water. The primary use of these models by the Agency at this stage is to provide a coarse screen for sorting out pesticides for which it is highly unlikely that drinking water concentrations would ever exceed human health levels of concern.

Since the models used are considered to be screening tools in the risk assessment process, the Agency does not use estimated environmental concentrations (EECs) from these models to quantify drinking water exposure and risk as a %RfD or %PAD. Instead, drinking water levels of comparison (DWLOCs) are calculated and used as a point of comparison against the model estimates of a pesticide's concentration in water. DWLOCs are theoretical upper limits on a pesticide's concentration in drinking water in light of total aggregate exposure to a pesticide in food, and from residential uses. Since DWLOCs address total aggregate exposure to thiamethoxam they are further discussed in the aggregate risk sections below.

Based on the PRZM/EXAMS and SCI-GROW models the estimated environmental concentrations (EECs) of thiamethoxam for acute exposures are estimated to be 11.4 parts per billion (ppb) for surface water and 1.94 ppb for ground water. The EECs for chronic exposures are estimated to be 0.77 ppb for surface water, and 1.94 ppb for ground water.

3. *From non-dietary exposure*. The term ''residential exposure'' is used in this document to refer to non-occupational, non-dietary exposure (e.g., for lawn and garden pest control, indoor pest control, termiticides, and flea and tick control on pets).

Thiamethoxam is not registered for use on any sites that would result in residential exposure. Although such uses have been requested, they are not being assessed at this time.

4. *Cumulative exposure to substances with a common mechanism of toxicity*. Section 408(b)(2)(D)(v) requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.''

EPA does not have, at this time, available data to determine whether thiamethoxam has a common mechanism of toxicity with other substances or how to include this pesticide in a cumulative risk assessment. Unlike other pesticides for which EPA has followed a cumulative risk approach based on a common mechanism of toxicity, thiamethoxam does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has not assumed that thiamethoxam has a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see the final rule for Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997).

D. Safety Factor for Infants and Children

1. *Safety factor for infants and children*—i. *In general*. FFDCA section 408 provides that EPA shall apply an additional tenfold margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the database on toxicity and exposure unless EPA determines that a different margin of safety will be safe for infants and children. Margins of safety are incorporated into EPA risk assessments either directly through use of a margin of exposure (MOE) analysis or through using uncertainty (safety) factors in calculating a dose level that poses no appreciable risk to humans.

ii. *Prenatal and postnatal sensitivity*. The developmental toxicity studies indicated no quantitative or qualitative evidence of increased susceptibility of rat or rabbit fetus to *in utero* exposure based on the fact that the developmental NOAELs are either higher than or equal to the maternal NOAELs. However, the reproductive studies indicate effects in male rats in the form of increased incidence and severity of testicular tubular atrophy. These data are considered to be evidence of increased quantitative susceptibility for male pups when compared to the parents.

iii. *Conclusion*. Based on: a. Effects on endocrine organs observed across species.

b. The significant decrease in alanine amino transferase levels in the companion animal studies and in the dog studies.

c. The mode of action of this chemical in insects (interferes with the nicotinic acetyl choline receptors of the insect's nervous system) thus a developmental neurotoxicity study is required.

d. The transient clinical signs of neurotoxicity in several studies across species.

e. The suggestive evidence of increased quantitative susceptibility in the rat reproduction study, the Agency is retaining the FQPA factor which is l0X.

E. Aggregate Risks and Determination of Safety

To estimate total aggregate exposure to a pesticide from food, drinking water, and residential uses, the Agency calculates DWLOCs which are used as a point of comparison against the model estimates of a pesticide's concentration in water (EECs). DWLOC values are not regulatory standards for drinking water. DWLOCs are theoretical upper limits on a pesticide's concentration in drinking water in light of total aggregate exposure to a pesticide in food and residential uses. In calculating a DWLOC, the Agency determines how much of the acceptable exposure (i.e., the PAD) is available for exposure through drinking water [e.g., allowable chronic water exposure (mg/kg/day) = cPAD - (average food + residential exposure)]. This allowable exposure through drinking water is used to calculate a DWLOC.

A DWLOC will vary depending on the toxic endpoint, drinking water consumption, and body weights. Default body weights and consumption values as used by the EPA are used to calculate DWLOCs: 2L/70 kg (adult male), 2L/60 kg (adult female), and 1L/10 kg (child). Default body weights and drinking water consumption values vary on an individual basis. This variation will be taken into account in more refined screening-level and quantitative drinking water exposure assessments. Different populations will have different DWLOCs. Generally, a DWLOC is calculated for each type of risk assessment used: acute, short-term, intermediate-term, chronic, and cancer.

When EECs for surface water and groundwater are less than the calculated DWLOCs, EPA concludes with reasonable certainty that exposures to the pesticide in drinking water (when considered along with other sources of exposure for which EPA has reliable data) would not result in unacceptable levels of aggregate human health risk at this time. Because EPA considers the aggregate risk resulting from multiple exposure pathways associated with a pesticide's uses, levels of comparison in drinking water may vary as those uses change. If new uses are added in the future, EPA will reassess the potential impacts of residues of the pesticide in drinking water as a part of the aggregate risk assessment process.

1. *Acute risk*. Using the exposure assumptions discussed in this unit for acute exposure, the acute dietary

exposure from food to thiamethoxam will occupy 3% of the aPAD for the U.S. population, 2% of the aPAD for females 13–49 years old, 7% of the aPAD for all infants less than 1 year old and 9% of the aPAD for children 1–2 years old. In addition, there is potential for acute dietary exposure to thiamethoxam in drinking water. The surface water EEC is 11.4 µg/L and the ground water EEC is 1.94 µg/L. Since the surface water value is greater than the ground water value, the surface water value will be used for comparison purposes and will protect for any concerns for ground water concentrations. After calculating DWLOCs and comparing them to the EECs for surface water, EPA does not expect the aggregate exposure to exceed 100% of the aPAD.

TABLE 4.—AGGREGATE RISK ASSESSMENT FOR ACUTE EXPOSURE TO THIAMETHOXAM

Population Subgroup	aPAD, mg/kg/day	% aPAD (Food)	Ground Water EEC, µg/L	Surface Water EEC, µg/L	DWLOC, µg/L
U.S. Population	0.1	3	1.94	11.4	3,400
All Infants (0–1 yr)	0.1	7	1.94	11.4	930
Children (1–2 yr)	0.1	9	1.94	11.4	910
Children (3–5 yr)	0.1	7	1.94	11.4	940
Children (6–12 yr)	0.1	4	1.94	11.4	960
Youth (13–19 yr)	0.1	2	1.94	11.4	980
Adult (20–49 yr)	0.1	2	1.94	11.4	3,400
Adult (50+ yr)	0.1	2	1.94	11.4	3,400
Females (13–49 yr)	0.1	2	1.94	11.4	2,900

[a] Population subgroups shown include the U.S. general population and the maximally exposed subpopulation of adults, infants and children, and women of child-bearing age for each exposure scenario.
[b] DWLOC = Maximum Water Exposure (mg/kg/day) H 1,000 µg/mg body weight (70 kg general population/males 13+, 60 kg females 13+, 10 kg infants and children) Water Consumption (2 L/day adults, 1 L/day infants and children). Maximum water exposure = aPAD - dietary exposure (mg/kg/day)

2. *Chronic risk*. Using the exposure assumptions described in this unit for chronic exposure, EPA has concluded that exposure to thiamethoxam from food will utilize 5% of the cPAD for the U.S. population, 13% of the cPAD for all infants < 1 year old and 19% of the cPAD for children 1–2 years old. Proposed residential uses are not being addressed in this risk assessment. In addition to chronic dietary exposure, there is potential for chronic dietary exposure to thiamethoxam in drinking water. The surface water EEC is 0.6 µg/L and the groundwater EEC is 1.94 µg/L. Since the groundwater value is greater than the surface water value, the groundwater value will be used for comparison purposes and will protect for any concerns for surface water concentrations. After calculating the DWLOCs and comparing them to the EECs for groundwater, EPA does not expect the aggregate exposure to exceed 100% of the cPAD.

TABLE 5.—AGGREGATE RISK ASSESSMENT FOR CHRONIC (NON-CANCER) EXPOSURE TO THIAMETHOXAM

Population Subgroup	cPAD, mg/kg/day	% cPAD (Food)	Surface Water EEC, µg/L	Ground Water EEC, µg/L	DWLOC µg/L
U.S. Population	0.0006	5	0.77	1.9	20
All Infants (0–1 yr)	0.0006	13	0.77	1.9	5.3
Children (1–2 yr)	0.0006	19	0.77	1.9	4.9
Children (3–5 yr)	0.0006	14	0.77	1.9	5.2
Children (6–12 yr)	0.0006	7	0.77	1.9	5.6
Youth (13–19 yr)	0.0006	4	0.77	1.9	5.8
Adult (20–49 yr)	0.0006	4	0.77	1.9	20
Adult (50+ yr)	0.0006	4	0.77	1.9	20
Females (13–49 yr)	0.0006	4	0.77	1.9	17

3. *Short-term risk*. Short-term aggregate exposure takes into account residential exposure plus chronic exposure to food and water (considered to be a background exposure level). Thiamethoxam is not registered for use

on any sites that would result in residential exposure. Therefore, the aggregate risk is the sum of the risk from food and water, which does not exceed the Agency's level of concern.

4. *Intermediate-term risk*. Intermediate-term aggregate exposure takes into account residential exposure plus chronic exposure to food and water (considered to be a background exposure level). Thiamethoxam is not registered for use on any sites that would result in residential exposure. Therefore, the aggregate risk is the sum of the risk from food and water, which does not exceed the Agency's level of concern.

5. Aggregate cancer risk for U.S. population. The cancer aggregate dietary risk estimate was calculated, using the Agency's 6% estimated market share for treatment of field corn. The dietary cancer risk from residues in food is 0.9 x 10^{-6}. For risk management purposes, EPA considers a cancer risk to be greater than negligible when it exceeds the range of 1 in 1 million. EPA has generally treated cancer risks up to 3 in 1 million as within the range of 1 in 1 million. The DWLOC for cancer aggregate risk (no residential uses) is calculated using the following equations:

DWLOCcancer(μg/L) = [chronic water exposure(mg/kg/day) x (body weight (kg))] ÷ [consumption (L) x 10^{-3} mg/μg]

chronic water exposure (mg/kg/day)=negligible risk ÷ Q* - [(chronic food exposure)(mg/kg/day)]

Assuming that the negligible risk value could be as high as 3 x 10^{-6} , the chronic water exposure value is estimated to be:

3 x 10^{-6} ÷ 3.77 x 10^{-2} - 0.0000245 = 0.0000551 mg/kg/day

The $DWLOC_{cancer}$ = 0.0000551 mg/kg/day x 70 kg ÷ 2L x 10^{-3} mg/μg = 1.9 μg/L

The surface water EEC is 0.6 μg/L and the ground water EEC is 1.9 μg/L. Since the ground water value is greater than, the surface water value it will be used for comparison purposes and will protect for any concerns for surface water concentrations. The estimated chronic ground water value for thiamethoxam (1.9 μg/L) is essentially at the $DWLOC_{cancer}$ level for the general population using the 6% market share for treated field, corn seed.

The Agency used a screening level model designed to estimate pesticide concentrations in shallow ground water. A number of factors lead EPA to believe that the actual lifetime exposure through drinking water will be less than the $DWLOC_{cancer}$. These reasons are as follows:

a. Thiamethoxam is systemic. EPA's Tier 1 ground water model assumes that all of the product that is applied to the crop is available for runoff. The registrant has submitted data to show that a percentage (15–25%) of the product is absorbed by the plant, resulting in that much less product available to leach into ground water. Although the registrant has submitted data on only 2 crops, beans and cucumbers, it is likely that the total amount of thiamethoxam that is available to leach into ground water is less than the amount EPA uses as an input into its model. Due to limited data on the amount absorbed, EPA is unable to quantify this.

b. Although the Agency model is based on aerobic soil half lives, EPA's risk assessment for cancer estimate is for lifetime exposure. Data indicate the anaerobic aquatic half life for thiamethoxam is shorter than the aerobic soil half life and longer than the aerobic aquatic half life. Although EPA is unable to predict with a high degree of certainty about what happens to thiamethoxam over time in ground water, this does provide some support for an expectation that concentrations in ground water will decline between annual applications.

c. Shallow ground water modeling is not the perfect model for representing all drinking water from ground water sources. It is likely to be an overestimate of most drinking water, which tends to originate from deeper sources. EPA's experience is that the model is reasonably accurate for shallow drinking water, but the Agency believes that it is less accurate for drinking water from deeper sources.

d. The Agency has established conditions of registration for the previous uses which include two prospective ground water studies and a retrospective monitoring study, so that the reasonable certainty of no harm finding will be sustained. Preliminary results have indicated no detections of thiamethoxam in ground water.

e. The cancer risk from the food uses alone is 0.9 x 10^{-6}. The dietary risk is based on residue data derived from the average of field trials, which were performed at a higher applied-on rate than were accepted by the EPA. It is not unusual in the Agency's experience for field trial data to be an order of magnitude above actual monitoring. Since thiamethoxam has only recently been registered, actual monitoring data is not yet available. It is likely that the actual risk contribution from food will be much lower than current data indicate, which would result in a larger $DWLOC_{cancer}$. EPA expects that this refined $DWLOC_{cancer}$ would be larger than the EECs for the proposed uses. It should be noted that there are no detectable residues in the subject corn commodities.

Thus, EPA does not expect that the general population would be exposed to levels exceeding the $DWLOC_{cancer}$ over a lifetime.

6. *Determination of safety*. Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result to the general population, and to infants and children from aggregate exposure to thiamethoxam residues.

A. Analytical Enforcement Methodology

Adequate enforcement methodology High Performance Liquid Chromatography using ultra violet or mass spectrometry (HPLC/UV or MS) is available to enforce the tolerance expression. The method may be requested from: Calvin Furlow, PIRIB, IRSD (7502C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW, Washington, DC 20460; telephone number: (703) 305–5229; e-mail address: furlow.calvin@epa.gov.

B. International Residue Limits

There are no international residue limits for thiamethoxam.

V. Conclusion

Therefore, the tolerances are established for combined residues of thiamethoxam, 3-[(2-chloro-5-thiazolyl)methyl]tetrahydro-5-methyl-*N*-nitro-4H-1,3,5-oxadiazin-4-imine and its metabolite *N*-(2-chloro-thiazol-5-ylmethyl)-*N'*-methyl-nitro-guanidine, in or on field corn forage at 0.10 ppm, sweet corn forage at 0.10 ppm, popcorn forage at 0.10 ppm, field corn stover at 0.05 ppm, sweet corn stover at 0.05 ppm, field corn grain at 0.07 ppm, popcorn grain at 0.02 ppm, and sweet corn (kernal and cob with husk removed) at 0.02 ppm.

VI. Objections and Hearing Requests

Under section 408(g) of the FFDCA, as amended by the FQPA, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. The EPA procedural regulations which govern the submission of objections and requests for hearings appear in 40 CFR part 178. Although the procedures in those regulations require some modification to reflect the amendments made to the FFDCA by the FQPA, EPA will continue to use those procedures, with appropriate adjustments, until the necessary modifications can be made. The new section 408(g) of the FFDCA provides essentially the same process

for persons to ''object'' to a regulation for an exemption from the requirement of a tolerance issued by EPA under new section 408(d) of FFDCA, as was provided in the old sections 408 and 409 of the FFDCA. However, the period for filing objections is now 60 days, rather than 30 days.

A. What Do I Need to Do to File an Objection or Request a Hearing?

You must file your objection or request a hearing on this regulation in accordance with the instructions provided in this unit and in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number OPP–2002–0298 in the subject line on the first page of your submission. All requests must be in writing, and must be mailed or delivered to the Hearing Clerk on or before December 31, 2002.

1. *Filing the request*. Your objection must specify the specific provisions in the regulation that you object to, and the grounds for the objections (40 CFR 178.25). If a hearing is requested, the objections must include a statement of the factual issues(s) on which a hearing is requested, the requestor's contentions on such issues, and a summary of any evidence relied upon by the objector (40 CFR 178.27). Information submitted in connection with an objection or hearing request may be claimed confidential by marking any part or all of that information as CBI. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2. A copy of the information that does not contain CBI must be submitted for inclusion in the public record. Information not marked confidential may be disclosed publicly by EPA without prior notice.

Mail your written request to: Office of the Hearing Clerk (1900C), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001. You may also deliver your request to the Office of the Hearing Clerk in Rm.104, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA. The Office of the Hearing Clerk is open from 8 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Office of the Hearing Clerk is (703) 603–0061.

2. *Tolerance fee payment*. If you file an objection or request a hearing, you must also pay the fee prescribed by 40 CFR 180.33(i) or request a waiver of that fee pursuant to 40 CFR 180.33(m). You must mail the fee to: EPA Headquarters Accounting Operations Branch, Office of Pesticide Programs, P.O. Box 360277M, Pittsburgh, PA 15251. Please identify the fee submission by labeling it ''Tolerance Petition Fees.''

EPA is authorized to waive any fee requirement ''when in the judgement of the Administrator such a waiver or refund is equitable and not contrary to the purpose of this subsection.'' For additional information regarding the waiver of these fees, you may contact James Tompkins by phone at (703) 305–5697, by e-mail at tompkins.jim@epa.gov, or by mailing a request for information to Mr. Tompkins at Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.

If you would like to request a waiver of the tolerance objection fees, you must mail your request for such a waiver to: James Hollins, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.

3. *Copies for the Docket*. In addition to filing an objection or hearing request with the Hearing Clerk as described in Unit VI.A., you should also send a copy of your request to the PIRIB for its inclusion in the official record that is described in Unit I.B.1. Mail your copies, identified by docket ID number OPP–2002–0298, to: Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001. In person or by courier, bring a copy to the location of the PIRIB described in Unit I.B.1. You may also send an electronic copy of your request via e-mail to: opp-docket@epa.gov. Please use an ASCII file format and avoid the use of special characters and any form of encryption. Copies of electronic objections and hearing requests will also be accepted on disks in WordPerfect 6.1/8.0 or ASCII file format. Do not include any CBI in your electronic copy. You may also submit an electronic copy of your request at many Federal Depository Libraries.

B. When Will the Agency Grant a Request for a Hearing?

A request for a hearing will be granted if the Administrator determines that the material submitted shows the following: There is a genuine and substantial issue of fact; there is a reasonable possibility that available evidence identified by the requestor would, if established resolve one or more of such issues in favor of the requestor, taking into account uncontested claims or facts to the contrary; and resolution of the factual issues(s) in the manner sought by the requestor would be adequate to justify the action requested (40 CFR 178.32).

VII. Regulatory Assessment Requirements

This final rule establishes a tolerance under section 408(d) of the FFDCA in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled *Regulatory Planning and Review* (58 FR 51735, October 4, 1993). Because this rule has been exempted from review under Executive Order 12866 due to its lack of significance, this rule is not subject to Executive Order 13211, *Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use* (66 FR 28355, May 22, 2001). This final rule does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, or impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (Public Law 104–4). Nor does it require any special considerations under Executive Order 12898, entitled *Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations* (59 FR 7629, February 16, 1994); or OMB review or any Agency action under Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* (62 FR 19885, April 23, 1997). This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA), Public Law 104–113, section 12(d) (15 U.S.C. 272 note). Since tolerances and exemptions that are established on the basis of a petition under section 408(d) of the FFDCA, such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) do not apply. In addition, the Agency has determined that this action 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, entitled *Federalism*(64 FR 43255, August 10, 1999). Executive Order 13132 requires

EPA to develop an accountable process to ensure ''meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications.'' ''Policies that have federalism implications'' is defined in the Executive order to include regulations that have ''substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.'' This final rule directly regulates growers, food processors, food handlers and food retailers, not States. This action does not alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of section 408(n)(4) of the FFDCA. For these same reasons, the Agency has determined that this rule does not have any ''tribal implications'' as described in Executive Order 13175, entitled *Consultation and Coordination with Indian Tribal Governments* (65 FR 67249, November 6, 2000). Executive Order 13175, requires EPA to develop an accountable process to ensure ''meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications.'' ''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 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. Thus, Executive Order 13175 does not apply to this rule.

VIII. 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. 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 this final rule in the **Federal Register**. This final rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticide and pests, Reporting and recordkeeping requirements.

Dated: October 24, 2002.

Debra Edwards,

Acting Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346(a) and 371.

2. Section 180.565 is amended by alphabetically adding commodities to the table in paragraph (a) to read as follows:

§ 180.565 Thiamethoxam; tolerances for residues.

(a) * * *

Commodity	Parts per million
* * * * *	
Corn, field, forage	0.10
Corn, pop, forage	0.10
Corn, sweet, forage	0.10
Corn, field, grain	0.020
Corn, pop, grain	0.02
Corn, field, stover	0.05
Corn pop, stover	0.05
Corn, sweet, stover	0.05
Corn, sweet, kernal plus cob with husks removed	0.02
* * * * *	

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[FR Doc. 02–27830 Filed 10–31–02; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Parts 172, 174, 175, 176, and 177

[Docket No. RSPA–01–10568 (HM–207B)]

RIN 2137–AC64

Hazardous Materials: Retention of Shipping Papers

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Final rule; response to appeals.

SUMMARY: In this final rule, RSPA is making changes to a final rule published on July 12, 2002, in which RSPA amended the Hazardous Materials Regulations (HMR) to require shippers and carriers to retain a copy of each hazardous material shipping paper, or an electronic image thereof, for a period of 375 days after the date the hazardous material is accepted by a carrier. This final rule responds to five appeals of the July 12, 2002 final rule.

EFFECTIVE DATES: This final rule is effective on November 1, 2002. Voluntary compliance is authorized as of August 12, 2002.

FOR FURTHER INFORMATION CONTACT: Deborah Boothe of the Office of Hazardous Materials Standards, (202) 366–8553, Research and Special Programs Administration, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590.

SUPPLEMENTARY INFORMATION:

I. Background

On July 12, 2002, The Research and Special Programs Administration (RSPA, we) published a final rule under Docket HM–207B (67 FR 46123) amending the Hazardous Materials Regulations (HMR; 49 CFR parts 171–180) to require shippers and carriers to retain a copy of each hazardous material shipping paper, or an electronic image thereof, for a period of 375 days after the date the hazardous material is accepted by a carrier. The July 12, 2002 final rule incorporates into the HMR the requirements in the Federal hazardous material transportation law (Federal hazmat law) to require that, after a hazardous material ''is no longer in transportation,'' each offeror and carrier of a hazardous material must retain the shipping paper ''or electronic image thereof for a period of 1 year to be accessible through their respective principal places of business.'' 49 U.S.C. 5110(e), added by Public Law 103–311, Title I, section 115, 108 Stat. 1678 (Aug. 26, 1994). That section also provides that the offeror and carrier ''shall, upon request, make the shipping paper available to a Federal, State, or local government agency at reasonable times and locations.''

The July 12, 2002 final rule requires each person who offers or transports a hazardous material in commerce to retain a copy of the shipping paper for 375 days after the date the shipment is accepted by the initial carrier. To facilitate enforcement of this requirement, the final rule requires each

shipping paper copy to include the date of initial acceptance. For rail shipments, the date of acceptance may be the date on the shipment waybill or bill of lading. The final rule also requires that copies of shipping papers must be made immediately available, if requested, to an authorized government official.

II. Appeals Received in Response to the Final Rule

We received five appeals of the July 12, 2002 final rule from the following industry associations involved in the transportation of hazardous materials: (1) American Trucking Associations (ATA), (2) Dangerous Goods Advisory Council (DGAC), (3) Truckload Carriers Association (TCA), (4) National Propane Gas Association (NPGA), and (5) International Vessel Operators Hazardous Materials Association (VOHMA). The appellants raise two major issues of concern, and they request clarification or revision of the final rule to provide for easier compliance. All the appellants expressed concern about the final rule requirement for shipping papers to be made ''immediately'' available, upon request, to an authorized official. In addition, VOHMA requests us to modify the final rule to permit a date on a bill of lading or waybill to be used as the shipment acceptance date for vessel shipments.

A. ''Immediately Available''

All appellants request that we remove the words ''immediately available'' in §§ 172.201(e), 174.24(b), 175.30(a)(2), 176.24(b), and 177.817(f), as modified in the July 12, 2002 final rule. Appellants argue that requiring a copy of a shipping paper, or an electronic image thereof, to be made immediately available upon request could be unreasonable and burdensome. Appellants note that we did not define the term ''immediately''; thus, appellants expressed concern that enforcement personnel may be unreasonable in the way that they interpret the requirement. DGAC provides a definition for ''immediately'' as taken from the American Heritage Dictionary of the English Language. According to DGAC, the dictionary definition ''states these words '* * * imply no delay whatever, as between request and response.' * * * The word 'immediately' does not appear in 49 U.S.C. 5110(e) * * * In fact, its use appears to conflict with the congressional intent for Paragraph 5110(e) * * *'' Appellants suggest that 48 hours is a reasonable time frame to provide an authorized official with requested documents for review and inspection. According to appellants, the final rule as written is different from the Federal Motor Carrier Safety Administrations's (FMCSA) definition of a ''principal place of business'' which allows motor carriers to make records available for inspection at its principal place of business within 48 hours (excluding weekends and holidays). Therefore, they contend that allowing 48 hours as a time frame would more closely resemble the FMCSA regulations in 49 CFR 390.5 concerning the definition of a ''principal place of business.''

In response to the appeals, we are revising §§ 172.201(e), 174.24(b), 175.30(a)(2), 176.24(b), and 177.817(f) in this final rule by removing the word ''immediately.'' Persons subject to the shipping paper retention requirement must make copies available, upon request, ''at reasonable times and locations.'' This change aligns the language in the regulations with the statutory language establishing the shipping paper retention requirement in § 5110(d) of Federal hazmat law. Generally, we expect that the requested documents will be made available to an inspector some time on the day that he or she is at the inspection site. However, the words ''at reasonable times and locations'' also take into account the fact that, in some instances, the principal place of business may be in a different time zone. VOHMA notes that ''some of the provisions of [the final rule] do not address international business considerations. For cargo originating at a terminal operated by the carrier in the Far East where the shipping documents are maintained in the carriers files as required by the IMDG code, there may be a delay of 12 or more hours due to time zones and international date lines.'' VOHMA, therefore, asks us to amend the final rule language to account for differences in time zones.

We do not agree with appellants' suggestion to allow 48 hours for compliance with an authorized official's request for the shipping document copies. As we stated in the preamble to the July 12, 2002 final rule, electronic capabilities such as facsimile machines and email permit companies to transmit copies of shipping papers from shipping locations to a principal place of business very quickly. We also do not believe that appellants have any basis for their fears about unreasonable enforcement of this requirement.

B. Shipment Acceptance Date

The July 12, 2002 final rule permits rail carriers to use the date on the shipment waybill or bill of lading as the date of acceptance required to be included on shipping papers. VOHMA requests a similar provision for shipments by vessel: ''The interlining of freight containers in the intermodal transportation system and similarity in booking and transfer practices should mean that the acceptability of the last modified version of the shipping paper should extend to the water mode as well. The date of the booking for a voyage corresponds to the date of booking for rail carriage and is currently captured in the electronic system.'' As we stated in the preamble to the July 12, 2002 final rule, it was not our intention to require shippers and carriers to implement new systems for preparing and dating shipping documentation. Shipping paper retention requirements should be sufficiently flexible to accommodate current transportation practices concerning acceptance dates for shipments. We understand that air carrier systems for completing and transmitting shipping documentation are similar to those for rail and vessel shipments. Therefore, in this final rule, we are revising §§ 172.201, 175.30, and 176.24 to permit use of the date on a waybill, airbill, or bill of lading for the date of acceptance required on a shipping paper.

C. Miscellaneous Clarification

VOHMA notes that a shipping paper prepared in accordance with the International Maritime Organization's Dangerous Goods Code (IMDG Code) may be used for further transportation within the United States. VOHMA suggests that § 176.24 of the HMR should be modified to reflect the provisions of § 171.12 authorizing transportation of shipments prepared in accordance with the IMDG Code. We agree, and are making the suggested change in this final rule.

III. Regulatory Analyses and Notices

A. Executive Order 12866 and DOT Regulatory Policies and Procedures

This final rule is not considered a significant regulatory action under Executive Order 12866 and was not reviewed by the Office of Management and Budget. This final rule is not considered significant under the regulatory policies and procedures of the Department of Transportation (44 FR 11034).

This final rule implements a statutory requirement that has been in effect since 1994. We do not anticipate any additional costs on offerors and carriers of hazardous materials. Therefore, preparation of a regulatory evaluation is not warranted.

B. Executive Order 13132

This final rule has been analyzed in accordance with the principles and criteria contained in Executive Order 13132 (''Federalism''). Federal hazardous materials transportation law preempts any State, local, or Indian tribe requirement on the preparation, execution, and use of shipping documents related to hazardous materials that is not substantively the same as this final rule, 49 U.S.C. 5125(b)(1)(B), but this final rule does not have substantial direct effects on the States, the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. The consultation and funding requirements of Executive Order 13132 do not apply.

Federal hazardous materials transportation law, 49 U.S.C. 5101–5127, contains an express preemption provision (49 U.S.C. 5125(b)) preempting state, local, and Indian tribe requirements that are not substantively the same as Federal requirements on certain subjects. These subjects are:

(1) The designation, description, and classification of hazardous materials;

(2) The packing, repacking, handling, labeling, marking, and placarding of hazardous materials;

(3) The preparation, execution, and use of shipping documents related to hazardous materials and requirements related to the number, contents, and placement of those documents;

(4) The written notification, recording, and reporting of the unintentional release in transportation of hazardous material; or

(5) The design, manufacture, fabrication, marking, maintenance, recondition, repair, or testing of a packaging or container represented, marked, certified, or sold as qualified for use in transporting hazardous material.

This final rule addresses item 3 above and preempts State, local, and Indian tribe requirements not meeting the ''substantively the same as'' standard. This final rule is necessary to assure that the HMR requirements for retention of shipping papers are consistent with Federal hazardous materials transportation law.

Federal hazardous materials transportation law provides at § 5125(b)(2) that, if DOT issues a regulation concerning any of these subjects, DOT must determine and publish in the **Federal Register** the effective date of federal preemption. The effective date may not be earlier than the 90th day following the date of issuance of the final rule and not later than two years after the date of issuance. The effective date of federal preemption of this final rule is 90 days from publication of this final rule in the **Federal Register**.

C. Executive Order 13175

This final rule has been analyzed in accordance with the principles and criteria contained in Executive Order 13175 (''Consultation and Coordination with Indian Tribal Governments''). Because this final rule does not have tribal implications, does not impose substantial direct compliance costs, and is required by statute, the funding and consultation requirements of Executive Order 13175 do not apply.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires an agency to assess the impact of its regulations on small entities unless the agency determines that a rule is not expected to have a significant impact on a substantial number of small entities. This final rule implements a statutory requirement that has been in effect since 1994. This final rule will not impose additional costs on offerors and carriers of hazardous material. I hereby certify that, while the final rule applies to a substantial number of small entities, there will not be a significant economic impact on those small businesses.

E. Unfunded Mandates Reform Act of 1995

This final rule imposes no mandates and thus does not impose unfunded mandates under the Unfunded Mandates Reform Act of 1995.

F. Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995, no person is required to respond to an information collection unless it displays a valid OMB control number. No new burdens are proposed under this final rule. RSPA has a current information collection approval under OMB No. 2137–0034, ''Shipping Papers and Emergency Response Information'' which includes the shipping paper retention requirement in the burden estimates.

G. Regulation Identifier Number (RIN)

A regulation identifier number (RIN) is assigned to each regulatory action listed in the Unified Agenda of Federal Regulations. The Regulatory Information Service Center publishes the Unified Agenda in April and October of each year. The RIN number contained in the heading of this document can be used to cross-reference this action with the Unified Agenda.

H. Environmental Assessment

This final rule does not affect packaging or hazard communication requirements for shipments of hazardous materials transported in commerce. We find that there are no significant environmental impacts associated with this final rule.

List of Subjects

49 CFR Part 172

Hazardous materials transportation, Hazardous waste, Labeling, Markings, Packaging and containers, Reporting and recordkeeping requirements.

49 CFR Part 174

Hazardous materials transportation, Radioactive materials, Railroad safety.

49 CFR Part 175

Air Carriers, Hazardous materials transportation, Radioactive materials, Reporting and recordkeeping requirements.

49 CFR Part 176

Hazardous materials transportation, Maritime carriers, Radioactive materials, Reporting and recordkeeping requirements.

49 CFR Part 177

Hazardous materials transportation, Motor carriers, Radioactive materials, Reporting and recordkeeping requirements.

In consideration of the foregoing, we are amending 49 CFR Parts 172, 174, 175, 176, and 177, as follows:

PART 172—HAZARDOUS MATERIALS TABLE, SPECIAL PROVISIONS, HAZARDOUS MATERIALS COMMUNICATIONS, EMERGENCY RESPONSE INFORMATION, AND TRAINING REQUIREMENTS

1. The authority citation for part 172 continues to read as follows:

Authority: 49 U.S.C. 5101–5127; 49 CFR 1.53.

2. In § 172.201, paragraph (e) as added in the July 12, 2002 final rule, 67 FR 46127, is revised to read as follows:

§ 172.201 Preparation and retention of shipping papers.

* * * * *

(e) Each person who provides a shipping paper must retain a copy of the shipping paper required by § 172.200(a), or an electronic image thereof, that is accessible at or through its principal place of business and must make the

shipping paper available, upon request, to an authorized official of a Federal, State, or local government agency at reasonable times and locations. For a hazardous waste, the shipping paper copy must be retained for three years after the material is accepted by the initial carrier. For all other hazardous materials, the shipping paper copy must be retained for 375 days after the material is accepted by the initial carrier. Each shipping paper copy must include the date of acceptance by the initial carrier, except that, for rail, vessel, or air shipments, the date on the shipment waybill, airbill, or bill of lading may be used in place of the date of acceptance by the initial carrier. A motor carrier (as defined in § 390.5 of Subchapter B of Chapter III of Subtitle B) that uses a shipping paper without change for multiple shipments of a single hazardous material (*i.e.*, one having the same shipping name and identification number) may retain a single copy of the shipping paper, instead of a copy for each shipment made, if the carrier also retains a record of each shipment made, to include shipping name, identification number, quantity transported, and date of shipment.

PART 174—CARRIAGE BY RAIL

3. The authority citation for part 174 continues to read as follows:

Authority: 49 U.S.C. 5101–5127; 49 CFR 1.53.

4. Section 174.24(b) as added by the July 12, 2002 final rule, 67 FR 46128, is revised to read as follows:

§ 174.24 Shipping papers.

* * * * *

(b) Each person receiving a shipping paper required by this section must retain a copy or an electronic image thereof, that is accessible at or through its principal place of business and must make the shipping paper available, upon request, to an authorized official of a Federal, State, or local government agency at reasonable times and locations. For a hazardous waste, each shipping paper copy must be retained for three years after the material is accepted by the initial carrier. For all other hazardous materials, each shipping paper copy must be retained for 375 days after the material is accepted by the initial carrier. Each shipping paper copy must include the date of acceptance by the initial carrier. The date on the shipping paper may be the date a shipper notifies the rail carrier that a shipment is ready for transportation, as indicated on the waybill or bill of lading, as an alternative to the date the shipment is picked up, or accepted, by the carrier.

PART 175—CARRIAGE BY AIRCRAFT

5. The authority citation for part 175 continues to read as follows:

Authority: 49 U.S.C. 5101–5127; 49 CFR 1.53.

6. In § 175.30, paragraph (a)(2) as amended in the July 12, 2002 final rule, 67 FR 46128, is revised to read as follows:

§ 175.30 Accepting and inspecting shipments.

(a) * * *

(1) * * *

(2) Described and certified on a shipping paper prepared in duplicate in accordance with part 172 of this subchapter or as authorized by § 171.11 of this subchapter. Each person receiving a shipping paper required by this section must retain a copy or an electronic image thereof, that is accessible at or through its principal place of business and must make the shipping paper available, upon request, to an authorized official of a federal, state, or local government agency at reasonable times and locations.

For a hazardous waste, each shipping paper copy must be retained for three years after the material is accepted by the initial carrier. For all other hazardous materials, each shipping paper copy must be retained for 375 days after the material is accepted by the carrier. Each shipping paper copy must include the date of acceptance by the carrier. The date on the shipping paper may be the date a shipper notifies the air carrier that a shipment is ready for transportation, as indicated on the airbill or bill of lading, as an alternative to the date the shipment is picked up or accepted by the carrier. Only an initial carrier must receive and retain a copy of the shipper's certification, as required by § 172.204 of this subchapter.

* * * * *

PART 176—CARRIAGE BY VESSEL

7. The authority citation for part 176 continues to read as follows:

Authority: 49 U.S.C. 5101–5127; 49 CFR 1.53.

8. Section 176.24 as amended in the July 12, 2002 final rule, 67 FR 46128,is revised to read as follows:

§ 176.24 Shipping papers.

(a) A person may not accept a hazardous material for transportation or transport a hazardous material by vessel unless that person has received a shipping paper prepared in accordance with part 172 of this subchapter, or as authorized by § 171.12 of this subchapter, unless the material is excepted from shipping paper requirements under this subchapter.

(b) Each person receiving a shipping paper required by this section must retain a copy or an electronic image thereof, that is accessible at or through its principal place of business and must make the shipping paper available, upon request, to an authorized official of a Federal, State, or local government agency at reasonable times and locations. For a hazardous waste, each shipping paper copy must be retained for three years after the material is accepted by the initial carrier. For all other hazardous materials, each shipping paper copy must be retained for 375 days after the material is accepted by the carrier. Each shipping paper copy must include the date of acceptance by the carrier. The date on the shipping paper may be the date a shipper presents a booking for carriage with the carrier as an alternative to the date the shipment is picked up, accepted, or loaded on the vessel by the carrier.

PART 177—CARRIAGE BY PUBLIC HIGHWAY

9. The authority citation for part 177 continues to read as follows:

Authority: 49 U.S.C. 5101–5127; 49 CFR 1.53.

10. In § 177.817, paragraph(f) as added in the July 12, 2002 final rule, 67 FR 46128, is revised, to read as follows:

§ 177.817 Shipping papers.

* * * * *

(f) *Retention of shipping papers.* Each person receiving a shipping paper required by this section must retain a copy or an electronic image thereof, that is accessible at or through its principal place of business and must make the shipping paper available, upon request, to an authorized official of a Federal, State, or local government agency at reasonable times and locations. For a hazardous waste, the shipping paper copy must be retained for three years after the material is accepted by the initial carrier. For all other hazardous materials, the shipping paper copy must be retained for 375 days after the material is accepted by the carrier. Each shipping paper copy must include the date of acceptance by the carrier. A motor carrier (as defined in § 390.5 of Subchapter B of Chapter III of Subtitle B) that uses a shipping paper without

change for multiple shipments of a single hazardous material (*i.e.*, one having the same shipping name and identification number) may retain a single copy of the shipping paper, instead of a copy for each shipment made, if the carrier also retains a record of each shipment made, to include shipping name, identification number, quantity transported, and date of shipment.

Issued in Washington, DC, on October 25, 2002, under authority delegated in 49 CFR part 1.

Ellen G. Engleman,

Administrator.

[FR Doc. 02–27735 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–60–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 011218304–1304–01; I.D. 102802E]

Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod by Vessels Using Trawl Gear in Bering Sea and Aleutian Islands Management Area

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

ACTION: Closure.

SUMMARY: NMFS is closing directed fishing for Pacific cod by vessels using trawl gear in the Bering Sea and Aleutian Islands management area (BSAI). This action is necessary to prevent exceeding the 2002 Pacific halibut bycatch allowance specified for the trawl Pacific cod fishery.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), October 29, 2002, until 2400 hrs, A.l.t., December 31, 2002.

FOR FURTHER INFORMATION CONTACT: Andrew Smoker, 907–586–7228.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the BSAI exclusive economic zone according to the Fishery Management Plan for the Groundfish Fishery of the Bering Sea and Aleutian Islands Area (FMP) prepared by the North Pacific Fishery Management Council under authority of the Magnuson-Stevens Fishery Conservation and Management Act. Regulations governing fishing by U.S. vessels in accordance with the FMP appear at subpart H of 50 CFR part 600 and 50 CFR part 679.

The 2002 halibut bycatch allowance specified for the BSAI trawl Pacific cod fishery, which is defined at § 679.21(e)(3)(iv)(E), is 1,434 metric tons (67 FR 956, January 8, 2002).

In accordance with § 679.21(e)(7)(v), the Administrator, Alaska Region, NMFS (Regional Administrator), has determined that the 2002 halibut bycatch allowance specified for the trawl Pacific cod fishery in the BSAI has been caught. Consequently, the Regional Administrator is closing directed fishing for Pacific cod by vessels using trawl gear in the BSAI.

Maximum retainable bycatch amounts may be found in the regulations at § 679.20(e) and (f).

Classification

This action responds to the best available information recently obtained from the fishery. The Assistant Administrator for Fisheries, NOAA, finds that the need to immediately implement this action to avoid exceeding the halibut bycatch allowance for the trawl Pacific cod fishery constitutes good cause to waive the requirement to provide prior notice and opportunity for public comment pursuant to the authority set forth at 5 U.S.C. 553(b)(B). These procedures are unnecessary and contrary to the public interest because the need to implement these measures in a timely fashion to avoid exceeding the halibut bycatch allowance for the trawl Pacific cod fishery constitutes good cause to find that the effective date of this action cannot be delayed for 30 days. Accordingly, under 5 U.S.C. 553(d)(3), a delay in the effective date is hereby waived.

This action is required by 50 CFR 679.21 and is exempt from review under Executive Order 12866.

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

Dated: October 28, 2002.

Bruce C. Morehead,

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

[FR Doc. 02–27853 Filed 10–29–02; 2:47 pm]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 67, No. 212
Friday, November 1, 2002

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 AGRICULTURE

Agricultural Marketing Service

7 CFR Part 54

[Docket Number LS–02–06]

RIN 0581–AC13

Changes in Fees for Federal Meat Grading and Certification Services

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed rule.

SUMMARY: The Agricultural Marketing Service (AMS) proposes to increase the hourly fees charged for voluntary Federal meat grading and certification services performed by the Meat Grading and Certification (MGC) Branch. The hourly fees would be adjusted by this action to reflect the increased cost of providing service and to ensure that the MGC Branch operates on a financially self-supporting basis.

DATES: Comments must be received on or before December 31, 2002.

ADDRESSES: Interested persons are invited to submit written comments to Larry R. Meadows, Chief; USDA, AMS, LS, MGC Branch, STOP 0248, Room 2628–S, 1400 Independence Avenue, SW., Washington, DC 20250–0248. Telephone number (202) 720–1246. Comments may also be submitted electronically to *Larry.Meadows@usda.gov* or faxed to (202) 690–4119.

All comments should reference docket number LS–02–06 and note the date and page number of this issue of the **Federal Register**.

Comments received may be inspected at the above address, between 8 a.m. and 4:30 p.m., e.s.t., Monday through Friday, except legal holidays.

FOR FURTHER INFORMATION CONTACT: Larry R. Meadows, Chief, MGC Branch, (202) 720–1246.

SUPPLEMENTARY INFORMATION:

Background

The Secretary of Agriculture is authorized by the Agricultural Marketing Act of 1946 (AMA), as amended (7 U.S.C. 1621, *et seq.*), to provide voluntary Federal meat grading and certification services to facilitate the orderly marketing of meat and meat products and to enable consumers to obtain the quality of meat they desire. The AMA also provides for the collection of fees from users of the Federal meat grading and certification services that are approximately equal to the cost of providing these services. The hourly fees are established by equitably distributing the program's projected operating costs over the estimated hours of service—revenue hours—provided to users of the service on a yearly basis. Program operating costs include employee salaries and benefits, which account for nearly 80 percent of the operating costs, and travel, training, and administrative costs. Periodically, the fees must be adjusted to ensure that the program remains financially self-supporting.

AMS regularly reviews its user-fee-financed programs to determine if the fees are adequate. The most recent review determined that the existing fee schedule for the MGC Branch would not generate sufficient revenues to recover operating costs for current and near-term periods while maintaining an adequate reserve balance. The operating loss for fiscal year (FY) 2002 is projected to total $1.6 million. Without a fee increase, the operating loss for FY 2003 is projected to reach $2.9 million. These combined losses will deplete MGC Branch's operating reserve and place the MGC Branch in an unstable financial position that will adversely affect its ability to provide meat grading and certification services.

This proposal is necessary to offset decreased revenue hours and increased program operating expenses incurred since the last fee increase. The MGC Branch has lost revenue due to the implementation of more efficient audit-based and pilot certification programs and the continued consolidation within the livestock and meat industry. Audit-based and pilot certification programs employ fewer personnel and, therefore, generate fewer revenue hours as compared to traditional certification services.

MGC Branch operating expenses have increased due to (1) information system upgrades mandated by changes in information system technology; (2) congressionally mandated salary increases for all Federal Government employees in 2001, 2002, and 2003; (3) inflation of nonsalary operating costs; and (4) accumulated increases in continental United States (CONUS) per diem rates, mileage rates, and office maintenance costs. In the past 9 years, the MGC Branch has made efforts to control operating costs by closing 3 field offices, reducing mid-level supervisory staff by over 50 percent, and reducing the number of support staff by 38 percent. At the same time, the MGC Branch has utilized automated information management systems for data collection, retrieval, and dissemination, applicant billing, and disbursement of employee entitlements. The reduction in field offices, supervisory staff, and support personnel and the increased use of automated systems has enabled the MGC Branch to absorb a substantial portion of the operating costs and minimize hourly fee increases during these years.

Despite these cost reduction efforts and hourly fee increases in 1998 and 2000, the MGC Branch incurred a $657,000 operating loss in FY 2001. Furthermore, AMS projects that without an hourly fee increase, the MGC Branch will lose approximately $8.6 million from FY 2002 through FY 2004 and totally deplete program reserves to the point of deficit operations (*i.e.* FY 2002, $1.6 million; FY 2003, $2.9 million; and FY 2004, $4.1 million).

In view of these increased costs, AMS proposes to increase the hourly fees. The base hourly fee for commitment applicants would increase from $45 to $55. A commitment applicant is a user of meat grading and certification services who agrees to pay for five continuous 8 hour days, Monday through Friday between the hours of 6 a.m. and 6 p.m., excluding legal holidays. The base hourly fee for noncommitment applicants would increase from $52 to $64. A noncommitment applicant is a user of meat grading and certification services, who agrees to pay an hourly fee without committing to a certain number of service hours. The premium hourly fee would increase from $57 to $70. The premium hourly fee is charged to

applicants when meat grading and certification services (1) exceed 8 hours per day, (2) are performed before 6 a.m. and after 6 p.m. Monday through Friday, and (3) any time on Saturday or Sunday, except on legal holidays. The legal holiday fee would increase from $90 to $110 and is charged to applicants for meat grading and certification services provided on legal holidays.

Executive Order 12866

This action has been determined to be not significant for purposes of Executive Order 12866, and has not been reviewed by the Office of Management and Budget.

Regulatory Flexibility Act

Pursuant to the requirements set forth in the Regulatory Flexibility Act (5 U.S.C. 601, *et seq.*), the Administrator of AMS considered the economic impact of this proposed action on small entities and determined that it will not have a significant economic effect on a substantial number of small entities.

AMS, through its MGC Branch, provides voluntary Federal meat grading and certification services to 450 businesses, including 152 livestock slaughterers, 79 facilities that process federally donated products, 74 meat processors, 46 livestock producers and feeders, 28 brokers, 26 organic certifying companies, 25 trade associations, 17 State and Federal entities, and 3 distributors. Seventy-two percent of these businesses qualify as small entities, a company that employs less than 500 employees. Small entities generate approximately 17 percent of the MGC Branch's revenues and are under no obligation to use voluntary Federal meat grading and certification services provided under the authority of the AMA.

Federal meat grading and certification services facilitate the orderly marketing of meat and meat products and enable consumers to obtain the quality of meat they desire. Grading services consist of the evaluation of carcass beef, lamb, pork, veal, and calf for compliance with the grades of the appropriate official U.S. Standard. The MGC Branch grades approximately 21.1 billion pounds of meat each year. Certification services consist of the evaluation of meat and meat products for compliance with specification and contractual requirements. Certification services are regularly used by meat purchasers to ensure that the quality and yields of the products they purchase comply with their stated requirements. The MGC Branch certifies approximately 18.1 billion pounds of meat and meat products each year.

This action would raise the hourly fees charged to users of Federal meat grading and certification services. AMS estimates that this action would provide the MGC Branch an additional $401,000 per month in FY 2003. Since small entities account for 17 percent of MGC Branch revenues, they would pay an average of $212 per month per applicant. This action and the projected increase in revenue hours would increase revenues by $4.8 million per year and replenish operating revenues for the projected losses of $2.6 million in FY 2002 and $2.3 million in FY 2003. Even with this action, the unit cost for MGC Branch service (revenue/total pounds graded and certified) would remain unchanged at approximately $0.0006 per pound.

This action is necessary to offset decreased revenue hours and increased program operating costs incurred since the last fee increase. The MGC Branch has lost revenue due to the implementation of more efficient audit-based and pilot certification programs and the continued consolidation within the livestock and meat industry. Audit-based and pilot certification programs employ fewer personnel and, therefore, generate fewer revenue hours as compared to traditional certification services.

MGC Branch operating expenses have increased due to (1) information system upgrades mandated by the information system technology; (2) congressionally mandated salary increases for all Federal Government employees in 2001, 2002, and 2003; (3) inflation of nonsalary operating costs; and (4) accumulated increases in continental United States (CONUS) per diem rates, mileage rates, and office maintenance costs. Since 1993, the MGC Branch has made efforts to control operating costs by closing 3 field offices, reducing mid-level supervisory staff by over 50 percent, and reducing the number of support staff by 38 percent. At the same time, the MGC Branch has utilized automated information management systems for data collection, retrieval, and dissemination, applicant billing, and disbursement of employee entitlements. The reduction in field offices, supervisory staff and support personnel and the increased use of automated systems has enabled the MGC Branch to absorb a substantial portion of the operating costs and minimize hourly fee increases over the past 9 years.

Despite these cost reduction efforts and hourly fee increases in 1998 and 2000, the MGC Branch incurred a $657,000 operating loss in FY 2001. Furthermore, AMS projects that without an hourly fee increase; the MGC Branch would lose approximately $8.6 million from FY 2002 through FY 2004 and totally deplete program reserves to the point of deficit operations.

In view of these increased costs, AMS proposes to increase the hourly fees for Federal meat grading and certification services. The base hourly fee for commitment applicants would increase from $45 to $55. A commitment applicant is a user of meat grading and certification services who agrees to pay for five continuous 8 hour days, Monday through Friday between the hours of 6 a.m. and 6 p.m., excluding legal holidays. The base hourly fee for noncommitment applicants would increase from $52 to $64. A noncommitment applicant is a user of meat grading and certification services, who agrees to pay an hourly fee without committing to a certain number of service hours. The premium hourly fee would increase from $57 to $70. The premium hourly fee is charged to applicants when meat grading and certification services (1) exceed 8 hours per day, (2) are performed before 6 a.m. and after 6 p.m. Monday through Friday, and (3) any time on Saturday or Sunday, except on legal holidays. The legal holiday fee would increase from $90 to $110 and is charged to applicants for meat grading and certification services provided on legal holidays.

Civil Justice Reform

This action has been reviewed under Executive Order 12988, Civil Justice Reform. This action is not intended to have retroactive effect and would not pre-empt any State or local laws, regulations, or policies, unless they present an irreconcilable conflict. There are no administrative procedures which must be exhausted prior to any judicial challenge to the provisions of this rule.

Paperwork Reduction Act

This action would not impose any additional reporting or recordkeeping requirements on users of Federal meat grading and certification services.

List of Subjects in 7 CFR Part 54

Food grades and standards, Food labeling, Meat and meat products.

For the reasons set forth in the preamble, it is proposed that 7 CFR part 54 be amended as follows:

PART 54—MEATS, PREPARED MEATS, AND MEAT PRODUCTS (GRADING, CERTIFICATION, AND STANDARDS)

1. The authority citation for 7 CFR part 54 continues to read as follows:

Authority: 7 U.S.C. 1621–1627.

§ 54.27 [Amended]

2. Section 54.27 is amended as follows:

a. In paragraph (a), remove ''$52'' and add ''$64'' in its place, remove ''$57'' and add ''$70'' in its place, remove ''$90'' and add ''$110'' in its place.

b. In paragraph (b), remove ''$45'' and add ''$55'' in its place, remove ''$57'' and add ''$70'' in its place, remove ''$90'' and add ''$110'' in its place.

Dated: October 28, 2002.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 02–27766 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 956

[Docket No. FV02–956–1 PR]

Sweet Onions Grown in the Walla Walla Valley of Southeast Washington and Northeast Oregon; Reopening of Comment Period on Establishment of Grade and Inspection Requirements

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Reopening of the comment period.

SUMMARY: Notice is hereby given that the comment period on the establishment of grade and inspection requirements for Walla Walla sweet onions is reopened.

DATES: Comments must be received by November 22, 2002.

ADDRESSES: Interested persons are invited to submit written comments concerning this proposal. Comments must be sent to the Docket Clerk, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20090–0237, Fax: (202) 720–8938, or e-mail: *moab.docketclerk@usda.gov*. Comments should reference the docket number and the date and page number of this issue of the **Federal Register** and will be available for public inspection in the Office of the Docket Clerk during regular business hours, or can be viewed at: *http://www.ams.usda.gov/fv/moab.html.*

FOR FURTHER INFORMATION CONTACT: George Kelhart, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20090–0237; Telephone: (202) 720–2491, Fax: (202) 720–8938.

Small businesses may request information on compliance with this proposed regulation by contacting: Jay Guerber, Marketing Order Information Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue SW., STOP 0237, Washington, DC 20090–0237; Telephone: (202) 720–2491, Fax: (202) 720–5698, or e-mail: *Jay.Guerber@usda.gov.*

SUPPLEMENTARY INFORMATION: A proposed rule was published in the **Federal Register** on July 22, 2002 (67 FR 47741). The proposed rule invited comments on the establishment of grade and inspection requirements for Walla Walla sweet onions. The rule would require that all Walla Walla sweet onions handled prior to June 10 of each marketing season be inspected and be at least U.S. Commercial grade. By establishing minimum standards early in the season, the rule is expected to improve producer returns by ensuring that early-season sweet onions are mature and marketable. The cost of the required inspection would be fully funded by the Walla Walla Sweet Onion Marketing Committee (Committee), the agency responsible for local administration of the marketing order regulating sweet onions grown in the Walla Walla Valley of Southeast Washington and Northeast Oregon. The rule also proposed that there would be no minimum quantity exemption from inspection requirements prior to June 10. The comment period ended September 20, 2002.

One comment was received. After evaluating that comment, USDA determined that additional information could clarify certain aspects of the proposal and provide further guidance to USDA in making a final decision on the proposal. The commenter's primary objection with the proposal is that the June 10 date is too early. The commenter stated that inspections should be required on all sweet onions shipped prior to June 15, at the earliest, because, contrary to the proposal's premise, any earlier date would not prevent immature onions from being marketed.

The commenter noted that there were no shipments of Walla Walla sweet onions during the 2002 season prior to June 10, and that this indicates the proposal could be ineffective. Further analysis of the impact the proposed June 10 date would have on early-season immature onion shipments would be useful to the USDA in making a final determination on this matter.

Further, regarding the higher potential cost of inspections to the Committee if a later date were to be used rather than June 10, the commenter suggested some alternatives, including not requiring all sweet onions shipped prior to an established date to be inspected. These alternatives were not discussed by the Committee prior to its submission of the proposed rule and further information regarding such alternatives also would be useful to USDA in making a final determination on this matter.

Although providing an additional period of time for comments would delay the final decision on this proposal, it would not delay the decision so as to negatively affect its effectiveness for the 2003 marketing season. Therefore, before proceeding further on the recommendation to establish grade and inspection requirements, USDA is reopening the comment period to allow the Committee, as well as other interested persons, more time to review the proposed rule and to submit additional information. Accordingly, the period in which to file written comments is reopened until November 22, 2002. This notice is issued pursuant to the Agricultural Marketing Agreement Act of 1937.

Authority: 7 U.S.C. 601–674.

Dated: October 28, 2002.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 02–27765 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–02–P

NUCLEAR REGULATORY COMMISSION

10 CFR Part 50

RIN 3150–AG48

Voluntary Fire Protection Requirements for Light Water Reactors; Adoption of NFPA 805 as a Risk-Informed, Performance-Based Alternative

AGENCY: Nuclear Regulatory Commission.

ACTION: Proposed rule.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is proposing to amend its fire protection requirements for nuclear power reactor licensees. The proposed rule would permit reactor licensees to voluntarily adopt a set of fire protection requirements contained in the National Fire Protection

Association (NFPA) Standard 805, ''Performance-Based Standard for Fire Protection for Light Water Reactor Electric Generating Plants, 2001 Edition'' (NFPA 805). The proposed rule would provide existing nuclear power plant licensees with an alternative set of risk-informed, performance-based fire protection requirements.

DATES: Submit comments by January 15, 2003. Comments received after this date will be considered if it is practical to do so, but the Commission is only able to ensure consideration of comments received on or before this date.

ADDRESSES: Submit written comments to: Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemaking and Adjudications Staff. Written comments may also be hand-delivered to 11555 Rockville Pike, Rockville, Maryland, between 7:30 a.m. and 4:15 p.m. on Federal workdays.

Documents related to this rulemaking may be examined and copied for a fee at the NRC's Public Document Room (PDR), One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland (NFPA standards and copyrighted NFPA 805 may only be examined in the PDR). Copies of NFPA 805 may be purchased from the NFPA Customer Service Department, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269–9101 and in PDF format through the NFPA Online Catalog (*www.nfpa.org*) or by calling 1–800–344–3555 or 617–770–3000.

The NRC maintains an Agencywide Documents Access and Management System (ADAMS), which provides text and image files of the agency's public documents. These documents may be accessed through the NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/NRC/ADAMS/index.html.* If you do not have access to ADAMS, or if you encounter any problems in accessing the documents stored in ADAMS, contact the NRC's Public Document Room (PDR) Reference Staff by telephone at 1–800–397–4209, or 301–415–4737, or via email to *pdr@nrc.gov.* Certain documents (other than NFPA 805) may also be accessed electronically via the NRC's interactive rulemaking Web site: *http://ruleforum.llnl.gov.*

FOR FURTHER INFORMATION CONTACT: Leon E. Whitney, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington DC 20555–0001. Mr. Whitney can also be reached by telephone 301–415–3081, or via email at: *lew1@nrc.gov.*

SUPPLEMENTARY INFORMATION:

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I. Background and Rulemaking Initiation

In 1971, the NRC promulgated General Design Criterion (GDC) 3, ''Fire protection,'' of Appendix A to 10 CFR part 50. Subsequently (largely as a result of the fire at Browns Ferry Nuclear Plant in 1975), the NRC developed specific guidance for implementing GDC 3, as provided in Branch Technical Position (BTP) Auxiliary Power Conversion Systems Branch (APCSB) 9.5–1, ''Guidelines for Fire Protection for Nuclear Power Plants,'' dated May 1, 1976, and Appendix A to BTP APCSB 9.5–1, ''Guidelines for Fire Protection for Nuclear Power Plants Docketed Prior to July 1, 1976,'' dated February 24, 1977. In the late 1970s, the NRC worked with licensees to establish configurations that meet this guidance, reaching closure on most issues. However, to resolve the remaining contested issues, the NRC published the final fire protection rule (10 CFR 50.48, ''Fire Protection'') and Appendix R to 10 CFR part 50 on November 10, 1980 (45 FR 76602).

Light water reactor licensees are currently required to have fire protection programs that comply with 10 CFR 50.48 and Criterion 3 of Appendix A to 10 CFR part 50 (GDC 3). A fire protection program that satisfies Criterion 3 is required for all operating nuclear power plants by 10 CFR 50.48(a). Criterion 3—''Fire protection,'' requires that structures, systems, and components (SSCs) important to safety shall be designed and located to minimize, consistent with other safety requirements, the probability and effects of fires and explosions. Further it requires that fire detection and fighting systems of appropriate capacity and capability be provided and designed to minimize the adverse effects of fires on SSCs important to safety. These fire protection requirements are deterministic.

As stated in 10 CFR 50.48(b)(1), with the exception of Sections III.G, III.J, and III.O of Appendix R, nuclear power plants that were licensed to operate before January 1, 1979, are exempt from the requirements of Appendix R to 10 CFR part 50, to the extent that features meeting the provisions of Appendix A to Branch Technical Position (BTP) APCSB 9.5–1 had been accepted by the NRC staff. These reactor plants otherwise must meet 10 CFR 50, Appendix R, as well as any requirements contained in plant specific fire protection license conditions and/or technical specifications. Nuclear power plants that were licensed to operate after January 1, 1979, must comply with 10 CFR 50.48(a) as well as any plant-specific fire protection license conditions and/or technical specifications. Their fire protection license conditions typically reference Safety Evaluation Reports (SERs) generated by the NRC as the product of initial licensing reviews against either Appendix A to BTP APCSB 9.5–1 and the criteria of certain sections of 10 CFR 50, Appendix R, or against NUREG 0800, the NRC's Standard Review Plan (SRP) for fire protection (which closely follows the structure of 10 CFR 50, Appendix R).

The NRC has issued approximately 900 exemptions from the technical requirements specified in Appendix R. These exemptions were granted to licensees that submitted a technical evaluation demonstrating that an alternative fire protection approach satisfied the underlying safety purpose of Appendix R. During the initial implementation period for ''Pre-1979 Appendix R plants,'' the NRC granted exemptions under the provisions of 10 CFR 50.48(c)(6), which has since been deleted. For exemptions requested by ''Pre-1979'' plants after the licensee's initial Appendix R implementation period, the NRC has conducted its reviews in accordance with the provisions specified in 10 CFR 50.12 ''Specific exemptions.'' ''Post-1979'' plants have also requested and, when deemed acceptable by the staff, received approval to deviate from their licensing requirements. The processing of exemption and deviation requests has placed a significant burden on the resources of the NRC and the nuclear industry.

Industry representatives and some members of the public have described the current deterministic fire protection requirements as ''prescriptive'' and an ''unnecessary regulatory burden.'' Beginning in the late 1990s, the Commission provided the NRC staff with guidance for identifying and

assessing performance-based approaches to regulation (see SECY–00–0191, ''High-Level Guidelines for Performance-Based Activities,'' dated September 1, 2000, and Staff Requirements Memorandum (SRM) entitled ''White Paper on Risk-Informed and Performance-Based Regulation,'' dated March 1, 1999, issued subsequent to SECY–98–144). This guidance augmented the risk-related guidance in the NRC's Probabilistic Risk Assessment (PRA) Policy Statement and Regulatory Guide 1.174, ''An Approach for Using Probabilistic Risk Assessment in Risk-Informed Decisions on Plant-Specific Changes to the Licensing Basis,'' dated July 1998.

In SECY–00–0009 dated January 13, 2000, the NRC staff requested and received Commission approval for proceeding with a rulemaking to permit reactor licensees to adopt NFPA 805 as a voluntary alternative to existing fire protection requirements. On February 24, 2000, in a Staff Requirements Memorandum (SRM) titled ''Rulemaking Plan, Reactor Fire Protection Risk-Informed, Performance-Based Rulemaking,'' the Commission directed the staff to proceed with this rulemaking.

The NFPA Standards Council approved 2001 Edition of NFPA 805 as a performance-based American National Standard for light water nuclear power plants, effective February 9, 2001. The NRC cooperatively participated in the development of NFPA 805. The standard specifies the minimum fire protection requirements for existing light water nuclear power plants during all modes (''phases'' in NFPA 805) of plant operation, including, shutdown, degraded conditions, and decommissioning.

The Nuclear Energy Institute (NEI) expressed support for the rulemaking in a letter dated September 13, 2001. The staff prepared a memorandum, dated October 9, 2001, informing the Commission that the staff had revised the rulemaking plan such that the staff would submit the proposed rule revision to the Commission by July 2002, and the final rule revision 12 months after the NRC published the proposed rule revision for public comment. Additionally, the staff informed the Commission that it was pursuing development of the implementation guidance to be endorsed by a regulatory guide. NEI is currently developing this guidance.

Draft Rule Language and Public Comment

On December 20, 2001 (66 FR 65661), the NRC published in the **Federal Register** draft rule language proposing to endorse NFPA 805, and posted this draft language on the NRC's interactive Rulemaking Forum Web site at *http://ruleforum.llnl.gov.* The NRC requested public comment on the draft rule language.

The comment period on the draft rule language ended on February 4, 2002. In response to the **Federal Register** notice the NRC received five sets of comments from the NRC staff, industry consultants, licensees and industry organizations, as summarized below:

An NRC staff member pointed out that the draft rule language inadvertently overlooked an entire class of licensees (i.e., the so-called ''post January 1, 1979 licensees''). The NRC agrees with this comment and has corrected this oversight in the proposed rule by including this class of licensee.

The Nuclear Energy Institute (NEI) disagreed with a proposed NRC exception to NFPA 805 which would not endorse the italicized exception contained in Section 3.3.5.3 of NFPA 805. This italicized exception had the effect of permitting existing electrical cable which does not comply with a flame propagation test acceptable to the NRC to remain as is. Compliance with an electrical cable flame propagation test has been in NRC guidance since 1981 (NUREG 0800, the NRC's Standard Review Plan or SRP). The largest single contributor to combustible fire loading in most areas of a nuclear power plant is electrical cable insulation in open cable trays. This was demonstrated by the cable fire at Brown's Ferry in 1975. The electrical cable insulation safety hazard in nuclear power plants should be mitigated by successful completion of a cable insulation fire propagation test (or the application of a fire retardant coating or the installation of fixed, automatic fire suppression, as stated in the rule language). Therefore, the NRC cannot endorse the italicized exception contained in Section 3.3.5.3 of NFPA 805.

NEI submitted a number of other specific comments, which were endorsed as a group by the Tennessee Valley Authority (TVA), none of which resulted in the NRC choosing to make changes to the draft rule language. These comments regarded: (1) Appropriate radiological limits for fire suppression activities; (2) licensee freedom to establish secondary fire protected safe shutdown paths; (3) the standing of ''docketed licensing-basis information'' within Chapter 3 of NFPA 805; (4) the need for the NFPA 805 Section 3.5.4 seismic/Class 1E emergency power buses fire pump requirements; (5) the need for seismically designed fire hose station standpipes in lieu of a plan for manual fire capabilities following an earthquake (see Section 3.6.4 of the standard); (6) the degree of flexibility in the deterministic 3-hour fire area boundary rating requirement of Section 4.2.3.2 of NFPA 805; (7) the use of recovery actions within the deterministic approach of the standard.

An industry consultant commented that the NRC should endorse, as part of the rulemaking, NFPA 805, Appendix B, ''Nuclear Safety Analysis,'' and its post-fire safe shutdown circuit analysis methodology for use by licensees in meeting the standard. Appendix B is now endorsed as discussed in section II below.

Another comment from an industry consultant stated that the rule should permit licensees to adopt only those NFPA 805 requirements that relate to post-fire safe shutdown, without meeting NFPA 805 requirements related to combustible/ignition control, and detection and suppression. This comment did not result in the NRC choosing to make any changes to the draft rule language.

II. Discussion

Discussion of Proposed Rule

The NRC has conducted a review of the technical requirements contained in NFPA 805, related to nuclear safety and radiological release, and has concluded that NFPA 805, taken as a whole, provides an acceptable alternative for satisfying General Design Criterion 3 (GDC 3) of Appendix A to 10 CFR Part 50. The standard contains a number of changes to the character of fire protection features when compared to current fire protection requirements (*e.g.*, no cold shutdown requirement, no specific requirement for emergency lighting, and no provision for an alternative shutdown capability). However, the NRC participated in the development of the standard, and has determined that NFPA 805, as excepted, when taken as an integrated whole, meets the underlying intent of the NRC's existing fire protection regulations and guidance, and achieves defense-in-depth and the goals, performance objectives, and performance criteria specified in Chapter 1 of the standard.

To determine that NFPA 805 contains the elements of an acceptable fire protection program, the NRC uses Regulatory Guide 1.189, ''Fire Protection for Operating Nuclear Power Plants''. Section C, ''Regulatory Position,'' contains a description of the eight elements of an acceptable fire

protection program. The NRC determined that all eight elements are adequately addressed in NFPA 805:

1. The delineation of organization, staffing, and responsibilities.

Section 3.2.2 of the standard defines the management authorities and responsibilities and establishes the general policy for the fire protection program. This section adequately meets the intent of this element in RG 1.189.

2. A fire hazards analysis sufficient to perform safe shutdown functions and minimize radioactive material releases in the event of a fire.

Within the standard, nuclear safety goals and performance criteria are defined in Chapter 1. Section 2.4.2 defines the methodology for performing a nuclear safety capability assessment necessary to meet these goals and criteria. The criteria in the standard is adequate to meet the intent of this element of RG 1.189.

3. The limitation of damage to structures, systems, and components important to safety so that the capability to safely shut down the reactor is ensured.

Within the standard, Chapters 4 & 5 establish the methodologies to determine the fire protection elements needed to limit fire damage and protect structures, systems, and components important to safety. The criteria in the standard is adequate to meet the intent of this element of RG 1.189.

4. Evaluation of fire test reports and fire data to ensure they are appropriate and adequate for ensuring compliance with regulatory requirements.

Section 3.11.2 establishes fire test qualifications for fire barriers to be in accordance with NFPA 251, Standard Methods for Tests of Fire Endurance of Building Construction and Materials or E–119, Standard Test Methods for Fire Tests of Building Construction and Materials. These standards are adequate and meet the intent of this element in RG 1.189.

5. Evaluation of compensatory measures for interim use for adequacy and appropriate length of use.

The standard has an adequate definition of compensatory actions and requires procedures to be established to accomplish these compensatory actions and limit the duration, Sections 1.6.8 and 3.2.3(2) respectfully. The criteria in the standard is adequate to meet the intent of this element of RG 1.189.

6. Training and qualification of fire protection personnel appropriate for their level of responsibility.

Section 2.7.3.4 discusses the qualification of personnel who apply engineering analysis and numerical models. Section 3.4 discusses the training and qualifications of the fire brigade and those plant personnel who will respond to a fire. The criteria in the standard is adequate to meet the intent of this element of RG 1.189.

7. Quality assurance.

Throughout the standard and in particular, Section 2.7, discusses the requirements for program documentation, configuration control, and quality. The NRC considers the standard adequate to meet the quality assurance guidance in RG 1.189.

8. Control of fire protection program changes.

Chapter 2 discusses plant change evaluations and configuration control of design basis documents. These sections will assist in maintaining compliance with the fire protection regulatory requirements and are adequate to meet the change control guidance in RG 1.189.

For these reasons, the NRC believes that NFPA 805 adequately provides requirements to meet the elements of an acceptable fire protection program.

Public Health and Safety Considerations: The NRC has determined that public health and safety and the common defense and security would continue to be adequately protected under NFPA 805. This determination is based, in part, on the goals, objectives, and performance criteria specified in Chapter 1 of NFPA 805. Those goals, objectives, and performance criteria provide for defense-in-depth to control fires; prevention of radioactive releases that adversely affect the public; and control of plant reactivity, inventory, and pressure, as well as decay heat removal, vital auxiliaries, and process monitoring.

The overall approach of NFPA 805 is consistent with the key principles for evaluating licensing basis changes, as described in NRC Regulatory Guide (RG) 1.174. Namely, the proposed change is consistent with defense-in-depth philosophy, maintains sufficient safety margins, and when the proposed change results in an increase in core damage frequency (CDF) or risk, the increase is small and consistent with the intent of the Commission's Safety Goal Policy Statement. In Section 2.2.9 of the standard, objective criteria for plant change evaluations are set forth: ''a risk-informed plant change evaluation shall be performed and the results used * * * to ensure that the public risk associated with fire-induced nuclear fuel damage accidents is low and that adequate defense-in-depth and safety margins are maintained. Therefore, the concepts and processes in NFPA 805 comprise a risk-informed, integrated, performance-based decision making process for evaluating plant changes related to fire protection systems and features. In accordance with 10 CFR 50.59(c)(4), because NFPA 805 contains its own change control process, reactor plant changes conducted under NFPA 805 therefore will not be subject to the requirements of 10 CFR 50.59.

As stated in Section 2.4.4 of NFPA 805, the Standard's general methodology requires that the plant change evaluation process must consist of an integrated assessment of the acceptability of change in risk, defense-in-depth, and safety margins. This approach requires engineering evaluations to assess the adequacy of the fire protection elements (*e.g.,* combustible and ignition control, fire detection and suppression, and fire confinement) and the nuclear safety element (*e.g.*, post-fire safe shutdown capability), to ensure that defense-in-depth philosophy is maintained.

The NFPA 805 approach also includes requirements, Section 2.4.3, for the application of acceptable codes and standards to assess the calculated margin between designed and qualified fire protection features versus specified nuclear safety and radioactive release performance criteria, as well as provisions for evaluating acceptable change in risk in terms of small increases in Core Damage Frequency (CDF) and Large Early Release Frequency (LERF) based on risk acceptance guidelines, as presented in NRC Regulatory Guide 1.174.

Chapters 1 and 2 of NFPA 805 specify performance criteria, nuclear safety objectives, and radioactive release performance criteria; provide flexibility for the program, processes, and analytical approach; and ensure that a performance failure will not result in an immediate safety concern (through application of the fire protection defense-in-depth philosophy and the assurance of adequate safety margins). Potential performance failures are assessed in advance to ensure that the licensee is capable of detecting the performance failure, and that adequate time is available to take the needed corrective actions upon detection.

NFPA 805 achieves the risk principles of the Commission's PRA Policy Statement (60 FR 42622) in the following manner:

PRA Policy Statement 1: The use of PRA technology should be increased in all regulatory matters to the extent supported by the state-of-the-art in PRA methods and data and in a manner that complements the NRC's deterministic approach and supports the

NRC's traditional defense-in-depth philosophy.

NFPA 805 Appendices B, C, and D providing methodologies for nuclear safety analysis (which includes post-fire safe shutdown circuit analysis), fire modeling, and PSA methods respectively, are state-of-the-art analytical approaches representing a consensus of members of a diverse national standards committee (the NFPA Technical Committee on Fire Protection for Nuclear Facilities).

The NFPA 805 deterministic approach (Section 4.2.3) was derived from existing NRC deterministic requirements.

In Section 4.2.4.1.5 of NFPA 805, the alternative NFPA performance-based approach includes the requirement that ''the effectiveness of fire protection systems and features shall demonstrate that the circuits and components required to achieve the nuclear safety performance criteria are maintained free of fire damage.'' Combined with the deterministic requirements of Section 3.3.1.2 (Control of Combustible Materials) and Section 3.3.1.3 (Control of Ignition Sources), Sections 3.4 (Industrial Fire Brigade), 3.5 (Water Supply), 3.6 (Standpipe and Hose Stations), 3.7 (Fire Extinguishers), 3.8 (Fire Alarm and Detection Systems), 3.9 (Automatic and Manual Water-based Fire Suppression Systems), 3.10 (Gaseous Fire Suppression Systems) and 3.11 (Passive Fire Protection Features), and the Nuclear Safety Goal, Objective and Performance Criteria of Chapter 1 of NFPA 805, NFPA strongly supports the NRC's traditional fire protection defense-in-depth and nuclear safety defense-in-depth philosophies.

PRA Policy Statement 2: PRA and associated analyses (*e.g.* sensitivity studies, uncertainty analyses, and importance measures) should be used in regulatory matters, where practical within the bounds of the state-of-the-art, to reduce unnecessary conservatism associated with current regulatory requirements, license commitments, and staff practices * * *

The performance-based approach of NFPA 805 (Section 4.2.4) would utilize the concepts of: Damage threshold; minimum damage threshold; fire scenario for the fire area under consideration; and sufficient margin between the maximum expected fire scenario and the limiting fire scenario in the context of protection of required nuclear safety success paths. These performance-based approach concepts reduce the conservatisms associated with the current largely deterministic reactor plant fire protection requirements, license commitments and NRC staff practices.

PRA Policy Statement 3: PRA evaluations in support of regulatory decisions should be as realistic as practicable and appropriate supporting data should be publicly available for review.

Section 2.7.1.1 of NFPA 805 says: ''The analyses performed to demonstrate compliance with this standard shall be documented for each nuclear power plant (NPP). The intent of the documentation is that the assumptions be clearly defined and that the results be easily understood, that results be clearly and consistently described, and that sufficient detail be provided to allow future review of the entire analyses. Documentation shall be maintained for the life of the plant and be organized carefully so that it can be checked for adequacy or accuracy either by an independent reviewer or by the AHJ [authority having jurisdiction].''

Section 2.7.2 of NFPA 805 addresses configuration control, and Section 2.7.3 addresses the quality of the calculational or numerical models, the appropriateness of their application, and the qualifications of the personnel who apply them.

Therefore, there would be a well-founded expectation that licensee NFPA 805 analyses would be readily available for review by the NRC or independent reviewers supporting licensee quality assurance activities.

PRA Policy Statement 4: The Commission's safety goals for nuclear power plants and subsidiary numerical objectives are to be used with appropriate consideration of uncertainties in making regulatory judgements on the need for proposing and backfitting new generic requirements on nuclear power plant licensees.

As a voluntary regulation, the proposed rule does not represent a new generic requirement on nuclear power plant licensees, and could be considered to not be bound by PRA Policy Statement 4. However, the following two qualitative safety goals and two supporting quantitative objectives would be met by licensees meeting Section 1.3.1 of NFPA 805 (Nuclear Safety Goal) and Section 1.3.2 of NFPA 805 (Radioactive Release Goal), and their supporting NFPA 805 nuclear and radioactive release objectives and performance criteria.

The NRC's two qualitative safety goals are: (1) Individual members of the public should be provided a level of protection from the consequences of nuclear power plant operation such that individuals bear no significant additional risk to life and health, and (2) Societal risks to life and health from nuclear power plant operation should be comparable to or less than the risks of generating electricity by viable competing technologies and should not be a significant addition to other societal risks.

Two quantitative objectives are used in determining achievement of the above safety goals: (1) The risk to an average individual in the vicinity of a nuclear power plant of prompt facilities that might result from reactor accidents should not exceed one-tenth of one percent (0.1 percent) of the sum of prompt fatality risks resulting from other accidents to which members of the U.S. population are generally exposed, and (2) The risk to the population in the area near a nuclear power plant of cancer fatalities that might result from nuclear power plant operation should not exceed one-tenth of one percent (0.1 percent) of the sum of cancer fatality risks resulting from all other causes.

As an outgrowth of the Commission's PRA Policy Statement, the NRC has embarked upon an effort to risk-inform 10 CFR Part 50. In SECY–99–264 (later endorsed in a Staff Requirements Memorandum (SRM) dated February 3, 2000) the NRC staff informed the Commission that it would conduct its work applying the set of safety principles established in Regulatory Guide (RG) 1.174. The NRC staff stated that it expects that changes to requirements would be consistent with the defense-in-depth philosophy, would maintain sufficient safety margins, would be performance-based to the extent possible, and would result in safety improvements or only small increases in risk, and would reduce any unnecessary burden. The NRC staff also stated that their approach would also ensure that adequate protection continues to be maintained. These considerations are addressed individually below:

Defense-in-Depth: This topic is fully discussed in connection with PRA Policy Statement 1 above.

Sufficient Safety Margins: Plant change evaluations are required by Section 2.4.4 of the standard. Section 2.4.4.3 of the standard states that plant change evaluations shall ensure that sufficient safety margins are met. Section A.2.4.4.3 of the standard explains safety margins in theory and in the contexts of fire modeling and fire PSA. Section 4.2.4.1.4 of the standard requires sufficient safety margin between the maximum expected fire scenarios and the limiting fire scenarios for required equipment and cables.

Performance-Based: NFPA 805 is inherently performance-based in that it requires the achievement of performance criteria.

Safety Improvements or Small Increases in Risk: NFPA has provisions

for evaluating acceptable change in risk in terms of CDF (core damage frequency) and LERF (large early release frequency). NFPA 805 Section 2.4.4.1 of the standard provides that ''The change in public health risk from any plant change shall be acceptable to the AHJ (NRC). CDF and LERF shall be used to determine the acceptability of the change.'' The NRC bases its risk acceptance guidelines on the information provided in NRC Regulatory Guide 1.174, An Approach for Using Probabilistic Risk Assessment in Risk-Informed Decisions on Plant Specific Changes to the Licensing Basis. In RG 1.174, ''small'' is defined in relation to total CDF (*e.g.*, when the calculated increase in risk is calculated to be in the range of 10E–6 per reactor year to 10E–5 per reactor year, the risk increase is acceptable if it can be reasonably shown that the total CDF is less than 10E–4 per reactor year).

Unnecessary Burden: The proposed rule is expected to reduce the need for licensee developed exemption requests targeted at relief from the existing deterministic, prescriptive fire protection requirements. Additionally, the proposed rule is expected to result in net reduced operating, training, and maintenance costs (through the elimination of conservatively required deterministic barriers and fire protection features) over the remaining life of the reactor plants and during their decommissioning.

Adequate Protection: Licensees which adopt NFPA 805 will be required by Section 2.4.4.1 of the standard to monitor the cumulative risk changes. Therefore, a series of small increases in public health risk (see ''Safety Improvements or Small Increases in Risk'' above) will not be allowed to accumulate into a significant total increase in fire risk. Therefore, adequate protection of the public from the effects of nuclear power plant fires will be maintained.

The NRC has considered the regulatory practicality of the proposed rule. The areas considered are as follows:

Change Control Processes: NFPA 805 Sections 2.2(h), 2.2(i), 2.2(j), 2.2.9, 2.2.10, 2.4.4, 2.6, and 2.7 contain direction relating to change control processes. The major change control process features addressed in these sections are plant change evaluations (assessment of changes in public health risk against risk acceptance criteria, defense-in-depth and safety margins), a plant fire risk performance monitoring program (addressing availability, reliability and performance and including corrective action), and fire protection program documentation adequacy, analysis quality, and configuration control. Under 10 CFR 50.59(c)(4), the existence of these change control process features would therefore mean that the provisions of 10 CFR 50.59 would not apply to licensees which have adopted NFPA 805. Therefore, the NRC expects no difficulties in licensee efforts to control and document plant changes under this rule.

Licensee Implementation: Sufficient methodologies are provided in NFPA 805 and adequate risk, fire and nuclear safety data are available to implement them. In Section III of this **Federal Register** notice (FRN), NFPA 805 analytical processes for plant-wide reviews are summarized. Therefore, the NRC expects no difficulties in licensee's efforts to implement this rule.

Inspectability: NFPA 805 Section 2.7.1.1 states: ''The analyses performed to demonstrate compliance with this standard shall be documented for each nuclear power plant (NPP). The intent of the documentation is that the assumptions be clearly defined and that the results be easily understood, that results be clearly and consistently described, and that sufficient detail be provided to allow future review of the entire analyses. Documentation shall be maintained for the life of the plant and be organized carefully so that it can be checked for adequacy and accuracy either by an independent reviewer or by the AHJ.'' Therefore, the NRC expects no difficulties in inspector efforts to review licensee implementation of this rule.

Enforcability: The proposed rule does not affect the existing requirements of 10 CFR 50.48(a), which include fire protection plan compliance with General Design Criterion (GDC) 3—''Fire Protection,'' seven specific fire protection plan requirements and features, the requirement to retain fire protection plan changes ''until the Commission terminates the reactor license'' and fire protection procedures for three years after they are superceded. Section (c)(3) of the proposed rule requires adopting licensees to maintain a fire protection program which complies with NFPA 805. Therefore, all requirements of that standard would be subject to enforcement, including the nuclear and radiological goals, performance objectives and performance criteria of Chapter 1 of NFPA 805. Therefore, the NRC expects no difficulties in enforcing against licensee failures to comply with 10 CFR 50.48(a), (f) or the main body of NFPA 805.

Quality Assurance: Section 2.7.3 of NFPA 805 requires that each analysis, calculation or evaluation performed shall be independently verified, calculational models and numerical methods shall be verified and validated, engineering methods and numerical models shall be used only within the scope, limitations and assumptions prescribed for them, personnel applying engineering analyses and numerical models shall be competent in their field and experienced in the application of these methods as they relate to nuclear power plants, nuclear power plant fire protection, and power plant operations. Therefore, the NRC expects no difficulties in licensee efforts to maintain the quality of their application of NFPA 805 requirements.

Section-by-Section Analysis

Section 50.48(c) National Fire Protection Standard NFPA 805

The proposed rule would add a new Paragraph (c) to 10 CFR 50.48. Paragraph (c) would permit reactor licensees to voluntarily adopt NFPA 805, with certain exceptions stated in the rule language, as an alternative set of fire protection requirements for the operation and/or decommissioning of light-water reactors. NFPA 805, when and if adopted by licensees, would constitute an acceptable means for operating reactors to comply with 10 CFR 50.48(a), and would be an alternative to meeting their existing fire protection requirements, and for decommissioning reactors would be an acceptable method for meeting 10 CFR 50.48(f).

Section 50.48(c)(1) Approval of Incorporation by Reference; 50.48(c)(2) Exceptions, Modifications and Supplementation of NFPA 805

Appendices B, C, and D of NFPA 805 constitute methodologies for conducting nuclear safety circuit analyses, nuclear power plant fire hazard modeling, and fire probabilistic safety assessments, respectively. At a number of locations within the standard appendices are referred to as ''acceptable methods,'' and at other locations within the standard the reader is directed to them for ''considerations when performing analyses.'' Although each of the three appendices begins with a disclaimer in the form ''Appendix (letter B, C or D) is not a part of the requirements of this NFPA document but is included for informational purposes only,'' the methodologies contained therein are nevertheless considered by the NRC to be ''specified in NFPA 805'' within the meaning of section (c)(4) of the proposed rule language, and therefore their use by licensees need not be

preceded by NRC approval of a license amendment request.

Section 50.48(c)(2)(*i*) Life Safety Goal; 50.48(c)(2)(*ii*) Plant Damage/Business Interruption Objectives

The Life Safety Goal and Plant Damage/Business Interruption Objectives of NFPA 805 are not within the regulatory charter of the NRC (see the Energy Reorganization Act of 1974) and, therefore, the NRC does not endorse them.

Section 50.48(c)(2)(iii) Use of Feed-and-Bleed

This paragraph does not accept the use of a high-pressure charging/injection pump coupled with the pressurizer PORVs as the sole fire protected shutdown path for maintaining reactor coolant inventory, pressure control, and decay heat removal capability (*i.e.*, feed-and-bleed) for PWRs.

Section 50.48(c)(2)(iv) Uncertainty Analysis

This paragraph makes clear that licensees need not prepare uncertainty analyses when conducting deterministic analyses under Section 2.2.6 and Chapter 4 of NFPA 805.

Section 50.48(c)(2)(v) Existing Cables

In lieu of installing cables meeting flame propagation tests as required by Section 3.3.5.3 of the standard, a flame retardant coating may be applied to the electric cables, or alternatively an automatic fixed fire suppression system may be installed. Either alternative would establish an equivalent level of fire protection to that provided by the presence of flame propagation test compliant cables. The italicized exception to Section 3.3.5.3 is not endorsed.

Electrical flame propagation test compliance has been in NRC guidance since 1981 (NUREG 0800, the NRC's Standard Review Plan or SRP). The NRC is unaware of any licensees which are using electrical cable which does not comply with flame propagation tests where an alternate means of protection (*e.g.*, fire retardant coating or automatic fixed suppression) has not been provided. Accordingly, the NRC does not expect any licensee to be adversely affected by this proposed exception.

Section 50.48(c)(2)(vi) Water Supply and Distribution

The italicized exception to Section 3.6.4 is not endorsed.

This paragraph would not allow a standpipe/hose station system in place of seismically qualified standpipes and hose stations unless previously approved in the licensing basis. Seismically qualified standpipes and hose stations have been in NRC guidance since 1976 (Appendix A to Branch Technical Position (BTP) APCSB 9.5–1. The NRC is unaware of any licensees using a non-seismically qualified standpipe/hose station system in place of a seismically qualified standpipe/hose station system. Accordingly, the NRC does not expect any licensee to be adversely affected by this proposed exception.

Section 50.48(c)(3) Compliance With NFPA 805

The use of the term ''Authority Having Jurisdiction'' (AHJ) within the standard, for the purposes of this rulemaking, means the U.S. Nuclear Regulatory Commission.

For purposes of transitioning to NFPA 805, the NRC expects that licensees will be able to treat existing reactor plant fire protection elements as ''previously approved'' for the purposes of the Chapter 3 delineation of fundamental program elements. This approach would normally be acceptable because licensees should either be in compliance with regulatory requirements or should have obtained approval from the NRC for exemptions or deviations from those requirements. Fire protection elements that have not been previously reviewed and approved would continue to be subject to normal NRC inspection and enforcement.

Section 50.48(c)(3)(i). A licensee may maintain a fire protection program that complies with NFPA 805 as an alternative to complying with paragraph (b) of this section for plants licensed to operate before January 1, 1979; or the fire protection license conditions for plants licensed to operate after January 1, 1979. The licensee shall submit a request to comply with NFPA 805 in the form of an application for license amendment under § 50.90. The application must identify any orders and license conditions that must be revised or superseded, and contain any necessary revisions to the plant's technical specifications and the bases thereof. The Director of the Office of Nuclear Reactor Regulation, or a designee of the Director, may approve the application if the Director or designee determines that the licensee has identified orders, license conditions, and the technical specifications that must be revised or superseded, and that any necessary revisions are adequate. Any approval by the Director or the designee of the Director shall be in the form of a license amendment approving the use of NFPA 805 together with any necessary revisions to the technical specifications.

This paragraph of the proposed rule language would allow licensees to adopt NFPA 805 as an acceptable means of meeting the fire protection program and GDC 3 requirements of 10 CFR 50.48(a). This section also describes the methods by which the licensees will submit their requests to adopt NFPA 805. If the NRC approves a licensee's request to use NFPA 805, the Director of NRR (or a designee of the Director) will issue a license amendment that: (1) removes superseded license conditions, and (2) includes a license condition imposing the use of NFPA 805. In addition, the NRC will issue an order revoking unnecessary and superseded exemptions and orders.

Licensees who are approved under paragraph (c)(3)(i) to use NFPA 805 are permitted to later return to compliance with paragraph (b) and their previous licensing basis. However, each licensee must comply with all applicable requirements, including submitting an application for a license amendment, and, as applicable, a request for exemption if the licensee wishes to reinstate a revoked exemption.

Section 50.48(c)(3)(ii). The licensee shall complete its implementation of the methodology in Chapter 2 of NFPA 805 (including all required evaluations and analyses) and, upon completion, modify the fire protection plan required by paragraph (a) of this section to reflect the licensee's decision to comply with NFPA 805, before changing its fire protection program or nuclear power plant as permitted by NFPA 805.

This section of the proposed rule language requires licensees to complete all of the NFPA 805 evaluations and analyses, and also modify their fire protection plan to indicate that they are adopting NFPA 805 as an alternative set of fire protection requirements. This is to ensure that the changeover to an NFPA 805 configuration is conducted in a complete, controlled, integrated, and organized manner. This also ensures that the NRC reactor oversight (inspection) process can effectively identify and monitor the changeover. This requirement of the proposed rule has the effect of precluding licensees from implementing NFPA 805 on a partial or selective basis (*e.g.*, in some fire areas and not others, or truncating the methodology within a given fire area).

50.48(c)(4) Alternative Methods and Analytical Approaches. A licensee may submit a request to use alternative methods and analytical approaches, including alternatives to the fundamental fire protection program

and minimum design requirements identified in Chapter 3 of NFPA 805, in lieu of those methods and approaches specified in NFPA 805. The request must be in the form of an application for license amendment under § 50.90. The Director of the Office of Nuclear Reactor Regulation, or a designee of the Director, may approve the application if the Director or designee determines that the alternative methods and analytical approaches:

This section of the proposed rule language provides licensees with a mechanism to gain plant-specific NRC approval of alternative methods and analytical approaches to those specified in NFPA 805. It allows licensees maximum flexibility to identify and apply new methods of analysis that may be appropriately used within NFPA 805. This approval mechanism is broad enough to allow licensees to apply risk-informed, performance-based methods to establish the (deterministic) fundamental elements of a fire protection program and the minimum design requirements for fire protection systems and features.

Section 50.48(c)(4)(i). Satisfy the goals, performance objectives, and performance criteria specified in NFPA 805 related to nuclear safety and radiological release.

Section 50.48(c)(4)(ii). Maintain safety margins.

Section 50.48(c)(4)(iii). Maintain fire protection defense-in-depth (fire prevention, fire suppression, and post-fire safe shutdown capability).

50.48(f) Licensees that have submitted the certifications required under Section 50.82(a)(1) shall maintain a fire protection program to address the potential for fires that could cause the release or spread of radioactive materials (*i.e.*, that could result in a radiological hazard). A fire protection program that complies with NFPA 805 shall be deemed to comply with the requirements of this paragraph.

III. Analytical Processes for Plant-Wide Reviews

This section describes how a licensee choosing to comply with NFPA 805 would conduct a plant-wide review in accordance with the NFPA 805 analytical process (under paragraphs (c)(3)(ii) of the proposed rule). The discussion first addresses the actions of licensees for operating light water reactors, and then addresses the actions of licensees for light water reactors that are undergoing decommissioning.

A. Operating Reactors

Section 2.2.1: Licensee establishes fundamental fire protection elements in accordance with Chapter 3 of NFPA 805 on a plant-wide basis, taking credit for alternatives that have been ''previously approved'' by the authority having jurisdiction (AHJ) (NRC).

Section 2.2.2: Licensee identifies fire area boundaries and fire hazards (possibly unchanged from the previous fire protection licensing basis).

Sections 2.2.3, 2.2.4, and 2.2.5: Licensee evaluates plant design on a fire area basis against the nuclear safety and radiation release performance criteria of Chapter 1, using either a deterministic or performance-based approach. A result of this analysis is the identification of the structures, systems, and components that are necessary to meet the two criteria (analogous to the ''protected systems'' identification process of Appendix R analyses).

Sections 2.2.6, 2.2.7, and 2.2.8: For a deterministic nuclear safety analysis, the licensee compares the existing fire protection licensing basis (*e.g.*, exemptions granted under Appendix R to 10 CFR part 50, SERs, approved deviations, and licensee-developed generic letter (GL) 86–10 engineering evaluations [*see GL 86–10 Paragraph C:* ''Documentation Required to Demonstrate Compliance'']) against the deterministic approach criteria of Section 4.2.3 of NFPA 805. A licensee may demonstrate compliance with Section 4.2.3 using existing engineering equivalency evaluations (*e.g.*, licensee-developed GL 86–10 engineering evaluations, or NRC approved exemption requests) if the licensee ensures that the reactor plant meets the threshold of Section 2.2.7 (that ''these existing engineering evaluations shall clearly demonstrate an equivalent level of fire protection compared to the deterministic requirements'').

For a performance-based nuclear safety analysis, the licensee will perform the engineering analyses (*e.g.*, using fire modeling or probabilistic safety analysis (PSA) methods) under either Section 4.2.4.1 or 4.2.4.2 of NFPA 805. For a deterministic or performance-based radiation release analysis, the licensee performs the analytical method in Section 4.3 to assess the fulfillment of Chapter 1 criteria.

Section 2.2.9: In the event of a change to a fire protection program element during the above analytical steps, the licensee will evaluate the risk impact to ensure that the public risk associated with fire-induced nuclear fuel damage accidents is low, and that adequate defense-in-depth and safety margins are maintained.

Section 2.2.10: The licensee shall establish a monitoring program to assess the performance of the fire protection program in meeting NFPA performance criteria.

Section 2.2.11: The fire protection program documentation must be developed and maintained in such a manner that facility design and procedural changes that could affect the fire protection engineering analysis assumptions can be identified and analyzed (see Section 2.3).

Section 2.7 of the standard has adequate requirements for the retention of licensee NFPA 805 analyses and evaluations so that NRC inspectors may effectively monitor the conduct and effect of licensee fire protection program changes.

B. *Decommissioning Reactors:* A licensee of a light water reactor that is being decommissioned or has permanently ceased operations would comply with the requirements of Chapter 5 of NFPA 805.

IV. Licensee Impact

Licensees may voluntarily adopt the NFPA 805 standard, and any additional burden associated with adopting the standard will be at their discretion. The NRC anticipates that significant additional analysis, beyond that currently documented by licensees, may be elected by licensees that choose to adopt NFPA 805. The level of effort required for each plant will depend upon the degree to which risk-informed and performance-based approaches have already been adopted for the subject reactor plant (*e.g.*, within the exemption or deviation processes for 10 CFR 50.48 and Appendix R to 10 CFR part 50), and the degree to which the licensee initiates changes to the reactor plant.

V. Benefits

The current fire protection requirements (10 CFR 50.48) were developed before the NRC or industry had the benefit of probabilistic risk assessments (PRAs) for fires, and before there was a significant body of operating experience. A revised fire protection rule could provide flexibility in achieving adequate fire protection. In addition, as discussed in SECY 96–134, ''Options for Pursuing Regulatory Improvement in Fire Protection Regulations for Nuclear Power Plants,'' dated June 21, 1996, a revised fire protection rule that would facilitate the use of alternative approaches may reduce the need for exemptions.

VI. Additional Issue for Public Comment

As well as seeking public comment on the proposed rule itself, the NRC is also seeking public comment regarding any other alternative consensus standards

that the agency should consider as voluntary alternatives to the current fire protection regulations. The NRC expects that once adopting the new licensing basis that provides additional flexibility above that provided by Appendix R, licensees will not return to an Appendix R licensing basis. Nevertheless, the NRC requests a response to the following specific questions: (1) Is there any likelihood that licensees who are approved to use NFPA 805 would later decide that they would like to comply with paragraph (b) and the licensing basis that existed immediately prior to approval of NFPA 805? and (2) Do you agree that a license amendment would be required to revert to compliance with Section 50.48(b), and if not, why not?

VII. Availability of Documents

The NRC is making the documents identified below available to interested persons through one or more of the following methods, as indicated.

Public Document Room (PDR). The NRC's Public Document Room is located at One White Flint North, 11555 Rockville Pike, Rockville, Maryland.

Rulemaking Forum Web Site. The NRC's interactive Rulemaking Forum Web site is located at *http://ruleforum.llnl.gov.* These documents may be viewed and downloaded electronically via this Web site.

NRC's Public Electronic Reading Room (PERR). The NRC's Public Electronic Reading room is located at *http://www.nrc.gov/reading-rm.html.* The subject document may be accessed using the ADAMS accession number (*e.g.*, ''ML#########'') provided below.

The NRC staff contact. The NRC's task manager for this rulemaking in the Office of Nuclear Reactor Regulation (NRR) is Leon Whitney. Mr. Whitney can be reached by telephone at 301–415–3081, or via email to *lew1@nrc.gov.*

Document	PDR	Web	PERR	NRC staff
Regulatory Analysis	X	X	ML021300034	X
Environmental Assessment	X	X	ML021300039	X
NFPA 805 Rule Language	X	X	ML021300030	X
Comments Received	X	X	ML020360038	
Comments Received	X	X	ML020360039	
Comments Received	X	X	ML020360043	
Comments Received	X	X	ML020390248	
Comments Received	X	X	ML020630629	

VIII. Electronic Access for Comment Submission

In addition to the addresses previously provided (see **ADDRESSES** section above) for submitting written comments, interested parties may submit comments via the NRC's interactive Rulemaking Forum Web site (*http://ruleforum.llnl.gov*). The Rulemaking Forum enables the industry and public to transmit comments as files (in any format), provided that your web browser supports that function. Information on the use of the Rulemaking Forum is available on the site. For additional assistance on the use of the interactive Rulemaking Forum Web site, contact Ms. Carol A. Gallagher by telephone at (301) 415–5905 or via email to *cag@nrc.gov.*

IX. Plain Language

The Presidential memorandum entitled, ''Plain Language in Government Writing,'' dated June 1, 1998, directed that the Government must write in plain language. This memorandum was published in the **Federal Register** on June 10, 1998 (63 FR 31883). In complying with this directive, the NRC has made editorial changes to improve the readability of the proposed rule language. The NRC requests comment on the proposed rule specifically with respect to the clarity and effectiveness of the language used. Comments should be sent to the addresses listed under either the **ADDRESSES** or ''Electronic Access for Comment Submission'' sections above.

X. Voluntary Consensus Standards

The National Technology Advancement and Transfer Act of 1995, Public Law 104–113, requires that Federal agencies use technical standards that are developed or adopted by voluntary consensus standards bodies, unless the use of such standards is inconsistent with applicable law or otherwise impractical. Under this proposed rule, the NRC would provide holders of operating licenses for nuclear power plants with the option to voluntarily adopt NFPA 805, as excepted, as an alternative set of fire protection requirements. The NRC is not aware of any consensus standard that could be adopted instead of NFPA 805, but will consider using an alternative standard if identified. If an alternative consensus standard is identified, the notifying submittal from the member of the public or industry should explain how it is comparable to, and how it could be used in addition to or instead of, NFPA 805 in the proposed rule.

XI. Environmental Assessment and Finding of No Significant Environmental Impact

The Commission has determined under the National Environmental Policy Act of 1969, as amended, and the Commission's regulations in Subpart A of 10 CFR part 51, that this proposed rule, if adopted, would not be a major Federal action significantly affecting the quality of the human environment and, therefore, an environmental impact statement is not required. The NRC determined that there would not be significant radiological or non-radiological impacts. Under NFPA 805, the environment would continue to be adequately protected because the methods used for fire detection, suppression, and mitigation are the same as those used under the existing fire protection requirements. Further there will be no change in the release of radiological or nonradiological effluents to the environment.

This determination is based on an evaluation of the goals, objectives and performance criteria in NFPA 805. These provide for defense-in-depth to control fires; control of plant reactivity, coolant inventory, and pressure; decay heat removal; vital auxiliaries; and process monitoring to minimize radioactive releases. The NRC has determined that the environmental impacts of the proposed action, the no-action alternative, and an alternative in which the NRC would develop its own risk-informed standard, were similar. Further, the NRC determined that the proposed action does not involve the use of any different resources than those considered in the current rule.

The general public should note that the NRC is seeking public participation. Comments on any aspect of the environmental assessment may be submitted to the NRC as indicated under either the **ADDRESSES** or ''Electronic Access for Comment Submission'' sections above.

The NRC has sent a copy of the draft environmental assessment and this

proposed rule to every State Liaison Officer and requested their comments on the environmental assessment.

XII. Paperwork Reduction Act Statement

This proposed rule contains information collection requirements that are subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq*). This rule has been submitted to the Office of Management and Budget for review and approval of the information collection requirements.

The burden to the public for these information collections is estimated to average four hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. In addition, there is a one-time estimated burden of 20,000 to 65,000 hours for each licensee, who chooses to use NFPA 805, to complete the required one-time plant-wide re-analysis of the reactor's fire protection systems, equipment, features, and procedures. The U.S. Nuclear Regulatory Commission is seeking public comment on the potential impact of the information collections contained in the proposed rule and on the following issues:

1. Is the proposed information collection necessary for the proper performance of the functions of the NRC, including whether the information will have practical utility?
2. Is the estimate of burden accurate?
3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?
4. How can the burden of the information collection be minimized, including the use of automated collection techniques?

Send comments on any aspect of these proposed information collections, including suggestions for reducing the burden, to the Records Management Branch (T–6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by Internet electronic mail at *INFOCOLLECTS@NRC.GOV;* and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB–10202, (3150–0011), Office of Management and Budget, Washington, DC 20503.

Comments to OMB on the information collections or on the above issues should be submitted by December 2, 2002. Comments received after this date will be considered if it is practical to do so, but assurance of consideration cannot be given to comments received after this date.

Public Protection Notification

The NRC may not conduct or sponsor, and a person is not required to respond to, a request for information or an information collection requirement unless the requesting document displays a currently valid OMB control number.

XIII. Regulatory Analysis

The Commission has prepared a draft regulatory analysis of this proposed regulation. The analysis examines the costs and benefits of the alternatives considered by the Commission. The draft regulatory analysis may be examined and/or copied for a fee at the NRC's Public Document Room, located at One White Flint North, Room 01–F15, 11555 Rockville Pike, Rockville, Maryland.

The Commission requests public comment on the draft regulatory analysis. Comments on the draft analysis may be submitted to the NRC as indicated in either the **ADDRESSES** or ''Electronic Access for Comment Submission'' sections above.

XIV. Regulatory Flexibility Act Certification

As required by the Regulatory Flexibility Act of 1980, 5 U.S.C. 605(b), the Commission certifies that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. This proposed rule would affect only the licensing and operation of nuclear power plants. The companies that own these plants do not fall within the definition of ''small entities'' found in the Regulatory Flexibility Act or within the size standards established by the NRC in 10 CFR 2.810.

XV. Backfit Analysis

The NRC has determined that a backfit analysis is not required for this proposed rule, because the rule does not involve any provisions that would impose backfits as defined in 10 CFR 50.109(a)(1). The proposed rule will establish voluntary alternative fire protection requirements for licensees with construction permits prior to January 1, 1979 (all existing LWR reactor plants). Licensees may adopt NFPA 805 as an alternative set of fire protection requirements by submitting a license amendment. However, current licensees may continue to comply with existing requirements. Any additional burden incurred by adopting NFPA 805 would be at the licensee's discretion. The proposed rule does not impose any new requirements, and therefore, does not constitute a backfit as defined in 10 CFR 50.109(a)(1).

List of Subjects in 10 CFR Part 50

Antitrust, Classified information, Criminal penalties, Fire protection, Intergovernmental relations, Nuclear power plants and reactors, Radiation protection, Reactor siting criteria, and Reporting and recordkeeping requirements.

For the reasons given in the preamble and under the authority of the Atomic Energy Act of 1954, as amended, the Energy Reorganization Act of 1974, as amended, and 5 U.S.C. 553, the NRC is proposing to adopt the following amendments to 10 CFR Part 50:

PART 50—DOMESTIC LICENSING OF PRODUCTION AND UTILIZATION FACILITIES

1. The authority citation for Part 50 continues to read as follows:

Authority: Secs. 102, 103, 104, 105, 161, 182, 183, 186, 189, 68 Stat. 936, 938, 948, 953, 954, 955, 956, as amended, sec. 234, 83 Stat. 444, as amended (42 U.S.C. 2132, 2133, 2134, 2135, 2201, 2232, 2233, 2239, 2282); secs. 201, as amended, 202, 206, 88 Stat. 1242, as amended, 1244, 1246 (42 U.S.C. 5841, 5842, 5846).

Section 50.7 also issued under Pub. L. 95–601, sec. 10, 92 Stat. 2951, as amended by Pub. L. 102–486, sec. 2902, 106 Stat. 3123 (42 U.S.C. 5851). Section 50.10 also issued under secs. 101, 185, 68 Stat. 936, 955, as amended (42 U.S.C. 2131, 2235); sec. 102, Pub. L. 91–190, 83 Stat. 853 (42 U.S.C. 4332). Sections 50.13, 50.54(dd), and 50.103 also issued under sec. 108, 68 Stat. 939, as amended (42 U.S.C. 2138). Sections 50.23, 50.35, 50.55, and 50.56 also issued under sec. 185, 68 Stat. 955 (42 U.S.C. 2235). Sections 50.33a, 50.55a and Appendix Q also issued under sec. 102, Pub. L. 91–190, 83 Stat. 853 (42 U.S.C. 4332). Sections 50.34 and 50.54 also issued under Pub. L. 97–415, 96 Stat. 2073 (42 U.S.C. 2239). Section 50.78 also issued under sec. 122, 68 Stat. 939 (42 U.S.C. 2152). Sections 50.80–50.81 also issued under sec. 184, 68 Stat. 954, as amended (42 U.S.C. 2234). Appendix F also issued under sec. 187, 68 Stat. 955 (42 U.S.C. 2237).

2. In § 50.48, paragraph (c) is added and paragraph (f) is revised to read as follows:

§ 50.48. Fire protection.

* * * * *

(c) National Fire Protection Standard NFPA 805—(1) Approval of incorporation by reference. National Fire Protection Association (NFPA) Standard 805, ''Performance-Based for Fire Protection for Light Water Reactor Electric Generating Plants, 2001 Edition'' (NFPA 805), which is referenced in this section, was approved for incorporation by reference by the Director of the Federal Register. A notice of any changes made to the material incorporated by reference will

be published in the **Federal Register**. Copies of NFPA 805 may be purchased from the NFPA Customer Service Department, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269–9101 and in PDF format through the NFPA Online Catalog (*www.nfpa.org*) or by calling 1–800–344–3555 or 617–770–3000. Copies are also available for inspection at the NRC Library, Two White Flint North, 11545 Rockville Pike, Rockville, Maryland 20852–2738, and at the NRC Public Document Room, Building One White Flint North, Room O1–F15, 11555 Rockville Pike, Rockville, Maryland 20852–2738. Copies are also available at the Office of the Federal Register, 800 N. Capitol Street, Suite 700, Washington, DC.

(2) Exceptions, modifications, and supplementation of NFPA 805. As used in this section, references to NFPA 805 are to the 2001 Edition, with the following exceptions, modifications, and supplementations:

(i) Life Safety Goal. The Life Safety Goal of Section 1.3.3 is not endorsed.

(ii) Plant Damage/Business Interruption Objectives. The Plant Damage/Business Interruption Objectives of Section 1.3.4 of NFPA 805 are not endorsed.

(iii) Use of feed-and-bleed. In demonstrating compliance with the performance criteria of Sections 1.5.1(b) and (c) of NFPA 805, a high pressure charging/injection pump coupled with the pressurizer power-operated relief valves (PORVs) as the sole fire-protected safe shutdown path for maintaining reactor coolant inventory, pressure control, and decay heat removal capability (*i.e.*, feed-and-bleed) for pressurized-water reactors (PWRs) is not permitted.

(iv) Uncertainty analysis. An uncertainty analysis performed in accordance with Section 2.7.3.5 is not required to support deterministic approach calculations.

(v) Existing cables. In lieu of installing cables meeting flame propagation tests as required by Section 3.3.5.3 of the standard, a flame retardant coating may be applied to the electric cables, or an automatic fixed fire suppression system may be installed to provide an equivalent level of protection. In addition, the italicized exception to Section 3.3.5.3 is not endorsed.

(vi) Water supply and distribution. The italicized exception to Section 3.6.4 is not endorsed.

(3) Compliance with NFPA 805. (i) A licensee may maintain a fire protection program that complies with NFPA 805 as an alternative to complying with paragraph (b) of this section for plants licensed to operate before January 1, 1979; or the fire protection license conditions for plants licensed to operate after January 1, 1979. The licensee shall submit a request to comply with NFPA 805 in the form of an application for license amendment under § 50.90. The application must identify any orders and license conditions that must be revised or superseded, and contain any necessary revisions to the plant's technical specifications and the bases thereof. The Director of the Office of Nuclear Reactor Regulation, or a designee of the Director, may approve the application if the Director or designee determines that the licensee has identified orders, license conditions, and the technical specifications that must be revised or superseded, and that any necessary revisions are adequate. Any approval by the Director or the designee of the Director shall be in the form of a license amendment approving the use of NFPA 805 together with any necessary revisions to the technical specifications.

(ii) The licensee shall complete its implementation of the methodology in Chapter 2 of NFPA 805 (including all required evaluations and analyses) and, upon completion, modify the fire protection plan required by paragraph (a) of this section to reflect the licensee's decision to comply with NFPA 805, before changing its fire protection program or nuclear power plant as permitted by NFPA 805.

(4) Alternative methods and analytical approaches. A licensee may submit a request to use alternative methods and analytical approaches, including fundamental fire protection program and minimum design requirements identified in Chapter 3 of NFPA 805, in lieu of those methods and approaches specified in NFPA 805. The request must be in the form of an application for license amendment under § 50.90. The Director of the Office of Nuclear Reactor Regulation, or designee of the Director, may approve the application if the Director or designee determines that the alternative methods and analytical approaches:

(i) Satisfy the goals, performance objectives, and performance criteria specified in NFPA 805 related to nuclear safety and radiological release.

(ii) Maintain safety margins.

(iii) Maintain fire protection defense-in-depth (fire prevention, fire suppression, and post-fire safe shutdown capability).

* * * * *

(f) Licensees that have submitted the certifications required under § 50.82(a)(1) shall maintain a fire protection program to address the potential for fires that could cause the release or spread of radioactive materials (*i.e.*, that could result in a radiological hazard). A fire protection program that complies with NFPA 805 shall be deemed to comply with the requirements of this paragraph.

Dated at Rockville, Maryland, this 25th day of October, 2002.

For the U.S. Nuclear Regulatory Commission.

Annette Vietti-Cook,

Secretary of the Commission.

[FR Doc. 02–27701 Filed 10–31–02; 8:45 am]

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NUCLEAR REGULATORY COMMISSION

10 CFR Part 50

[Docket No. PRM–50–79]

Lawrence T. Christian, et. al.; Receipt of Petition for Rulemaking

AGENCY: Nuclear Regulatory Commission.

ACTION: Petition for rulemaking; notice of receipt.

SUMMARY: The Nuclear Regulatory Commission (NRC) is publishing for public comment a notice of receipt of a petition for rulemaking, dated September 4, 2002, which was filed with the Commission by Lawrence T. Christian, et al. The petition was docketed by the NRC on September 23, 2002, and has been assigned Docket No. PRM–50–79. The petition requests that the NRC amend its regulations regarding offsite emergency plans for nuclear power plants to insure that all day care centers and nursery schools in the vicinity of nuclear power facilities are properly protected in the event of a radiological emergency.

DATE: Submit comments by January 15, 2003. Comments received after this date will be considered if it is practical to do so, but assurance of consideration can only be given to comments received on or before this date.

ADDRESSES: Mail comments to: Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemakings and Adjudications Staff.

Deliver comments to: 11555 Rockville Pike, Rockville, Maryland between 7:30 a.m. and 4:15 p.m. on Federal workdays.

For a copy of the petition, write to Michael T. Lesar, Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

You may also provide comments via the NRC's interactive rulemaking website at *http://ruleforum.llnl.gov*. This site allows you to upload comments as files in any format, if your web browser supports the function. The petition and any public comments received are available on the site. For information about the interactive rulemaking website, contact Carol Gallagher at (301) 415–5905 or via e-mail at *CAG@nrc.gov*.

The petition and copies of comments received may be inspected, and copied for a fee, at the NRC Public Document Room, (first floor) 11555 Rockville Pike, Rockville, Maryland. These same documents may be accessed via the NRC's Agencywide Documents Access and Management System (ADAMS) on the Internet at *http://www.nrc.gov/reading-rm/adams.html*. The ADAMS accession number for the petition is ML022590350.

FOR FURTHER INFORMATION CONTACT: Michael T. Lesar, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Telephone: 301–415–7163 or Toll-free: 1–800–368–5642. E-mail: *MTL@nrc.gov*.

SUPPLEMENTARY INFORMATION:

Background

The Nuclear Regulatory Commission received a petition for rulemaking dated September 4, 2002, submitted by Lawrence T. Christian, et al. (the petitioners). The petition was docketed by the NRC on September 23, 2002, and assigned Docket No. PRM–50–79.

The Petitioners

Lawrence T. Christian submitted a letter and attachments stating the substance of the petition. Mr. Christian identified himself as a resident of the evacuation zone around the Three Mile Island Nuclear Power Station (TMI) and as the father of two preschool-aged children, including a four-year-old daughter who attends a nursery school within eyesight of TMI. Attached to the petition are pages bearing the signatures of over 3,000 public co-signers. Most of the co-petitioners indicated that they were residents of the State of Pennsylvania.

The Petitioners' Interest in the Requested Action

According to the petitioners, there are currently no Federally-mandated requirements specifically designed to protect daycare centers and nursery schools located in the evacuation zones around nuclear power stations. They believe that this regulatory deficiency puts preschool children at risk in the event of a nearby radiological accident and undermines FEMA requirements that offsite plans adequately protect the public health and safety.

The petition states that Mr. Christian became aware of this situation after he contacted several daycare centers and nursery schools in his York County, Pennsylvania, community, and learned that none of them has an adequate emergency evacuation plan in case of a radiological emergency at the nearby TMI plant. Mr. Christian conducted an informal survey of local daycare and nursery school directors, and learned that most of them do not know what to do in case of a radiological emergency. Mr. Christian found that most daycare and nursery school directors in his area:

1. Do not believe that they have been given adequate information or training to handle an evacuation of children in their care during a radiological emergency.
2. Do not have copies of radiological emergency evacuation plans for their localities.
3. Are frequently uncertain or mistaken as to how an evacuation of their own institution would proceed. Some directors assume that parents would pick up their own children; others assume that center or school staff would have to transport the children, but have no clear plan for executing a staff-run evacuation. Some mistakenly believe that York County would provide emergency bus service and relocation centers if an evacuation were necessary.
4. Do not know where children would or should be taken in the event of an emergency evacuation in response to a radiological accident.
5. Do not know whether the children in their charge would be transported in approved child-safety seats during an evacuation.
6. Assume that, if no organized mass transportation were provided for the children in their charge, daycare center and nursery school employees would be required to stay in the workplace until every child had been safely picked up by their parents.
7. Believe that the question of evacuation plans for their institutions needs to be addressed in a systematic way.

The petition states that Mr. Christian reported his findings to the York County Board of Commissioners and the York County Director of Emergency Management, expressing his alarm at this gap in emergency planning. Mr. Christian received responses from the York County Director of Emergency Management and the Executive Director of York County's Department of Emergency Services indicating that Pennsylvania State law did not require licensed daycare centers and nursery schools to plan for radiological emergencies, and that the county did not have the authority to mandate such planning. Mr. Christian was advised by York County emergency management officials to ask municipal government officers in his community for emergency planning assistance concerning local daycare and nursery schools.

According to the petition, municipal government officials advised Mr. Christian to have the director of his daughter's nursery school work with Exelon Corporation, which owns and operates TMI, to develop an evacuation plan for the school. The school director requested Exelon's assistance, but had received no response after 30 days. Moreover, the school director informed Mr. Christian that her institution did not have the resources to arrange for bus or van transportation for students in the event of an emergency, and that, should an accident occur at TMI, the school would have to request that parents pick up their children individually.

The petitioners note that Federal Emergency Management Agency (FEMA) regulations pertaining to Radiological Emergency Readiness Planning (RERP) mandate that emergency offsite plans protect the public health and safety, and they stress that preschool-aged children are members of the public covered by that mandate. The petitioners believe that voluntary, ad hoc emergency evacuation plans that rely on parents to enter an evacuation zone to pick up preschool students during a radiological emergency are inadequate to protect the health and safety of the children at risk. The petitioners claim that Federally-required RERPs already mandate that public and private elementary, middle, junior, and high schools located in evacuation zones around nuclear power plants be provided with designated relocation centers, designated emergency transportation, rosters of emergency bus drivers, and educational materials about radiological emergency procedures. These institutions are also required to undergo state of readiness checks and must be included in local radiological emergency preparedness exercises. The petitioners contend that because no corresponding standard measure of adequate protection currently exists for daycare centers and nursery schools in the vicinity of nuclear power facilities, Federal, state and county emergency plans do not properly take these preschool institutions into account.

The Petitioners' Request

The petitioners request that the NRC immediately establish a standard measure of adequate protection by creating new rules requiring that emergency planning for daycare centers and nursery schools located in evacuation zones be included in the offsite emergency plans of all NRC nuclear power facility licensees. The petitioners request that the NRC amend its regulations to insure that all children attending daycare centers and nursery schools within the evacuation zone are:

1. Assigned to designated relocation centers established safely outside the evacuation zone.
2. Provided with designated transportation to relocation centers in the event of an emergency evacuation.
3. Transported in approved child-safety seats that meet State and Federal laws as they pertain to the transportation of children and infants under 50 pounds in weight or 4′9″ in height.

The petitioners also request that the following be mandated by NRC regulations:

4. The creation and maintenance of working rosters of emergency bus drivers and back-up drivers for nursery school and daycare center evacuation vehicles, and the establishment of a system for notifying these individuals in the event of a radiological emergency. These rosters should be regularly checked and updated, with a designated back-up driver listed for each vehicle and route.
5. Notification of emergency management officials by individual preschools as to the details of each institution's radiological emergency plan.
6. Annual site inspections of daycare centers and nursery schools within the evacuation zone by emergency management officials.
7. Participation of daycare centers and nursery schools within the evacuation zone in radiological emergency preparedness exercises designed to determine each institution's state of readiness.
8. Creation of identification cards, school attendance lists, and fingerprint records for all children who are to be transported to a relocation center, to insure no child is left behind or is unable, due to age, to communicate his or her contact information to emergency workers.
9. Development by emergency management officials of educational materials for parents informing them what will happen to their children in case of a radiological emergency, and where their children can be picked up after an emergency evacuation.
10. Stocking of potassium iodide (KI) pills and appropriate educational materials at all daycare centers and nursery schools within the evacuation zone.
11. Radiological emergency preparedness training for all daycare center and nursery school employees within the evacuation zone.
12. Listing of designated relocation centers for daycare centers and nursery schools in area phone directories so that parents can quickly and easily find where their children will be sent in case of a radiological emergency.
13. Establishment of toll-free or 911-type telephone lines to provide information about radiological emergency plans and procedures for daycare centers and nursery schools within the evacuation zone.
14. Creation of written scripts for use by the local emergency public broadcast system that include information about evacuation plans and designated relocation centers for daycare centers and nursery schools.

The Petitioners' Justification

In support of their request, the petitioners detail their reasons for asking the NRC to change its regulations to include the aforementioned protective measures aimed at securing the health and safety of preschoolers in evacuation zones surrounding nuclear power plants. The petitioners stated reasons for requesting that the NRC amend its rules to mandate these emergency planning measures are as follows:

Establishment of Designated Relocation Centers

The petitioners note that FEMA emergency planning regulations require that the health and safety of the general public be protected in the event of a radiological accident at a nuclear power plant. Preschoolers are part of the general population and their well-being must be provided for. The petitioners claim that the designation of emergency relocation centers for all elementary, middle school and high school students is already standard practice, and contend that the establishment of such centers for preschoolers is no less vital. Because the thyroid glands of young children are highly susceptible to damage by exposure to radiation, the petitioners stress that children attending daycare centers and nursery schools in the evacuation zone should be moved to safety as quickly and as efficiently as possible. If parents are forced to backtrack into the evacuation zone to fetch their preschool-aged children and carry them to safety one-by-one, frantic parents will clog evacuation routes. The petitioners conclude that radiological emergency plans should provide for the mass evacuation of children from daycare centers and nursery schools located in the evacuation zone to relocation centers situated at a safe distance from the nuclear power facility.

Provision of Designated Transportation; Creation of Working Rosters of Emergency Bus Drivers

The petitioners note that most daycare centers and nursery schools currently have no access to public school buses or school bus drivers. If frantic parents must drive personal vehicles into the evacuation zone to pick up their children during a radiological emergency, evacuation routes will be clogged with private cars, the evacuation will be impeded, and the health and well-being of preschool children will not be adequately protected. Therefore, the petitioners conclude that the NRC should require that offsite emergency plans provide for designated busses or vans, manned by designated emergency drivers, to transport children from daycare centers and nursery schools located in the evacuation zone to designated relocation centers.

Use of Assigned and Installed, Approved Child-Safety Seats in the Evacuation of Preschoolers

The petitioners note that newborns and infants cannot safely be placed on a standard bus seat and transported out of the evacuation zone. Unrestrained children could roll or fall off the seats and be injured or killed en route to designated relocation centers. Federal law requires all children under 50 lbs or under the height of 4′9″ to be placed in federally-approved child safety seats when riding in motor vehicles. The use of approved child-safety seats is the only safe and legal way to transport small children. The petitioners conclude that NRC regulations should require that infants and young children being evacuated during a radiological emergency be properly secured in approved child safety seats.

Notification to Emergency Management Officials; Annual Site Inspections; Inclusion of Daycare Centers and Nursery Schools in Radiological Preparedness Exercises

The petitioners maintain that these measures are necessary to insure that daycare centers and nursery schools properly comply with the requested regulations and implement the

suggested emergency planning provisions.

Use of Identification Cards, School Attendance Lists and Fingerprinting To Keep Track of Children During an Emergency Evacuation

The petitioners note that most children under the age of three do not know their parents' legal names, but will simply identify them as ''Mommy'' or ''Daddy''. Preschool children are also typically unable to state their home address or phone number. Young children therefore have no effective means of communicating their parents' names or contact information to teachers, caregivers, or emergency workers. The petitioners conclude that identifying and tracking young children through the use of ID cards, school attendance lists, and fingerprinting is necessary to ensure that no preschool-aged child is left behind in a radiological emergency.

Preparation of Educational Materials for the Parents of Preschoolers

The petitioners contend that such materials are necessary in order to properly inform parents about procedures for evacuating their preschool-aged children from the danger zone in case of a radiological emergency.

Stocking of KI Tablets and the Preparation of Relevant Educational Materials for the Parents of Preschoolers

The petitioners note that preschool-aged children are particularly susceptible to thyroid damage due to exposure to radiation. Since the ingestion of KI protects against this damage, the petitioners contend that KI should be stocked by daycare centers and nursery schools in the evacuation zone for distribution to the children their charge in case of radiological emergency. However, because parents may be unaware of a young child's allergy to iodine, the petitioners believe that daycare centers and nursery schools should prepare for possible future radiological emergencies by having parents sign release forms giving daycare and nursery school workers standing permission to administer KI to their children, in the proper children's dose, in case of radiological emergency.

Radiological Emergency Preparedness Training for Employees of Daycare Centers and Nursery Schools

The petitioners maintain that radiological emergency preparedness training is necessary to equip employees of daycare centers and nursery schools to properly respond in case of a radiological accident.

Phone Listings for Designated Relocation Centers Assigned to Local Daycare Centers and Nursery Schools; Toll-free and 911 Information Lines

The petitioners claim that many parents are not acquainted with, or may not even have access to information about emergency procedures for evacuating their preschool-aged children from the danger zone following a radiological accident. Moreover, even if parents are well-informed, in the event of a radiological emergency, someone other than a parent (*e.g.,* a grandparent, neighbor or friend) may be called upon to pick up a child from a designated relocation center. These individuals will need quick access to information about emergency plans and designated relocation centers for local preschools. Finally, the general public should have access to this information. The petitioners conclude that dedicated information lines and easy-to-find phone listings should be set up in order to avoid confusion in case of an emergency.

Creation of Written Scripts for the Public Emergency Broadcast System Which Include Information About Emergency Plans and Designated Relocation Centers for Daycare Centers and Nursery Schools

The petitioners believe that, during an emergency, parents might panic if they cannot locate their children and do not have timely information about their movements in the event of an evacuation. The emergency broadcast system could be used to inform parents that their preschool-aged children have left their buildings and are en route to designated relocation centers. The petitioners contend that this will free parents to redirect their efforts toward escaping the danger zone themselves, rather than further exacerbating traffic problems by trying to move back into the evacuation zone to fetch their children from daycare centers or nursery schools. Finally, the petitioners say, the general public should have access to such information during a radiological emergency. The petitioners conclude that the public emergency broadcast system should prepare to disseminate information about the evacuation of daycare centers and nursery schools in the event of a radiological accident.

Specialized Evacuation Needs of Preschool-aged Children

The petitioners also offer a statement in support of their request which focuses on the specialized evacuation needs of preschool-aged children. They note that very young children are more difficult to safely transport than school-aged children and would require more and different kinds of care from emergency workers. The petition makes the following points in this connection:

1. Most children under the age of three have no effective way of communicating their parents legal names, but identify them only as ''Mommy'' and ''Daddy''.
2. Most children under the age of three cannot tell you their home address or phone number, and therefore have no effective means of communicating their contact information.
3. Infants and newborns are usually unable to walk, so they are completely dependent on others for their safe relocation during an emergency evacuation.
4. Infants and newborns have special dietary and sanitary needs.
5. Infants and newborns can be easily injured if not properly handled, due to the weakness in their young spines and necks.
6. Preschool children must be transported in approved child-safety seats when being evacuated. Young children cannot ride unsecured in bus seats, as they might fall off and be injured or killed.
7. Unlike public school teachers, nursery school teachers and daycare center employees have little or no emergency evacuation training.
8. Infants, newborns, toddlers, and preschoolers are physically and emotionally dependent on adults for their overall well-being. During an emergency, these needs are greatly amplified. Planning and training for, and providing proper supervision of the emergency evacuation of such young children is a therefore a necessity.
9. Very young children have an especially high susceptibility to damage and health risks caused by radiation exposure. Because they are especially vulnerable, children in daycare centers and nursery schools require special protection in a radiological emergency.

The Petitioners' Conclusion

The petitioners maintain that without new NRC requirements concerning offsite emergency plans no standard measure of adequate protection will ever exist for daycare centers and nursery schools located within evacuation zones surrounding nuclear power facilities. The petitioners note that a FEMA fact sheet concerning emergency radiological planning states that Federal law mandates that ''plans and preparedness must be determined

to adequately protect the public health and safety by providing reasonable assurance that appropriate measures can be taken offsite in the event of a radiological emergency.'' The petitioners add that society as a whole has a moral obligation to make sure that every possible measure is in place to insure the safety and well-being of young children.

The petitioners contend that, if the NRC refuses to require the basic protections for preschoolers laid out in the petition, the agency will be perpetuating an improper implementation of FEMA regulations as they pertain to properly protecting the public in the event of a radiological emergency. The petitioners stress that the NRC's principal duty is to safeguard the public, and maintain that, barring the adoption of the provisions requested by the petitioners, the NRC will be guilty of negligence in the fulfillment of its duty.

Dated at Rockville, Maryland, this 28th day of October, 2002.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 02–27861 Filed 10–31–02; 8:45 am]

BILLING CODE 7590–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 02–AEA–18]

Establishment of Class E Airspace; Crisfield, MD

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at Crisfield Municipal Airport, Crisfield, MD. The development of a Standard Instrument Approach Procedure (SIAP) to serve flights operating into Crisfield Municipal Airport under Instrument Flight Rules (IFR) makes this action necessary. Controlled airspace extending upward from 700 feet Above Ground Level (AGL) is needed to contain aircraft executing the approach. The area would be depicted on aeronautical charts for pilot reference.

DATES: Comments must be received on or before December 2, 2002.

ADDRESSES: Send comments on the proposal in triplicate to: Manager, Airspace Branch, AEA–520, Docket No. 02–AEA–18, FAA Eastern Region, 1 Aviation Plaza, Jamaica, NY, 11434–4809.

The official docket may be examined in the Office of the Regional Counsel, AEA–7, FAA Eastern Region, 1 Aviation Plaza, Jamaica, NY, 11434–4809.

An informal docket may also be examined during normal business hours in the Airspace Branch, AEA–520, FAA Eastern Region, 1 Aviation Plaza, Jamaica, NY, 11434–4809.

FOR FURTHER INFORMATION CONTACT: Mr. Francis T. Jordan, Jr., Airspace Specialist, Airspace Branch, AEA–520 FAA Eastern Region, 1 Aviation Plaza, Jamaica, NY 11434–4809: telephone: (718) 553–4521.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this action must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 02–AEA–18''. The postcard will be date/time stamped and returned to the commenter. All communications received on or before the closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this action may be changed in light of comments received. All comments submitted will be available for examination in the Rules Docket closing both before and after the closing date for comments. A report summarizing each substantive public contact with the FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Office of the Regional Counsel, AEA–7, FAA Eastern Region, 1 Aviation Plaza, Jamaica, NY, 11434–4809. Communications must identify the docket number of this NPRM. Persons interested in being placed on a mailing list for future NPRMs should also request a copy of Advisory Circular No. 11–2A, which describes the application procedure.

The Proposal

The FAA is considering an amendment to Part 71 of the Federal Aviation Regulations (14 CFR Part 71) to establish Class E airspace area at Crisfield, MD. The development of a SIAP to serve flights operating IFR into the airport makes this action necessary. Controlled airspace extending upward from 700 feet AGL is needed to accommodate the SIAP. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface of the earth are published in Paragraph 6005 of FAA Order 7400.9K, dated August 30, 2002, and effective September 16, 2002, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this proposed regulation—(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) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that would only affect air traffic procedures and air navigation, it is certified that this proposed rule would not have significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR Part 71 as follows:

PART 71—[AMENDED]

1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; EO 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9K, Airspace Designations and Reporting Points, dated August 30, 2002 and effective September 16, 2002, is proposed to be amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

AEA MD E5, Crisfield [NEW]

Crisfield Municipal Airport
(Lat. 38°01′01″ N., long. 75°49′44″ W.)

That airspace extending upward from 700 feet above the surface within a 6.0-mile radius of Crisfield Municipal Airport, Crisfield, MD.

Issued in Jamaica, New York on October 23, 2002.

John G. McCartney,

Acting Assistant Manager, Air Traffic Division, Eastern Region.

[FR Doc. 02–27844 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 314

[Docket No. 85N–0214]

180–Day Generic Drug Exclusivity for Abbreviated New Drug Applications

AGENCY: Food and Drug Administration, HHS.

ACTION: Proposed rule; withdrawal.

SUMMARY: The Food and Drug Administration (FDA) is announcing the withdrawal of a proposed rule published in the **Federal Register** of August 6, 1999 (64 FR 42873) (the August 1999 proposed rule). FDA proposed to amend its regulations governing 180-day exclusivity and the timing of certain abbreviated new drug application (ANDA) approvals under the Federal Food, Drug, and Cosmetic Act (the act). The proposed amendments to the regulations were made in response to court decisions that affected the agency's previous interpretation of relevant provisions of the act. Since the proposed rule was published, there have been additional court decisions that address FDA's interpretation of the act, including the interpretation described in portions of the proposed rule. In light of these decisions, FDA is withdrawing the August 1999 proposed rule and will reevaluate its interpretation of the act. FDA will continue to regulate directly from the statute and applicable regulations and make regulatory decisions on an issue-by-issue basis.

DATES: The proposed rule is withdrawn November 1, 2002.

FOR FURTHER INFORMATION CONTACT: J. Kenneth Borgerding, Center for Drug Evaluation and Research (HFD–7), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–594–2041.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of August 6, 1999 (64 FR 42873), FDA proposed to amend its regulations governing 180-day generic drug exclusivity under the act. The August 1999 proposed rule was an effort to clarify existing eligibility requirements for 180-day generic drug exclusivity and to describe new eligibility requirements for ANDA sponsors. The August 1999 proposed rule described a number of challenges to FDA's previous interpretations of relevant statutory provisions and proposed a new approach to implementing 180-day generic drug exclusivity. The publication of the proposed amendments was FDA's response to then-recent court decisions affecting portions of its regulations. (See *Mova Pharmaceutical Corp.* v. *Shalala*, 140 F.3d 1060 (D.C. Cir. 1998), and *Granutec, Inc.* v. *Shalala*, 139 F.3d 889, 1998 WL 153410 (4th Cir. Apr. 3, 1998)).

The Drug Price Competition and Patent Term Restoration Act of 1984 (Public Law 98–417) (the Hatch-Waxman Amendments) created section 505(j) of the act (21 U.S.C. 355(j)). The ANDA approval program established by section 505(j) of the act permits a generic version of a previously approved innovator drug to be approved without submission of a full new drug application (NDA). An ANDA references a previously approved drug product (the ''listed drug'') and relies on the agency's prior finding of safety and effectiveness for that drug product.

Applicants seeking approval for an NDA must include in their NDA information about patents for the drug that is the subject of the NDA. FDA publishes this patent information as part of the agency's publication ''Approved Drug Products with Therapeutic Equivalence Evaluations'' (the Orange Book).

Under section 505(j)(2)(A)(vii) of the act, generic drug applicants must include in an ANDA a patent certification for each patent listed in the Orange Book for the listed drug. The applicant must certify to one of the following for each listed patent: (1) That no patent information on the listed drug has been submitted to FDA; (2) that such patent has expired; (3) the date on which such patent will expire; or (4) that such patent is invalid, unenforceable, or will not be infringed by the manufacture, use, or sale of the drug product for which the ANDA is submitted. These certifications are referred to as ''paragraph I,'' ''paragraph II,'' ''paragraph III,'' and ''paragraph IV'' certifications, respectively. The ANDA applicant must also provide notice of a paragraph IV certification to each owner of the patent that is the subject of the certification and to the holder of the approved NDA to which the ANDA refers.

Section 505(j)(5)(B)(iv) of the act provides an incentive for ANDA applicants to file paragraph IV certifications challenging patents that may be invalid, unenforceable, or not infringed by the drug product that is the subject of the ANDA. In certain circumstances, the first ANDA applicant with a paragraph IV certification is granted 180-day exclusivity. The 180-day exclusivity gives the first ANDA applicant protection from market competition by subsequent generic versions of the same drug product for a 180-day period from either the date the first ANDA applicant begins commercially marketing its drug product or from the date of a court decision holding the patent that is the subject of the paragraph IV certification invalid, unenforceable, or not infringed.

In 1994, FDA issued its final rule implementing the patent and marketing exclusivity provisions of the Hatch-Waxman Amendments. The requirements for 180-day exclusivity are contained in § 314.107(c)(1) (21 CFR 314.107(c)(1)).

In 1998, two appellate courts found that FDA's interpretation of section 505(j)(5)(B)(iv) of the act as expressed in § 314.107(c)(1) was not supported by the act (*Mova*, 140 F.3d at 1077; *Granutec*, 139 F.3d at 889). The *Mova* and *Granutec* courts concluded that the ''successful defense'' requirement imposed by § 314.107(c)(1) which required an ANDA applicant to be sued for patent infringement and to win before it could qualify for 180-day exclusivity was invalid. They held that 180 days of marketing exclusivity should be granted to the first ANDA applicant that files a paragraph IV certification, regardless of whether the applicant is subsequently sued for patent infringement.

Shortly after these decisions, the agency published a guidance for industry entitled ''180–Day Generic Drug Exclusivity Under the Hatch-Waxman Amendments to the Federal

Food, Drug, and Cosmetic Act'' (June 1998) (63 FR 37890, July 14, 1998), detailing its new approach to 180-day exclusivity in response to the *Mova* and *Granutec* court decisions. The agency also published an interim rule revoking the ''successful defense'' requirement of § 314.107(c)(1) (63 FR 59710, November 5, 1998). Since that time, the agency has regulated directly from the statute on issues not specifically addressed by the remaining regulations governing 180-day exclusivity.

In the August 1999 proposed rule, the agency described a new approach to implementing the 180-day generic drug exclusivity consistent with the act. The August 1999 proposed rule addressed the issues resulting from the *Mova* and *Granutec* court decisions and responded to other 180-day exclusivity issues not currently addressed by the regulations.

Since publication of the August 1999 proposed rule, there has been extensive litigation of issues relating to ANDA approvals and 180-day exclusivity. Among these litigated issues was whether 180-day exclusivity would begin to run with the first district or other court decision finding the patent invalid, unenforceable, or not infringed or with a final court decision from which no appeal has been or can be taken.

FDA's interpretation of the words ''the court'' contained in section 505(j)(5)(B)(iii) of the act was initially challenged and reviewed by the court in *TorPharm, Inc.* v. *Shalala*, No. 97–1925, 1997 U.S. Dist. LEXIS 21983 (D.D.C. Sep. 15, 1997), *appeal withdrawn and remanded*, 1998 U.S. App. LEXIS 4681 (D.C. Cir. Feb. 5, 1998); *vacated* No. 97–1925 (D.D.C. Apr. 9, 1998). This provision of the act governs the approval of ANDAs when the NDA holder has brought a timely patent infringement action in response to the ANDA applicant's notice of filing a paragraph IV certification to a listed patent. The district court found that ''the court,'' as stated in section 505(j)(5)(B)(iii) of the act, refers to the first court that decides that the patent is invalid or not infringed. Hence, the court found that under the act, the agency must make the ANDA approval effective on the date of the first relevant court decision, regardless of appeal status.

In another case decided after the proposed rule was published, the agency's interpretation of the phrase ''a decision of a court'' contained in section 505(j)(5)(B)(iv) of the act was successfully challenged in Mylan *Pharmaceuticals, Inc.* v. *Shalala*, 81 F. Supp.2d 30 (D.D.C. Jan. 4, 2000) (*Mylan I*). Section 505(j)(5)(B)(iv) of the act governs the eligibility for and timing of 180-day exclusivity. In the regulations in § 314.107 implementing this provision of the act, FDA interpreted ''court'' to mean the court that enters final judgment from which no appeal can be or has been taken (21 CFR 314.107(e)(1) (1999)). The *Mylan I* court found that this interpretation was not consistent with the plain language of the act, and concluded that ''court'' in the phrase ''a decision of a court'' means the first court that renders a decision finding the patent which is the subject of the certification to be invalid, unenforceable, or not infringed.

In response to the litigation and in an effort to provide guidance to the pharmaceutical industry regarding the timing of approval of ANDAs following an unsuccessful patent infringement action by the NDA holder and the start of 180-day generic drug exclusivity, the agency issued a guidance for industry entitled ''Court Decisions, ANDA Approvals, and 180-day Exclusivity Under the Hatch-Waxman Amendments to the Federal Food, Drug, and Cosmetic Act'' (March 2000) (the March 2000 guidance for industry). FDA announced that it would interpret the term ''court'' as found in section 505(j)(5)(B)(iii)(I) and (j)(5)(B)(iv) of the act to mean the first court that renders a decision finding the patent at issue invalid, unenforceable, or not infringed. FDA also announced that it would apply the new guidance policy prospectively. In the case of a district court decision, FDA may approve the ANDA as of the date the district court enters its decision. Also, for eligible applicants, 180-day exclusivity will begin to run on that date.

After the March 2000 guidance for industry was issued, the agency's interpretation of the meaning of ''court decision'' was again litigated in a consolidated case, *Mylan Pharmaceuticals, Inc.* v. *Henney*, 94 F.Supp.2d. 36 (D.D.C. 2000) (*Mylan II*). The court in *Mylan II* found that ''a decision of a court'' contained in section 505(j)(5)(B)(iv)(II) of the act means all court decisions, whether subsequently vacated, settled, appealed, or otherwise mooted. *Id.* at 54.

In the **Federal Register** of July 13, 2000 (65 FR 43233), FDA issued an interim rule to amend its regulations governing the definition of ''court decision'' as detailed in the March 2000 guidance for industry and consistent with the *TorPharm* and *Mylan* court decisions.

The opinion of the United States Court of Appeals for the D.C. Circuit in *Teva Pharmaceuticals, USA, Inc.* v. *FDA*, 182 F.3d 1003 (D.C. Cir. 1999) also rejected the agency's interpretation of the act. The *Teva* court found that under the facts of that case, a dismissal of a declaratory judgment action for lack of subject matter jurisdiction was a court decision triggering the running of exclusivity. In *Teva*, the underlying dismissal was based on an express finding that the plaintiff lacked a reasonable apprehension of a patent infringement suit, and thus there was no case or controversy concerning infringement of the patent to give the court jurisdiction. Under these circumstances, the court held that, although the court did not opine directly on the question of infringement, the dismissal for lack of subject matter jurisdiction was a decision of a court finding the patent invalid or not infringed that triggered 180-day exclusivity. This holding was directly at odds with the approach the agency proposed in the August 1999 proposed rule to deal with dismissals of declaratory judgment actions under section 505(j)(5)(B)(iii) of the act. (See 64 FR 42873 at 42881.)

II. Comments on the Proposed Rule

FDA received several comments on the August 1999 proposed rule. Comments were received from pharmaceutical companies, attorneys, trade associations, generic companies, the Federal Trade Commission, and chemical companies. The comments addressed a wide variety of issues described in the August 1999 proposed rule. Some comments favored and some opposed all or parts of the August 1999 proposed rule.

III. Withdrawal of the Proposed Rule

After careful consideration of the comments on the August 1999 proposed rule and the multiple court decisions affecting the agency's interpretation of the provisions of the act relating to 180-day exclusivity and ANDA approvals, FDA has concluded that it is appropriate to withdraw the August 1999 proposed rule at this time. The agency will continue to regulate directly from the statute and applicable FDA regulations to make 180-day exclusivity decisions on an issue-by-issue basis. The agency will also carefully evaluate possible options for future rulemaking addressing 180-day exclusivity and the timing of ANDA approvals.

Dated: October 23, 2002.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 02–27797 Filed 10–31–02; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[COTP San Diego 02–026]

RIN 2115–AA97

Security Zones; Port of San Diego, CA

AGENCY: Coast Guard, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to establish moving and fixed security zones around and under all cruise ships that are located in the Port of San Diego. These proposed security zones are needed for national security reasons to protect the public and ports from potential terrorist acts. Entry into these zones will be prohibited, unless specifically authorized by the Captain of the Port San Diego.

DATES: Comments and related material must reach the Coast Guard on or before November 29, 2002.

ADDRESSES: You may mail comments and related material to Coast Guard Marine Safety Office San Diego, 2716 North Harbor Drive, San Diego, California, 92101. The Port Operations Department maintains the public docket for this rulemaking. Comments and material received from the public, as well as documents indicated in this preamble as being available in the docket, will become part of this docket and will be available for inspection or copying at the Port Operations Department, 2716 North Harbor Drive, San Diego, California, 92101, between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Lieutenant Commander Rick Sorrell, Chief, Port Operations Department, Marine Safety Office San Diego, (619) 683–6495.

SUPPLEMENTARY INFORMATION:

Request for Comments

We encourage you to participate in this rulemaking by submitting comments and related material. If you do so, please include your name and address, identify the docket number for this rulemaking (COTP San Diego 02–026), indicate the specific section of this document to which each comment applies, and give the reason for each comment. Please submit all comments and related material in an unbound format, no larger than 8½ by 11 inches, suitable for copying. If you would like to know your submission reached us, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period. We may change this proposed rule in view of them.

In our final rule, we will include a concise general statement of the comments received and identify any changes from the proposed rule based on the comments. If as we anticipate, we make the final rule effective less than 30 days after publication in the **Federal Register**, we will explain our good cause for doing so as required by 5 U.S.C. 553(d)(3).

Public Meeting

We do not now plan to hold a public meeting. But you may submit a request for a meeting by writing to Marine Safety Office San Diego at the address under **ADDRESSES** explaining why one would be beneficial. If we determine that one would aid this rulemaking, we will hold one at a time and place announced by a separate notice in the **Federal Register**.

Background and Purpose

Since the September 11, 2001, terrorist attacks on the World Trade Center in New York, the Pentagon in Arlington, Virginia, and Flight 93, the Federal Bureau of Investigation (FBI) has issued several warnings concerning the potential for additional terrorist attacks within the United States. In addition, the ongoing hostilities in Afghanistan and growing tensions in Iraq have made it prudent for U.S. ports to be on a higher state of alert because the Al Qaeda organization and other similar organizations have declared an ongoing intention to conduct armed attacks on U.S. interests worldwide.

In its effort to thwart terrorist activity, the Coast Guard has increased safety and security measures on U.S. ports and waterways. As part of the Diplomatic Security and Antiterrorism Act of 1986 (Pub. L. 99–399), Congress amended section 7 of the Ports and Waterways safety Act (PWSA), 33 U.S.C. 1226, to allow the Coast Guard to take actions, including the establishment of security and safety zones, to prevent or respond to acts of terrorism against individuals, vessels, or public or commercial structures. The Coast Guard also has authority to establish security zones pursuant to the Magnuson Act (50 U.S.C. 191 *et seq.*) and implementing regulations promulgated by the President in subparts 6.01 and 6.04 of part 6 of Title 33 of the Code of Federal Regulations.

In this particular rulemaking, to address the aforementioned security concerns, and to take steps to prevent the catastrophic impact that a terrorist attack against a cruise ship would have on the public interest, the Coast Guard proposes to establish security zones around and under cruise ships entering, departing, or moored within the port of San Diego. These security zones will help the Coast Guard prevent vessels or persons from engaging in terrorist actions against cruise ships. The Coast Guard believes the establishment of security zones is prudent for cruise ships because they carry multiple passengers.

On November 4, 2001, we issued a rule under docket COTP San Diego 01–022 which was published in the **Federal Register** (67 FR 6648, Feb. 13, 2002) under temporary section 165.T11–030 of Title 33 of the Code of Federal Regulations (CFR). In that rulemaking, the Coast Guard established a rule creating 100 yard security zones around cruise ships that enter, are moored in, or depart from the Port of San Diego.

On June 12, 2002, a change in effective period temporary rule was issued, under docket COTP SD 02–013, and was published in the **Federal Register** (67 FR 41845, June 20, 2002) under the same previous temporary section 165.T11–030, which is set to expire at 11:59 pm on December 21, 2002. The Captain of the Port has determined the need for continued security regulations exists. The proposed regulation differs slightly from temporary section 165.T11–030 in one way. Although, while implicit in the temporary rule, the security zones proposed here will be described as extending from the water's surface to the sea floor. This more specific description is intended to discourage unidentified scuba divers and swimmers from coming within close proximity of a cruise ship.

Accordingly, this rulemaking proposes to make permanent the temporary security zones established on November 4, 2001, under docket COTP San Diego 01–022, 33 CFR 165.T11–030 published in the **Federal Register** at 67 FR 6648 (February 13, 2002). This temporary rulemaking effective period was extended until December 21, 2002 by a notice in the **Federal Register** published June 20, 2002 (67 FR 41845).

Discussion of Proposed Rule

The Coast Guard proposes to establish moving and fixed security zones around all cruise ships that are anchored, moored, or underway within the port of San Diego. These proposed security zones will take effect upon the entry of any cruise ship into the waters within the San Diego sea buoy and will remain into effect until the cruise ship passes the San Diego sea buoy on its departure

from the Port of San Diego. This proposed rule, for security concerns, prohibits entry of any vessel inside the security zone surrounding a cruise ship. These security zones are within a 100 yard radius around any cruise ship that is anchored at a designated anchorage; that is moored, or in the process of mooring, at any berth within the San Diego port; and that is underway.

These security zones are needed for national security reasons to protect cruise ships, the public, transiting vessels, adjacent waterfront facilities, and the port from potential subversive acts, accidents, or other events of a similar nature. Entry into these zones will be prohibited unless specifically authorized by the Captain of the Port or his designated representative. Vessels already moored when these security zones take effect are not required to get underway to avoid either the moving or fixed zones unless specifically ordered to do so by the Captain of the Port or his designated representative.

This zone will be enforced by the official patrol, (Coast Guard commissioned, warrant or petty officers) onboard Coast Guard vessels and patrol craft. The official patrol may also be onboard patrol craft and resources of any government agency that has agreed to assist the Coast Guard in the performance of its duties. The Captain of the Port will enforce these zones and may request the use of resources and personnel of other government and private agencies to assist in the patrol and enforcement of the regulation. This regulation is proposed under the authority of 33 U.S.C. 1226 in addition to the authority contained in 33 U.S.C. 1231 and 50 U.S.C. 191.

Vessels or persons violating this section will be subject to the penalties set forth in 33 U.S.C. 1232. Pursuant to 33 U.S.C. 1232 and 33 CFR part 27, any violation of the security zone described herein, is punishable by civil penalties (not to exceed $27,500 per violation, where each day of a continuing violation is a separate violation), criminal penalties (imprisonment up to 6 years and a maximum fine of $250,000), and in rem liability against the offending vessel. Any person who violates this section, using a dangerous weapon, or who engages in conduct that causes bodily injury or fear of imminent bodily injury to any officer authorized to enforce this regulation, also faces imprisonment up to 12 years.

Vessels or persons violating this section are also subject to the penalties set forth in 50 U.S.C. 192: seizure and forfeiture of the vessel to the United States; a maximum criminal fine of $10,000; and imprisonment up to 10 years.

Regulatory Evaluation

This proposed rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040, February 26, l979).

We expect the economic impact of this proposed 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 due to the minimal time that vessels will be restricted from the area. Also, the zones will encompass only a small portion of the waterway. The Port of San Diego can accommodate only a few cruise ships moored at the same time. Most cruise ship calls at each location occur on only one day each week, and are generally less than 18 hours in duration. Furthermore, vessels will be able to pass safely around the zones, and vessels and people may be allowed to enter these zones on a case-by-case basis with permission of the Captain of the Port.

The sizes of the zones are the minimum necessary to provide adequate protection for the cruise ships, their crews and passengers, other vessels operating in the vicinity of the cruise ships and their crews, adjoining areas, and the public. The entities most likely to be affected are commercial vessels transiting the main ship channel en route the Port of San Diego and pleasure craft engaged in recreational activities and sightseeing. The security zones will prohibit any commercial vessels from meeting or overtaking a cruise ship in the main ship channels, effectively limiting the use of the channel. However, the moving security zones will only be effective during cruise ship transits, which will last for approximately 60 minutes. In addition, vessels are able to safely transit around the zones while a vessel is moored or at anchor in the Port of San Diego.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this proposed 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 proposed rule would not have a significant economic impact on a substantial number of small entities. We expect this proposed rule may affect the following entities, some of which may be small entities: The owners and operators of private and commercial vessels intending to transit or anchor in these small portions near the cruise ships covered by these security zones, of the port of San Diego. The impact to these entities would not be significant since these zones are proposed to encompass only small portions of the waterway for limited period of times (while the cruise ships are transiting, moored). Delays, if any, are expected to be less than sixty minutes in duration. Small vessel traffic can pass safely around the area and vessels engaged in recreational activities, sightseeing and commercial fishing have ample space outside of the security zone to engage in these activities. When a cruise ship is at anchor, vessel traffic will have ample room to maneuver around the security zone. The outbound or inbound transit of a cruise ship will last about 60 minutes. Although this regulation prohibits simultaneous use of portions of the channel, this prohibition is of short duration. While a cruise ship is moored, commercial traffic and small recreational traffic will have an opportunity to coordinate movement through the security zone with the patrol commander.

If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this rule would have a significant economic impact on it, please submit a comment (*see* **ADDRESSES**) explaining why you think it qualifies and how and to what degree this rule would economically affect it.

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 proposed rule so that they can better evaluate its effects on them and participate in the rulemaking. If the proposed rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact

LTJG Joseph Brown, Marine Safety Office San Diego, (619) 683–6495

Collection of Information

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

Federalism

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

Unfunded Mandates Reform Act

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

Taking of Private Property

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

Protection of Children

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

Indian Tribal Governments

This proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would 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. We invite your comments on how this proposed rule might impact tribal governments, even if that impact may not constitute a ''tribal implication'' under the Order.

Energy Effects

We have analyzed this proposed 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.

Environment

We have considered the environmental impact of this proposed rule and concluded that, under figure 2–1, paragraph (34)(g), of Commandant Instruction M16475.lD, this rule is categorically excluded from further environmental documentation because we are proposing to establishing a security zone. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES.**

List of Subjects in 33 CFR Part 165

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

For the reasons discussed in the preamble, the Coast Guard proposes to amend 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 and 160.5; 49 CFR 1.46.

2. Add § 165.1108 to read as follows:

§ 165.1108 Security Zones; Cruise Ships, Port of San Diego, California.

(a) *Definition.* ''Cruise ship'' as used in this section means a passenger vessel, except for a ferry, over 100 feet in length, authorized to carry more than 12 passengers for hire; capable of making international voyages lasting more than 24 hours, any part of which is on the high seas; and for which passengers are embarked, disembarked or at a port of call in the San Diego port.

(b) *Location.* The following areas are security zones:

(1) All waters, extending from the surface to the sea floor, within a 100 yard radius around any cruise ship that is anchored at a designated anchorage within the San Diego port area inside the sea buoys bounding the port of San Diego.

(2) The shore area and all waters, extending from the surface to the sea floor, within a 100 yard radius around any cruise ship that is moored at any berth within the San Diego port area inside the sea buoys bounding the Port of San Diego; and

(3) All waters, extending from the surface to the sea floor, within a 100 yard radius around any cruise ship that is underway on the waters inside the sea buoys bounding the Port of San Diego.

(c) *Regulations.* (1) In accordance with the general regulation in § 165.33 of the part, entry into or remaining in this zone is prohibited unless authorized by the Coast Guard Captain of the Port, San Diego or his designated representative.

(2) Persons desiring to transit the area of the security zone may contact the Captain of the Port at telephone number (619) 683–6495 or on VHF–FM channel 16 (156.8 MHz) to seek permission to transit the area. If permission is granted, all persons and vessels must comply with the instructions of the Captain of the Port or his or her designated representative.

(d) **Authority:** In addition to 33 U.S.C. 1231, the authority for this section includes 33 U.S.C. 1226.

(e) *Enforcement.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the security zone by the San Diego Port Police.

Dated: October 11, 2002.

S.P. Metruck,

Commander, US Coast Guard, Captain of the Port, San Diego, California.

[FR Doc. 02–27849 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–15–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[Docket #WA–01–006; FRL–7267–9]

Approval and Promulgation of Air Quality Implementation Plans; State of Washington; Yakima Carbon Monoxide Redesignation to Attainment and Designation of Areas for Air Quality Planning Purposes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On September 26, 2001, the State of Washington submitted a request to redesignate the Yakima ''not classified'' carbon monoxide (CO) nonattainment area to attainment for the CO National Ambient Air Quality Standard (NAAQS). The State also submitted a CO maintenance plan for Yakima. In this action, EPA is proposing to approve the Yakima CO redesignation request and the maintenance plan. In the Final Rules Section of this **Federal Register**, EPA is approving the State's redesignation request and State Implementation Plan (SIP) revision, involving the maintenance plan, as a direct final rule without prior proposal because the Agency views the redesignation and SIP revision as noncontroversial and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this proposed rule, no further activity is contemplated in relation to this rule. If EPA receives 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. 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.

DATES: Comments on this proposed rule must be received in writing by December 2, 2002.

ADDRESSES: *Written comments may be mailed to:* Steven K. Body, Office of Air Quality, EPA Region 10, 1200 Sixth Ave., Seattle, WA 98101.

Copies of the documents relevant to this action are available for public inspection between 8 a.m. and 4 p.m., Monday through Friday at the following office: United States Environmental Protection Agency, Region 10, Office of Air Quality, 1200 Sixth Ave., Seattle WA 98101.

FOR FURTHER INFORMATION CONTACT: Steven K. Body, Office of Air Quality, EPA Region10, 1200 Sixth Ave. Seattle WA 98101. Telephone at (206) 553–0782.

SUPPLEMENTARY INFORMATION: For additional information see the direct final rule, of the same title, published in the rules section of this **Federal Register**.

Dated: August 12, 2002.

Ronald A. Kreizenbeck,

Acting Regional Administrator, Region 10.

[FR Doc. 02–27834 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Part 171

[Docket No. RSPA–99–5013 (HM–229)]

RIN 2137–AD21

Hazardous Materials: Revisions to Incident Reporting Requirements and the Hazardous Materials Incident Report Form

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Notice of proposed rulemaking; status.

SUMMARY: In a notice of proposed rulemaking (NPRM) published on July 3, 2001, RSPA (we) proposed changes to RSPA's Hazardous Materials Incident Report (DOT Form F 5800.1). This notice is to inform the public that we have contracted with a professional form development contractor to provide recommendations for the layout of the form consistent with RSPA's goals outlined in the NPRM. Also, the contractor will provide a web-based form to fulfill RSPA's goal of electronic, internet-based reporting and will draft detailed instructions to assist in completing the forms. Members of the regulated community may be contacted to participate in focus groups to test the proposed form and subsequent alternative layouts developed by the contractor. The contract is expected to be completed by December 31, 2002.

FOR FURTHER INFORMATION CONTACT: For comments or questions concerning the contract discussed in this update, contact Ron DiGregorio at the Office of Hazardous Materials Planning and Analysis, telephone (202) 366–4484, Research and Special Programs Administration. For comments or questions concerning the NPRM or rulemaking, contact Michael Johnsen at the Office of Hazardous Materials Standards, telephone (202) 366–8553 or Kevin Coburn, at the Office of Hazardous Materials Planning & Analysis, telephone (202) 366–4555, Research and Special Programs Administration.

SUPPLEMENTARY INFORMATION:

I. Background

On July 3, 2001, RSPA (''we'') published an NPRM (66 FR 35155) proposing revisions to the incident reporting requirements of the Hazardous Materials Regulations and the hazardous materials incident report form, DOT Form F 5800.1. Our intent is to improve the clarity of the form to make it more user-friendly and to allow for electronic scanning of the form.

We included a proposed revision to DOT Form F 5800.1 in the NPRM that incorporated elements found in recent versions of the U.S. Census form and other government forms that are subjected to scanning for electronic data storage, retrieval and analysis. We received several comments concerning the layout of the form, which will be addressed in the final rule. However, we believe that the recommendations of a company well experienced in developing these types of forms could further improve the usefulness of the form. The contractor will consider incorporating recommendations on the format from commenters into its suggested layouts. RSPA will review the suggestions submitted by the contractor in addition to comments received in response to the NPRM, during the development of the revised form that will be part of the final rule.

It is important to note that the final content (*i.e.,* specific information which will be reported) of the form will be determined by RSPA. The contractor will use the content of the proposed form as published in the NPRM and will maintain the data elements as they appear in the proposed form, though wording and order of the questions may vary.

RSPA seeks to compile an accurate database of incidents meeting the criteria specified in § 171.16. A form that can be completed easily and accurately will assist us in compiling accurate data and reduce the information collection burden on the regulated community.

A comprehensive set of instructions for completing the form will answer questions a filer may have without requiring the filer to contact us directly. Clear and concise instructions will also improve the accuracy of the data submitted by providing examples and explanations for each of the questions posed on the form.

We believe that a web-based DOT Form F 5800.1 that can be completed online is essential to our efforts for reducing burden on members of the regulated community and obtaining accurate reporting data. It also assists us in meeting our obligations under the Government Paperwork Elimination Act to accept electronic documents for transactions conducted with the public and regulated communities. In addition to reducing paperwork and postage costs, the on-line version of the form will include logic patterns to minimize accidental errors and remove non-required questions, as the form will ''respond'' to the data entered into it. This will reduce the time required to complete the form.

RSPA retains final authority as to the format and content of the incident report form.

Issued in Washington, DC, on October 28, 2002.

Robert A. McGuire,

Associate Administrator for Hazardous Materials Safety.

[FR Doc. 02–27852 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–60–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1018–AG96

Endangered and Threatened Wildlife and Plants; Designation of Critical Habitat for *Delphinium bakeri* and *Delphinium luteum* (Baker's and Yellow Larkspur)

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; notice of availability of draft economic analysis; reopening of comment period.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce the availability of the draft economic analysis for the proposed designation of critical habitat for *Delphinium bakeri* (Baker's larkspur) and *Delphinium luteum* (yellow larkspur) located in Marin and Sonoma counties, California. We are reopening the comment period for the proposal to designate critical habitat for these species to allow all interested parties to comment simultaneously on the proposed rule and the associated draft economic analysis. Comments previously submitted need not be resubmitted as they will be incorporated into the public record as part of this extended comment period, and will be fully considered in the final rule.

DATES: We will accept comments on both the draft economic analysis and the proposed critical habitat designation until December 2, 2002.

ADDRESSES: Written comments and information should be submitted to the Field Supervisor, Sacramento Fish and Wildlife Office, U.S. Fish and Wildlife Service, 2800 Cottage Way, Suite W–2605, Sacramento, CA 95825. For the electronic mail address, and further instructions on commenting, refer to Public Comments Solicited section of this notice.

FOR FURTHER INFORMATION CONTACT: Glen Tarr, at the address above (telephone 916/414–6600; facsimile 916/414–6710).

SUPPLEMENTARY INFORMATION:

Background

Delphinium bakeri and *Delphinium luteum* (Baker's and yellow larkspur) are perennial herbs in the buttercup family (Ranunculaceae) endemic to (native and restricted to) Sonoma and Marin counties in California. *Delphinium bakeri* produces dark blue or purplish flowers in April and May, while *D. luteum* produces bright yellow flowers from March to May.

We listed both plants as endangered species under the Endangered Species Act of 1973, as amended (Act) (16 U.S.C. 1531 *et seq.*) on January 6, 2000 (65 FR 4156). On June 18, 2002, we proposed six critical habitat units for the plants, totaling 1,786 hectares (ha) (4,412 acres (ac)) (67 FR 41367). For *Delphinium bakeri,* we proposed two units in Sonoma and Marin counties, California totaling 740 ha (1,828 ac), while for *D. luteum,* we proposed four units in Sonoma and Marin counties totaling 1,046 ha (2,584 ac). All of the area proposed as critical habitat is in private ownership.

Critical habitat receives protection from destruction or adverse modification through required consultation under section 7 of the Act with regard to actions carried out, funded, or authorized by a Federal agency. Section 4(b)(2) of the Act requires that the Secretary of the Interior shall designate or revise critical habitat based upon the best scientific and commercial data available, after taking into consideration the economic impact of specifying any particular area as critical habitat.

The public comment period for the June 18, 2002, proposal originally closed on August 19, 2002. We have prepared a draft economic analysis on the effects of the proposed critical habitat designation, and are now announcing its availability for review. The draft analysis estimates the foreseeable economic impacts of the critical habitat designation on government agencies and private businesses and individuals. Reopening of the comment period will provide the public an opportunity to evaluate and comment on both the proposed rule and the draft economic analysis. Comments already submitted on the proposed designation of critical habitat for *Delphinium bakeri* and *D. luteum* do not need to be resubmitted as they will be fully considered in the final determinations.

Public Comment Solicited

The final economic analysis concerning the designation of critical habitat for *Delphinium bakeri* and *D. luteum* will consider information and recommendations from all interested parties. We will accept written comments and information during this reopened comment period. If you wish to comment, you may submit your comments and materials concerning this proposal by any of several methods:

You may mail or hand-deliver written comments and information to the Field Supervisor, Sacramento Fish and Wildlife Office, U.S. Fish and Wildlife Service, 2800 Cottage Way, Suite W–2605, Sacramento, CA 95825. Hand deliveries must be made during normal business hours.

You may also send comments by electronic mail (e-mail) to: *fw1bakers_yellow_larkspur@fws.gov.*

Hand-delivered or mailed comments and information should be submitted to the Sacramento Fish and Wildlife Office, as found in the **ADDRESSES** section. Comments and information submitted by e-mail should be addressed to *fw1bakers_yellow_larkspur@fws.gov.* If you submit comments by e-mail, please submit them as an ASCII file and avoid the use of special characters and any form of encryption. Please also include a return address in your e-mail message. If you do not receive a confirmation from the system that we have received your e-mail message, contact us directly by calling our Sacramento Fish and Wildlife Office at telephone number 916/414–6600, during normal business hours.

We solicit comments or suggestions from the public, other concerned governmental agencies, tribes, the scientific community, industry, or any other interested parties concerning the proposal or the draft economic analysis. We particularly seek comments concerning:

(1) Plans or potential for development within the area proposed to be designated, notwithstanding the comments of the county employee contacted in preparing the economic analysis;

(2) Plans or potential for conversion of land within the area proposed to be designated to other types of agricultural uses, such as vineyards, which might require a permit under section 404 of the Clean Water Act, or other types of Federal permits;

(3) The likelihood of ''stigma effects'' and costs associated with the designation; and

(4) The likely effects and resulting costs arising from the California Environmental Quality Act and other State laws as a result of the designation.

Comments and materials received, as well as supporting documentation used in preparation of the proposal to designate critical habitat, will be available for inspection, by appointment, during normal business hours at our office listed in the **ADDRESSES** section. Copies of the draft economic analysis are available on the Internet at *www.r1.fws.gov* or by writing or calling Glen Tarr or Susan Moore, at the address or telephone number listed above.

Author

The primary author of this notice is Glen Tarr (*see* **ADDRESSES** section).

Authority

The authority for this action is the Endangered Species Act of 1973 (16 U.S.C. 1531 *et seq.*).

Dated: October 23, 2002.

Paul Hoffman,

Acting Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 02–27872 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–55–P

Notices

Federal Register

Vol. 67, No. 212

Friday, November 1, 2002

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–02–08]

Notice of Farm Security and Rural Investment Act of 2002 National Organic Certification Cost-Share Program

AGENCY: Agricultural Marketing Services, USDA.

ACTION: Notice.

SUMMARY: This Notice invites all States of the United States of America, its territories, the District of Columbia, and the Commonwealth of Puerto Rico (collectively hereinafter called States) to submit a Standard Form 424, Application for Federal Assistance, and to enter into a Cooperative Agreement with the Agricultural Marketing Service for the Allocation of National Organic Certification Cost-Share Funds. The Agricultural Marketing Service (AMS) has allocated $5.0 million for this organic certification cost-share program in Fiscal Year 2002. Funds will be available under this program to all interested States to assist organic producers or organic handlers certified to the National Organic Program. States interested in obtaining cost-share funds for their organic producers or organic handlers will have to submit an Application for Federal Assistance, and will have to enter into a cooperative agreement with AMS for the allocation of such funds.

DATES: Completed applications for federal assistance along with signed cooperative agreements must be received by December 31, 2002 in order to participate in the program.

ADDRESSES: Applications for federal assistance and cooperative agreements shall be requested from and submitted to: Robert Pooler, Marketing Specialist, National Organic Program, USDA/AMS/TMP/NOP, Room 4008-South, Ag Stop 0268, 1400 Independence Avenue, SW., Washington, DC 20250–0264; Telephone: (202) 720–3252; Fax: (202) 205–7808; E-mail: *bob.pooler@usda.gov.* Additional information may be found through the National Organic Program's homepage at *http://www.ams.usda.gov/nop.*

FOR FURTHER INFORMATION CONTACT: Robert Pooler, Marketing Specialist, National Organic Program, USDA/AMS/TM/NOP, Room 4008-South, Ag Stop 0268, 1400 Independence Avenue, SW., Washington, DC 20250–0264; Telephone: (202) 720–3252; Fax: (202) 205–7808; E-mail: *bob.pooler@usda.gov.*

SUPPLEMENTARY INFORMATION: This National Organic Certification Cost-Share Program is part of the Farm Security and Rural Investment Act of 2002 (Act) Public Law 107–171, 116 Stat. 134, 7 U.S.C. § 6523. Under this Act, USDA is authorized to provide certification cost share assistance to producers or handlers of organic agricultural products in all States. This National Organic Certification Cost-Share Program provides financial assistance to organic producers or organic handlers of agricultural products in obtaining certification under the National Organic Program authorized under the Organic Foods Production Act of 1990, as amended (7 U.S.C. 6501 *et seq.*). To participate in the program, interested States must complete a Standard Form 424, Application for Federal Assistance, and enter into a written cooperative agreement with AMS. The program will provide cost-share assistance, through participating States, to organic producers or organic handlers who have been certified by a USDA accredited certifying agent to the National Organic Program beginning April 29, 2002. Sections 10606 (b)(1) and (2) 7 U.S.C. 6523, of the Act requires that payments be limited to 75 percent of the costs incurred by a producer or handler in obtaining certification under the National Organic Program as certified to and approved by the Secretary, up to a maximum of $500.00 per year.

Producers who participate in the Organic Certification Cost-Share Program authorized under Section 1524 of the Federal Crop Insurance Act, as amended, (7 U.S.C. 1501–1524) are not eligible to participate in the producer portion of the National Organic Certification Cost-Share Program.

Authority: Pub. L. No. 107–171–116 Stat. 134, 7 U.S.C. § 6523.

Dated: October 28, 2002.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 02–27768 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Food Safety and Inspection Service

[Docket No. 02–038N]

National Advisory Committee on Meat and Poultry Inspection

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Notice of public meeting.

SUMMARY: The National Advisory Committee on Meat and Poultry Inspection (NACMPI) will hold a public meeting on November 6–7, 2002, to review and discuss three issues: Education and Training of the Field Workforce to Achieve a Public Health Vision, Escherichia coli 0157:H7 Developments, and Procedures for Evaluating State Meat and Poultry Inspection Programs. Three subcommittees of the full committee will also meet on November 6, 2002, to work on the issues discussed during the full Committee session.

DATES: The full Committee will hold a public meeting on Wednesday, November 6, and Thursday, November 7, 2002 from 8:30 a.m. to 5 p.m. Subcommittees will hold open meetings on Wednesday, November 6, 2002 from 7 p.m. to 9 p.m. Note: FSIS was not able to publish notification of this public meeting in the **Federal Register** at least 15 days prior to the meeting, as required by Departmental Regulation 1041–001, due to late changes to the agenda.

ADDRESSES: All Committee meetings will take place at the Holiday Inn Capitol at the Smithsonian, located at 550 C Street SW., Washington, DC 20024. The full committee meeting will be held in the ''Columbia Ballroom'' and Sub-Committee 1 will meet in break out room ''Apollo (second floor),'' subcommittee 2 will meet in the ''Mercury'' (second floor), and Subcommittee 3 will meet in the ''Mars (first floor).'' A meeting agenda is available on the Internet at *http://*

www.fsis.usda.gov/OPPDE/nacmpi, which is a sub-web page of the FSIS home page at *http://www.fsis.usda.gov.* Submit one original and two copies of written comments to the FSIS Docket Room, reference docket #02–038N, U.S. Department of Agriculture, Food Safety and Inspection Service, Room 102 Cotton Annex, 300 12th Street SW., Washington, DC 20250–3700. Comments may also be sent by facsimile (202) 205–0381. The comments and the official transcript of the meeting, when they become available will be kept in the FSIS Docket Room at the address provided above. All comments received in response to this notice will be considered part of the public record and will be available for reviewing in the FSIS Docket Room between 8:30 a.m. and 4:30 p.m., Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Charles L. Gioglio for technical information at (202) 205–0010 and Sonya L. West for meeting information at (202) 720–2561, FAX (202) 205–0157, or e-mail *sonya.west@usda.gov.* Persons requiring a sign language interpreter or other special accommodations should notify Ms. West by October 30, 2002, at the above numbers or by e-mail. Information is also available on the Internet at *http://www.fsis.usda.gov/OPPDE/nacmpi.*

SUPPLEMENTARY INFORMATION:

Background

On January 19, 2001, the Secretary of Agriculture renewed the charter for the NACMPI. The Committee provides advice and recommendations to the Secretary of Agriculture pertaining to the Federal and State meat and poultry inspection programs pursuant to sections 301(a)(4), 7(c), 24, 205, 301(a)(3), and 301(c) of the Federal Meat Inspection Act and sections 5(a)(3), 5(a)(4), 5(c), 8(b), and 11(e) of the Poultry Products Inspection Act. The Administrator of FSIS is the chairperson of the Committee. Membership of the Committee is drawn from representatives of consumer groups; producers, processors, and marketers from the meat and poultry industry; State government officials; and academia. The current members of the NACMPI are: Dr. Gladys Base, Spelman College; Nancy Donley, Safe Tables Our Priority; Sandra Eskin, American Association of Retired Persons; Dr. James Denton, University of Arkansas; Carol Tucker Foreman, Food Policy Institute, Consumer Federation of America; Michael Govro, Oregon Department of Agriculture; Martin Holmes, North American Meat Processors; Dr. Lee C. Jan, Texas Department of Health; Dr. Alice Johnson, National Food Processors Association; Collette Schultz Kaster, Premium Standard Farms; Dr. Daniel E. Lafontaine, South Carolina Meat Poultry Inspection Department; Dr. Irene Leech, Virginia Tech; Charles Link, Cargill Turkey Products; Dr. Catherine Logue, North Dakota State University; Dr. Dale Morse, New York Department of Health; John Neal, Courseys Smoked Meats, and Michael Mamminga, Iowa Department of Agriculture and Land Stewardship.

The Committee has three subcommittees to deliberate on specific issues and make recommendations to the whole Committee.

All interested parties are welcome to attend the meetings and to submit written comments and suggestions concerning issues the Committee will review and discuss.

Members of the public will be required to register before entering the meeting.

Additional Public Notification

Public awareness of all segments of rulemaking and policy development is important. Consequently, in an effort to better ensure that minorities, women, and persons with disabilities are aware of this notice, FSIS will announce it and make copies of this **Federal Register** publication available through the FSIS Constituent Update. FSIS provides a weekly Constituent Update, which is communicated via Listserv, a free e-mail Subscription service. In addition, the update is used to provide information regarding FSIS policies, procedures, regulations, Federal Register notices, FSIS public meetings, recalls, and any other types of information that could affect or would be of interest to our constituents/stakeholders. The constituent Listserv consists of industry, trade, and farm groups, consumer interest groups, allied health professionals, scientific professionals, and other individuals that have requested to be included. Through the Listserv and Web page, FSIS is able to provide information to a much broader, more diverse audience. For more information contact the Congressional and Public Affairs Office, at (202) 720–9113. To be added to the free e-mail subscription service (Listserv) go to the ''Constituent Update'' page on the Internet at *http://www.fsis.usda.gov/oa/update/update.htm.* Click on the ''Subscribe to the Constituent Update Listserv'' link, then fill out and submit the form.

Done at Washington, DC, on: October 29, 2002.

Dr. Garry L. McKee,

Administrator.

[FR Doc. 02–27841 Filed 10–29–02; 2:40 pm]

BILLING CODE 3410–DM–P

DEPARTMENT OF AGRICULTURE

Forest Service

Boise National Forest; Idaho; Upper Middle Fork Payette River Project

AGENCY: Forest Service, USDA.

ACTION: Revised notice of intent to prepare an environmental impact statement.

SUMMARY: The Cascade Ranger District of the Boise National Forest will prepare an environmental impact statement (EIS) for a resource management project in the Middle Fork of the Payette River drainage. The project involves 864 acres of timber stand treatment in the 15,881-acre project area, less than a mile of road construction, nearly 3 miles of road reconstruction, and less than a mile of road decommissioning. The entire project area is located within watersheds that drain directly into the Middle Fork of the Payette River or its tributaries. The project area is located 12 miles east of Cascade, Idaho, and about 100 miles north of Boise, Idaho.

DATES: Comments concerning the scope of the analysis should be postmarked within 30 days following publication of this announcement in the **Federal Register**. The draft environmental impact statement is expected in January 2003 and the final environmental impact statement is expected in April 2003.

ADDRESSES: Send written comments to Keith Dimmett, Cascade Ranger District, P.O. Box 696, Cascade, ID 83611.

FOR FURTHER INFORMATION CONTACT: Keith Dimmett, Project Leader, Cascade Ranger District at the address mentioned above or by calling (208)382–7430.

SUPPLEMENTARY INFORMATION: The NFMA planning for this project was initiated in the spring of 2001 with the Upper Middle Fork Payette River Ecosystem Analysis at the Watershed Scale (EAWS). A letter announcing plans to complete the EAWS and soliciting comments was mailed to interested individuals and/or groups in March of 2001.

A notice of intent to prepare an EIS for a similar project in the same location appeared on page 24097 of the **Federal Register** on May 11, 2001. This revised notice is being provided due to minor changes since the original notification,

changed on-the-ground conditions, and because of the time that has elapsed since the original notice of intent. In July 2001 the Forest Supervisor elected to delay the Upper Middle Fork Payette River Project until a variety of road restoration measures aimed at reducing road-related sedimentation and enhancing bull trout habitat in the project area were implemented. A large portion of those restoration activities were implemented in the summer of 2002 as part of the Middle Fork Roads Restoration Project, with the remaining activities scheduled for implementation in the summer of 2003.

Roughly 70 percent of the project area occurs within one of two inventoried roadless areas (IRA's). A portion of the Peace Rock IRA occupies an estimated 8,947 acres, and a section of the Stony Meadows IRA another 2,357 acres of the project area. A large portion of the project area also occurs within Management Area 43 (Peace Rock). The Proposed Action does not include any management activities within either IRA or within Management Area 43. Instead, management activities associated with the Proposed Action have been confined to the roaded portion of the project area, consisting of roughly 4,302 acres. The Middle Fork Payette River originates within, and runs through the center of the project area. The Forest Plan discloses that that segment of the river from Railroad Pass to the Middle Fork Bridge on the #409 road is potentially eligible for inclusion in the National Wild and Scenic River system as a ''wild'' river. However, in June of 1991 the Forest Plan corrected to show that this segment of the river is potentially eligible as a ''recreational'' river.

Purpose and Need for Action

Two primary objectives have been identified for the project: (1) Reduce current and future stand susceptibility to western spruce budworm, Douglas-fir beetle, and/or mountain pine beetle, and; (2) improve long-term stand growth to or near levels indicative of healthy, sustainable forests.

Proposed Action

The Proposed Action would treat an estimated 864 acres in the 15,881 acre project area. Proposed activities would occur within a portion of the 67,637 acre Gold Fork/Clear Creek Management Area 53. An estimated 4.0 MMbf of timber would be harvested using ground-based (683 acres), skyline (24 acres), and helicopter (157 acres) yarding systems. The Proposed Action would employ a variety of silvicultural prescriptions including commercial thin (169 acres), improvement cut/sanitation (427 acres), seed cut shelterwood (92 acres), final removal shelterwood (141 acres), and clearcut with reserve trees (35 acres). The existing transportation system would be improved to facilitate log haul and reduce sedimentation with individual sections of 2.9 miles of road being reconstructed. An estimated 0.7 miles of specified road and 0.2 miles of temporary road would be constructed to facilitate harvest. In addition, 0.9 miles of the #409F road, currently closed year-round would be decommissioned.

Possible Alternatives

One alternative to the Proposed Action, a No Action Alternative, has been discussed thus far. Other alternatives will likely be developed as issues are identified and information received.

Responsible Official

Suzanne C. Rainville, Acting Forest Supervisor, Boise National Forest, 1249 South Vinnell Way, Boise, ID 83709.

Nature of Decision To Be Made

The Boise National Forest Supervisor will decide the following. Should roads be built and timber harvested within the project area at this time, and if so; where within the project area, and how many miles of road should be built; and which stands should be treated and what silvicultural systems should be used? What design features and/or mitigation measures should be applied to the project? Should the decommissioning of existing roads be implemented at this time?

Scoping Process

The agency invites written comments and suggestions on the scope of the analysis. In addition to this notice, a proposed action letter will be sent to interested government officials, agencies, groups, and individuals. No public meetings are currently planned.

Preliminary Issues

Preliminary concerns with the Proposed Action include: (1) Potential impacts on sediment delivery to area streams; (2) potential impacts on bull trout, and; (3) potential impacts on the visual quality of the area.

Comment Requested

This notice of intent initiates the scoping process which guides the development of the environmental impact statement. Specific written comments on the proposed action will be most helpful.

Early Notice of Importance of Public Participation in Subsequent Environmental Review

A draft environmental impact statement will be prepared for comment. The comment period on the draft environmental impact statement will be 45 days from the date the Environmental Protection Agency publishes the notice of availability in the **Federal Register**.

The Forest Service believes, at this early stage, it is important to give reviewers notice of several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp.* v. *NRCD,* 435 U.S. 519, 533 (1978). Also, environmental objections that could be raised at the draft environmental impact statement stage but that are not raised until after completion of the final environmental impact statement may be waived or dismissed by the courts. *City of Angoon* v. *Hodel,* 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris,* 409 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45-day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider them and respond to them in the final environmental impact statement.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the draft environmental impact statement should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

Comments received, including the names and addresses of those who comment, will be considered part of the public record on this proposal and will be available for public inspection.

(Authority: 40 CFR 1501.7 and 1508.22; Forest Service Handbook 1909.15, Section 21)

Dated: October 21, 2002.

Suzanne C. Rainville,

Acting Forest Supervisor.

[FR Doc. 02–27737 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Toolbox Fire Recovery Project, Fremont National Forest, Lake County, OR

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an environmental impact statement.

SUMMARY: The USDA, Forest Service will prepare an environmental impact statement (EIS) on a proposal to assist the recovery of areas burned in 2002 by the Toolbox Complex Fires (includes Toolbox Fire, Silver Fire and small portion of Winter Fire). This will include proposals to salvage burned timber, implement re-forestation and implement projects to alleviate the potential for future damage to riparian and aquatic resources as a result of the Toolbox Complex Fires. The 48,000 acre project area is located on the Silver Lake Ranger District and is centered approximately 13 miles south of Silver Lake, Oregon, within the Silver Creek, Silver Lake and Summer Lake Watersheds.

DATES: Comments concerning the scope of the analysis must be received by December 2, 2002.

ADDRESSES: Send written comments to Carolyn Wisdom, District Ranger, Silver Lake Ranger District, PO Box 129, Silver Lake, OR 97638.

FOR FURTHER INFORMATION CONTACT: Rick Elston, Toolbox Fire Recovery Project Interdisciplinary Team Leader, Silver Lake Ranger District, *Phone:* (541) 576–7569. E-mail *relston@fs.fed.us.*

SUPPLEMENTARY INFORMATION: In July 2002 the Toolbox Complex Fires burned approximately 85,000 acres, of which 49,500 occur on the Fremont National Forest. The remainder of the fire includes approximately 8,000 acres of Bureau of Land Management Administered lands and 27,500 acres of private land. The 48,000 acre decision area for the Toolbox Fire Recovery Projects includes those portions of the Toolbox Complex Fires that occurred within the Silver Creek, Silver Lake and Summer Lake Watersheds on National Forest System lands.

Purpose and Need for Action

The purpose and need for action in the project planning area is to create conditions that would facilitate our efforts to:

—Recover habitat lost and soil damaged as a result of intense fire and reduce the likelihood of future loss or damage from reburn;
—Restore damaged riparian areas resulting from the Toolbox Complex Fire;
—Protect remaining live stands from insect infestations associated with fire-killed trees;
—Develop a long term sustainable forest through re-forestation and fuels reduction; and
—Salvage burned timber, while it retains some merchantable value.

Proposed Action

The proposed project would include the following activities:

—Reforestation of areas that sustained high tree mortality including existing plantations that were affected by the fire;
—Re-vegetation of burned riparian areas;
—Reconstruction of roads open to the public and repair of roads closed to the public but still required for administrative use; decommissioning of degraded roads;
—Riparian Restoration including adding large wood to deficient stream channels; and
—Salvage harvest of approximately 21,500 acres in the Silver Creek, Silver Lake and Summer Lake Watersheds and removal of hazardous trees along open roads and at recreational facilities.

Most of the proposed timber salvage units would be harvested using ground-based logging systems. Access for salvage would require reconstruction of about 9 miles of existing roads, primarily by adding surfacing, and construction of approximately 12 miles of new temporary roads and 14 miles of temporary roads located on old road locations. The temporary roads would be closed and obliterated after completion of project activities. Approximately 10 to 15% of the area to be salvaged would be harvested using helicopter based logging systems, including areas salvaged within Riparian Habitat Conservation Areas (RHCAs). All activities within RHCAs would be in accordance with Fremont National Forest Land and Resource Management Plan (LRMP) Standards and Guidelines, as amended by the Inland Native Fish Strategy (INFISH). Other connected actions in association with salvage include water barring and erosion control measures such as scattering of slash on skid trails and treatment of slash.

Planting of tree seedlings following site preparation would occur on approximately 28,500 acres, including areas that are salvage harvested and existing plantations or young stands in which fire damage occurred. Most or all seedlings would be ponderosa pine. Reduction of fuels, including those created by the fire, by salvage activity and by site preparation would occur throughout the project area. A variety of fuel treatment methods would be used, including removing marketable timber through salvage harvest, burning in place, piling and burning, yarding tops to landings to be burned, or lopping and scattering to speed decay. In order to meet desired fuels conditions some areas may be ''pretreated'' (by thinning very small diameter trees) and prescribed burned. In some instances this may require a Forest Plan amendment.

Additional proposed activities include:

—Approximately 35 miles of road decommissioning to promote watershed recovery;
—Approximately 880 acres of aspen stand protection;
—Placement of large woody debris or other in-stream structures to meet Riparian Management Objectives in approximately 8 miles of Silver Creek and 6 miles of West Fork Silver Creek;
—Approximately 10 acres of riparian area deciduous plantings;
—Approximately 1,300 acres of contour falling (using dead trees) on steep slopes to protect water quality;
—Culvert replacement where Forest Road 27 crosses West Fork Silver Creek to improve fish passage;
—Approximately 2,500 acres of plantation thinning; and
—Re-routing sections of the Fremont National Recreation Trail if necessitated by salvage activity.

All proposed activities are responsive to the stated purpose and need for this project.

Possible Alternatives

A full range of alternatives will be considered, including a ''no-action'' alternative in which none of the activities proposed above would be implemented. Based on the issues gathered through scoping, the action alternatives would differ in (1) The silvicultural and post-harvest treatments prescribed (2) the amount and location of harvest (3) the amount and location of fuels reduction activity. Tentative

alternatives to the proposed action include an alternative that does not require the construction of additional temporary or permanent roads, other than temporary re-opening of existing roads, and that does not consider salvage removal from RHCAs. Another alternative would emphasize removal (or other fuels treatment options) of dead timber in the size classes most likely to reburn. Currently available science on snag and coarse woody debris dependent species habitat will be a factor in alternative development and could result in a proposal of a site-specific Forest Plan amendment to update standards and guidelines for these species. Consideration of various regeneration strategies including planting at relatively low stocking levels could also be a factor that differentiates alternatives.

Scoping Process

Public participation will be sought at several points during the analysis, including listing of this project in the Fall 2002 and subsequent issues of the Fremont-Winema National Forest's Schedule of Proposed Activities; letters to agencies, organizations, and individuals who have previously indicated their interest in such activities; and a legal notice in the *Klamath Herald and News*. Public meetings may be scheduled during the fall/winter of 2002–2003. The scoping process will include: Identifying potential issues, identifying major issues to be analyzed in depth, eliminating non-significant issues or those previously covered by a relevant environmental analysis, considering additional alternatives based on themes which will be derived from issues recognized during scoping activities, and identifying potential environmental effects of this proposed action and alternatives (*i.e.,* direct, indirect and cumulative effects and connected actions).

Preliminary Issues

Preliminary issues include: Snag and downed wood habitat; big game thermal cover; disturbance of cultural resources; potential noxious weed expansion; effects of proposed activities on soils exposed by the fire; effects of proposed activities on the recovery of water quality and resident fisheries resource; ability of proposed activities to contribute to restoration of historic vegetation composition, structures, and patterns; potential loss of commercial timber value; and economic viability of timber salvage.

Public comments about this proposal are requested in order to assist in properly scoping issues, determining how to best manage the resources, and fully analyzing environmental effects. Comments received to this notice, including names and addresses of those who comment, will be considered part of the public record on this proposed action and will be available for public inspection. Comments submitted anonymously will be accepted and considered; however, those who submit anonymous comments will not have standing to appeal the subsequent decision under 36 CFR parts 215 and 217. Additionally, pursuant to 7 CFR 1.27(d), any person may request the agency to withhold a submission from the public record by showing how the Freedom of Information Act (FOIA) permits such confidentiality. Persons requesting such confidentiality should be aware that, under FOIA, confidentiality may be granted in only very limited circumstances, such as to protect trade secrets. The Forest Service will inform the requester of the agency's decision regarding the request for confidentiality, and where the request is denied, the agency will return the submission and notify the requester that the comments may be resubmitted with or without name and address within a specified number of days.

Early Notice of Importance of Public Participation in Subsequent Environmental Review

The comment period on the draft environmental impact statement will be 45 days from the date the Environmental Protection Agency publishes the notice of availability in the **Federal Register**. The draft EIS is expected in June 2003 and the final EIS is expected in October 2003.

The Forest Service believes, at this early stage, it is important to give reviewers notice of several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 553 (1978). Also, environmental objections that could be raised at the draft environmental impact statement stage but that are not raised until after completion of the final environmental impact statement may be waived or dismissed by the courts. *City of Angoon* v. *Hodel*, 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris*, 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45 day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider them and respond to them in the final EIS.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the draft environmental impact statement should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

The Forest Service is the lead agency. The Responsible Official is the Forest Supervisor, Fremont National Forest, 1301 South ''G'' Street, Lakeview, Oregon 97630–9701. The Responsible Official will decide which, if any, of the proposed projects will be implemented. The Responsible Official may also decide on site-specific Forest Plan amendments regarding standards and guidelines for snag and coarse woody debris, as well as big game habitat, if warranted by the analysis of those components in light of recent science.

The Responsible Official will document the Toolbox Fire Recovery Project decision and reasons for the decision in the Record of Decision. That decision will be subject to Forest Service Appeal Regulations (36 CFR part 215).

Dated: October 21, 2002.

Charles R. Graham,

Forest Supervisor.

[FR Doc. 02–27786 Filed 10–31–02; 8:45 am]

BILLING CODE 3410–11–M

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Additions and Deletions

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

ACTION: Additions to and deletions from Procurement List.

SUMMARY: This action adds to the Procurement List services to be

furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and deletes from the Procurement List products and a service previously furnished by such agencies.

EFFECTIVE DATE: December 1, 2002.

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:

Additions

On August 30, 2002, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (67 FR 55776) of proposed additions to the Procurement List. After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services and impact of the additions on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4. I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

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

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

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

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

Services

Service Type/Location: Janitorial/Custodial, EPA, Standard Chlorine Site, Delaware City, New Castle, Delaware.

NPA: The Chimes, Inc., Baltimore, Maryland.

Contract Activity: Environmental Protection Agency, Philadelphia, Pennsylvania.

Service Type/Location: Janitorial/Custodial, Stewart Newburgh USARC, New Windsor, New York.

NPA: Occupations, Inc., Middletown, New York.

Contract Activity: 77th Regional Support Command, Fort Totten, New York.

Deletions

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 products and service the Government.

2. The action will result in authorizing small entities to furnish the products 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 products and service proposed for deletion to the Procurement List.

After consideration of the relevant matter presented, the committee has determined that the products and service listed below are no longer suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

Accordingly, the following products and service are deleted from the Procurement List:

Products

Product/NSN: Pocket Planning Set—2000.
7510–01–450–5423.

Product/NSN: Pocket Planning Set—2001
7510–01–450–5428.

Product/NSN: Pocket Planning Set—2002
7510–01–450–5435.

Product/NSN: Organizer, Day Planner, Travel Size
7530–00–D16–0057.

Product/NSN: 2000 Tabbed Monthly—3 hole
7510–01–463–0798.

Product/NSN: 2000 Tabbed Monthly—7 hole
7510–01–463–0799.

Product/NSN: Daymax Tabbed Monthly—7 hole
7510–01–463–0801.

Product/NSN: Daymax Tabbed Monthly—3 hole
7510–01–463–0803.

Product/NSN: Executive/Personal Time Management System—LE Black
7530–01–458–3130.

NPA: The Easter Seal Society of Western Pennsylvania, Pittsburgh, PA

Contract Activity: Office Supplies & Paper Products Acquisition Center, New York, New York.

Service

Service Type/Location: Janitorial/Custodial, U.S. Federal Building, Minneapolis, Minnesota.

NPA: Tasks Unlimited, Inc., Minneapolis, Minnesota.

Contract Activity: GSA, Public Buildings Service.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 02–27824 Filed 10–31–02; 8:45 am]

BILLING CODE 6353–01–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 products and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

Comments must be received on or before: December 1, 2002.

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 the notice for each product or service will be required to procure the products and services listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

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

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

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

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

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

Products

Product/NSN: Bag, Trash, Cloth 2090–01–478–3561.
NPA: West Texas Lighthouse for the Blind, San Angelo, Texas.
Contract Activity: Defense Supply Center Columbus, Columbus, Ohio.
Product/NSN: Can, Friction Top 8110–00–178–8291 8110–00–178–8292.
NPA: East Texas Lighthouse for the Blind, Tyler, Texas.
Contract Activity: Defense Supply Center Philadelphia, Philadelphia, Pennsylvania.
Product/NSN: Container Fuel Sample 8110–01–371–8315.
NPA: East Texas Lighthouse for the Blind, Tyler, Texas.
Contract Activity: Defense Supply Center Philadelphia, Philadelphia, Pennsylvania.
Product/NSN: Cushion Seat, Vehicular 2540–01–107–3371.
NPA: Work Services Corporation, Wichita Falls, Texas.
Contract Activity: Defense Supply Center Columbus, Columbus, Ohio.
Product/NSN: Highlighter, Fluorescent, Flat 7520–00–NIB–1620 7520–01–238–1728.
NPA: Winston-Salem Industries for the Blind, Winston-Salem, North Carolina.
Contract Activity: Office Supplies & Paper Products Acquisition Center, New York, New York.
Product/NSN: Highlighters, Free-Ink, Flat 7520–00–NIB–1625 7520–00–NIB–1630 7520–00–NIB–1631.
NPA: Winston-Salem Industries for the Blind, Winston-Salem, North Carolina.
Contract Activity: Office Supplies & Paper Products Acquisition Center, New York, New York.
Product/NSN: Windsock 8345–00–NSH–0001 (NFES–308).
NPA: Development Workshop, Inc., Idaho Falls, Idaho.
Contract Activity: BLM National Interagency Fire Center, Boise, Idaho.

Services

Service Type/Location: Office Supply Center, Richard Bolling Federal Building, Kansas City, Missouri.
NPA: Alphapointe Association for the Blind, Kansas City, Missouri.
Contract Activity: U.S. Army Corps of Engineers, Kansas City, Missouri.

Sheryl D. Kennerly,
Director, Information Management.

[FR Doc. 02–27825 Filed 10–31–02; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021018240–2240–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e) (4) and (11)), the Department of Commerce is issuing notice of our intent to delete the system of records entitled ''Agriculture Census Records for 1974 and 1978, Commerce/Census—1.'' This system of records is no longer collected or maintained by the U.S. Census Bureau.

DATES: *Effective Date:* The deletion will become effective as proposed without further notice on December 2, 2002. *Comment Date:* To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: This Privacy Act System of Records is being deleted because the records are no longer collected or maintained by the U.S. Census Bureau.

Dated: October 29, 2002.

Brenda Dolan,
Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27817 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–U

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021023246–2246–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e)(4) and (11)), the Department of Commerce is issuing notice of our intent to amend the system of records entitled Commerce/Census-2, ''Employee Productivity Measurement Records.'' We invite public comment on the proposed change in this publication.

DATES: The amendments will become effective as proposed without further notice on December 2, 2002.

Comment Date: To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: The amendment updates administrative information concerning the locations of the system files, the categories of individuals covered by the system, the purpose of the system of records, and the disposal of the records in the system in addition to other minor administrative updates.

Accordingly, the Employee Productivity Measurement Records system notice originally published at 45 FR 82105, December 12, 1980, is amended by the addition of the following information updates.

Commerce/Census-2

SYSTEM LOCATION:

Strike ''and Bureau of the Census, Personal Census Service Branch, Pittsburg, Kansas 66762.'' Before ''1201'' insert ''National Processing Center,''. Strike the remainder of the paragraph after ''Also at the following Census Regional Offices:'' and insert ''101 Marietta Street, NW., Suite 3200, Atlanta, Georgia 30303–2700; 2 Copley Place, Suite 301, P.O. Box 9108, Boston, Massachusetts 02117–9108; 901 Center Park Drive, Suite 106, Charlotte, North Carolina 28217–2935; 2255 Enterprise Drive, Suite 5501, Chicago, Illinois 60154; 6303 Harry Hines Boulevard, Suite 210, Dallas, Texas 75235–2569; 6900 West Jefferson Avenue, Suite 100,

Denver, Colorado 80235–2032; 1395 Brewer Park Boulevard, Detroit, Michigan 48207; Gateway Tower II, 400 State Avenue, Suite 600, Kansas City, Kansas 66101–2410; 15359 Sherman Way, Suite 300, Van Nuys, California 91406–4224; Jacob K. Javits Federal Building, 26 Federal Plaza, Room 37–130, New York, New York 10278–0044; 21st Floor, 1601 Market Street, Philadelphia, Pennsylvania 19103–2395; 700 5th Avenue, Suite 5100, Seattle, Washington, 98104–5018.''

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Insert ''Bureau'' between ''Census'' and employees.''

CATEGORIES OF RECORDS IN THE SYSTEM:

After ''percent performance,'' insert ''percent of time or standard (incentive coverage),''.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:*

PURPOSE(S):

Add ''The purpose of this system of records is to determine employee performance and work group productivity, to improve workforce performance, and to evaluate the cost effectiveness of the programs that the Bureau manages.''

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

(1) In the event that a system or records maintained by the Department to carry out its functions indicates a violation or potential violation of law or contract, whether civil, criminal or regulatory in nature, and whether arising by general statute or particular program statute or contract, or rule, regulation, or order issued pursuant thereto, or the necessity to protect an interest of the Department, the relevant records in the system of records may be referred to the appropriate agency, whether Federal, state, local or foreign, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute or contract, or rule, regulation or order issued pursuant thereto, or protecting the interest of the Department.

(2) A record from this system of records may be disclosed to a Federal, state or local agency maintaining civil, criminal or other relevant enforcement information or other pertinent information, such as current licenses, if necessary to obtain information relevant to a Department decision concerning the assignment, hiring or retention of an individual, the issuance of a security clearance, the letting of a contract, or the issuance of a license, grant or other benefit.

(3) A record from this system of records may be disclosed to a Federal, state, local or international agency, in response to its request, in connection with the assignment, hiring or retention of an individual, the issuance of a security clearance, the reporting of an investigation of an individual, the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

(4) A record from this system of records may be disclosed in the course of presenting evidence to a court, magistrate or administrative tribunal, including disclosures to opposing counsel in the course of settlement negotiations.

(5) A record in this system of records may be disclosed to a Member of Congress submitting a request involving an individual when the individual has requested assistance from the Member with respect to the subject matter of the record.

(6) A record in this system of records may be disclosed to the Office of Management and Budget in connection with the review of private relief legislation as set forth in OMB Circular No. A–19 at any stage of the legislative coordination and clearance process as set forth in that Circular.

(7) A record in this system of records may be disclosed to the Department of Justice in connection with determining whether disclosure thereof is required by the Freedom of Information Act (5 U.S.C. 552).

(8) A record in this system of records may be disclosed to a contractor of the Department having need for the information in the performance of the contract, but not operating a system of records within the meaning of 5 U.S.C. 552a(m).

(9) A record in this system may be transferred to the Office of Personnel Management: for personnel research purposes; as a data source for management information; for the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained; or for related manpower studies.

(10) A record from this system of records may be disclosed to the Administrator, General Services, or his designee, during an inspection of records conducted by GSA as part of that agency's responsibility to recommend improvements in records management practices and programs under authority of 44 U.S.C. 2904 and 2906. Such disclosure shall be made in accordance with the GSA regulations governing inspection of records for this purpose, and any other relevant (*i.e.* GSA or Commerce) directive. Such disclosure shall not be used to make determinations about individuals.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

After ''paper copy'' add: ''and electronic records'.

RETRIEVABILITY:*

SAFEGUARDS:

Insert ''s'' at the end of the word ''Tape''; insert ''and'' after ''Tapes''; insert ''and'' before ''sensitive''; insert ''are'' between ''materials'' and ''held''.

RETENTION AND DISPOSAL:

Change ''Records'' to ''records'', and insert before ''records'' the following: ''In accordance with the General Records Schedule and Census Bureau records control schedules that are approved by the National Archives and Records Administration,''.

SYSTEMS MANAGER(S) AND ADDRESS:

Delete ''Administration.'' Insert ''Field Operations''.

NOTIFICATION PROCEDURE:

Insert ''Privacy Act'' between ''Department's'' and ''rules.''

RECORD ACCESS PROCEDURES:*

CONTESTING RECORD PROCEDURES:*

RECORDS SOURCE CATEGORIES:*

* Indicates that there are no changes to that paragraph of the notice.

Dated: October 29, 2002

Brenda Dolan,

Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27818 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021023247–2247–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e)(4) and

(11)), the Department of Commerce is issuing notice of our intent to amend the system of records entitled Commerce/Census-3, ''Individual and Household Statistical Survey Records and Special Studies Records.'' We invite public comment on the proposed change in this publication.

DATES: The amendments will become effective as proposed without further notice on December 2, 2002.

Comment Date: To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: The amendment updates administrative information concerning the locations of the system files, the categories of individuals covered by the system, the categories of records in the system, the purpose of the system of records, and the disposal of the records in the system in addition to other minor administrative updates. Accordingly, the Individual and Household Statistical Surveys and Special Studies Records system notice originally published at 45 FR 82105, December 12,1980, is amended by the addition of the following information updates.

Commerce/Census-3

SYSTEM LOCATION:

Insert after ''20233;'' ''Bureau of the Census, Bowie Computer Center 1701, Melford Boulevard, Bowie, Maryland 20717''. Insert before ''1201 East 10th Street'' ''National Processing Center,''.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Delete the sentence and insert the following information. ''This system contains information on households and individuals designated for statistical sample surveys. It includes:

(1) Household respondents age 15 year old or over selected for participation in the Current Population Survey, a survey with monthly interviewing and monthly supplements.

(2) Household members 15 years old and over who participate in the Survey of Income and Program Participation, a survey with monthly interviewing.

(3) Household respondents 15 years old or older selected for participation in the Survey of Program Dynamics, a longitudinal survey conducted on a yearly basis.

(4) Household respondents age 16 years or over selected for participation in the American Housing Surveys, conducted on a yearly basis.

(5) All household members age 12 and over who participate in the National Crime Victimization Survey, a monthly survey with supplements that include the Police Public Contact Survey and the School Crime Supplement.

(6) Household respondents selected for participation in the National Survey of Fishing, Hunting, and Wildlife-Associated Recreation, a survey conducted every five years.

(7) Women selected for participation in the National Longitudinal Survey of Women, a longitudinal survey conducted every two years.

(8) College graduates in science and engineering selected for participation in the National Survey of College Graduates, conducted biennially.

(9) Household respondents selected for participation in the New York City Housing and Vacancy Survey, conducted triennially.

(11) Household respondents age 15 year or over selected for participation in the American Community Survey, a survey with monthly interviewing.

(12) Persons age 16 years old or over selected to provide information for the consumer unit for the Consumer Expenditure Survey, which includes a quarterly interview and a diary survey.

(13) Owners of nonfarm, privately owned residential properties selected to provide information on the characteristics of homeowner and rental properties for the Residential Finance Survey, conducted decennially.''

PURPOSE(S):

Add ''The purpose of this system of records is to conduct research on the methodology associated with various aspects of surveys, such as data quality checks and review during post data collection processing because of an unusual inconsistency or other data problem. Special studies' data maintained by the Bureau of the Census are collected in order to conduct research on the methodology associated with various aspects of surveys (*e.g.*, cognitive testing of questionnaires, usability testing of computer software and equipment, nonresponse research, questionnaire design, etc.). These data are used solely for statistical purposes.''

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete all citations. Add ''13 U.S.C. 8, 141, and 182''.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM:

Delete paragraph (1). Renumber ''(2)'' as ''(1)'' and ''(3)'' as ''(2)''.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

After ''hard disk'' insert ''local area network, audio and video tape, CD-ROM, and DVD''.

RETRIEVABILITY:

Change ''Unique'' to ''unique'' and before ''unique'' insert ''Name, address, Social Security number, and''.

SAFEGUARDS:

At the end of the paragraph add ''Computer systems processing sensitive information meet the basic security requirements for discretionary access control as defined by DOD 5200.28 STD, commonly referred to as C2-level security. This level of security controls through use of specific security features, access to information such that only properly authorized individuals, or processes operating on their behalf, will have access to read, write, create, or delete information.''

RETENTION AND DISPOSAL:

Strike ''approved GSA Schedules'' and insert ''the General Records Schedule and Census Bureau records control schedules that are approved by the National Archives and Records Administration.''

SYSTEMS MANAGER(S) AND ADDRESS:

Strike ''Privacy Officer, Program and Policy Development Office,'' and add ''Associate Director for Demographic Programs and Associate Director for Methodology and Standards''.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

Insert ''system of'' between ''this'' and ''records'' in the first sentence.

Dated: October 29, 2002.

Brenda Dolan,

Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27819 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021023248–2248–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e) (4) and (11)), the Department of Commerce is issuing notice of our intent to amend the system of records entitled Commerce/Census-4, ''Minority-Owned Business Enterprises Survey Records.'' We invite public comment on the proposed change in this publication.

DATES: The amendments will become effective as proposed without further notice on December 2, 2002.

Comment Date: To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: The amendment updates administrative information concerning the locations of the system files, the categories of individuals covered by the system, the categories of records in the system, the purpose of the system of records, safeguards, and the disposal of the records in the system in addition to other minor administrative updates. Accordingly, the Minority-Owned Business Enterprises Survey Records system notice originally published at 45 FR 82105, December 12, 1980, is amended by the addition of the following information updates.

Commerce/Census-4

TITLE:

Add ''Women-and'' before Minority-Owned.

SYSTEM LOCATION:

After the last zip code add: ''Bureau of the Census, Bowie Computer Center, 17101 Melford Boulevard, Bowie, Maryland 20715; Bureau of the Census, National Processing Center, 1201 East 10th Street, Jeffersonville, Indiana 47132.''

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Strike ''Female and minority'' and insert ''Ethnicity, race, and gender of''.

CATEGORIES OF RECORDS IN THE SYSTEM:

After ''race,'' insert ''ethnicity,'' and after ''geographic area,'' insert ''place of birth, and''. Strike ''Name and social security number are deleted from partners and stockholders once other data are coded.'' Strike ''of minority business enterprises.''.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:*

PURPOSE(S):

Add ''The purpose of this system of records is to conduct research on the methodology associated with various aspects of surveys, such as data quality checks and review during post data collection processing because of an unusual inconsistency or other data problem.''

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM*

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

After ''tape'' add: ''and CD–ROM.''

RETRIEVABILITY:

Delete ''Filed'' and insert ''Retrieved''.

SAFEGUARDS:

After the last sentence add: ''Computer systems processing sensitive information meet the basic security requirements for discretionary access control as defined by DOD 5200.28 STD, commonly referred to as C2-level security. This level of security controls through use of specific security features, access to information such that only properly authorized individuals, or processes operating on their behalf, will have access to read, write, create, or delete information.''

RETENTION AND DISPOSAL:

Delete ''unit's Records Control Schedule'' and insert ''Census Bureau's records schedule approved by the National Archives and Records Administration''.

SYSTEMS MANAGER(S) AND ADDRESS:

Strike ''Administration'' and insert ''Economic Programs''.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

Insert ''system of'' between ''this'' and ''record'' in the first sentence and change ''record'' to ''records''.

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* Indicates that there are no changes to that paragraph of the notice.

Dated: October 29, 2002.

Brenda Dolan,

Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27820 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021023249–2249–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e) (4) and (11)), the Department of Commerce is issuing notice of our intent to amend the system of records entitled Commerce/Census—6, ''Population Census Personal Service Records for 1900 and All Subsequent Decennial Censuses.'' We invite public comment on the proposed change in this publication.

DATES: The amendments will become effective as proposed without further notice on December 2, 2002. *Comment date:* To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: The amendment updates administrative information concerning the locations of the system files, the categories of individuals covered by the system, the categories of records in the system, the purpose of the system of records, retrievability, safeguards, and the disposal of the records in the system in addition to other minor administrative updates. Accordingly, the Population Census Records Personal Service Records for 1900 and All Subsequent Decennial Censuses system notice originally published at 45 FR 82105, December 12, 1980, is amended by the addition of the following information updates.

Commerce/Census—6

TITLE:

Delete ''Personal Service'' and change ''1900'' to ''1910''.

SYSTEM LOCATION:

Strike ''Personal Census Services Branch, Pittsburg, Kansas 66762'' and add ''National Processing Center, 1201 East 10th Street, Jeffersonville, Indiana 47132.''

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Strike ''(1900–1970)'' and add ''(1910 and all subsequent decennial censuses)''.

CATEGORIES OF RECORDS IN THE SYSTEM:

After ''head of household'' strike ''date of birth'' and insert ''age (at time of census) or month/year of birth (depending on census year),''. Before ''education'' insert ''limited''.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:*

PURPOSE(S):

Add ''The 1910–1990 decennial census records are searched and official census transcripts of the results are provided to the named persons(s), their heirs, or legal representatives, upon receipt of a signed Application for Search of Census Records (Form BC–600). Census transcripts provide proof of age for Social Security or other retirement benefits. They can also be used in making passport applications, to prove relationship in settling estates, in limited genealogy research or to satisfy other situations where a birth certificate or other legal documentation is needed but not available.''

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM:

Change ''15 CFR part 60'' to ''15 CFR part 50''.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:*

RETRIEVABILITY:

Delete the entire sentence and add: ''Some census records are indexed by the SOUNDEX system—a numerical coding of the surname. The majority of census records are arranged on a geographic basis where the address must be known to determine which roll of microfilm contains the name(s) for which a search is requested.''

SAFEGUARDS:

After the last sentence add: ''Details from confidential records can only be released to the named persons, their heirs, or legal representatives upon submission of a notarized transcript application. Individual records are confidential for 72 years (Title 44, U.S.C. 2108(b)).''

RETENTION AND DISPOSAL:

Add: ''Records are stored at the Census Bureau's National Processing Center in Jeffersonville, Indiana, and also are provided to the National Archives and Records Administration for permanent retention. Records stored at the National Archives and Records Administration are not made public for 72 years.''

SYSTEMS MANAGER(S) AND ADDRESS:

Strike ''Administration'' and insert ''Economic Programs''.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

Insert ''system of'' between ''this'' and ''record'' in the first sentence and change ''record'' to ''records''.

* Indicates that there are no changes to that paragraph of the notice.

Dated: October 29, 2002.

Brenda Dolan,

Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27821 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Office of the Secretary

[Docket No.: 021023250–2250–01]

Privacy Act of 1974; System of Records

AGENCY: Office of Administration, Office of the Secretary, Department of Commerce.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e) (4) and (11)), the Department of Commerce is issuing notice of our intent to amend the system of records entitled Commerce/Census 7, ''Special Censuses of Population Conducted for State and Local Government.'' We invite public comment on the proposed change in this publication.

DATES: The amendments will become effective as proposed without further notice on December 2, 2002. *Comment Date:* To be considered, written comments must be submitted on or before December 2, 2002.

ADDRESSES: Comments may be mailed to Gerald W. Gates, Chief, Policy Office, U.S. Census Bureau, Washington, DC 20233.

SUPPLEMENTARY INFORMATION: The amendment updates administrative information concerning the categories of individuals covered by the system, the authority for maintenance of the system, the purpose of the system of records, safeguards, the retention and disposal of the records in the system, and the system manager in addition to other minor administrative updates. Accordingly, the Special Censuses of Population Conducted for State and Local Government system notice originally published at 45 FR 82105, December 12, 1980, is amended by the addition of the following information updates.

Commerce/Census—7

SYSTEM LOCATION:

Insert before ''1210 East 10th Street,'' ''National Processing Center,''. Delete ''47102'' and insert ''47132''.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Strike ''requesting a census'' and insert after ''the'' ''geographical boundaries of local units of government requesting a special census during non-decennial years''.

CATEGORIES OF RECORDS IN THE SYSTEM: *

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Strike ''8'' and insert ''196''. Add ''These collections are conducted under procedures published at 15 CFR, Part 50''.

PURPOSE(S):

Add ''The purpose of this system of records is to verify the accuracy and quality of data collection and processing.''

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM:*

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:*

RETRIEVABILITY:*

SAFEGUARDS:

After the last sentence add: ''Computer systems processing sensitive information meet the basic security requirements for discretionary access control as defined by DOD 5200.28 STD, commonly referred to as C2-level security. This level of security controls through use of specific security features, access to information such that only properly authorized individuals, or processes operating on their behalf, will have access to read, write, create, or delete information.''

RETENTION AND DISPOSAL:

Insert at the beginning ''In accordance with the Census Bureau records control schedule approved by the National Archives and Records Administration,'' change ''Tapes'' to ''tapes'' insert ''are'' after ''tapes''. Strike ''2'' and insert ''three''.

SYSTEMS MANAGER(S) AND ADDRESS:

Strike ''Administration'' and insert ''Field Operations''.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

Insert ''system of'' between ''this'' and ''record'' in the first sentence and change ''record'' to ''records''.

* Indicates that there are no changes to that paragraph of the notice.

Dated: October 29, 2002.

Brenda Dolan,

Department of Commerce, Freedom of Information/Privacy Act Officer.

[FR Doc. 02–27822 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

International Trade Administration

Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity to Request Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of opportunity to request administrative review of antidumping or countervailing duty order, finding, or suspended investigation.

Background

Each year during the anniversary month of the publication of an antidumping or countervailing duty order, finding, or suspension of investigation, an interested party, as defined in section 771(9) of the Tariff Act of 1930, as amended, may request, in accordance with § 351.213 (2002) of the Department of Commerce (the Department) Regulations, that the Department conduct an administrative review of that antidumping or countervailing duty order, finding, or suspended investigation.

Opportunity to Request a Review: Not later than the last day of November 2002, interested parties may request administrative review of the following orders, findings, or suspended investigations, with anniversary dates in November for the following periods:

	Periods
Antidumping Duty Proceedings	
ARGENTINA: A–357–405—Barbed Wire & Barbless Fencing Wire	11/1/01–10/31/02
BRAZIL: A–351–809—Circular Welded Non-Alloy Steel Pipe	11/1/01–10/31/02
KAZAKHSTAN: A–834–806—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
MEXICO: A–201–805—Circular Welded Non-Alloy Steel Pipe	11/1/01–10/31/02
NETHERLANDS: A–421–807—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
REPUBLIC OF KOREA: A–580–809—Circular Welded Non-Alloy Steel Pipe	11/1/01–10/31/02
ROMANIA: A–485–806—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
TAIWAN: A–583–835—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
TAIWAN: A–583–814—Circular Welded Non-Alloy Steel Pipe	11/1/01–10/31/02
TAIWAN: A–583–826—Collated Roofing Nails	11/1/01–10/31/02
THAILAND: A–549–817—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
THE PEOPLE'S REPUBLIC OF CHINA: A–570–865—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
THE PEOPLE'S REPUBLIC OF CHINA: A–570–850—Collated Roofing Nails	11/1/01–10/31/02
THE PEOPLE'S REPUBLIC OF CHINA: A–570–831—Fresh Garlic	11/1/01–10/31/02
THE PEOPLE'S REPUBLIC OF CHINA: A–570–826—Paper Clips	11/1/01–10/31/02
THE PEOPLE'S REPUBLIC OF CHINA: A–570–864—Pure Magnesium in Granular Form	4/30/01–10/31/02
UKRAINE: A–823–811—Certain Hot-Rolled Carbon Steel Flat Products	5/3/01–10/31/02
Countervailing Duty Proceedings	
None.	
Suspension Agreements	
MEXICO: A–201–820—Fresh Tomatoes	11/1/01–10/31/02
UKRAINE: A–823–808—Certain Cut-to-Length Carbon Steel	11/1/01–10/31/02

In accordance with § 351.213(b) of the regulations, an interested party as defined by section 771(9) of the Act may request in writing that the Secretary conduct an administrative review. For both antidumping and countervailing duty reviews, the interested party must specify the individual producers or exporters covered by an antidumping finding or an antidumping or countervailing duty order or suspension agreement for which it is requesting a review, and the requesting party must state why it desires the Secretary to review those particular producers or exporters. If the interested party intends for the Secretary to review sales of merchandise by an exporter (or a producer if that producer also exports merchandise from other suppliers) which were produced in more than one country of origin and each country of origin is subject to a separate order, then the interested party must state specifically, on an order-by-order basis, which exporter(s) the request is intended to cover.

Six copies of the request should be submitted to the Assistant Secretary for Import Administration, International Trade Administration, Room 1870, U.S. Department of Commerce, 14th Street & Constitution Avenue, NW., Washington, DC 20230. The Department also asks parties to serve a copy of their requests to the Office of Antidumping/Countervailing Enforcement, Attention: Sheila Forbes, in room 3065 of the main Commerce Building. Further, in accordance with § 351.303(f)(1)(i) of the regulations, a copy of each request must be served on every party on the Department's service list.

The Department will publish in the **Federal Register** a notice of ''Initiation of Administrative Review of Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation'' for requests received by the last day of November 2002. If the Department does not receive, by the last day of November 2002, a request for review of entries covered by an order, finding, or suspended investigation listed in this notice and for the period identified above, the Department will instruct the Customs Service to assess antidumping or countervailing duties on those entries at a rate equal to the cash deposit of (or bond for) estimated antidumping or countervailing duties required on those entries at the time of entry, or withdrawal from warehouse, for consumption and to continue to

collect the cash deposit previously ordered.

This notice is not required by statute but is published as a service to the international trading community.

Dated: October 25, 2002.

Holly A. Kuga,

Senior Office Director, Group II, Office 4, AD/CVD Enforcement.

[FR Doc. 02–27857 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–848]

Notice of Extension of Time Limit of Preliminary Results of New Shipper Review: Freshwater Crawfish Tail Meat From the People's Republic of China

AGENCY: Import Administration, International Trade Administration, U.S. Department of Commerce.

SUMMARY: The Department of Commerce is extending the time limit of the preliminary results of the new shipper review of the antidumping duty order on freshwater crawfish tail meat from the People's Republic of China until no later than February 13, 2003. The period of review is September 1, 2001, through February 28, 2002. This extension is made pursuant to section 751(a)(2)(B)(iv) of the Tariff Act of 1930, as amended.

EFFECTIVE DATE: November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Douglas Kirby or Thomas Gilgunn, AD/CVD Enforcement, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington D.C. 20230; telephone: (202) 482–3782 or (202) 482–4236, respectively.

SUPPLEMENTARY INFORMATION:

Applicable Statutes and Regulations

Unless otherwise indicated, all citations to the statute are references to the provisions of the Tariff Act of 1930, as amended (the Act). In addition, unless otherwise indicated, all citations to the Department's regulations are to the provisions codified at 19 CFR Part 351(2002).

Statutory Time Limits

Section 751(a)(2)(B)(iv) of the Act requires the Department to issue the preliminary results of a new shipper review within 180 days after the date on which the new shipper review was initiated, and final results of review within 90 days after the date on which the preliminary results were issued. However, if the Department determines the issues are extraordinarily complicated, section 751(a)(2)(B)(iv) of the Act allows the Department to extend the deadline for the preliminary results to up to 300 days after the date on which the new shipper review was initiated.

Background

On March 29, 2002 the Department received a timely request from Weishan Zhenyu Foodstuff Co., Ltd. (Zhenyu), in accordance with section 751(a)(2)(B) of the Act and section 351.214(c) of the regulations, for a new shipper review of the antidumping duty order on freshwater crawfish tail meat from the People's Republic of China (''PRC''), which has a September anniversary date. On April 23, 2002 the Department initiated this new shipper review covering the period September 1, 2001, through February 28, 2002. *See Freshwater Crawfish Tail Meat From the People's Republic of China: Initiation of New Shipper Antidumping Review* (67 FR 21218). On September 26, 2002, the Department extended the preliminary results of this review by 33 days until November 22, 2002. *See Freshwater Crawfish Tail Meat From the People's Republic of China: Notice of Extension of Time Limit of Preliminary Results of New Shipper Review* (67 FR 60640).

Extension of Time Limits for Preliminary Results

Pursuant to section 751(a)(2)(B)(iv) of the Act, the Department may extend the deadline for completion of the preliminary results of a new shipper review if it determines that the case is extraordinarily complicated. The Department has determined that this case is extraordinarily complicated, and the preliminary results of this new shipper review cannot be completed within the statutory time limit of 180 days. The Department finds that this new shipper review is extraordinarily complicated because of the issues that must be addressed. The Department is now analyzing the respondent's supplemental questionnaire response containing additional information concerning affiliation, date of sale, and factor value data. Given the issues in this case, the Department may find it necessary to request further information in this new shipper review. Therefore, in accordance with section 351.214(i)(2) of the regulations, the Department is extending the time limit for the completion of preliminary results for an additional 83 days. The preliminary results will now be due no later than February 13, 2003.

This notice is published pursuant to sections 751(a)(2)(B) and 777(i)(1) of the Act.

Dated: October 25, 2002.

Richard O. Weible,

Acting Deputy Assistant Secretary for Import Administration, Group III.

[FR Doc. 02–27855 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–588–810]

Mechanical Transfer Presses from Japan: Extension of Time Limit for Preliminary Results of Antidumping Duty Administrative Review, and Preliminary Rescission, in Part, of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce is extending the time limit for the preliminary results of the administrative review of mechanical transfer presses (MTPs) from Japan until no later than February 28, 2003. The period of review is February 1, 2001 through January 31, 2002. This extension is made pursuant to section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act).

EFFECTIVE DATE: November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Jacqueline Arrowsmith, Office of AD/CVD Enforcement VII, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington D.C. 20230; telephone: (202) 482–5255.

SUPPLEMENTARY INFORMATION:

The Applicable Statute

Unless otherwise indicated, all citations to the statute are references to the Act. In addition, unless otherwise indicated, all citations to the Department's regulations are to the regulations codified at 19 CFR Part 351 (2001).

Background

On February 19, 2001, the Department of Commerce (the Department) received a timely request for administrative review of the antidumping duty order on MTPs from Japan from respondent Hitatchi Zosen Corporation (HZC), and its subsidiary Hitatchi Zosen Fukui Corporation d/b/a H&F Corporation (H&F). *See Antidumping Duty Order: Mechanical Transfer Presses from*

Japan, 55 FR 5642 (February 16, 1990). On February 28, 2001, the Department received a timely request from the petitioner, IHI-Verson Press Technology, LLC, for an administrative review of HZC, H&F, Komatsu, Ltd., and Komatsu American Industries, LLC. On March 27, 2002, the Department published a notice of initiation of this administrative review, covering the period of February 1, 2001 through January 31, 2002 (*see* 67 FR 14696), for HZC and its subsidiary H&F, and Komatsu, Ltd. On May 22, 2002, we published *Mechanical Transfer Presses from Japan: Final Results of Antidumping Duty Administrative Review and Revocation, in-Part*, in which we revoked this antidumping duty order, in part, with respect to Komatsu, Ltd. The revocation was effective for subject merchandise entered, or withdrawn from warehouse, for consumption on or after February 1, 2001. *See* 67 FR 35958. Therefore, we are preliminarily rescinding this review with respect to Komatsu, Ltd. The preliminary results for HZC/H&F are currently due no later than October 31, 2002.

Extension of Time Limits for Preliminary Results

Due to several complex issues involving normal value, it is not practicable to complete this review within the time limits mandated by section 751(a)(3)(A) of the Act. The Department is therefore extending the time period for issuing the preliminary results of this review by 120 days, from October 31, 2002, until no later than February 28, 2003, in accordance with section 751(a)(3)(A) of the Act. The final results continue to be due 120 days after the publication of the preliminary results. This notice is published pursuant to sections 751(a)(3)(A) and 777(i)(1) of the Act.

Dated: October 25, 2002.

Richard O. Weible,

Acting Deputy Assistant Secretary for Import Administration, Group III.

[FR Doc. 02–27854 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–501]

Notice of Extension of Time Limit of Preliminary Results of Administrative Review: Natural Bristle Paint Brushes From the People's Republic of China

AGENCY: Import Administration, International Trade Administration, U.S. Department of Commerce.

SUMMARY: The Department of Commerce is extending the time limit of the preliminary results of the administrative review of the antidumping duty order on natural bristle paint brushes from the People's Republic of China until no later than January 23, 2003. The period of review is February 1, 2001, through January 31, 2002. This extension is made pursuant to section 751(a)(2)(B)(iv) of the Tariff Act of 1930, as amended.

EFFECTIVE DATE: November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Douglas Kirby or Sean Carey, AD/CVD Enforcement, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington D.C. 20230; telephone: (202) 482–3782 or (202) 482–3964, respectively.

SUPPLEMENTARY INFORMATION:

Applicable Statutes and Regulations

Unless otherwise indicated, all citations to the statute are references to the provisions of the Tariff Act of 1930, as amended (the Act). In addition, unless otherwise indicated, all citations to the Department's regulations are to the provisions codified at 19 CFR Part 351 (2002).

Statutory Time Limits

Section 351.213(h)(1) of the Department's regulations requires the Department to issue the preliminary results of an administrative review within 245 days after the last day of the anniversary month of the order or suspension agreement for which the administrative review was requested, and final results of review within 120 days after the date on which notice of the preliminary results was published in the Federal Register. However, if the Department determines that it is not practicable to complete the review within this time period, section 351.213(h)(2) of the Regulations allows the Department to extend the 245–day period to 365 days and may extend the 120–day period to 180 days.

Background

On February 1, 2002, the Department published a notice of opportunity to request an administrative review of the antidumping duty order on natural bristle paint brushes and brush heads from the People's Republic of China (PRC) (67 FR 4945). On February 28, 2002, the Department received a timely request from petitioner for administrative reviews of Hunan Provincial Native Produce and Animal By-Products Import and Export Corporation (Hunan) and Hebei Founder Import and Export Company (Hebei). On March 27, 2002, the Department initiated an administrative review of the antidumping duty order on natural bristle paintbrushes and brush heads, for the period from February 1, 2001 through January 31, 2002, in order to determine whether merchandise imported into the United States is being sold at less than fair value with respect to these two companies. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Requests for Revocations in Part* (67 FR 14696).

On May 1, 2002 the Department issued antidumping questionnaires to Hebei and Hunan. In its reply to Section A of the questionnaire, Hebei stated that it had made no sales or shipments of subject merchandise to the United States during the POR. The Department also performed a U.S. Customs Service (Customs) query for entries of natural bristle paintbrushes and brush heads, classified under the Harmonized Tariff Schedule of the United States (HTSUS) item number 9603.40.40.40, from the PRC during the POR. We found no entries or shipments from Hebei during the POR. Thus, the Department rescinded the review with respect to Hebei. *See Natural Bristle Paintbrushes and Brush Heads From the People's Republic of China; Notice of Rescission, In Part, of Antidumping Administrative Review*, 67 FR 58018 (September 13, 2002). The Department's preliminary results in the review of Hunan are currently due October 31, 2002.

Extension of Time Limits for Preliminary Results

Pursuant to section 751(a)(2)(B) of the Act, the Department may extend the deadline for completion of the preliminary results of an administrative review if it determines that it is not practicable to complete the review within the time specified in section 351.213(h)(2) of the Department's regulations. The Department has determined that the preliminary results of this administrative review cannot be completed within the statutory time limit of 245 days. The Department finds that it is not practicable to complete the preliminary results of this administrative review because there are a number of issues that must be addressed. For example, the Department has prepared a supplemental questionnaire requesting additional information on the respondent's questionnaire responses concerning affiliation and date of sale. Given the issues in this case, the Department may find it necessary to request even more information in this administrative

review, as well as to conduct verification. Therefore, in accordance with section 351.213(h)(2) of the Department's regulations, the Department is extending the time limit for the completion of preliminary results by 85 days. The preliminary results will now be due no later than January 23, 2003. The final results continue to be due within 120 days of the publication of the preliminary results.

This notice is published pursuant to sections 751(a)(2)(B) and 777(i)(1) of the Act.

Dated: October 25, 2002.

Richard O. Weible,

Acting Deputy Assistant Secretary for Import Administration, Group III.

[FR Doc. 02–27856 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 101102B]

Fraser River Sockeye and Pink Salmon Fisheries; Inseason Orders

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

ACTION: 2002 inseason orders.

SUMMARY: NMFS publishes the Fraser River salmon inseason orders regulating salmon fisheries in U.S. waters. The orders were issued by the Fraser River Panel (Panel) of the Pacific Salmon Commission (Commission) and subsequently approved and issued by NMFS during the 2002 sockeye and pink salmon fisheries within the U.S. Fraser River Panel Area. These orders established fishing times, areas, and types of gear for U.S. treaty Indian and all-citizen fisheries during the period the Commission exercised jurisdiction over these fisheries. Due to the frequency with which inseason orders are issued, publication of individual orders is impracticable. The 2002 orders are therefore being published in this document to avoid fragmentation.

DATES: Each of the following inseason actions was effective upon announcement on telephone hotline numbers as specified at 50 CFR 300.97(b)(1); those dates and times are listed under **SUPPLEMENTARY INFORMATION.**

Comments will be accepted through November 18, 2002.

ADDRESSES: Comments may be mailed to D. Robert Lohn, Regional Administrator, Northwest Region, NMFS, 7600 Sand Point Way N.E., BIN C15700–Bldg. 1, Seattle, WA 98115–0070. Information relevant to this document is available for public review during business hours at the office of the Regional Administrator, Northwest Region, NMFS.

FOR FURTHER INFORMATION CONTACT: David Cantillon, 206–526–4140.

SUPPLEMENTARY INFORMATION: The treaty between the Government of the United States of America and the Government of Canada concerning Pacific Salmon was signed at Ottawa on January 28, 1985, and subsequently was given effect in the United States by the Pacific Salmon Treaty Act (Act) at 16 U.S.C. 3631–3644. Under authority of the Act, Federal regulations at 50 CFR part 300 subpart F provide a framework for implementation of certain regulations of the Commission and inseason orders of the Commission's Panel for U.S. sockeye and pink salmon fisheries in the Fraser River Panel Area.

The regulations close the Fraser River Panel Area (U.S.) to U.S. sockeye and pink salmon fishing unless opened by Panel regulation or by inseason regulations published by NMFS that give effect to Panel orders. During the fishing season, NMFS may issue regulations that establish fishing times and areas consistent with the Commission agreements and inseason orders of the Panel. Such orders must be consistent with domestic legal obligations. The Regional Administrator, Northwest Region, NMFS, issues the inseason orders. Official notification of these inseason actions of NMFS is provided by two telephone hotline numbers described at 50 CFR 300.97(b)(1). Inseason orders must be published in the **Federal Register** as soon as practicable after they are issued. Due to the frequency with which inseason orders are issued, publication of individual orders is impractical. Therefore, the 2002 orders are being published in this document to avoid fragmentation.

The following inseason orders were adopted by the Panel and issued for U.S. fisheries by NMFS during the 2002 fishing season. The times listed are local times, and the areas designated are Puget Sound Management and Catch Reporting Areas as defined in the Washington State Administrative Code at Chapter 220–22.

Order No. 2002–01: Issued 4 p.m., July 19, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gillnets from 12 p.m. (noon) Sunday, July 21, 2002, to 12 p.m. (noon) Wednesday, July 24, 2002.

Order No. 2002–02: Issued 4 p.m., July 23, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Extended for drift gillnets from 12 p.m. (noon) Wednesday, July 24, 2002, to 12 p.m. (noon) Saturday, July 27, 2002.

Order No. 2002–03: Issued 3 p.m., July 29, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gillnets from 4 p.m. Monday, July 29, 2002, to 12 p.m. (noon) Friday, August 2, 2002.

Areas 6, 7 and 7A: Open for net fishing from 4 a.m to 8 p.m. Wednesday, July 31, 2002.

Order No. 2002–04: Issued 3 p.m., August 1, 2002

All-Citizen Fisheries

Areas 7 and 7A: Purse Seines open from 9 a.m. to 3 p.m. on Friday, August 2, 2002.

Drift Gillnets open from 4 p.m. to 10 p.m. on Friday, August 2, 2002.

Order No. 2002–05: Issued 3 p.m., August 2, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gillnets from 4 p.m. Friday, August 2 to 12 p.m. (noon) Monday, August 5, 2002.

Areas 6, 7 and 7A: Open for net fishing from 6 a.m to 11 p.m. Saturday, August 3, 2002.

All-Citizen Fisheries

Areas 7 and 7A Reef Net: Open for net fishing 5 a.m. Saturday, August 3, 2002, until 9 p.m. Saturday, August 3, 2002, and then again 5 a.m. Sunday, August 4, 2002, until 9 p.m. Sunday, August 4, 2002, and then again 5 a.m. Monday, August 5, 2002, until 9 p.m. Monday, August 5, 2002.

Order No. 2002–06: Issued 3 p.m., August 6, 2002.

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gill nets from 4 p.m. Tuesday, August 6, 2002 to 12 p.m. (noon) Friday, August 9, 2002.

All-Citizen Fisheries

Areas 7 and 7A Purse Seine: Open for purse seine in that portion of Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia, from 2 p.m. Thursday, August 8, 2002 to 3 p.m Thursday, August 8, 2002.

Areas 7 and 7A Gill Net: Open for gill net in that portion of Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia, from 4 p.m. Thursday, August 8, 2002 to 8 p.m. Thursday, August 8, 2002.

Order No. 2002–07: Issued 4 p.m., August 9, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gill nets from 4 p.m. Friday, August 9, 2002 to 12 p.m. (noon) Tuesday, August 13, 2002.

Areas 6, 7 and 7A: Open for that portion of Area 6, Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia for net fishing from 5 a.m. to 5 p.m. on Sunday, August 11, 2002.

All-Citizen Fisheries

Non-Treaty Gill Net: Open for that portion of Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia for gill net from 4 p.m. to 8 p.m. on Monday, August 12, 2002.

Non-Treaty Reef Net: Open for that portion of Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia for reef net from 5 a.m. to 9 p.m. on Saturday, August 10, 2002.

Order No. 2002–08: Issued 4 p.m., August 12, 2002

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open for drift gill nets from 4 p.m. Friday, August 9, 2002, to 6 p.m. Monday, August 12, 2002.

All-Citizen Fisheries

Non-Treaty Gill Net: Open for that portion of Area 7 and Area 7A south and east of a line from Iwersen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia for gill net from 4 p.m. to 8 p.m. on Monday, August 12, 2002.

Inseason Order 2002–08 supersedes all previous inseason orders implementing 2002 orders of the Fraser River Panel.

Order No. 2002–09: Issued 5 p.m., August 23, 2002

All-Citizen Fisheries

Non-Treaty Gill Net: Open for that portion of Areas 7 and 7A south and east of a line from Iweresen's Dock on Point Roberts to Georgina Point Light at the entrance to Active Pass in British Columbia as follows:

Area 7A: Open from 8 a.m. to 8 p.m. on Saturday, August 24, 2002, and from 8 a.m. to 8 p.m. on Sunday, August 25, 2002.

Areas 7 and 7A: Open from 8 a.m. to 8 p.m. on Monday, August 26, 2002.

The Assistant Administrator for Fisheries NOAA (AA), finds that good cause exists for the inseason orders to be issued without affording the public prior notice and opportunity for comment under 5 U.S.C. 553(b)(B) as such prior notice and opportunity for comment is impracticable and contrary to the public interest. Prior notice and opportunity for public comment is impracticable because NMFS has insufficient time to allow for prior notice and opportunity for pubic comment between the time the stock abundance information is available to determine how much fishing can be allowed and the time the fishery must open and close in order to harvest the appropriate amount of fish while they are available.

Moreover, such prior notice and opportunity for public comment is contrary to the public interest because not closing the fishery upon attainment of the quota would allow the quota to be exceeded and thus compromise the conservation and allocation objectives established preseason, and it does not allow fishers appropriately controlled access to the available fish at the time they are available.

The AA also finds good cause to waive the 30–day delay in the effective date, required under 5 U.S.C. 553(d)(3), of the inseason orders. A delay in the effective date of the inseason orders would not allow fishers appropriately controlled access to the available fish at that time they are available.

This review is authorized by 50 CFR 300.97, and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 3636(b).

Dated: October 25, 2002.

Bruce C. Morehead,

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

[FR Doc. 02–27874 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 102202C]

Marine Mammals; File No. 881–1443

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

ACTION: Issuance of permit amendment.

SUMMARY: Notice is hereby given that the Alaska SeaLife Center, P.O. Box 1329, Seward, AK 99664 has been issued an amendment to scientific research Permit No. 881–1443–05.

ADDRESSES: The amendment 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; phone (301)713–2289; fax (301)713–0376;

Regional Administrator, Alaska Region, National Marine Fisheries Service, NOAA, P.O. Box 21668, Juneau, AK 99802–1668 (907/586–7221).

FOR FURTHER INFORMATION CONTACT: Amy Sloan or Ruth Johnson, (301)713–2289.

SUPPLEMENTARY INFORMATION: The requested amendment has been granted under the authority of the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 *et seq.*), the provisions of § 216.39 of 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 fish and wildlife (50 CFR part 222).

Issuance of this amendment, as required by the ESA was based on a finding that such permit (1) was applied for in good faith, (2) will not operate to the disadvantage of the endangered species which is the subject of this permit, and (3) is consistent with the purposes and policies set forth in section 2 of the ESA.

The amendment extends the expiration date of the permit from March 31, 2003, to March 31, 2004.

Dated: October 28. 2202.

Eugene T. Nitta,

Acting Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 02–27875 Filed 10–31–02; 8:45 am]

BILLING CODE 3510–22–S

CONSUMER PRODUCT SAFETY COMMISSION

Sunshine Act Meeting

TIME AND DATE: Friday, November 8, 2002, 10 a.m.

LOCATION: Room 420, East West Towers, 4330 East West Highway, Bethesda, Maryland.

(This meeting was previously scheduled for Thursday, October 24, 2002.)

STATUS: Open to the public.

MATTER TO BE CONSIDERED:

Petition HP 99 1 Polyvinyl Chloride (PVC).

The staff will brief the Commission on Petition HP 99–1 requesting a ban of polyvinyl chloride (PVC) in all toys and other products intended for children five of age and under.

For a recorded message containing the latest agenda information, call (301) 504–0709.

CONTACT PERSON FOR ADDITIONAL INFORMATION: Todd A. Stevenson, Office of the Secretary, 4330 East West Highway, Bethesda, MD 20207 (301) 504–0800.

Dated: October 30, 2002.

Todd A. Stevenson,

Secretary.

[FR Doc. 02–27984 Filed 10–30–02; 11:20 am]

BILLING CODE 6355–01–M

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0154]

Federal Acquisition Regulation; Information Collection; Davis Bacon Act-Price Adjustment (Actual Method)

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 the Davis-Bacon Act price adjustment (actual method). The clearance currently expires on January 31, 2003.

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 December 31, 2002.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the General Services Administration, FAR Secretariat (MVP), 1800 F Street, NW, Room 4035, Washington, DC 20405.

FOR FURTHER INFORMATION CONTACT: Linda Nelson, Acquisition Policy Division, GSA (202) 501–1900.

SUPPLEMENTARY INFORMATION:

A. Purpose

The clause at 52.222–32, Davis-Bacon Act-Price Adjustment (Actual Method), requires that a contractor must submit at the exercise of each option to extend the term of the contract, including a statement of the amount claimed for incorporation of the most current wage determination by the Department of Labor, and any relevant supporting data, including payroll records, that the contracting officer may reasonably require.

The contracting officer may include this clause in fixed-price solicitations and contracts, subject to the Davis-Bacon Act, that will contain option provisions to extend the term of the contract. Generally, this clause is only appropriate if contract requirements are predominantly services subject to the Service Contract Act and the construction requirements are substantial and segregable.

B. Annual Reporting Burden

Respondents: 900.
Responses Per Respondent: 1.
Annual Responses: 900.
Hours Per Response: 90.
Total Burden Hours: 81,000.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents 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. 9000–0154, Davis-Bacon Act-Price Adjustment (Actual Method), in all correspondence.

Dated: October 28, 2002.

Al Matera,

Director, Acquisition Policy Division.

[FR Doc. 02–27762 Filed 10–31–02; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF DEFENSE

Department of the Army

Performance Review Boards Membership

AGENCY: Department of the Army, DoD.

ACTION: Notice.

SUMMARY: Notice is given of the names of members of a Performance Review Board for the Department of the Army.

EFFECTIVE DATE: October 28, 2002.

FOR FURTHER INFORMATION CONTACT: Marilyn Ervin, U.S. Army Senior Executive Service Office, Assistant Secretary of the Army, Manpower & Reserve Affairs, 111 Army, Washington, DC 20310–0111.

SUPPLEMENTARY INFORMATION: Section 4314(c)(1) through (5) of Title 5, U.S.C., requires each agency to establish, in accordance with regulations, one or more Senior Executive Service performance review boards. The boards shall review and evaluate the initial appraisal of senior executives' performance by supervisors and make recommendations to the appointing authority or rating official relative to the performance of these executives.

The members of the Performance Review Board for the U.S. Army Communications-Electronics Command (CECOM), U.S. Army Materiel Command are:

1. BG Michael R. Mazzucchi, Program Executive Officer, Command, Control and Communications (Tactical).
2. Mr. Edward Bair, Program Executive Officer, Intelligence, Electronic Warfare and Sensors.
3. Mr. Edward Thomas, Director, CECOM Software Engineering Center, U.S. Army Communications-Electronics Command.
4. Mr. John Perrapato, Deputy Program Executive Officer, Command and Control Systems.
5. Mr. Edward Elgart, Director, CECOM Acquisition Center, U.S. Army Communications-Electronics Command.

The members of the Performance Review Board for the U.S. Army Aviation and Missile Command (AMCOM), U.S. Army Materiel Command are:

1. Ms. L. Marlene Cruze, Director, Acquisition Center, U.S. Army Aviation and Missile Command.
2. Dr. Richard Amos, Acting Associated Director (Systems), Research, Development and Engineering Center, U.S. Army Aviation and Missile Command.
3. Mr. John Chapman, Executive Director of Integrated Materiel Management Center, U.S. Army Aviation and Missile Command.
4. Mr. Bill Reeves, Assistant to the Deputy Commanding General for Research, Development and Acquisition, U.S. Army Space and Missile Defense Command.

Luz D. Ortiz,

Army Federal Register Liaison Officer.

[FR Doc. 02–27823 Filed 10–31–02; 8:45 am]

BILLING CODE 3710–08–M

DEPARTMENT OF EDUCATION

National Assessment Governing Board; Meeting

AGENCY: National Assessment Governing Board; Education.

ACTION: Notice of open meeting and partially closed meetings.

SUMMARY: This notice sets forth the schedule and proposed agenda of a forthcoming meeting of the National Assessment Governing Board. This notice also describes the functions of the Board. Notice of this meeting is required under Section 10(a)(2) of the Federal Advisory Committee Act. The document is intended to notify the general public of their opportunity to attend. Individuals who will need accommodations for a disability in order to attend the meeting (i.e. interpreting services, assistive listening devices, materials in alternative format) should notify Munira Mwalimu at 202–357–6938 or at *Munira.Mwalimu@ed.gov* no later than November 8, 2002. We will attempt to meet requests after this date, but cannot guarantee availability of the requested accommodation. The meeting site is accessible to individuals with disabilities.

DATES: November 14–November 16, 2002.

Times: November 14: Assessment Development Committee: Open Session—1 p.m. to 3 p.m.; Ad Hoc Committee on Background Questions: Open Session—3 p.m. to 4:30 p.m.; Ad Hoc Committee on NAEP Sampling Studies: Open Session—3 p.m. to 4:30 p.m.; Executive Committee Meeting: Open Session—5 p.m.–6:30 p.m.; Closed Session 6:30 p.m. to 7 p.m.

November 15: Full Board Meeting: Open Session 8:15 a.m.–10:15 a.m.; Committee Meetings: Assessment Development Committee 10:30 a.m.–12:30 p.m.; Committee on Standards, Design and Methodology, 10:30 a.m.–12:30 p.m.; Reporting and Dissemination Committee, 10:30 a.m.–12:30 p.m.; Full Board—Open Meeting 12:30 p.m.–2:30 p.m.; Closed Meeting 2:30 p.m.–4 p.m.

November 16: Full Board Meeting: Open Session 9 a.m.–12 p.m.

Location: Holiday Inn Select Old Town, 480 King Street, Alexandria, VA 22314.

FOR FURTHER INFORMATION CONTACT: Munira Mwalimu, Operations Officer, National Assessment Governing Board, 800 North Capitol Street, NW, Suite 825, Washington, DC, 20002–4233, Telephone: (202) 357–6938.

SUPPLEMENTARY INFORMATION: The National Assessment Governing Board is established under section 412 of the National Education Statistics Act of 1994 (Title IV of the Improving America's Schools Act of 1994, as amended by the No Child Left Behind Act of 2001 (Public Law 107–110).

The Board is established to formulate policy guidelines for the National Assessment of Educational Progress (NAEP). The Board's responsibilities include selecting subject areas to be assessed, developing assessment objectives, developing appropriate student achievement levels for each grade and subject tested, developing guidelines for reporting and disseminating results, and developing standards and procedures for interstate and national comparisons.

The Executive Committee will meet in partially closed session on November 14 from 6:30–7 p.m. to receive independent cost estimates on contract initiatives for NAEP. The meeting must be conducted in closed session because public disclosure of this information would likely have an adverse financial effect on the NAEP program. The discussion of this information would be likely to significantly impede implementation of a proposed agency action if conducted in open session. Such matters are protected by exemption 9(B) of 552b(c) of Title 5 U.S.C.

On November 15, 2002 the full board will convene in open session from 8:15 a.m.–10:15 a.m. The Board will approve the agenda and introduce new Board Members. Secretary Paige will administer the oath of office for new Board members and address the Board. The Board will then receive the Executive Director's report and a NAEP Update from the Deputy Commissioner of NCES, Gary Phillips. From 10:30 a.m. to 12:30 p.m., the Board's standing committees—the Assessment Development Committee, the Committee on Standards, Design, and Methodology, and the Reporting and Dissemination Committee will meet in open session.

The full Board will reconvene in open session on November 15, 2002 from 12:30 p.m.–1:30 p.m. to discuss the work of a proposed Commission to study 12th grade NAEP. From 1:30 p.m. to 2 p.m. the Board will receive an update on NAEP/NAGB reauthorization and on the new reading framework project. From 2:30 p.m. to 4 p.m. the full board will meet in closed session to review and discuss test items from the upcoming 2003 Main Reading Assessment. Disclosure of the specific test items for the NAEP Reading Assessment would significantly impede implementation of the NAEP program, and is therefore protected by exemption 9(B) of Section 552b(c) of Title 5 U.S.C.

On November 16, the full Board will meet in open session from 9 a.m. to 12 p.m. The Board will receive a briefing from the National Urban League on efforts to reduce achievement gaps. This presentation will be followed by Board actions on policies and Committee reports. The November 16, 2002 session of the Board meeting will adjourn at 12 noon.

Summaries of the activities of the closed session and related matters, which are informative to the public and consistent with the policy of section 5 U.S.C. 552b (c), will be available to the public within 14 days of the meeting. Records are kept of all Board proceedings and are available for public inspection at the U.S. Department of Education, National Assessment Governing Board, Suite #825, 800 North Capitol Street, NW, Washington, DC, from 9 a.m. to 5 p.m. Eastern Standard Time.

Dated: October 29, 2002.

Roy Truby,

Executive Director, National Assessment Governing Board.

[FR Doc. 02–27783 Filed 10–31–02; 8:45 am]

BILLING CODE 4000–1–M

DEPARTMENT OF ENERGY

Proposed Agency Information Collection Submitted for OMB Review and Comment

AGENCY: Department of Energy.

ACTION: Notice and request for OMB review and comment.

SUMMARY: The Department of Energy (DOE) has submitted the proposed collection of information described in this Notice to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). These forms will certify to DOE that respondents were advised of the requirements for occupying or continuing to occupy a Human Reliability Program (HRP) position. The HRP is a new program which merges the Personnel Security Assurance Program (PSAP) and the Personnel Assurance Program (PAP) into one DOE human reliability program. The HRP forms will be identical to the OMB approved PSAP forms, just changing the name of the program. In addition to the above, the DOE has requested approval of two new forms, the HRP Certification form and the HRP Alcohol Testing form. The HRP Certification form is used internally to assure that an individual in an HRP position has met all of the annual program requirements. The HRP Alcohol Testing form is identical to the Department of Transportation (DOT) alcohol testing form with the only change being the insertion of the HRP in place of the DOT.

DATES: Comments regarding this collection must be received on or before December 2, 2002. If you anticipate that you will be submitting comments, but find it difficult to do so within the time period allowed by this Notice, please advise the OMB Desk Officer of your intention to make a submission as soon as possible. The Desk Officer may be telephoned at (202) 395–7318. In addition, please notify the DOE contact listed in this Notice.

ADDRESSES: Address comments to the DOE Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 10102, 735 17th Street, NW., Washington, DC 20503. (Comments should also be addressed to Susan L. Frey, Director, Records Management Division [IM–11], Office of Records and Business Management, Office of the Chief Information Officer, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585–1290.

SUPPLEMENTARY INFORMATION: *This package contains:* (1) OMB No. 1910–1800.

Current and proposed titles are listed below:

Current—Refusal of Consent [for Personnel Security Assurance Program (PSAP)].

New—Refusal of Consent [for Human Reliability Program (HRP)].

Current—Authorization and Consent To Release Personnel Security Assurance Program (PSAP) Records in Connection with PSAP.

New—Authorization and Consent To Release Human Reliability Program (HRP) Records in Connection with HRP.

Current—Acknowledgment and Agreement To Participate in the Personnel Security Assurance Program (PSAP).

New—Acknowledgment and Agreement To Participate in the Human Reliability Program (HRP).

(2) *New forms:*

U. S. Department of Energy Human Reliability Program (HRP) Certification.

Human Reliability Program (HRP) Alcohol Testing Form (identical to DOT OMB No. 2105–0529).

(3) *Purpose:* To merge the PSAP and PAP into one Department of Energy Human Reliability Program, therefore, using the already OMB approved forms, just changing the name of the program on the forms. Two new forms are being initiated. One will certify that an individual in an HRP position has met all annual program requirements; and the other follows an identical Department of Transportation Alcohol Testing Form that is approved under OMB Control No. 2105–0529.

(4) *Type of Respondents:* DOE, management and operating contractors, and offsite contractors.

(5) *Estimated Number of Burden Hours:* 54,500.

Statutory Authority: Paperwork Reduction Act of 1995, P.L. No. 104–13, U.S.C. section 3507(h)(1).

Issued in Washington, DC on October 25, 2002.

Susan L. Frey,

Director, Records Management Division, Office of Records and Business Management, Office of the Chief Information Officer.

[FR Doc. 02–27802 Filed 10–31–02; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Science Financial Assistance Program Notice 03–07; Low Dose Radiation Research Program—Basic Research

AGENCY: Department of Energy.

ACTION: Notice inviting grant applications.

SUMMARY: The Office of Biological and Environmental Research (OBER) of the Office of Science (SC), U.S. Department of Energy (DOE) and the Office of Biological and Physical Research (OBPR), National Aeronautics and Space Administration (NASA), hereby announce their interest in receiving grant applications for new research to develop a better scientific basis for understanding exposures and risks to humans from low dose and low fluence radiation. Topics of high priority include endogenous oxidative damage versus low dose radiation-induced damage, radio-adaptive responses, bystander effects, and individual genetic susceptibility to low dose radiation exposure. Research should employ genome-wide or proteome-wide high-throughput screening methods whenever possible, and priority will also be given to the use of three-dimensional biological models. Research should support the DOE/OBER Low Dose Radiation Research Program, and may include complementary research of direct interest to the NASA/OBPR Space Radiation Health Program of sufficient scientific merit to qualify for partial NASA support. Please review the **SUPPLEMENTARY INFORMATION** section below for further discussion of programmatic needs.

The Office of Biological and Environmental Research of the Office of Science, U.S. Department of Energy also announces its interest in receiving smaller applications for grants to support collaborative work between two or more laboratories, one or more of which should be funded to do low dose-related research. Please review the **SUPPLEMENTARY INFORMATION** section on Glue Grants, below, for further details.

In addition, we anticipate a separate request for modeling projects in the near future.

DATES: Preapplications (letters of intent), including information on collaborators, areas of research, and a one-page summary of the proposed research, should be submitted by December 6, 2002.

Formal applications submitted in response to this notice must be received by 4:30 p.m., E.S.T., Thursday, February 27, 2003, in order to be accepted for merit review and to permit timely consideration for award in Fiscal Year 2003.

ADDRESSES: Preapplications referencing Program Notice 03–07, should be sent to Ms. Joanne Corcoran by E-mail: *joanne.corcoran@science.doe.gov,* with a copy to Dr. Noelle Metting at: *noelle.metting@science.doe.gov.*

Formal applications in response to this solicitation are to be electronically submitted by an authorized institutional business official through DOE's Industry Interactive Procurement System (IIPS) at: *http://e-center.doe.gov/.* IIPS provides for the posting of solicitations and receipt of applications in a paperless environment via the Internet. In order to submit applications through IIPS your business official will need to register at the IIPS website. The Office of Science will include attachments as part of this notice that provide the appropriate forms in PDF fillable format that are to be submitted through IIPS. Color images should be submitted in IIPS as a separate file in PDF format and identified as such. These images should be kept to a minimum due to the limitations of reproducing them. They should be numbered and referred to in the body of the technical scientific application as Color image 1, Color image 2, etc. Questions regarding the operation of IIPS may be E-mailed to the IIPS Help Desk at: *HelpDesk@e-center.doe.gov* or you may call the help desk at: (800) 683–0751. Further information on the use of IIPS by the Office of Science is available at: *http://www.sc.doe.gov/production/grants/grants.html.*

If you are unable to submit an application through IIPS please contact the Grants and Contracts Division, Office of Science at (301) 903–5212 in order to gain assistance for submission through IIPS or to receive special approval and instructions on how to submit printed applications.

FOR FURTHER INFORMATION CONTACT: Dr. Noelle Metting, telephone: (301) 903–8309, E-mail: *noelle.metting@science.doe.gov,* Office of Biological and Environmental Research, U.S. Department of Energy, SC–72/Germantown Building, 1000 Independence Avenue SW., Washington, DC 20585–1290. For specific information on NASA/OBPR interests, contact Dr. Walter Schimmerling, telephone (202) 358–2205, E-mail: *wschimmerling@hq.nasa.gov,* NASA Headquarters, Mail Code UB, Washington, DC 20546–0001.

SUPPLEMENTARY INFORMATION:

(1) Specifics for the Low Dose Radiation Research Program (DOE)

The DOE/OBER Low Dose Radiation Research Program has the challenge of conducting research that can be used to inform the development of future national radiation risk policy for the public and the workplace. For the present solicitation, DOE/OBER is chiefly concerned with very low doses of low Linear Energy Transfer (LET) radiation (electrons, x- and gamma-rays). The focus of research should be on doses of low LET radiation that are at or near current workplace exposure limits. In general, research in this program should focus on total radiation doses that are less than or equal to 10 rads. Some experiments will likely involve selected exposures to higher doses of radiation for comparisons with previous experiments or for determining the validity of extrapolation methods previously used to estimate the effects of low doses of radiation from observations made at high doses. This research program will be a success if the science it generates is useful to policy makers, standard setters, and the public. Successful applicants will be expected to effectively communicate research results through publication in peer-reviewed journals. They will also be encouraged to communicate with the wider community of concerned persons, so that current thinking and the public debate is better able to reflect sound science.

Research projects utilizing the systems biology or discovery science approach, including the tools of comparative genomics and proteomics are especially sought. Research projects that use experimental protocols or cell microenvironments that will lead to an understanding of radiobiological responses in intact human tissue are also strongly encouraged.

Not all research on the biological effects of low doses of radiation will be equally useful for the development of radiation risk policy, though the path from basic radiation biology research to radiation risk policy is admittedly not clear at this time. In the present context, the research considered to be most useful will focus on biological responses that are known to be induced at low doses of radiation, have the potential to directly impact (*i.e.*, increase or decrease) subsequent development of cancer or other harmful health impacts, are quantifiable, could potentially be linked to the development of a biologically based model for radiation risk, and could potentially lead to the development of biological predictors (biomarkers) of individual risk.

Alternatively, a biological response of interest could meet all of the above criteria only at high doses but may actually be absent (as opposed to simply undetectable) at low doses of radiation. Since evidence is accumulating that the mechanisms of action are different after high versus low doses of radiation, such studies would help define these mechanisms. Defining the doses where these mechanisms shift is of critical importance.

Endogenous oxidative damage in relation to low dose radiation induced damage. A key goal of this research program will remain the elucidation of similarities and differences between endogenous oxidative damage and damage induced by low levels of ionizing radiation, as well as understanding the health risks from both. This information will underpin our interpretation of the biological effects of exposure to low doses of ionizing radiation. Although qualitative descriptions of differences and/or similarities between the types of damage induced under both conditions will be useful in the design and interpretation of experiments in other parts of the program, there is a need for quantification of the levels of damage induced by normal oxidative processes and incremental increases due to low dose irradiation.

Living organisms are subject to a daily plethora of environmental insults. Carcinogenesis in an individual occurs as a function of all the forces and phenomena that go into the production of that individual's phenotype. These include (but are not limited to) individual genotype, as well as current and historical aspects of diet, physical exercise, and exposures to chemicals and radiation. To understand all factors responsible for individual responses to radiation, we are also soliciting research on key factors that influence the extent of metabolic, endogenously produced oxidative damage and, concomitantly, affect susceptibility to low doses of radiation.

Radio-Adaptive Response—The ability of a low dose of radiation to induce cellular changes that alter the level of subsequent radiation-induced or spontaneous damage. If low doses of radiation regularly and predictably induce a protective response in cells exposed to subsequent low doses of radiation or to spontaneous damage, this could have a substantial impact on estimates of adverse health risk from low dose radiation. The generality and extent of the induction process need to be quantified, and the responsible genes and proteins discovered. By ''generality'' is meant its applicability to different cell tissue types and species; by ''extent'' is meant quantification over a range of priming doses, dose rates, and time constants of action.

Bystander effects—Biological responses observed in cells that are not directly traversed by radiation but are neighbors of an irradiated cell. Research is sought to characterize and determine mechanisms of low LET radiation

induced bystander effect, and to quantify its induction and extent as a function of dose. Bystanders in cell monolayers have already been shown to respond with gene induction and/or production of clastogenic changes. A detrimental bystander effect, in essence, ''amplifies'' the biological effects (and the effective radiation dose) of a low dose exposure by effectively increasing the number of cells that experience adverse effects to a number greater than the number of cells directly exposed to radiation. Conversely, bystander cells may exert a protective effect on the irradiated cell or cells, although very few studies to detect this effect have been tried. More importantly, entirely different types or levels of bystander effects may be occurring in three-dimensional tissues, organs, and intact organisms. Hence, only those applications that address effects in tissues, or in tissue-like models, will be considered for funding. New research projects studying bystander effects in isolated cells or cell monolayers will not be considered.

Because applications to study bystander effects are limited to three-dimensional biological models, investigators are also encouraged to propose novel bioimaging protocols for the purpose of *in situ* quantification.

The DOE Low Dose Program is currently funding several projects to develop micro-irradiation devices capable of delivering low doses of low LET radiation to individual cells or to specific parts of individual cells. Investigators are encouraged to use these irradiators, as appropriate, through collaborative means, and funds are available to assist in the collaborative use of these or comparable tools. Information on the microbeam irradiators can be found at: *http://lowdose.tricity.wsu.edu.*

Individual genetic susceptibility to low dose radiation. The Low Dose Radiation Research Program is interested in determining if genetic differences exist that result in increased risk for radiation-induced cancer in sensitive individuals or sub-populations. It may prove to be of value to address the three previously discussed research areas of interest (endogenous damage, radio-adaptive responses, and bystander effects) from the standpoint of genetic susceptibility. A major goal for this solicitation is to support additional work that seeks to identify patterns of genetic polymorphisms significantly impacting radiation sensitivity or resistance and characterizes their mechanism of action. Research should employ genome-wide or proteome-wide high-throughput screening methods that have a chance of ultimately detecting complex, multi-gene patterns indicative of or related to susceptibility. New studies focused only on a single or even a few hundred genes will not be funded.

A new resource that is now available to all Low Dose Program investigators, but might be of particular interest to those proposing research in the area of genetic susceptibility, is a tissue repository containing cells from patients who developed second cancers following total body irradiation and hematopoietic stem cell transplantation (HSCT). Presently there are EBV-transformed cell lines from 25 individuals exposed to radiation who subsequently developed a skin tumor, and an equal number from exposed individuals that have not yet developed a second cancer. A much larger tissue resource will be available in the future. Please contact directly Dr. Jeffrey L. Schwartz, Associate Professor of Radiation Oncology, University of Washington, (206) 598–4091, E-mail: *jschwart@u.washington.edu,* for collaborative opportunities.

General information resources. Information on the Low Dose Radiation Research Program can be found on the web site: *http://lowdose.tricity.wsu.edu.* Prospective proposers are also encouraged to visit the National Center for Biotechnology Information (NCBI) website: *http://www.ncbi.nlm.nih.gov/,* for information on techniques and resources, and especially its Science Primer web site: *http://www.ncbi.nlm.nih.gov/About/primer/snps.html,* for an introduction to single nucleotide polymorphisms (SNPs).

(2) Specifics for the Space Radiation Health Program (NASA)

The NASA/OBPR Space Radiation Health Program is charged with providing input for the determination of health risks to humans visiting the space radiation environment. NASA is especially interested in human exposure to low fluences of high-energy particulate ionizing radiation (protons and heavy ions). Applications whose principal focus is on low LET radiation are encouraged to include complementary research with high-energy particulate ionizing radiation that leverages progress, resources, and technology used for the low LET radiation research. Investigators with currently funded low dose projects may also apply for supplementary funding to address closely related research of interest to NASA.

The primary area of emphasis of the NASA/OBPR Space Radiation Health Program is the development of mechanistic insights into biological effects of space radiation that account for radiation risks. Applications are required to be hypothesis-driven and are expected to obtain their data in ground-based experimental radiobiology studies with protons and high-energy heavy ion beams in the energy range corresponding to space radiation. This is mainly a ground-based program using accelerator facilities to simulate space radiation. In addition to the research topics already described above this includes research on non-phenomenological predictors of late cell and tissue effects and the control and modification of radiation effect mechanisms

A short description of the current Space Radiation Health Strategic Program may be found at: *http://spaceresearch.nasa.gov/common/docs/1998_radiation_strat_plan.pdf.* Activities of OBPR, including research opportunities, descriptions of previous tasks, and other relevant information can be found at: *http://SpaceResearch.nasa.gov.* A description of the ground-based facilities and experimental program at Brookhaven National Laboratory can be found at: *http://www.bnl.gov/medical/NASA/NASA%20Page.htm.* The proton therapy facilities at Loma Linda University Medical Center are described at: *http://www.llu.edu/llu/ci/nasa/.* Finally, a description of the NASA Specialized Center of Research and Training at the Lawrence Berkeley National Laboratory may be found at: *http://www.lbl.gov/lifesciences/NSCORT.*

Scientists working in rapidly developing areas of biological sciences not necessarily associated with the study of radiation are particularly encouraged to consider the contributions that their field of study can make to Radiation Health. Applications are required to provide evidence for expertise in radiation, either by reference to the Principal Investigator's work or by inclusion of active collaborators expert in radiation research. Hypotheses should be substantiated by presentation of preliminary data wherever feasible, or by adequate references to the published literature. Experimental applications should include a clear discussion of the relevant aspects of the required radiation dosimetry and an estimate of the statistical power of the expected results.

Research applications to which NASA will assign high priority:

a. Studies that increase the confidence in the accuracy of extrapolating the probability of radiation-induced genetic

alterations or carcinogenesis from rodents to humans.

b. Determination of carcinogenic risks following irradiation by protons and HZE particles.

c. Determination if exposure to heavy ions at the level that would occur in deep space poses a risk to the integrity and function of the central nervous system.

d. Studies likely to result in the development of biological countermeasures in humans that could lead to prevention or intervention (including genetic or pharmacological agents) against effects of radiation damage in space.

Research that can lead to future space flight investigations will be welcome, and should take into account the impact of gender, age, nutrition, stress, genetic predisposition, or sensitivity to other factors of importance in managing space radiation risks.

NASA envisions that the selected applications will be structured and operated in a manner that supports the country's educational initiatives and goals (including historically black colleges and universities and other minority universities), and in particular the need to promote scientific and technical education at all levels. NASA envisions that the selected applications will support the goals for public awareness and outreach to the general public. The selected investigators are invited to participate in NASA-funded educational programs.

The applications represent an opportunity to enhance and broaden the public's understanding and appreciation of radiation effects, as specified in the DOE Low Dose Program emphasis on communication of research results and the OBPR Policy for Education and Public Outreach. Therefore, all investigators are strongly encouraged to promote general scientific literacy and public understanding of radiation induced health risk research through formal and/or informal education opportunities. If appropriate, applications should include a clear and concise description of the education and outreach activities proposed. Examples include such items as involvement of students in the research activities, technology transfer plans, public information programs that will inform the general public of the benefits being gained from the research, and/or plans for incorporation of scientific results obtained into educational curricula consistent with educational standards.

Where appropriate, the supported institution will be required to produce, in collaboration with NASA, a plan for communicating to the public the value and importance of their work.

The particles of interest to the Space Radiation Health Program are protons with energies between 20 and 1000 MeV, and nuclei of He, C, N, O, Ne, Si, Ar, Ca, Mn, and Fe, with energies between 50 and 3000 MeV/nucleon. Fluences of interest are of the order of 1–2 particles per cell; studies with higher fluences will need to be justified by compelling arguments, including an explanation of how the results can be applied in the low fluence regime. NASA has developed facilities for use of protons at Loma Linda University Medical School and high-energy heavy ion beams at the Brookhaven National Laboratory Alternating Gradient Synchrotron (AGS). A dedicated irradiation facility, using the Booster Synchrotron at Brookhaven, is under construction and is expected to be operational in 2003. Applications should not budget for the use of beams at these facilities, which is paid by NASA. NASA will cooperate with DOE to expand the range of technical resources available for experimentation and analysis of experimental results at Brookhaven.

(3) Specifics for Glue Grants

The Low Dose Radiation Research Program also announces its interest in receiving applications for the purpose of supporting collaborative work between two or more laboratories, one or more of which should be funded to do low dose-related research. These small grants are primarily designed to support post-doctoral or graduate-student research that will enable laboratories with complementary expertise to develop and apply innovative new approaches to low dose research. Comparative studies between laboratories already using similar experimental approaches are also encouraged. At least one of the applicants must hold a grant focusing on low dose issues. All applicants must have at least 1 year (and preferably 2 years) of support remaining on their core grants at the time of award. Collaborative glue grants can be set up between laboratories funded by such diverse agencies as DOE, NIH/NCI, NASA, DOD, EPA, the European Union, Canada, France, and Japan, but in any case preference will be given to proposed research that is of interest to the DOE Low Dose Radiation Research Program. The proposed collaborative research should add a new dimension or approach to at least one of the studies it is linking. Applications for these small grants must follow the instructions in IIPS for electronic submission. Please note: the Project Description should not exceed five pages.

Program Funding

It is anticipated that up to $4 million will be available from DOE/OBER for new basic research awards during FY 2003, contingent upon the availability of funds. Multiple year funding of grant awards is expected, and is also contingent upon the availability of appropriated funds, progress of the research, and continuing program need. Up to ten 3-year Glue Grants may be awarded, each averaging $60,000 total costs per year. Up to $0.5M will be available from NASA for joint funding of new research in Fiscal Year 2003, also contingent upon the availability of funds. Funds will be available from DOE to assist in the collaborative use of certain microbeam irradiators. NASA provides beam time at the Brookhaven AGS and the Loma Linda proton accelerator; investigators will not be required to pay for the beam time. It is expected that most awards will be from 1 to 3 years and will range from $100,000 to $500,000 per year (total costs).

Collaboration

Applicants are encouraged to collaborate with researchers in other institutions, such as universities, industry, non-profit organizations, federal laboratories and Federally Funded Research and Development Centers (FFRDCs), including the DOE National Laboratories, where appropriate, and to incorporate cost sharing and/or consortia wherever feasible. Additional information on collaboration is available in the Application Guide for the Office of Science Financial Assistance Program that is available via the Internet at: *http://www.sc.doe.gov/production/grants/Colab.html.*

Merit and Relevance Review

Applications will be subjected to scientific merit review (peer review) and will be evaluated against the following evaluation criteria listed in descending order of importance as codified at 10 CFR 605.10(d):

1. Scientific and/or Technical Merit of the Project.
2. Appropriateness of the Proposed Method or Approach.
3. Competency of Applicant's Personnel and Adequacy of Proposed Resources.
4. Reasonableness and Appropriateness of the Proposed Budget.

The evaluation will include program policy factors such as the relevance of

the proposed research to the terms of the announcement and the Department's programmatic needs. External peer reviewers are selected with regard to both their scientific expertise and the absence of conflict-of-interest issues. Non-federal reviewers may be used, and submission of an application constitutes agreement that this is acceptable to the investigator(s) and the submitting institution. Applications found to be scientifically meritorious and programmatically relevant will be selected in consultation with DOE and NASA selecting officials depending upon availability of funds in each agency's budget. In the course of the selection process, projects will be identified as addressing DOE requirements, NASA requirements, or both. The selected projects will be required to acknowledge support by one or both agencies, as appropriate, in all public communications of the research results.

The Application

(Please Note Information Below on Page Limits)

Information about the development and submission of applications, eligibility, limitations, evaluation, selection process, and other policies and procedures may be found in the Application Guide for the Office of Science Financial Assistance Program and 10 CFR part 605. Electronic access to the Guide and required forms is made available via the World Wide Web: *http://www.science.doe.gov/production/grants/guide.html.* DOE is under no obligation to pay for any costs associated with the preparation or submission of applications if an award is not made.

Adherence to type size and line spacing requirements is necessary for several reasons. No applicants should have the advantage of providing more text in their applications by using small type. Small type may also make it difficult for reviewers to read the application. Applications must have 1-inch margins at the top, bottom, and on each side. Type sizes must be 10 point or larger. Line spacing is at the discretion of the applicant but there must be no more than 6 lines per vertical inch of text. Pages should be standard 8½″ × 11″ (or metric A4, *i.e.*, 210 mm × 297 mm). Applications must be written in English, with all budgets in U.S. dollars.

Applicants are asked to use the following ordered format:

- *Face Page* (DOE F 4650.2 (10–91)).
- *Project Abstract Page;* single page only, should contain:

—Title,
—PI name,
—Abstract text should concisely describe the overall project goal in one sentence, and limit background/significance of project to one sentence. Short descriptions of each individual aim should focus on what will actually be done

- *Relevance Statement;* single page only, should identify DOE- or NASA-relevant research that each specific aim is intended to address.
- *Budget pages* for each year and a summary budget page for the entire project period (using DOE F 4620.1).
- *Budget Explanation.*
- Budget pages and budget explanation for each collaborative subproject, if any.
- *Project Description, 20 pages or less,* exclusive of attachments. Applications with Project Descriptions longer than 20 pages will be returned to applicants and will not be reviewed for scientific merit. (Project Descriptions for Glue Grants should not exceed 5 pages.) The Project Description should contain the following five parts:

—Goals,
—Background (concisely-stated, relevant),
—Experimental Approach,
—Preliminary Studies (or Progress, if this is a renewal application),
—Statistical Design and Methodologies

- *Literature Cited.*
- *Collaborative Arrangements* (if applicable).
- *Biographical Sketches* (limit 2 pages per senior investigator, consistent with NIH guidelines).
- *Facilities and Resources* description.
- *Current and Pending Support* for each senior investigator.
- *Letters of Intent* from collaborators (if applicable).

The Office of Science, as part of its grant regulations, requires at 10 CFR 605.11(b) that a recipient receiving a grant to perform research involving recombinant DNA molecules and/or organisms and viruses containing recombinant DNA molecules shall comply with the National Institutes of Health ''Guidelines for Research Involving Recombinant DNA Molecules'', which is available via the World Wide Web at: *http://www.niehs.nih.gov/odhsb/biosafe/nih/rdna-apr98.pdf,* (59 FR 34496, July 5, 1994), or such later revision of those guidelines as may be published in the **Federal Register**.

DOE requirements for reporting, protection of human and animal subjects and related special matters can be found on the World Wide Web at: *http://www.science.doe.gov/production/grants/Welfare.html.*

The Catalog of Federal Domestic Assistance number for this program is 81.049, and the solicitation control number is ERFAP 10 CFR part 605.

Issued in Washington, DC on October 28, 2002.

John Rodney Clark,

Associate Director of Science for Resource Management.

[FR Doc. 02–27800 Filed 10–31–02; 8:45 am]

BILLING CODE 6450–03–P

DEPARTMENT OF ENERGY

Environmental Management Site-Specific Advisory Board, Idaho National Engineering and Environmental Laboratory

AGENCY: Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: This notice announces a meeting of the Environmental Management Site-Specific Advisory Board (EM SSAB), Idaho National Engineering and Environmental Laboratory. The Federal Advisory Committee Act (Pub. L. No. 92–463, 86 Stat. 770) requires that public notice of these meetings be announced in the **Federal Register**.

DATES: Tuesday, November 19, 2002, 8 a.m.–6 p.m., Wednesday, November 20, 2002, 8 a.m.–5 p.m.

Public participation sessions will be held on: Tuesday, November 19, 2002, 12:15–12:30 p.m., 5:45–6 p.m., Wednesday, November 20, 2002, 11:45–12 noon, 4–4:15 p.m.

These times are subject to change as the meeting progresses. Please check with the meeting facilitator to confirm these times.

ADDRESSES: West Coast Downtown, 1800 Fairview Avenue, Boise, Idaho 83702, *Reservations:* (208) 344–7691.

FOR FURTHER INFORMATION CONTACT: Ms. Wendy Lowe, Idaho National Engineering and Environmental Laboratory (INEEL) Citizens' Advisory Board (CAB) Facilitator, Jason Associates Corporation, 545 Shoup Avenue, Suite 335B, Idaho Falls, ID 83402, Phone (208) 522–1662 or visit the Board's Internet Home page at *http://www.ida.net/users/cab.*

SUPPLEMENTARY INFORMATION: *Purpose of the Board:* The purpose of the Board is to make recommendations to DOE and its regulators in the areas of future use, cleanup levels, waste disposition and cleanup priorities at the INEEL.

Tentative Agenda Topics: (Agenda topics may change up to the day of the

meeting. Please contact Jason Associates for the most current agenda or visit the CAB's Internet site at *www.ida.net/users/cab/*.)

- Transition in INEEL's mission to Nuclear Energy
- Possible remedial actions to reduce risks associated with the buried waste at the Radioactive Waste Management Complex
- Performance Management Plan for Accelerating Cleanup and recent activities under the Environmental Management program
- Design for Stage II of the Pit 9 removal action
- Fiscal Year 2003 funding allocation for the INEEL cleanup program
- Final Idaho High-Level Waste and Facilities Disposition Environmental Impact Statement
- Consolidation of spent nuclear fuel into dry storage
- Remediation approach for the V Tanks in Waste Area Group I (Test Area North)
- The Draft Remedial Action Work Plan for the Sorting, Sizing and Staging Treatment Facility and the waste acceptance criteria for the INEEL Comprehensive Environmental Response, Compensation, and Liability Act Disposal Facility
- Status of the Waste Incidental to Reprocessing Determination if the lawsuit has been resolved
- Completion of the 3,100 Cubic Meter Project
- Status of Advanced Mixed Waste Treatment Project
- Values and priorities that should inform decisions related to decontamination and decommissioning of facilities at INEEL
- Possible changes in how the CAB issues press releases proposed by the Public Communications Committee
- Possible evaluation of presentations delivered to the CAB

Public Participation: This meeting is open to the public. Written statements may be filed with the Board facilitator either before or after the meeting. Individuals who wish to make oral presentations pertaining to agenda items should contact the Board Chair at the address or telephone number listed above. Request must be received five days prior to the meeting and reasonable provision will be made to include the presentation in the agenda. The Deputy Designated Federal Officer, Jerry Bowman, Assistant Manager for Laboratory Development, Idaho Operations Office, U.S. Department of Energy, is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Every individual wishing to make public comment will be provided equal time to present their comments. Additional time may be made available for public comment during the presentations. This **Federal Register** notice is being published less than 15 days prior to the meeting date due to programmatic issues that had to be resolved prior to the meeting date.

Minutes: The minutes of this meeting will be available for public review and copying at the Freedom of Information Public Reading Room, 1E–190, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585 between 9 a.m. and 4 p.m., Monday through Friday except Federal holidays. Minutes will also be available by writing to Ms. Wendy Lowe, INEEL CAB Facilitator, Jason Associates Corporation, 545 Shoup Avenue, Suite 335B, Idaho Falls, ID 83402 or by calling (208) 522–1662.

Issued at Washington, DC on October 28, 2002.

Belinda G. Hood,

Acting Deputy Advisory Committee Management Officer.

[FR Doc. 02–27801 Filed 10–31–02; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL03–7–000, et al.]

Cities of Anaheim, et al.; Electric Rate and Corporate Regulation Filings

October 10, 2002.

The following filings have been made with the Commission. The filings are listed in ascending order within each docket classification.

1. Cities of Anaheim, Azusa, Banning, and Riverside, California

[Docket No. EL03–7–000]

Take notice that on October 4, 2002, the Cities of Anaheim, Azusa, Banning, and Riverside, California (Southern Cities) filed a Petition for Declaratory Order, Request for Expedited Procedures, and Request for Waiver of Filing Fee. Southern Cities seek a determination of the propriety of a withdrawal provision in the Transmission Control Agreement that will enable them to participate in the California ISO as Participating Transmission Owners.

Comment Date: October 31, 2002.

2. LMB Funding, Limited Partnership

[Docket No. EL03–8–000]

Take notice that on October 4, 2002, LMB Funding, Limited Partnership (Petitioner) filed a Petition for Declaratory Order Disclaiming Jurisdiction and Request for Expedited Consideration. Petitioner is seeking a disclaimer of jurisdiction in connection with a lease financing involving a generating plant of approximately 600 MW to be located in Lower Mount Bethel Township, Northampton County, Pennsylvania.

Comment Date: November 4, 2002.

3. Westar Generating, Inc.

[Docket Nos. ER01–1305–004]

Take notice that on October 7, 2002, in compliance with the Commission's September 5, 2002 ''Order Conditionally Approving Uncontested Settlement,'' 100 FERC ¶ 61,255 (2002), in the above-referenced dockets, Westar Generating, Inc. (Westar) submitted a new Order 614 designation for the Purchase Power Agreement between Westar and Western Resources, Inc. (Western), and changes to Section 3.2 of Article III of the Settlement Agreement as required by the Order in the above-referenced proceedings.

A copy of this filing was served on every participant to the proceedings.

Comment Date: October 28, 2002.

4. Southwest Power Pool, Inc.

[Docket Nos. ER02–1705–003]

Take notice that on October 7, 2002, Southwest Power Pool, Inc. (SPP) submitted for filing the compliance filing required by the Federal Energy Regulatory Commission's September 5, 2002 issued in the proceeding listed above. Southwest Power Pool, Inc., 100 FERC ¶ 61,248.

Comment Date: October 28, 2002.

5. Duke Energy Corporations

[Docket No. ER02–2008–002]

Take notice that on October 7, 2002, in compliance with the Commission's order in Docket Nos. ER02–2008–000 and ER02–2008–001 issued September 5, 2002, Duke Energy Corp., 100 FERC 61,251, Duke Energy Corporation, on behalf of Duke Electric Transmission, filed a revised Interconnection and Operating Agreement by and between Duke Electric Transmission and GenPower Anderson, LLC. The Interconnection and Operating Agreement was made effective as of September 9, 2002 by the Commission.

Comment Date: October 28, 2002.

6. New England Power Pool and ISO New England Inc.

[Docket Nos. ER02–2330–001 and EL00–62–052]

Take notice that on October 7, 2002, New England Power Pool and ISO New England Inc. tendered for filing with the Federal Energy Regulatory Commission (Commission) a Compliance Filing in response to the Commission's September 20, 2002 Order issued in the above proceedings. Copies of these materials were sent to the NEPOOL

Participants, Non-Participant Transmission Customers and the New England state governors and regulatory commission.

Comment Date: October 28, 2002.

7. Pinnacle West Capital Corporation

[Docket No. ER02–2385–001]

Take notice that on October 8, 2002, Pinnacle West Capital Corporation (PWCC) tendered for filing a refund report for the time value of revenues received from Phelps Dodge Energy Services (PDES).

A copy of this filing has been served on PDES.

Comment Date: October 29, 2002.

8. Westar Energy, Inc.

[Docket No. ER03–9–001]

Take notice that on October 8, 2002, Westar Energy, Inc. (Westar Energy) filed an errata to its Notification of Change in Status and Petition for Acceptance of Revised Market Rate Schedules. The errata corrects the proposed tariff sheets to comply with Order No. 614.

Comment Date: October 29, 2002.

9. El Paso Electric Company

[Docket No.ER03–23–000]

Take notice that on October 8, 2002, El Paso Electric Company (EPE) tendered for filing eight umbrella service agreements for firm transmission service, two umbrella service agreements for non-firm transmission service, and seven service agreements and accompanying specification sheets for firm transmission service transactions of exactly one year (collectively, TSAs) between EPE and nine of its customers. The rates, terms, and conditions of the TSAs are those of EPE's Open Access Transmission Tariff (OATT). EPE seeks effective dates for the TSAs in accordance with their service commencement dates.

Comment Date: October 29, 2002.

10. Los Esteros Critical Energy Facility, LLC

[Docket No. ER03–24–000]

Take notice that on October 8, 2002, Los Esteros Critical Energy Facility, LLC (Los Esteros) tendered for filing, under section'205 of the Federal Power Act, a request for authorization to make wholesale sales of electric energy, capacity and ancillary services at market-based rates, to reassign transmission capacity, and to resell firm transmission rights. Los Esteros proposes to own and operate an approximately 180 megawatt simple cycle natural gas-fired generation facility located in Santa Clara County, California.

Comment Date: October 29, 2002.

11. Blue Spruce Energy Center, LLC

[Docket No. ER03–25–000]

Take notice that on October 8, 2002, Blue Spruce Energy Center, LLC (the Applicant) tendered for filing, under section'205 of the Federal Power Act (FPA), a request for authorization to make wholesale sales of electric energy, capacity, replacement reserves, and ancillary services at market-based rates, to reassign transmission capacity, and to resell firm transmission rights. Applicant proposes to own and operate a 300 MW gas fired, simple cycle electric generating facility in Aurora, Colorado.

Comment Date: October 29, 2002.

12. Wisconsin Electric Power Company

[Docket No. ER03–26–000]

Take notice that on October 8, 2002, Wisconsin Electric Power Company (Wisconsin Electric) tendered for filing revisions to the Wisconsin Corporation Operating Companies (WEC Operating Companies) Joint Ancillary Services Tariff. (WEC Operating Companies FERC Electric Tariff, Original Volume No. 2) Wisconsin Electric respectfully requests an effective date October 15, 2002.

Comment Date: October 29, 2002.

13. Edison Sault Electric Company

[Docket No. ES03–3–000]

Take notice that on October 2, 2002, Edison Sault Electric Company (Edison Sault) filed an application pursuant to section 204 of the Federal Power Act seeking authorization to issue, over a two-year period, long-term and short-term debt to its parent company, Wisconsin Energy Corporation, and/or short term debt to other third-party lenders, with no more than $50 million outstanding at any one time. Edison Sault also requests a waiver of the Commission's competitive bidding and negotiated placement requirements at 18 CFR 34.2.

Comment Date: October 23, 2002.

Standard Paragraph

Any person desiring to intervene or to protest this filing should file 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). 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. All such motions or protests should be filed on or before the comment date, and, to the extent applicable, must be served on the applicant and on any other person designated on the official service list. This filing is available for review at the Commission or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the ''RIMS'' link, select ''Docket #'' and follow the instructions (call 202–208–2222 for assistance). 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.

Linwood A. Watson, Jr.,

Deputy Secretary.

[FR Doc. 02–27903 Filed 10–31–02; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER02–2227–001, et al.]

Creed Energy Center, LLC, et al.; Electric Rate and Corporate Regulation Filings

October 15, 2002.

The following filings have been made with the Commission. The filings are listed in ascending order within each docket classification.

1. Creed Energy Center, LLC

[Docket No. ER02–2227–001]

Take notice that on October 10, 2002, Creed Energy Center, LLC tendered for filing a revised rate schedule to correct an error in the name of the company.

Comment Date: October 31, 2002

2. RockGen Energy LLC

[Docket No. ER02–2314–001]

Take notice that on October 10, 2002, RockGen Energy LLC (the Applicant) tendered for filing with the Federal Energy Regulatory Commission (Commission), under section'205 of the Federal Power Act, a compliance filing pursuant to the Commission's September 10, 2002 Order in the above-captioned proceeding.

Comment Date: October 31, 2002.

3. Allegheny Energy Service Corporation, on behalf of Monongahela Power Company, The Potomac Edison Company, and West Penn Power Company (Allegheny Power)

[Docket No. ER02–2561–001]

Take notice that on October 10, 2002, Allegheny Energy Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company, and West Penn Power Company (Allegheny Power), filed an amendment to its Interconnection Agreement (Agreement) with Mill Run Windpower LLC as First Revised Sheet No. 12 to First Revised Service Agreement No. 345 under Allegheny Power's Open Access Transmission Tariff. The proposed effective date for First Revised Sheet No.12 to First Revised Service Agreement No. 345 is September 20, 2002.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, and the West Virginia Public Service Commission.

Comment Date: October 31, 2002.

4. NorthWestern Energy, L.L.C.

[Docket No. ER02–2569–000]

Take notice that on October 4, 2002 NorthWestern Energy, L.L.C. (NWE) filed with the Federal Energy Regulatory Commission (Commission) pages of Exhibit No. NWE–3 that were inadvertently omitted from NWE's September 20, 2002 filing with the Commission. On October 7, 2002, NWE filed a few more pages to Exhibit No. NWE–3 that were inadvertently omitted from the October 4, 2002 filing.

Comment Date: October 28, 2002.

5. CP Power Sales Eighteen, L.L.C.

[Docket No. ER03–30–000]

Take notice that on October 10, 2002, CP Power Sales Eighteen, L.L.C. tendered for filing a Notice of Succession. Effective September 10, 2002, CP Power Sales Eighteen, L.L.C. changed its name to Midwest Generation Energy Services, LLC.

Comment Date: October 31, 2002.

6. The United Illuminating Company

[Docket No. ER03–31–000]

Take notice that on October 10, 2002, The United Illuminating Company (The United Illuminating Company) tendered for filing with the Federal Energy Regulatory Commission (Commission) an Interconnection Agreement between UI and Cross-Sound Cable Company, LLC , executed pursuant to UI's Open Access Transmission Tariff, FERC Electric Tariff, Original Volume No. 4, as amended.

Comment Date: October 31, 2002.

7. Virginia Electric and Power Company

[Docket Nos. ER03–32–000]

Take notice that on October 10, 2002 Virginia Electric and Power Company (Dominion Virginia Power), tendered for filing revisions to its Amended and Restated Interconnection and Operating Agreement (I&O Agreement), First Revised Rate Schedule FERC No. 126, between Dominion Virginia Power and Old Dominion Electric Cooperative (Old Dominion). The revisions address generation reserves in Section 8.05(a), operating costs in Section 11.01, reserve capacity charges in Appendix I and the appropriate billing format in Appendix L.

Dominion Virginia Power respectfully requests that the Commission allow the revised I&O Agreement to become effective on January 1, 2001 and allow the revisions in Section 8.05(a) and Appendix I to become effective as of January 1, 2002.

Copies of the filing were served upon Old Dominion, the Virginia State Corporation Commission and the North Carolina Utilities Commission.

Comment Date: October 31, 2002.

8. Duquesne Light Company

[Docket No. ER03–33–000]

Take notice that on October 11, 2002, Duquesne Light Company (DLC) filed a Service Agreement for Retail Network Integration Transmission Service and a Network Operating Agreement for Retail Network Integration Transmission Service dated October 11, 2002 with Constellation NewEnergy, Inc. under DLC's Open Access Transmission Tariff (Tariff). The Service Agreement and Network Operating Agreement adds Constellation NewEnergy, Inc. as a customer under the Tariff. DLC requests an effective date of October 11, 2002 for the Service Agreement.

Comment Date: November 1, 2002.

Standard Paragraph

Any person desiring to intervene or to protest this filing should file 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). 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. All such motions or protests should be filed on or before the comment date, and, to the extent applicable, must be served on the applicant and on any other person designated on the official service list. This filing is available for review at the Commission or may be viewed on the Commission's web site at *http://www.ferc.gov* using the ''RIMS'' link, select ''Docket #'' and follow the instructions (call 202–208–2222 for assistance). 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.

Linwood A. Watson, Jr.,

Deputy Secretary.

[FR Doc. 02–27904 Filed 10–31–02; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7403–2]

Agency Information Collection Activities: Submission for OMB Review; Comment Request; NSPS for Glass Manufacturing Plants (40 CFR Part 60, Subpart CC)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Title: NSPS for Glass Manufacturing Plants (40 CFR part 60, subpart CC), OMB Control Number 2060–0054, expiration date October 31, 2002. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 2, 2002.

ADDRESSES: Send comments, referencing EPA ICR Number 1131.07 and OMB Control Number 2060–0054, to the following addresses: Susan Auby, United States Environmental Protection Agency, Collection Strategies Division (Mail Code 2822T), 1200 Pennsylvania Avenue, NW., Washington, DC 20460–0001; and to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB),

Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR, contact Susan Auby at EPA by phone at: (202) 566–1672, by E-Mail to: *auby.susan@epa.gov*, or download from the Internet at: *http://www.epa.gov/icr*, and refer to EPA ICR Number 1131.07. For technical questions about the ICR, contact Gregory Fried, Air, Hazardous Waste and Toxics Branch, at (202) 564–7016.

SUPPLEMENTARY INFORMATION:

Title: NSPS for Glass Manufacturing Plants (40 CFR part 60, subpart CC), OMB Control Number 2060–0054, EPA ICR Number 1131.07, expiration date October 31, 2002. This is a request for extension of a currently approved collection.

Abstract: The NSPS for Glass Manufacturing Plants (40 CFR part 60, subpart CC) were proposed on June 15, 1979 and promulgated on October 7, 1980, and amended October 19, 1984. Approximately 45 sources are currently subject to the standard, and it is estimated that no additional sources will become subject to the standard in the next three years. The standards do not apply to hand glass melting furnaces, glass melting furnaces designed to produce less than 4,550 kilograms of glass per day, or all-electric melters. Experimental furnaces are not subject to the emission standards at 40 CFR 60.292. The standards set particulate matter emission limits. There are separate limits for sources using ''modified-process'' glass melting furnaces. Modified-process is defined as any technique designed to minimize emissions without add-on controls. Emission limits are specific for the type of glass produced, and are listed at 40 CFR 60.292(a) and 60.293(b).

Owners or operators of the affected facilities described must make initial notifications, conduct and report on a performance test, demonstrate and report on continuous monitor performance, maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility. Semiannual reports of excess emissions are required. These notifications, reports, and records are required, in general, for all sources subject to NSPS. The recordkeeping and reporting requirements specific to glass manufacturing plants are detailed in the CFR. This information is being collected to assure compliance with 40 CFR part 60, subpart CC.

Any owner or operator subject to the provisions of this part shall maintain a file of these measurements, and retain the file for at least two years following the date of such measurements, maintenance reports, and records. All reports are sent to the delegated State or local authority. In the event that there is no such delegated authority, the reports are sent directly to the EPA Regional Office.

In the Administrator's judgment, particulate matter emissions from glass manufacturing plants cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Therefore, NSPS were promulgated for this source category at 40 CFR part 60, subpart CC.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on October 29, 2001. Comments were not received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 7 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: Glass manufacturing plants.

Estimated Number of Respondents: 45.

Frequency of Response: Initial, semiannual, and on occasion.

Estimated Total Annual Hour Burden: 590.

Estimated Total Annualized Capital, O&M Cost Burden: $261,000.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the addresses listed above. Please refer to EPA ICR Number 1131.07 and OMB Control Number 2060–0054 in any correspondence.

Dated: October 24, 2002.

Doreen Sterling,

Acting Director, Collection Strategies Division.

[FR Doc. 02–27835 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7403–3]

Agency Information Collection Activities: Submission for OMB Review; Comment Request, Reporting Requirements Under EPA's Voluntary Aluminum Industrial Partnership

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Title: Reporting Requirements under EPA's Voluntary Aluminum Industrial Partnership. OMB Control Number 2060–0411, expiration date 10/31/02. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 2, 2002.

ADDRESSES: Send comments, referencing EPA ICR No. 1867.02 and OMB Control No. 2060–0411, to the following addresses: Susan Auby, U.S. Environmental Protection Agency, Collection Strategies Division (Mail Code 2822T), 1200 Pennsylvania Avenue, NW., Washington, DC 20460–0001; and to Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Susan Auby at EPA by phone at (202) 566–1672, by E-Mail at *Auby.Susan@epamail.epa.gov* or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1867.02. For technical questions about the ICR contact Jerome Blackman

at (202) 564–8995; email at *Blackman.jerome@epa.gov*.

SUPPLEMENTARY INFORMATION:

Title: Reporting Requirements under EPA's Voluntary Aluminum Industrial Partnership, OMB Control Number 2060–0411, EPA ICR Number 1867.02, expiration date 10/31/02. This is a request for extension of a currently approved collection.

Abstract: EPA's Voluntary Aluminum Industrial Partnership (VAIP) was initiated in 1995 and is an important voluntary program contributing to the overall reduction in emissions of greenhouse gases. This program focuses on reducing per fluorocarbon (PFC) emission from the production of primary aluminum. Eight of the nine U.S. producers of primary aluminum participate in this program. PFCs are very potent greenhouse gases with global warming potentials several thousand times that of carbon dioxide and they persist in the atmosphere for thousands of years. EPA has developed this ICR to renew authorization to collect information from companies in the VAIP. Participants voluntarily agree to the following: designating a VAIP liaison; undertaking technically feasible and cost-effective actions to reduce PFC emissions; and reporting to EPA, on an annual basis, the PFC emissions or production parameters used to estimate emissions. The information contained in the annual reports of VAIP members is used by EPA to assess the success of the program in achieving its goals. The information contained in the annual reports may be considered confidential business information and is maintained as such.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on August 12, 2002. No comments were received.

Burden Statement: The annual track reporting and recordkeeping burden for this collection of information is estimated to be roughly 73 hours per respondent. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

- *Estimated Number of Respondents:* 8.
- *Frequency of Response:* Annually.
- *Estimated Total Annual Hour Burden:* 584.
- *Estimated Total Annualized Capital, O& M Cost Burden:* $0.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the addresses listed above. Please refer to EPA ICR No. 1867.02 and OMB Control No. 2060–0411 in any correspondence.

Dated: October 24, 2002.

Doreen Sterling,

Acting Director, Collection Strategies Division.

[FR Doc. 02–27836 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7403–1]

Agency Information Collection Activities: Submission for OMB Review; Comment Request; NPDES Storm Water Program Phase II

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: NPDES Storm Water Program Phase II, OMB Control Number 2040–0211, expiration date October 31, 2002. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 2, 2002.

ADDRESSES: Send comments, referencing EPA ICR No. 1820.03 and OMB Control No. 2040–0211, to the following addresses: Susan Auby, U.S. Environmental Protection Agency, Collection Strategies Division (Mail Code 2822T), 1200 Pennsylvania Avenue, NW, Washington, DC 20460–0001; and to Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Susan Auby at EPA by phone at (202) 566–1672, by E-Mail at *auby.susan@epa.gov* or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1820.03. For technical questions about the ICR contact Jack Faulk at (202) 564–0768 or via E-Mail at *faulk.jack@epa.gov.*

SUPPLEMENTARY INFORMATION:

Title: NPDES Storm Water Program Phase II, OMB Control Number 2040–0211, EPA ICR Number 1820.03, expiration date October 31, 2002. This is a request for extension of a currently approved collection.

Abstract: This ICR addresses Phase II of the NPDES storm water program. Under the Phase II rule, EPA regulates storm water discharges from construction sites with activities disturbing equal to or greater than one acre and less than five acres of land, and small municipal separate storm sewer systems (MS4s) located in Bureau of the Census-designated ''urbanized areas.'' Additional construction sites and small MS4s may be designated by the NPDES permitting authority. NPDES permits provide the mechanism for establishing appropriate controls on these Phase II sources. The Phase II rule also includes a provision that allows industrial facilities regulated under Phase I of the NPDES storm water program to obtain an exclusion from NPDES permitting requirements if they can certify to a condition of ''no exposure'' on their site.

Permits were not required for small construction sites and regulated small MS4s during the first three years of the program. The data collection effort during this first three-year period was limited to the submittal and review of no exposure certifications and some preliminary Agency work in developing specific program elements. A significant increase in burden for this ICR is the product of that fact.

After general permits for small MS4s and small construction sites are issued in December of 2002, NPDES permitting authorities, including the Water Permits Division of the EPA Office of Wastewater Management, intend to use the data contained in storm water

permit applications, construction waiver certifications, storm water pollution prevention plans (SWPPPs), no exposure certifications, and reports to set appropriate permit conditions, track discharges covered by storm water permits, and assess permit compliance. Other organizations, including EPA's Office of Enforcement and Compliance Assurance environmental groups, will most likely use the same collected information to assess the regulated community's level of compliance and to measure the overall effectiveness of the NPDES storm water program.

It is expected that respondents will submit information in hard copy form. The information from them will be entered into a computer database and the original document will be filed. The information will be submitted by the respondents directly to each NPDES-authorized State or Territory, or to EPA in areas where EPA is the NPDES permitting authority. Plans are underway to allow electronic submission of much of the required information but these options are not included in the ICR. At the time those options become available, EPA will update this information collection to reflect a revised burden estimate.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on July 16, 2002; no comments were received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 21 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: NPDES permittees, including operators of small municipal separate storm sewer systems, small construction activity, and industrial facilities identified in 40 CFR 122.26(b)(14)(i)–(ix) and (xi) that qualify for a no exposure exemption.

Estimated Number of Respondents: 327,163.

Frequency of Response: Varies.

Estimated Total Annual Hour Burden: 3,873,197.

Estimated Total Annualized Capital, O&M Cost Burden: $0.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the addresses listed above. Please refer to EPA ICR No. 1820.03 and OMB Control No. 2040–0211 in any correspondence.

Dated: October 22, 2002.

Doreen Sterling,

Acting Director, Collection Strategies Division.

[FR Doc. 02–27837 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6634–5]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 or *http://www.epa.gov/compliance/nepa/*.

Weekly receipt of Environmental Impact Statements.

Filed October 21, 2002, through October 25, 2002.

Pursuant to 40 CFR 1506.9.

EIS No. 020438, DRAFT EIS, NPS, NC, Carl Sandburg Home National Historic Site, General Management Plan, implementation, located in the Village of Flat Rick, Henderson County, NC, comment period ends: December 16, 2002, contact: Tim Bemisderser (404) 562–3124 ext.693.

EIS No. 020439, DRAFT EIS, FRC, ID, Bear River Hydroelectric Project, application for a new license (relicense) for three existing hydroelectric projects: Soda (FERC No. 20–019), Grace-Cove (FERC No. 2401–007) and Oneida (FERC No. 472–017), Bear River Basin, Caribou and Franklin Counties, ID, comment period ends: December 31, 2002, contact: Susan O'Brien (202) 502–8449.

EIS No. 020440, FINAL EIS, IBR, AZ, Reach 11 Recreation Master Plan, Central Arizona Project (CAP) Canal, between Cave Creek and Scottsdale Roads, for recreational purposes, Flood Detention Basin, city of Phoenix, Maricopa County, AZ, wait period ends: December 2, 2002, contact: Sandra Eto (602) 216–3857. This document is available on the Internet at: (*http://www.apo.lc.usbr.gov.*)

EIS No. 020441, DRAFT EIS, FRC, WV, NC, VA, Greenbrier Pipeline Project, (Docket Nos. CPO 2–396–000 and PF 01–1–000), propose to construct and operate a natural gas pipeline and associated above ground facilities, extending from east of Clendenin, Kanawha County, WV, VA and Granville County, NC, comment period ends: December 16, 2002, contact: Magalie R. Salas (202) 502–8659. This document is available on the Internet at: (*http://www.ferc.gov.*)

EIS No. 020442, DRAFT EIS, COE, FL, Ona Mine Project, proposes to construct and operate a surface mine for the recovery of phosphate rock, in Western Hardee County, FL, comment period ends: December 16, 2002, contact: Charles A. Schnepel (813) 840–2908. This document is available on the Internet at: *www.saj.usace.army.mil/permit/hot-topies/hot-topics.htm.*

EIS No. 020443, DRAFT EIS, NRC, FL, Generic EIS–License renewal of nuclear plants for the St. Lucie Units 1 and 2, Supplement 11, NUREG–1437, implementation, Hutchinson Island, St. Lucie County, FL, comment period ends: January 15, 2003, contact: Dr. Michael T. Masnik (301) 415–1191. This document is available on the Internet at: *http://www.nrc.gov/Reading-rm.html.*

EIS No. 020444, DRAFT EIS, FTA, NC, South Corridor Light Rail Project, to provide light rail service between the town of Pineville and Charlotte's downtown, city of Charlotte, Charlotte-Mecklenburg County, NC, comment period ends: December 16, 2002, contact: Alex McNeil (404) 564–3511.

Amended Notices

EIS No. 010305, DRAFT SUPPLEMENT, FAA, MN, Flying Cloud Airport, substantive changes to alternatives and new information, extension of the runways 9R/27L and 9L/27R, long-term comprehensive development, in the city of Eden Prairie, Hennepin County, MN, due: January 22, 2003, contact: Glen Orcutt (612) 713–4354. Revision of FR notice published on 8/30/2002: CEQ comment period ending

10/25/2002 has been extended to 1/22/2003.

EIS No. 220343, DRAFT EIS, SFW, CA, Natomas Basin Habitat Conservation Plan, issuance of incidental take permit and the adoption of an implementing agreement or agreements, Natomas Basin, Sacramento and Sutter Counties, CA, due: October 28, 2002, contact: Vicki Campbell (916) 414–6600. Revision of FR notice published on 10/11/2002: CEQ comment period ending on 10/28/2002 has been extended to 12/2/2002.

Dated: October 29, 2002.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 02–27826 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6634–6]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared pursuant to the Environmental Review Process (ERP), under section 309 of the Clean Air Act and section 102(2)(c) of the National Environmental Policy Act as amended. Requests for copies of EPA comments can be directed to the Office of Federal Activities at (202) 564–7167.

An explanation of the ratings assigned to draft environmental impact statements (EISs) was published in FR dated April 12, 2002 (67 FR 17992).

Draft EISs

ERP No. D–AFS–K65245–AZ Rating EC2, Kachina Village Forest Health Project, forest health improvements and wildfire reduction potentials on national forest system land, implementation, Coconino National Forest, Mormon Lake Ranger District, Coconino County, AZ.

Summary: EPA expressed environmental concerns related to transportation system planning, fire risk conditions on adjacent private lands, ecological justification for harvesting large trees, funding for mitigation and details of road decommissioning. EPA requested this information be included in the final EIS.

ERP No. D–AFS–K65246–AZ Rating LO, Flagstaff/Lake Mary ecosystem analyses area, amendment to the Coconino Forest Plan, implementation, Coconino National Forest, Peaks and Mormon Lake Ranger Districts, Coconino County, AZ.

Summary: EPA has no objections to the proposed action.

ERP No. D–AFS–K65364–CA Rating LO, Red Star Restoration Project, removal of fire-killed trees, fuel reduction, road reconstruction and decommissioning and associated restoration, Tahoe National Forest, Foresthill Ranger District, Placer County, CA.

Summary: EPA had no objections to the proposed project, given that the ecological restoration activities, including road decommissioning, mitigation measures, and monitoring are implemented as described in the Draft EIS.

ERP No. D–BLM–K65242–CA Rating LO, Coachella Valley California Desert Conservation Area Plan Amendment, Santa Rosa and San Jacinto Mountains Trails Management Plan, implementation, Riverside and San Bernardino Counties, CA.

Summary: EPA had no objections to the proposed plan, and requested that additional information concerning adaptive management and monitoring be provided in the Final EIS.

ERP No. D–BPA–L08062–WA Rating EC2, Grand Coulee-Bell 500–kV Transmission Line Project, construction and operation, U.S. Army COE section 10 permit issuance, Douglas, Lincoln, Grant Spokane Counties, WA.

Summary: EPA expressed environmental concerns regarding the alternatives, air quality, cultural resources, water quality, characterization of expected effects and threatened and endangered species. EPA requested additional information be added to the EIS to more fully discuss alternative actions, how the project will comply with existing TMDLs, clearly define resources at risk and include a biological assessment.

ERP No. D–COE–G01015–TX Rating LO, Three Oaks Mine Project, construction and operation of a surface lignite mine, U.S. Amry COE section 404 permit issuance, Lee and Bastrop Counties, TX.

Summary: EPA has no objections to the selection of the preferred alternative. EPA requested that clarification information be added to several items to strengthen the Final EIS.

ERP No. D–NPS–K65244–CA Rating LO, Yosemite Fire Management Plan, alternative for carrying out the fire management program, implementation, Yosemite National Park, Sierra Nevada, Mariposa, Tuolumne, Madera and Mono Counties, CA.

Summary: EPA had no objections to the proposed plan and commended the Park Service for its thorough and user friendly Draft EIS.

ERP No. DS–AFS–J65314–MT Rating LO, Meadow Smith Project, new and additional information concerning management actions designed to maintain the presence of and protect the unique characteristics of open-grow, large-tree ponderosa pine and western larch forest communities, Flathead National Forest, Swan Lake Ranger District, Lake and Missoula Counties, MT.

Summary: EPA expressed lack of objections and noted opportunities for increased mitigation measures with no more than minor changes to the proposed action resulting in improved aquatic health, especially improved fish passage.

Final EISs

ERP No. F–BLM–K65231–CA, Northern and Eastern Mojave Planning Area (NEMO), California Desert Conservation Area Plan Amendments, implementation Mojave Desert, CA.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. F–BLM–K65330–CA, Northern and Eastern Colorado Desert Plan (Plan), implementation, comprehensive framework for managing species and habitats (BLM), Joshua Tree National Park (JTNP) and Chocolate Mountains Aerial Gunnery Range, California Desert, Riverside, Imperial and San Bernardino Counties, CA.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. F–NPS–K65229–CA, Santa Cruz Island Primary Restoration Plan, implementation, Channel Island National Park, Santa Cruz Island, Santa Barbara County, CA.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. FA–NOA–E91007–00, South Atlantic Region Shrimp Fishery Management Plan, amendment 5, additional information concerning rock shrimp in the Exclusive Economic Zone (EEZ), NC, SC, FL and GA.

Summary: EPA's previous issues have been resolved. Therefore, EPA has no objection to the proposed action and supports additional future amendments describing actions intended to generate data on bycatch and characteristics of rock shrimp essential habitats.

Dated: October 29, 2002.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 02–27827 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7392–3]

Asthma Research Strategy

AGENCY: Environmental Protection Agency.

ACTION: Notice of availability of a final document.

SUMMARY: The U.S. Environmental Protection Agency (EPA) is announcing the availability of a final document, *Asthma Research Strategy*, EPA 600/R–01/061. The *Asthma Research Strategy* serves to guide the planning of EPA research efforts led by the Office of Research and Development (ORD) to address the significant issues of exposures, effects, risk assessment, and risk management of environmental pollutants relevant to asthma.

ADDRESSES: A limited number of copies of the *Asthma Research Strategy* are available from EPA's National Service Center for Environmental Publications (NSCEP) in Cincinnati, Ohio (telephone: 1–800–490–9198 or 513–489–8190). Please provide the title and the EPA number when ordering from NSCEP. Internet users may download a copy from EPA's ORD home page at *http://www.epa.gov/ORD.*

FOR FURTHER INFORMATION CONTACT: James Raub, National Center for Environmental Assessment/Research Triangle Park Office (MD–B–243–01), U.S. Environmental Protection Agency, Research Triangle Park, NC 27711; telephone: 919–541–4157; facsimile: 919–541–1818; e-mail: *raub.james@epa.gov.*

SUPPLEMENTARY INFORMATION: The *Asthma Research Strategy* was developed in light of increasing rates of asthma, particularly in children, in the United States. Since the EPA is required to set pollutant standards to protect susceptible populations, a coordinated research effort is needed to study environmental pollutants that influence the incidence and severity of asthma. EPA has developed a plan to coordinate research efforts aimed at addressing the following issues: Factors contributing to the induction and exacerbation of asthma (*e.g.*, combustion-related products, bioaerosols, and air toxics); susceptibility factors contributing to asthma (*e.g.*, genetics, health status, socioeconomic status, residence and exposure history, and lifestyle and activity patterns); and risk assessment and risk management of environmental pollutants relevant to asthma. The *Asthma Research Strategy* identifies and prioritizes the research needed to provide information to close the gaps in our knowledge of asthma and to control environmental factors that contribute to the prevalence and severity of asthma. The Strategy supplements and expands on other U.S. agency efforts to better understand this complex disease.

Asthma is characterized by chronic airway inflammation, mucus secretion, airway remodeling, and reversible airway obstruction. The disease has a definite genetic component, and can be caused by a variety of factors. In susceptible individuals, the inflammation causes recurrent episodes of wheezing, breathlessness, chest tightness, and cough particularly at night and/or early morning. Airflow obstruction usually associated with these symptoms is partly reversible either spontaneously or with treatment. Inflammation also causes an increase in airway responsiveness to a variety of stimuli. Most types of asthma are linked to allergic responses to common aeroallergens present in the indoor and outdoor environment. Common allergens include: house-dust mites, cockroaches, animal secretions, pollens, and molds. Exacerbation of asthma may occur with subsequent re-exposure to allergens or by exposure to a number of nonspecific triggers such as respiratory viruses, tobacco smoke, or certain air pollutants.

EPA has prepared the *Asthma Research Strategy* to strengthen the scientific foundation of the EPA risk assessments and risk management decisions. Agency research strategies provide a framework of research needs and priorities to guide its programs over the next 5 to 10 years. The Strategy includes a stable, long-term, core program of research in hazard identification, dose-response and exposure assessment, and risk reduction, as well as problem-oriented research that addresses current critical needs identified by EPA program offices and regions.

This *Asthma Research Strategy* was subjected to external peer review by independent scientific experts. The final Strategy reflects the comments of both internal and external peer review.

Dated: October 2, 2002.

Paul Gilman,

Assistant Administrator for Research and Development.

[FR Doc. 02–27829 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7375–2]

Proposed CERCLA Section 122(h) Administrative Settlement; Martin Young And the Martin Young Trust, Yonkelowitz Junkyard Site, Hoopeston, Vermilion County, Illinois

AGENCY: Environmental Protection Agency.

ACTION: Notice; request for public comment.

SUMMARY: In accordance with section 122(i) of the Comprehensive Environmental Response, Compensation, and Liability Act, as amended (''CERCLA''), 42 U.S.C. 9622(i), notice is hereby given of a proposed administrative settlement for recovery of past response costs concerning the Yonkelowitz Junkyard Site in Hoopeston, Vermilion County, Illinois with the following settling parties: Martin Young and the Martin Young Trust. The settlement requires Martin Young to pay $50,000 to the Hazardous Substance Superfund. Also, the settlement requires the Martin Young Trust to pay to the Hazardous Substance Superfund, within 60 days of receipt, all proceeds received from the sale, lease, transfer, mortgage, grant of, or conveyance of any interest, etc. in property located at the northwest corner of the intersection of First Avenue and Main Street, Hoopeston, Vermilion County, Illinois. The settlement includes a covenant not to sue the settling parties pursuant to section 107(a) of CERCLA, 42 U.S.C. 9607(a), with respect to past response costs. For thirty (30) days following the date of publication of this notice, the Agency will receive written comments relating to the settlement. The Agency will consider all comments received and may modify or withdraw its consent to the settlement if comments received disclose facts or considerations which indicate that the settlement is inappropriate, improper, or inadequate. The Agency's response to any comments received will be available for public inspection at the United States Environmental Protection Agency, Region 5, 77 West Jackson Blvd., Chicago, Illinois 60604–3590.

DATES: Comments must be submitted on or before December 2, 2002.

ADDRESSES: The proposed settlement is available for public inspection at the United States Environmental Protection Agency, Region 5, 77 West Jackson Blvd., Chicago, Illinois 60604–3590. A copy of the proposed settlement may be

obtained from Sally Jansen, Environmental Specialist, United States Environmental Protection Agency, Region 5, 77 West Jackson Blvd. (SE–5J), Chicago, Illinois 60604–3590, (312) 353–9046. Comments should reference the Yonkelowitz Junkyard Site, Hoopeston, Vermilion County, Illinois and EPA Docket No. V–W–'02–C–690 and should be addressed to Diana Embil, Associate Regional Counsel, United States Environmental Protection Agency, Region 5, 77 West Jackson Blvd. (C–14J), Chicago, Illinois 60604–3590, (312) 886–7889.

FOR FURTHER INFORMATION CONTACT: Diana Embil, Associate Regional Counsel, United States Environmental Protection Agency, Region 5, 77 West Jackson Blvd. (C–14J), Chicago, Illinois 60604–3590, (312) 886–7889.

Dated: April 29, 2002.

William E. Muno,

Director, Superfund Division, Evionmental Protection Agency, Region 5.

[FR Doc. 02–27832 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7403–4]

Clean Water Act Class II: Proposed Administrative Penalty Assessments and Opportunities To Comment Regarding Pick Your Part Auto Wrecking—Chula Vista; Pick Your Part Auto Wrecking—Help Yourself; Pick Your Part Auto Wrecking—Santa Paula; Pick Your Part Auto Wrecking—Sun Valley; Pick Your Part Auto Wrecking—Wilmington

AGENCY: Environmental Protection Agency (''EPA'').

ACTION: Notice.

SUMMARY: EPA is providing notice of five proposed administrative penalty assessments for alleged violations of the Clean Water Act (''Act''). EPA is also providing notice of opportunity to comment on the proposed assessments.

EPA is authorized under section 309(g) of the Act, 33 U.S.C. 1319(g), to assess a civil penalty after providing the person subject to the penalty notice of the proposed penalty and the opportunity for a hearing, and after providing interested persons notice of the proposed penalty and a reasonable opportunity to comment on its issuance. Under section 309(g), any person who has violated the conditions of a National Pollutant Discharge Elimination System permit may be assessed a penalty in a ''Class II'' administrative penalty proceeding. Class II proceedings under section 309(g) are conducted in accordance with the ''Consolidated Rules of Practice Governing the Administrative Assessment of Civil Penalties, Issuance of Compliance or Corrective Action Orders, and the Revocation, Termination or Suspension of Permits,'' 40 CFR part 22 (''Consolidated Rules''), published at 64 FR 40138, 40177 (July 23, 1999).

On September 30, 2002, EPA commenced the following Class II proceedings for the assessment of penalties by filing with Danielle Carr, Regional Hearing Clerk, U.S. EPA, Region IX, 75 Hawthorne Street, San Francisco, California 94105, (415) 972–3871, the following Complaints:

In the Matter of Pick Your Part Auto Wrecking—Chula Vista, Docket No. CWA–9–2002–01; Pick Your Part Auto Wrecking—Help Yourself, Docket No. CWA–9–2002–07; Pick Your Part Auto Wrecking—Santa Paula, Docket No. CWA–9–2002–08; Pick Your Part Auto Wrecking—Sun Valley, Docket No. CWA–9–2002–09; Pick Your Part Auto Wrecking—Wilmington, Docket No. CWA–9–2002–10.

Each Complaint proposes a penalty of up to One Hundred Thirty Seven Thousand, Five Hundred Dollars ($137,500) for violations of NPDES Permit No. CAS000001 (issued by the California State Water Resources Control Board (Order No. 97–03–DWQ)) and sections 301(a) and 308(a) of the Act, 33 U.S.C. 1311(a), 1318(a), at Pick Your Part facilities in Chula Vista, Santa Paula, Sun Valley, and Wilmington, California.

The procedures by which the public may comment on a proposed Class II penalty or participate in a Class II penalty proceeding are set forth in the Consolidated Rules. The deadline for submitting public comment on a proposed Class II penalty is thirty (30) days after issuance of public notice. The Regional Administrator of EPA, Region 9, may issue an order upon default if the respondent in the proceeding fails to file a response within the time period specified in the Consolidated Rules.

FOR FURTHER INFORMATION CONTACT: Persons wishing to receive a copy of EPA's Consolidated Rules, review one or more of the Complaints, or other documents filed in these proceedings, comment upon the proposed assessments, or otherwise participate in the proceedings should contact Danielle Carr, Regional Hearing Clerk, U.S. EPA, Region IX, 75 Hawthorne Street, San Francisco, California 94105, (415) 972–3871. The administrative record for this proceeding is located in the EPA Regional Office identified above, and the file will be open for public inspection during normal business hours. All information submitted by Pick Your Part is available as part of the administrative record, subject to provisions of law restricting public disclosure of confidential information. In order to provide opportunity for public comment, EPA will issue no final order assessing a penalty in these proceedings prior to thirty (30) days after the date of publication of this notice.

Cat Kuhlman,

Acting Director, Water Division.

[FR Doc. 02–27831 Filed 10–31–02; 8:45 am]

BILLING CODE 6560–50–P

FARM CREDIT ADMINISTRATION

Farm Credit Administration Board; Regular Meeting

AGENCY: Farm Credit Administration.

SUMMARY: Notice is hereby given, pursuant to the Government in the Sunshine Act (5 U.S.C. 552b(e)(3)), that the November 14, 2002 regular meeting of the Farm Credit Administration Board (Board) will not be held. The FCA Board will hold a special meeting at 9 a.m. on Thursday, November 7, 2002. An agenda for this meeting will be published at a later date.

FOR FURTHER INFORMATION CONTACT: Jeanette C. Brinkley, Acting Secretary to the Farm Credit Administration Board, (703) 883–4009, TTY (703) 883–4056.

ADDRESSES: Farm Credit Administration, 1501 Farm Credit Drive, McLean, Virginia 22102–5090.

Dated: October 29, 2002.

Jeanette C. Brinkley,

Acting Secretary, Farm Credit Administration Board.

[FR Doc. 02–27914 Filed 10–29–02; 4:21 pm]

BILLING CODE 6705–01–P

FEDERAL COMMUNICATIONS COMMISSION

[Report No. AUC–01–32–H (Auction No. 32); DA 02–2623]

Auction No. 32 Construction Permits for New AM Broadcast Stations Scheduled for December 10, 2002; Notice and Filing Requirements, Minimum Opening Bids, Upfront Payments and Other Procedural Issues

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: This document announces the procedures and minimum opening bids for the upcoming auction of construction permits for new AM broadcast stations (Auction No. 32) scheduled to begin December 10, 2002. This document is intended to familiarize prospective bidders with the procedures and minimum opening bids for this auction.

DATES: Auction No. 32 is scheduled to begin on December 10, 2002.

FOR FURTHER INFORMATION CONTACT: Auctions and Industry Analysis Division: Kenneth Burnley, Legal Branch, at (202) 418–0660; Linda Sanderson, or Roy Knowles, Auctions Operations Branch at (717) 338–2888. Media Contact: Meribeth McCarrick at (202) 418–0654. Audio Division: Lisa Scanlan or Edward DeLaHunt at (202) 418–2700.

SUPPLEMENTARY INFORMATION: This is a summary of the *Auction No. 32 Procedures Public Notice* released on October 15, 2002. The complete text of the *Auction No. 32 Procedures Public Notice,* including attachments, 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–B402, Washington, DC 20554. The *Auction No. 32 Procedures Public Notice* 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 to *qualexint@aol.com.*

I. General Information

A. Introduction

1. By the *Auction No. 32 Procedures Public Notice,* the Wireless Telecommunications Bureau (''WTB'') and the Media Bureau (''MB'') (collectively, the ''Bureaus'') announce the procedures and minimum opening bids for the upcoming auction of construction permits for new AM broadcast stations (''Auction No. 32'').[1] On September 16, 2002, in accordance with the Balanced Budget Act of 1997, the Bureaus released the *Auction No. 32 Comment Public Notice,* seeking comment on the establishment of reserve prices and/or minimum opening bids for Auction No. 32. In addition, the Bureaus sought comment on a number of procedures to be used in Auction No. 32. The Bureaus received two comments and one reply comment in response to the *Auction No. 32 Comment Public Notice.*

i. Construction Permits To Be Auctioned

2. Auction No. 32 will include construction permits for three new AM broadcast stations. These construction permits are the subject of pending, mutually exclusive short-form applications (FCC Form 175) filed on or before February 1, 2000, and participation in this auction is limited to the applicants identified in Attachment A of the *Auction No. 32 Procedures Public Notice.* All applications within a mutually exclusive applicant group (''MX Group'') are directly mutually exclusive with one another, and therefore a single AM construction permit will be auctioned for each MX Group identified in Attachment A of the *Auction No. 32 Procedures Public Notice.* The minimum opening bids and upfront payments for these construction permits are also included in Attachment A of the *Auction No. 32 Procedures Public Notice.*

3. *MX Group AM 38:* Applicants Alvin Lou Media, Inc. (''ALM'') and Victor A. Michael (''Michael'') filed comments in response to the *Auction No. 32 Comment Public Notice.* Both request that the auction be held in abeyance pending resolution of their respective Applications for Review, in which ALM and Michael challenge the Media Bureau's finding that ALM and Powell Meredith Communications Company (''PMCC'') should proceed to auction. ALM and Michael both argue that PMCC's technical proposal is unacceptable, and thus PMCC should not be allowed to proceed to auction.

4. The Bureaus will not delay the auction for MX Group AM 38 as requested by the commenters. In the *Broadcast First Report and Order,* 63 FR 48615 (September 11, 1998), the Commission directed the Bureaus to defer technical review until the post-auction submission of long-form applications by the winning bidders. This is consistent with Congress and the Commission's overall objective of minimizing delay in the award of construction permits, and promoting deployment of new broadcasting service to the public as expeditiously as possible. Further, to the extent ALM and Michael rely on pending challenges to the determination that ALM and PMCC should proceed to auction, they have not shown irreparable harm or that the public interest would be served by delaying the auction schedule. Any grant of a construction permit won in competitive bidding remains subject to Commission or judicial review and the ultimate disposition of issues presented on appeal.

5. As stated in the *Broadcast First Report and Order* all pending mutually exclusive applications for broadcast services must be resolved through a system of competitive bidding. When two or more short-form applications are accepted for filing within an MX Group, mutual exclusivity exists for auction purposes. Once mutual exclusivity exists for auction purposes, even if only one applicant within an MX Group submits an upfront payment, that applicant is required to submit a bid in order to obtain the construction permit.

B.Rules and Disclaimers

i. Relevant Authority

6. Prospective bidders must familiarize themselves thoroughly with the Commission's rules relating to the AM broadcast service contained in title 47, part 73 of the Code of Federal Regulations. Prospective bidders must also be familiar with the rules relating to broadcast auctions and competitive bidding proceedings in title 47, part 1, subpart Q and part 73, subpart I of the Commission's rules. Prospective bidders must also be thoroughly familiar with the procedures, terms and conditions contained in the *Auction No. 32 Procedures Public Notice,* the *Auction No. 32 Comment Public Notice,* the *Broadcast First Report and Order,* the *Broadcast Reconsideration Order,* 64 FR 24523 (May 7, 1999), and the *New Entrant Bidding Credit Reconsideration Order,* 64 FR 44856 (August 18, 1999).

7. The terms contained in the Commission's rules, relevant orders, and public notices are not negotiable. The Commission may amend or supplement the information contained in our public notices at any time, and will issue public notices to convey any new or supplemental information to bidders. It is the responsibility of all prospective bidders to remain current with all Commission rules and with all public notices pertaining to this auction. Copies of most Commission documents, including public notices, can be retrieved from the FCC Auctions Internet site at *http://wireless.fcc.gov/auctions.* Additionally, documents are 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 or 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

[1] These procedures were adopted following actual notice and an opportunity to comment provided to all of the parties in this closed auction.

via e-mail qualexint@aol.com. When ordering documents from Qualex, please provide the appropriate FCC number (for example, FCC 98–194 for the *Broadcast First Report and Order* and FCC 99–74 for the *Broadcast Reconsideration Order*).

ii. Prohibition of Collusion

8. Bidders are reminded that § 1.2105(c) of the Commission's rules prohibits competing applicants from communicating with each other during the auction about bids, bidding strategies, or settlements unless they have identified each other as parties with whom they have entered into agreements under § 1.2105(a)(2)(viii). For further details regarding the anti-collusion rule, refer to the *AM Auction Filing Window and Application Freeze Public Notice,* released November 19, 1999. For Auction No. 32, this prohibition became effective at the short-form application deadline (February 1, 2000) and will end on the down payment due date after the auction (to be announced in a future public notice). Applicants certified compliance with § 1.2105(c) when they signed their short-form applications. However, the Bureaus caution that merely filing a certifying statement as part of an application will not outweigh specific evidence that collusive behavior has occurred, nor will it preclude the initiation of an investigation when warranted.

9. Bidders in Auction No. 32 are encouraged not to use the same individual acting as an authorized bidder for any other applicant. A violation of the anti-collusion rule could occur if an individual acts as the authorized bidder for two or more competing applicants, and conveys information concerning the substance of bids or bidding strategies between the bidders he/she is authorized to represent in the auction. A violation could similarly occur if the authorized bidders are different individuals employed by the same organization (*e.g.*, law firm or consulting firm).

10. In addition, § 1.65 of the Commission's rules requires an applicant to *maintain* the accuracy and completeness of information furnished in its pending application and to notify the Commission within 30 days of any substantial change that may be of decisional significance to that application. Thus, § 1.65 requires an auction applicant to notify the Commission of any violation of the anti-collusion rules immediately upon learning of such violation. Bidders therefore are required to make such notification to the Commission immediately upon discovery.

11. A summary listing of documents from the Commission and the Bureaus addressing the application of the anti-collusion rules may be found in Attachment D of the *Auction No. 32 Procedures Public Notice.*

iii. Due Diligence

12. Potential bidders are reminded that they are solely responsible for investigating and evaluating all technical and market place factors that may have a bearing on the value of the AM broadcast facilities in this auction. The FCC makes no representations or warranties about the use of this spectrum for particular services. Applicants should be aware that an FCC auction represents an opportunity to become an FCC permittee in the broadcast service, subject to certain conditions and regulations. An FCC auction does not constitute an endorsement by the FCC of any particular service, technology, or product, nor does an FCC construction permit or license constitute a guarantee of business success. Applicants should perform their individual due diligence before proceeding as they would with any new business venture.

13. Potential bidders are strongly encouraged to conduct their own research prior to Auction No. 32 in order to determine the existence of pending proceedings that might affect their decisions regarding participation in the auction. Participants in Auction No. 32 are strongly encouraged to continue to conduct due diligence examinations regarding pending proceedings and other legal developments with respect to the construction permits for which they may bid during the course of the auction. Bidders should be aware that certain applications (including those for modification), petitions for rulemaking, requests for special temporary authority (''STA''), waiver requests, petition to deny, petitions for reconsideration, and applications for review may be pending before the Commission and relate to particular applicants or the construction permits available in Auction No. 32. In addition, certain judicial proceedings that may relate to particular applicants or the construction permits available in Auction No. 32 may be commenced or may be pending or subject to further review. We note that resolution of these matters could have an impact on the availability of spectrum in Auction No. 32. Some of these matters (whether before the Commission or the courts) may not be resolved at the time of the auction. In the event that a final determination reached in a pending proceeding requires a winning bidder to surrender a construction permit(s) won in Auction No. 32, the Commission will return payments relating to such construction permit(s) to the payor of record. The Commission, however, will not pay interest on the returned payment(s) as it lacks the legal authority to do so.

14. Bidders are solely responsible for identifying associated risks and for investigating and evaluating the degree to which such matters may effect their ability to bid on, otherwise acquire, or make use of the construction permits available in Auction No. 32.

iv. Bidder Alerts

15. By submitting an FCC Form 175 application, applicants have certified under penalty of perjury that they are legally, technically, financially and otherwise qualified to hold a license, and not in default on any payment for Commission licenses or construction permits (including down payments) or delinquent on any non-tax debt owed to any Federal agency. Prospective bidders are reminded that submission of a false certification to the Commission is a serious matter that may result in severe penalties, including monetary forfeitures, license revocations, exclusion from participation in future auctions, and/or criminal prosecution.

16. As is the case with many business investment opportunities, some unscrupulous entrepreneurs may attempt to use Auction No. 32 to deceive and defraud unsuspecting investors. Common warning signals of fraud include the following:

- The first contact is a ''cold call'' from a telemarketer, or is made in response to an inquiry prompted by a radio or television infomercial.
- The offering materials used to invest in the venture appear to be targeted at IRA funds, for example by including all documents and papers needed for the transfer of funds maintained in IRA accounts.
- The amount of the minimum investment is less than $25,000.
- The sales representative makes verbal representations that: (a) The Internal Revenue Service (''IRS''), Federal Trade Commission (''FTC''), Securities and Exchange Commission (''SEC''), FCC, or other government agency has approved the investment; (b) the investment is not subject to state or federal securities laws; or (c) the investment will yield unrealistically high short-term profits. In addition, the offering materials often include copies of actual FCC releases, or quotes from FCC personnel, giving the appearance of

FCC knowledge or approval of the solicitation.

Information about deceptive telemarketing investment schemes is available from the FTC at (202) 326–2222 and from the SEC at (202) 942–7040. Complaints about specific deceptive telemarketing investment schemes should be directed to the FTC, the SEC, or the National Fraud Information Center at (800) 876–7060. Consumers who have concerns about specific proposals may also call the FCC Consumer Center at (888) CALL–FCC ((888) 225–5322).

v. National Environmental Policy Act (NEPA) Requirements

17. Permittees must comply with the Commission's rules regarding the National Environmental Policy Act (NEPA). The construction of a broadcast antenna facility is a federal action and the permittee must comply with the Commission's NEPA rules for each such facility. The Commission's NEPA rules require, among other things, that the permittee consult with expert agencies having NEPA responsibilities, including the U.S. Fish and Wildlife Service, the State Historic Preservation Office, the Army Corp of Engineers and the Federal Emergency Management Agency (through the local authority with jurisdiction over floodplains). The permittee must prepare environmental assessments for facilities that may have a significant impact in or on wilderness areas, wildlife preserves, threatened or endangered species or designated critical habitats, historical or archaeological sites, Indian religious sites, floodplains, and surface features. The permittee must also prepare environmental assessments for facilities that include high intensity white lights in residential neighborhoods or excessive radio frequency emission.

C. Auction Specifics

i. Auction Date

18. Auction No. 32—will begin on Tuesday, December 10, 2002. The initial schedule for bidding will be announced by public notice at least one week before the start of the auction. Unless otherwise announced, bidding on all construction permits will be conducted on each business day until bidding has stopped on all construction permits.

ii. Auction Title

19. Auction No. 32—New AM Broadcast Stations.

iii. Bidding Methodology

20. The bidding methodology for Auction No. 32 will be simultaneous multiple round bidding. The Commission will conduct this auction over the Internet. Telephonic bidding will also be available. As a contingency, the FCC Wide Area Network will be available as well. Qualified bidders are permitted to bid telephonically or electronically.

iv. Pre-Auction Dates and Deadlines

21. Listed are important dates associated with Auction No. 32:

Auction Seminar—November 6, 2002
Upfront Payments (via wire transfer)—November 15, 2002; 6 p.m. ET
Mock Auction—December 5, 2002
Auction Begins—December 10, 2002

v. Requirements for Participation

22. Those wishing to participate in the auction must:

- Be listed on Attachment A of the *Auction No. 32 Procedures Public Notice*.
- Submit a sufficient upfront payment and an FCC Remittance Advice Form (FCC Form 159) by 6 p.m. ET, November 15, 2002.
- Comply with all provisions outlined in this public notice and applicable Commission rules.

vi. General Contact Information

23. The following is a list of general contact information relating to Auction No. 32.

General Auction Information: General Auction Questions, Seminar Registration
FCC Auctions Hotline, (888) 225–5322, Press Option #2, or direct (717) 338–2888, Hours of service: 8 a.m.—5:30 p.m. ET
Auction Legal Information: Auction Rules, Policies, Regulations
Auctions and Industry Analysis Division, Legal Branch (202) 418–0660
Licensing Information: Rules, Policies, Regulations, Licensing Issues, Due Diligence, Incumbency Issues
Audio Division, (202) 418–2700
Technical Support: Electronic Filing, Automated Auction System
FCC Auctions Technical Support Hotline, (202) 414–1250 (Voice), (202) 414–1255 (TTY), Hours of service: Monday through Friday 8 a.m. to 6 p.m. ET
Payment Information: Wire Transfers, Refunds
FCC Auctions Accounting Branch, (202) 418–1995, (202) 418–2843 (Fax)
Telephonic Bidding:
Will be furnished only to qualified bidders
FCC Copy Contractor: Additional Copies of Commission Documents
Qualex International, Portals II, 445 12th Street, SW., Room CY–B402, Washington, DC 20554, (202) 863–2893, (202) 863–2898, (Fax) *qualexint@aol.com* (E-mail)
Press Information:
Meribeth McCarrick (202) 418–0654
FCC Forms:
(800) 418–3676 (outside Washington, DC), (202) 418–3676 (in the Washington Area) *http://www.fcc.gov/formpage.html*
FCC Internet Sites:
http://www.fcc.gov, http://wireless.fcc.gov/auctions

II. Short-Form (FCC Form 175) Application Requirements

A. Maintaining the Accuracy of FCC Form 175 Information

24. As noted in the *Auction No. 32 Comment Public Notice,* and under 47 CFR 1.65, applicants have an obligation to maintain the completeness and accuracy of information in their short-form applications. Amendments reporting substantial changes of possible decisional significance in information contained in short-form applications, as defined by 47 CFR 1.2105(b)(2), will not be accepted and may in some instances result in the dismissal of the short-form application. Applicants should report these modifications to their FCC Form 175 by electronic mail and submit a letter, briefly summarizing the changes, to the attention of Margaret Wiener, Chief, Auctions and Industry Analysis Division, at the following address: *auction32@fcc.gov.* The electronic mail summarizing the changes must include a subject or caption referring to Auction No. 32. The Bureaus request that parties format any attachments to electronic mail as Adobe® Acrobat® (pdf) or Microsoft® Word documents.

25. A separate copy of the letter should be faxed to the attention of Kathryn Garland at (717) 338–2850. Questions about other changes should be directed to Kenneth Burnley of the Auctions and Industry Analysis Division at (202) 418–0660.

26. In addition, applicants should make these changes to their FCC Form 175 applications on-line after release of the public notice explaining the status of the applications.

B. Requirements for Logging on to the FCC Auction 175 Application & Search System

27. Although applicants submitted their original FCC Form 175 applications by using a Taxpayer Identification Number (TIN), any review of and updates to these applications will require the use of an FCC Registration Number (FRN). On August 24, 2001, the

FCC adopted a rule requiring all persons and entities doing business with the FCC to acquire a unique identifying number called the FRN and to provide it with all applications or feeable filings as well as other transactions involving payment of money. This requirement became effective on December 3, 2001. Use of an FRN is mandatory for all filers logging on to the FCC Auctions 175 Application & Search system.

28. To obtain an FRN, an applicant must register their TIN using the CORES. To access CORES, point web browser to the FCC Auctions page at *http://wireless.fcc.gov/auctions/* and click the CORES link under Related Sites. Next, follow the directions provided to register and receive your FRN. Applicants need to be sure to retain this number and password and keep such information strictly confidential.

29. A filing window for review and resubmission of FCC Form 175 applications will open after the future release of a public notice announcing the status of applications. This public notice announcing the status of applications will contain additional information for reviewing and accessing applications.

30. *Very Important*: Before logging on to the FCC Form 175 Applications & Search system, *all* applicants must send their FRN to the FCC Operations Group. To do this, include entity name, TIN, and FRN in an e-mail to *auction32@fcc.gov* or fax to Kathryn Garland at (717) 338–2850. This information *must* be received by 5 p.m. ET, Friday, October 25, 2002. For further information, contact: FCC Technical Support at (202) 414–1250. Hours of service: Monday through Friday 8 a.m. to 6 p.m. ET.

C. Electronic Review of Short-Form Applications (FCC Form 175)

31. As noted in the *Auction Filing Window Public Notice,* 66 FR 33699 (June 25, 2001), applicants may review their own and other applicants' completed FCC Form 175s after the FCC has issued a public notice concerning the status of the applications. The FCC Form 175 electronic review system will be available at that time, and may be used to locate and print applicants' FCC Form 175 information. Applicants will also be able to view other applicants' completed FCC Form 175 applications. There is no fee for accessing this system. Instructions for electronic review of FCC Form 175 applications will be discussed in the public notice concerning the status of the applications.

D. Installment Payments

32. Installment payment plans will not be available in Auction No. 32.

III. Pre-Auction Procedures

A. Application Processing and Minor Corrections

33. The FCC will process all timely submitted applications to determine which are acceptable for filing, and subsequently will issue a public notice identifying: (i) Those applications accepted for filing; (ii) those applications rejected; and (iii) those applications which have minor defects that may be corrected, and the deadline for filing such corrected applications.

34. As described more fully in the Commission's rules, after the short-form filing deadline, applicants may make only minor corrections to their FCC Form 175 applications. For example, permissible minor changes include deletion and addition of authorized bidders (to a maximum of three) and certain revision of exhibits. Applicants will not be permitted to make major modifications to their applications (*e.g.*, change their construction permit selections, change the engineering information submitted with the FCC Form 175, change the certifying official, changes in ownership of the applicant that would constitute a change of control of the applicant, or changes affecting eligibility for the new entrant bidding credit).

B. Auction Seminar

35. On November 6, 2002, the FCC will sponsor a free seminar for Auction No. 32 at the Federal Communications Commission, located at 445 12th Street, SW. (Room 4–B516), Washington, DC. The seminar will provide attendees with information about pre-auction procedures, conduct of the auction, FCC Automated Auction System, and the broadcast service and auction rules. The seminar will also provide an opportunity for prospective bidders to ask questions of FCC staff.

36. To register, complete the registration form included as Attachment B of the *Auction No. 32 Procedures Public Notice* and submit it by Monday, November 4, 2002. Registrations are accepted on a first-come, first-served basis.

C. Upfront Payments—Due November 15, 2002

37. In order to be eligible to bid in the auction, applicants must submit an upfront payment accompanied by an FCC Remittance Advice Form (FCC Form 159). After the FCC Form 175 becomes available electronically, filers will have access to an electronic version of the FCC Form 159 that can be printed and faxed to Mellon Bank in Pittsburgh, PA. All upfront payments must be received at Mellon Bank by 6 p.m. ET on November 15, 2002.

Please note that:

- All payments must be made in U.S. dollars.
- All payments must be made by wire transfer.
- Upfront payments for Auction No. 32 go to a lockbox number different from the ones used in previous FCC auctions, and different from the lockbox number to be used for post-auction payments.
- Failure to deliver the upfront payment by the November 15, 2002 deadline will result in dismissal of the application and disqualification from participation in the auction.

i. Making Auction Payments by Wire Transfer

38. Wire transfer payments must be received by 6 p.m. ET on November 15, 2002. To avoid untimely payments, applicants should discuss arrangements (including bank closing schedules) with their banker several days before they plan to make the wire transfer, and allow sufficient time for the transfer to be initiated and completed before the deadline. Applicants will need the following information:

ABA Routing Number: 043000261
Receiving Bank: Mellon Pittsburgh
BENEFICIARY (BNF): FCC/Account # 910–1203
OBI Field: (Skip one space between each information item)
''AUCTIONPAY''
FCC REGISTRATION NUMBER (FRN): (same as FCC Form 159, block 11 and/or 21)
PAYMENT TYPE CODE (same as FCC Form 159, block 24A: A32U)
FCC CODE 1 (same as FCC Form 159, block 28A: ''32'')
PAYER NAME (same as FCC Form 159, block 2)
LOCKBOX NO. # 358425

Note: The BNF and Lockbox number are specific to the upfront payments for this auction; do not use BNF or Lockbox numbers from previous auctions.

39. Applicants must fax a completed FCC Form 159 (Revised 2/00) to Mellon Bank at (412) 209–6045 at least one hour before placing the order for the wire transfer (but on the same business day). On the cover sheet of the fax, write ''Wire Transfer—Auction Payment for Auction Event No. 32.'' Bidders should confirm receipt of their upfront payment at Mellon Bank by contacting their sending financial institution.

ii. FCC Form 159

40. A completed FCC Remittance Advice Form (FCC Form 159, Revised 2/00) must be faxed to Mellon Bank in order to accompany each upfront payment. Proper completion of FCC Form 159 (Revised 2/00) is critical to ensuring correct credit of upfront payments. Detailed instructions for completion of FCC Form 159 are included in Attachment C of the *Auction No. 32 Procedures Public Notice.* An electronic version of the FCC Form 159 will be accessible after the FCC Form 175 becomes available electronically. The FCC Form 159 can be completed electronically, but must be filed with Mellon Bank via facsimile.

iii. Amount of Upfront Payment

41. The Commission delegated to the Bureaus the authority and discretion to determine appropriate upfront payment(s) for each auction. In addition, in the *Part 1 Fifth Report and Order,* 65 FR 52323 (August 29, 2000), the Commission ordered that ''former defaulters,'' *i.e.*, applicants that have ever been in default on any Commission licenses or have ever been delinquent on any non-tax debt owed to any Federal agency, be required to pay upfront payments fifty percent greater than non-former defaulters.''

42. In the *Auction No. 32 Comment Public Notice,* we proposed translating bidders' upfront payments to bidding units to define a bidder's maximum initial eligibility. In order to bid on a construction permit, otherwise qualified bidders who applied for that construction permit on Form 175 must have an eligibility level that meets the number of bidding units assigned to that construction permit. An applicant's total upfront payment must be enough to establish eligibility to bid on the construction permit applied for on Form 175, or else the applicant will not be eligible to participate in the auction. No comments were received; therefore, we adopt our proposal. The specific upfront payments and bidding units for each construction permit are set forth in Attachment A of the *Auction No. 32 Procedures Public Notice.*

43. Former defaulters should calculate their upfront payment for all construction permits by multiplying the number of bidding units they wish to purchase by 1.5. In order to calculate the number of bidding units to assign to former defaulters, the Commission will divide the upfront payment received by 1.5 and round the result up to the nearest bidding unit.

Note: An applicant's actual bidding in any round will be limited by the bidding units reflected in its upfront payment, in conjunction with the selections made on the FCC Form 175.

iv. Applicant's Wire Transfer Information for Purposes of Refunds

44. The Commission will use wire transfers for all Auction No. 32 refunds. To ensure that refunds of upfront payments are processed in an expeditious manner, the Commission is requesting that all pertinent information as listed be supplied to the FCC. Applicants can provide the information electronically after the FCC Form 175 becomes available for review. Wire Transfer Instructions can also be manually faxed to the FCC, Financial Operations Center, Auctions Accounting Group, ATTN: Tim Dates or Gail Glasser, at (202) 418–2843 by November 15, 2002. All refunds will be returned to the payer of record as identified on the FCC Form 159 unless the payer submits written authorization instructing otherwise. For additional information, please call (202) 418–1995.

Name of Bank
ABA Number
Contact and Phone Number
Account Number to Credit
Name of Account Holder
FCC Registration Number (FRN)
Taxpayer Identification Number
Correspondent Bank (if applicable)
ABA Number
Account Number

(Applicants should also note that implementation of the Debt Collection Improvement Act of 1996 requires the FCC to obtain a Taxpayer Identification Number (TIN) before it can disburse refunds.) Eligibility for refunds is discussed in section V.D.

D. Auction Registration

45. Approximately ten days before the auction, the FCC will issue a public notice announcing all qualified bidders for the auction. Qualified bidders are those applicants whose FCC Form 175 applications have been accepted for filing and have timely submitted upfront payments sufficient to make them eligible to bid on the construction permit for which they applied.

46. All qualified bidders are automatically registered for the auction. Registration materials will be distributed prior to the auction by two separate overnight mailings, one containing the confidential bidder identification number (BIN) required to place bids and the other containing the SecurID cards. These mailings will be sent only to the contact person at the contact address listed in the FCC Form 175.

47. Applicants that do not receive both registration mailings will not be able to submit bids. Therefore, any qualified applicant that has not received both mailings by noon on Tuesday, December 3, 2002, should contact the Auctions Hotline at 717–338–2888. Receipt of both registration mailings is critical to participating in the auction and each applicant is responsible for ensuring it has received all of the registration material.

48. Qualified bidders should note that lost bidder identification numbers or SecurID cards can be replaced only by appearing *in person* at the FCC Auction Headquarters located at 445 12th Street, SW., Washington, DC 20554. Only an authorized representative or certifying official, as designated on an applicant's FCC Form 175, may appear in person with two forms of identification (one of which must be a photo identification) in order to receive replacements. Qualified bidders requiring replacements must call Technical Support prior to arriving at the FCC.

E. Electronic Bidding

49. The Commission will conduct this auction over the Internet. Telephonic bidding will also be available. As a contingency, the FCC Wide Area Network will be available as well. The telephone number through which the backup FCC Wide Area Network may be accessed will be announced in a later public notice. Qualified bidders are permitted to bid telephonically or electronically, *i.e.*, over the Internet or the FCC's Wide Area Network. In either case, each authorized bidder must have its own Remote Security Access SecurID card, which the FCC will provide at no charge. Each applicant with less than three authorized bidders will be issued two SecurID cards, while applicants with three authorized bidders will be issued three cards. For security purposes, the SecurID cards and the FCC Automated Auction System user manual are only mailed to the contact person at the contact address listed on the FCC Form 175. Please note that each SecurID card is tailored to a specific auction, therefore, SecurID cards issued for other auctions or obtained from a source other than the FCC will not work for Auction No. 32. The telephonic bidding phone number will be supplied in the first overnight mailing of the confidential bidder identification number. Each applicant's bidding preference has been defaulted to electronic. Applicants should modify this preference during the FCC Form 175 resubmit window if they intend to bid telephonically.

50. Please note that the SecurID cards can be recycled, and we encourage bidders to return the cards to the FCC. We will provide pre-addressed envelopes that bidders may use to return the cards once the auction is over.

F. Mock Auction

51. All qualified bidders will be eligible to participate in a mock auction on Thursday, December 5, 2002. The mock auction will enable applicants to become familiar with the FCC Automated Auction System prior to the auction. Participation by all bidders is strongly recommended. Details will be announced by public notice.

IV. Auction Event

52. The first round of bidding for Auction No. 32 will begin on Tuesday, December 10, 2002. The initial bidding schedule will be announced in the public notice listing the qualified bidders, which is released approximately 10 days before the start of the auction.

A. Auction Structure

i. Simultaneous Multiple Round Auction

53. In the *Auction No. 32 Comment Public Notice*, we proposed to award all construction permits in a simultaneous multiple round auction. We received no comments on this issue. We therefore conclude that it is operationally feasible and appropriate to auction the new AM broadcast station construction permits through a simultaneous multiple round auction. Unless otherwise announced, bids will be accepted from eligible bidders on all construction permits in each round of the auction.

ii. Maximum Eligibility and Activity Rules

54. In the *Auction No. 32 Comment Public Notice*, we proposed that the amount of the upfront payment submitted by a bidder would determine the maximum initial eligibility (as measured in bidding units) for each bidder. We received no comments on this issue.

55. For Auction No. 32, we adopt our proposal. The amount of the upfront payment submitted by a bidder determines the maximum initial eligibility (in bidding units) for each bidder. Note again that each construction permit is assigned a specific number of bidding units equal to the upfront payment listed in Attachment A of the *Auction No. 32 Procedures Public Notice* on a bidding unit per dollar basis. The total upfront payment defines the maximum number of bidding units on which the applicant will be permitted to bid and hold high bids. As there is no provision for increasing a bidder's maximum eligibility during the course of an auction, prospective bidders are cautioned to calculate their upfront payments carefully. The total upfront payment does not affect the total dollars a bidder may bid on any given construction permit.

56. In addition, we received no comments on our proposal for a single stage auction. Therefore, in order to ensure that the auction closes within a reasonable period of time, we adopt our proposal with the following activity requirements: a bidder must either, place a valid bid and/or be the standing high bidder during each round of the auction rather than wait until the end before participating. A bidder is required to be active on 100 percent of their bidding eligibility. Failure to maintain the requisite activity level will result in the use of an activity rule waiver, if any remain, or a reduction in the bidder's bidding eligibility, thus eliminating them from the auction.

iii. Activity Rule Waivers and Reducing Eligibility

57. In the *Auction No. 32 Comment Public Notice*, we proposed that each bidder in the auction would be provided three activity rule waivers. Bidders may use an activity rule waiver in any round during the course of the auction. We received no comments on this issue.

58. Based upon our experience in previous auctions, we adopt our proposal that each bidder be provided three activity rule waivers that may be used in any round during the course of the auction. Use of an activity rule waiver preserves the bidder's current bidding eligibility despite the bidder's activity in the current round being below the required minimum level. An activity rule waiver applies to an entire round of bidding. We are satisfied that our practice of providing three waivers over the course of the auction provides a sufficient number of waivers and flexibility to the bidders, while safeguarding the integrity of the auction.

59. The FCC Automated Auction System assumes that bidders with insufficient activity would prefer to use an activity rule waiver (if available) rather than lose bidding eligibility. Therefore, the system will automatically apply a waiver (known as an ''automatic waiver'') at the end of any bidding period where a bidder's activity level is below the minimum required. If a bidder has no waivers remaining and does not satisfy the required activity level, the bidder's eligibility will be permanently reduced, eliminating them from the auction.

60. A bidder may proactively use an activity rule waiver as a means to keep the auction open without placing a bid. If a bidder submits a proactive waiver (using the proactive waiver function in the bidding system) during a bidding period in which no bids are submitted, the auction will remain open and the bidder's eligibility will be preserved. An automatic waiver invoked in a round in which there are no new valid bids will not keep the auction open. Note: Once a proactive waiver is placed during a round, that waiver cannot be unsubmitted.

iv. Auction Stopping Rules

61. For Auction No. 32, the Bureaus proposed to employ a simultaneous stopping rule. Under this rule, bidding will remain open on all construction permits until bidding stops on every construction permit. The auction will close for all construction permits when one round passes during which no bidder submits a new acceptable bid on any construction permit, or applies a proactive waiver. After the first such round, bidding closes simultaneously on all construction permits.

62. The Bureaus also proposed retaining discretion to implement a modified version of the simultaneous stopping rule. The modified version will close the auction for all construction permits after the first round in which no bidder submits a proactive waiver, or a new bid on any construction permit on which it is not the standing high bidder. Thus, absent any other bidding activity, a bidder placing a new bid on a construction permit for which it is the standing high bidder will not keep the auction open under this modified stopping rule.

63. The Bureaus further proposed retaining the discretion to keep the auction open even if no new acceptable bids or proactive waivers are submitted in a round. In this event, the effect will be the same as if a bidder had submitted a proactive waiver. Thus, the activity rule will apply as usual, and a bidder with insufficient activity will either lose bidding eligibility or use an activity rule waiver (if any remain).

64. In addition, the Bureaus proposed that they reserve the right to declare that the auction will end after a designated number of additional rounds (''special stopping rule''). If the Bureaus invoke this special stopping rule, it will accept bids in the final round(s) only for construction permits on which the high bid increased in at least one of the preceding specified number of rounds. The Bureaus proposed to exercise this

option only in circumstances such as where the auction is proceeding very slowly, where there is minimal overall bidding activity or where it appears likely that the auction will not close within a reasonable period of time. Before exercising this option, the Bureaus are likely to attempt to increase the pace of the auction by, for example, increasing the number of bidding rounds per day, and/or adjusting the amount of the minimum bid increments for the construction permits.

65. The Bureaus received no comments on these issues, therefore, we adopt all of the proposals concerning the auction stopping rules. Auction No. 32 will begin under the simultaneous stopping rule, and the Bureaus will retain the discretion to invoke the other versions of the stopping rule. The Bureaus believe that these stopping rules are most appropriate for Auction No. 32, because their experience in prior auctions demonstrates that the auction stopping rules balance the interests of administrative efficiency and maximum bidder participation.

v. Auction Delay, Suspension, or Cancellation

66. In the *Auction No. 32 Comment Public Notice*, the Bureaus proposed that, by public notice or by announcement during the auction, the Bureaus may delay, suspend, or cancel the auction in the event of natural disaster, technical obstacle, evidence of an auction security breach, unlawful bidding activity, administrative or weather necessity, or for any other reason that affects the fair conduct of competitive bidding.

67. Because this approach has proven effective in resolving exigent circumstances in previous auctions, we adopt our proposed auction cancellation rules. By public notice or by announcement during the auction, the Bureaus may delay, suspend or cancel the auction in the event of natural disaster, technical obstacle, evidence of an auction security breach, unlawful bidding activity, administrative or weather necessity, or for any other reason that affects the fair and competitive conduct of competitive bidding. In such cases, the Bureaus, in their sole discretion, may elect to resume the auction starting from the beginning of the current round, resume the auction starting from some previous round, or cancel the auction in its entirety. Network interruption may cause the Bureaus to delay or suspend the auction. We emphasize that exercise of this authority is solely within the discretion of the Bureaus, and its use is not intended to be a substitute for situations in which bidders may wish to apply their activity rule waivers.

B. Bidding Procedures

i. Round Structure

68. The initial bidding schedule will be announced in the public notice listing the qualified bidders, which is released approximately 10 days before the start of the auction. The round structure for each bidding round contains a single bidding round followed by the release of the round results. Multiple bidding rounds may be conducted in a given day. Details regarding round result formats and locations will also be included in the qualified bidders public notice referenced.

69. The Bureaus have the discretion to change the bidding schedule in order to foster an auction pace that reasonably balances speed with the bidders' need to study round results and adjust their bidding strategies. The Bureaus may increase or decrease the amount of time for the bidding rounds and review periods, or the number of rounds per day, depending upon the bidding activity level and other factors.

ii. Reserve Price or Minimum Opening Bid

70. *Background.* The Balanced Budget Act calls upon the Commission to prescribe methods by which a reasonable reserve price will be required or a minimum opening bid established when FCC licenses or construction permits are subject to auction (*i.e.*, because mutually exclusive applications have been accepted), unless the Commission determines that a reserve price or minimum opening bid is not in the public interest. Consistent with this mandate, the Commission directed the Bureaus to seek comment on the use of a minimum opening bid and/or reserve price prior to the start of each auction. Among other factors, the Bureaus must consider the amount of spectrum being auctioned, levels of incumbency, the availability of technology to provide service, the size of the geographic service areas, the extent of interference with other spectrum bands, and any other relevant factors that could have an impact on valuation of the spectrum being auctioned. The Commission concluded that the Bureaus should have the discretion to employ either or both of these mechanisms for future auctions.

71. In the *Auction No. 32 Comment Public Notice,* the Bureaus proposed to establish minimum opening bids for Auction No. 32 and to retain discretion to lower the minimum opening bids. Specifically, for Auction No. 32, the Bureaus proposed calculating the minimum opening bid based on the potential value of the spectrum, including the type of service, market size, industry cash flow data and recent broadcast transactions. The Bureaus received no comments on this issue, therefore, they adopt their proposal. The specific minimum opening bids for each construction permit are set forth in Attachment A of the *Auction No. 32 Procedures Public Notice.*

iii. Minimum Accepted Bids and Bid Increments

72. In the *Auction No. 32 Comment Public Notice,* the Bureaus proposed to use a fixed percentage to calculate minimum acceptable bids. They further proposed to retain the discretion to change the minimum acceptable bids and bid increments if circumstances so dictate. The Bureaus received no comment on this issue.

73. In each round, each eligible bidder will be able to place a bid on the particular construction permit for which it applied in any of nine different amounts. The Auctions Bidding System interface will list the nine acceptable bid amounts for each construction permit.

74. For Auction No. 32, the Bureaus proposed to use a fixed 10 percent bid increment. This means that the minimum acceptable bid for a construction permit will be approximately 10 percent greater than the previous standing high bid received on the construction permit. The minimum acceptable bid amount will be calculated by multiplying the standing high bid times one plus the fixed percentage—*i.e.*, minimum acceptable bid amount = (standing high bid) * (1.10){rounded}. We will round the result using our standard rounding procedure for minimum acceptable bid calculations: results above $10,000 are rounded to the nearest $1,000; results below $10,000 but above $1,000 are rounded to the nearest $100; and results below $1,000 are rounded to the nearest $10.

75. At the start of the auction and until a bid has been placed on a construction permit, the minimum acceptable bid for that construction permit will be equal to its minimum opening bid. Corresponding additional bid amounts will be calculated using bid increments defined as the difference between the minimum opening bid times one plus the percentage increment, rounded as described, and the minimum opening bid—*i.e.*, bid increment = (minimum opening bid)(1 + percentage increment){rounded} − (minimum opening bid). At the start of

the auction and until a bid has been placed on a construction permit, the nine acceptable bid amounts for each construction permit consist of the minimum opening bid and additional amounts are calculated using multiple bid increments (*i.e.*, the second bid amount equals the minimum opening bid plus the bid increment, the third bid amount equals the minimum opening bid plus two times the bid increment, etc.).

Example bid amount calculation for construction permits at the start of the auction and without standing high bids:

1st bid amount = minimum opening bid
2nd bid amount = minimum opening bid + (bid increment)
3rd bid amount = minimum opening bid + 2(bid increment)
* * * * *
9th bid amount = minimum opening bid + 8(bid increment)

76. Once there is a standing high bid on the construction permit, the Auctions Bidding System will calculate a minimum acceptable bid for that construction permit for the following round, as described. The difference between the minimum acceptable bid and the standing high bid for each construction permit will define the bid increment—*i.e.*, bid increment = (minimum acceptable bid)—(standing high bid). The nine acceptable bid amounts for each construction permit consist of the minimum acceptable bid (the standing high bid plus one bid increment) and additional amounts calculated using multiple bid increments (*i.e.*, the second bid amount equals the standing high bid plus two times the bid increment, the third bid amount equals the standing high bid plus three times the bid increment, etc.).

Example bid amount calculation for construction permits with standing high bids:

1st bid amount = standing high bid + bid increment
2nd bid amount = standing high bid +2(bid increment)
3rd bid amount = standing high bid +3(bid increment)
* * * * *
9th bid amount = standing high bid +9(bid increment)

77. The Bureaus retain the discretion to change the minimum acceptable bids and bid increments and the methodology for determining the minimum acceptable bids and bid increments if they determine circumstances so dictate. The Bureaus will do so by announcement in the FCC Automated Auction System. The Bureaus may also use its discretion to adjust the minimum bid increment without prior notice if circumstances warrant.

iv. High Bids

78. At the end of each round, the FCC Automated Auction System determines the standing high bid for each construction permit based on the gross dollar amounts of the bids received for each construction permit.

79. In the case of tied high bids, a random number generator will be used to determine the standing high bid. A random number will be assigned to each bid. The tie bid having the highest random number will become the standing high bid.

v. Bidding

80. During a bidding round, a bidder may submit a bid, subject to its eligibility, as well as remove a bid placed in the same bidding round. Bidders also have the option of making multiple submissions in each bidding round. If a bidder submits multiple bids for a construction permit in the same round, the system takes the last bid entered as that bidder's bid for the round. Bidders should note that the bidding units associated with the construction permit for which the bidder has removed its bid do not count towards the bidder's activity at the close of the round.

81. Please note that all bidding will take place remotely either through the FCC Automated Auction System or by telephonic bidding. (Telephonic bid assistants are required to use a script when entering bids placed by telephone. Telephonic bidders are therefore reminded to allow sufficient time to bid by placing their calls well in advance of the close of a round. Normally, four to five minutes are necessary to complete a bid submission.) There will be no on-site bidding during Auction No. 32.

82. A bidder's ability to bid on a specific construction permit in the first round of the auction is determined by two factors: (i) The construction permit applied for on FCC Form 175 and (ii) the upfront payment amount deposited. The bid submission screens will allow bidders to submit bids on only the construction permit for which the bidder applied on its FCC Form 175.

83. The FCC Automated Auction System requires each bidder to be logged in during the bidding round using the bidder identification number provided in the registration materials, and the generated SecurID code. Bidders are strongly encouraged to print bid confirmations *after* they submit their bids.

84. In each round, eligible bidders will be able to place bids on a given construction permit in any of nine different amounts. For each construction permit, the FCC Automated Auction System interface will list the nine acceptable bid amounts in a drop-down box. Bidders may use the drop-down box to select from among the nine acceptable bid amounts. The FCC Automated Auction System also includes an import function that allows bidders to upload text files containing their bid information.

85. Until a bid has been placed on a construction permit, the minimum acceptable bid for that construction permit will be equal to its minimum opening bid. Once there is a standing high bid on a construction permit, the FCC Automated Auction System will calculate a minimum acceptable bid for that construction permit for the following round, as described in section IV.B.iii.

vi. Bid Removal and Bid Withdrawal

86. In the *Auction No. 32 Comment Public Notice,* we proposed bid removal and bid withdrawal procedures. With respect to bid withdrawals, we proposed that bidders not be permitted to withdraw bids in any round. We received no comments on this issue. Therefore, the Bureaus adopt their proposal and will not permit bidders to withdrawal bids in any round during the auction.

87. Bid Removal Procedures. Before the close of a bidding round, a bidder has the option of removing any bids placed in that round. By using the ''remove bid'' function in the bidding system, a bidder may effectively ''unsubmit'' any bid placed within that round. Removing a bid will affect a bidder's activity for the round in which it is removed, *i.e.*, a bid that is subsequently removed does not count toward the bidder's activity requirement. Once a round closes, a bidder may no longer remove a bid. No comments were received on this issue, therefore, we adopt these procedures for Auction No. 32.

vii. Round Results

88. Bids placed during a round will not be published until the conclusion of that bidding period. After a round closes, the Bureaus will compile reports of all bids placed, current high bid, new minimum accepted bid, and bidder eligibility status (bidding eligibility and activity rule waivers), and post the reports for public access. Reports reflecting bidders' identities and bidder identification numbers for Auction No. 32 will be available before and during

the auction. Thus, bidders will know in advance of this auction the identities of the bidders against which they are bidding.

viii. Auction Announcements

89. The FCC will use auction announcements to announce items such as schedule changes. All FCC auction announcements will be available by clicking a link on the FCC Automated Auction System.

V. Post-Auction Procedures

A. Down Payments

90. After bidding has ended, the Commission will issue a public notice declaring the auction closed, identifying the winning bidders and winning bids for each construction permit, and any down payments due.

91. Within ten business days after release of the auction closing notice, each winning bidder must submit sufficient funds (in addition to its upfront payment) to bring its total amount of money on deposit with the Government to 20 percent of its net winning bids (actual bids less any applicable bidding credit).

B. Long-Form Application

92. Within thirty days after release of the auction closing public notice, winning bidders must electronically submit a properly completed long-form application and required exhibits for the construction permit won through Auction No. 32. Winning bidders that are claiming new entrant status must include an exhibit demonstrating their eligibility for the bidding credit. Further filing instructions will be provided to the auction winners at the close of the auction.

C. Default and Disqualification

93. Any high bidder that defaults or is disqualified after the close of the auction (*i.e.*, fails to remit the required down payment within the prescribed period of time, fails to submit a timely long-form application, fails to make full payment, or is otherwise disqualified) will be subject to the payments described in 47 CFR 1.2104(g)(2). In such event the Commission may re-auction the construction permit or offer it to the next highest bidder (in descending order) at their final bid. In addition, if a default or disqualification involves gross misconduct, misrepresentation, or bad faith by an applicant, the Commission may declare the applicant and its principals ineligible to bid in future auctions, and may take any other action that it deems necessary, including institution of proceedings to revoke any existing licenses or construction permits held by the applicant.

D. Refund of Remaining Upfront Payment Balance

94. All applicants that submitted upfront payments but were not winning bidders for a construction permit in Auction No. 32 will be entitled to a refund of their upfront payment balance after the conclusion of the auction. All refunds will be returned to the payer of record, as identified on the FCC Form 159, unless the payer submits written authorization instructing otherwise.

95. Qualified bidders that have exhausted all of their activity rule waivers and have no remaining bidding eligibility must submit a written refund request. If you have completed the refund instructions electronically, then only a written request for the refund is necessary. If not, the request must also include wire transfer instructions, Taxpayer Identification Number (TIN) and FCC Registration Number (FRN). Send refund request to: Federal Communications Commission, Financial Operations Center, Auctions Accounting Group, Gail Glasser or Tim Dates, 445 12th Street, SW., Room 1–C863, Washington, DC 20554.

96. Bidders are encouraged to file their refund information electronically using the refund information portion of the FCC Form 175, but bidders can also fax their information to the Auctions Accounting Group at (202) 418–2843. Once the information has been approved, a refund will be sent to the party identified in the refund information.

Note: Refund processing generally takes up to two weeks to complete. Bidders with questions about refunds should contact Gail Glasser at (202) 418–0578 or Tim Dates at (202) 418–0496.

Federal Communications Commission.

Margaret Wiener,

Chief, Auctions and Industry Analysis Division, WTB.

[FR Doc. 02–27816 Filed 10–31–02; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than November 15, 2002.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 3030-B4470:

1. Lee Investments, LLLP, Lakeland, Georgia, including William Larry Lee, Ann S. Lee, William Alexander Lee, and Mary Carol Lee Green; to acquire voting shares of FMB Bancshares, Inc., Lakeland, Georgia, and thereby indirectly acquire voting shares of Farmers & Merchants Bank, Lakeland, Georgia.

Board of Governors of the Federal Reserve System, October 28, 2002.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 02–27858 Filed 10–31–02; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise

noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center Web site at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than November 25, 2002.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 3030-B4470:

1. Pinnacle S–Corp, Inc., Elberton, Georgia; to become a bank holding company by acquiring 100 percent of the voting shares of Pinnacle Financial Corporation, Elberton, Georgia, and thereby indirectly acquire voting shares of Pinnacle Bank, Elberton, Georgia.

Board of Governors of the Federal Reserve System, October 28, 2002.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 02–27859 Filed 10–31–02; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Prospective Grant of Exclusive License: Pharmaceutical Methods of Delivering Folic Acid in a Hormonal Replacement or Contraceptive Composition

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This is a notice in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i) that the Centers for Disease Control and Prevention (CDC), Technology Transfer Office, Department of Health and Human Services (DHHS), is contemplating the grant of a worldwide, limited field of use, exclusive license to practice the inventions embodied in the patent and patent applications referred to below to Johnson & Johnson Pharmaceutical Research & Development, L.L.C., having a place of business in Raritan, New Jersey. The patent rights in these inventions relate to the administration of folic acid in a contraceptive or hormonal replacement composition and have been assigned to Ortho-McNeil Pharmaceutical, Inc. (Raritan, New Jersey) and the government of the United States of America. The patent and patent applications to be licensed are:

Title: Pharmaceutical Methods of Delivering Folic Acid in a Hormonal Replacement or Contraceptive Composition,

U.S. Patent Application Serial No. 09/292,027.

Filing Date: 04/16/1999.

Domestic Status: Patent No.: 6,190,693.

Issue Date: 02/20/2001.

The prospective exclusive license will be royalty-bearing and will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404.7. The prospective exclusive license may be granted unless, within 60 days from the date of this published Notice, CDC receives written evidence and argument that the grant of this license would not be consistent with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Folic acid is a vitamin. It plays a crucial role in DNA synthesis, and in hematopoiesis (although the details of this role remain undefined). Folic acid is involved, for example, in single carbon transfers (such as those required for purine and pyrimidine metabolism), and in the re-methylation of homocysteine to methionine. Numerous disorders can result from insufficient intake of folic acid. Enhanced effects of risk factors for cervical dysplasia (*e.g.* HPV infection) have been linked to decreased folic acid levels. Sub-optimal body stores of folic acid, as measured by red cell folic acid concentrations, may amplify oncogenic risk. Administering folic acid can reduce the onset of disorders such as cardiovascular disease and cervical dysplasia. This invention provides a pharmaceutical composition comprising (a) an oral contraceptive for preventing pregnancy in a subject, and (b) folic acid in an amount sufficient to treat or prevent a disorder which (c) afflicts subjects for whom the oral contraceptive is indicated at a higher-than-normal incidence, and (d) is treatable or preventable by folic acid administration.

ADDRESSES: Requests for a copy of this patent, inquiries, comments, and other materials relating to the contemplated license should be directed to Andrew Watkins, Director, Technology Transfer Office, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, Mailstop K–79, Atlanta, GA 30341, telephone: (770) 488–8610; facsimile: (770) 488–8615. Applications for a license filed in response to this notice will be treated as objections to the grant of the contemplated license. Only written comments and/or applications for a license which are received by CDC within sixty days of this notice will be considered. Comments and objections submitted in response to this notice will not be made available for public inspection, and, to the extent permitted by law, will not be released under the Freedom of Information Act, 5 U.S.C. 552. A signed Confidential Disclosure Agreement will be required to receive a copy of any pending patent application.

Dated: October 26, 2002.

James D. Seligman,

Associate Director for Program Services, Centers for Disease Control and Prevention (CDC).

[FR Doc. 02–27788 Filed 10–31–02; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2141–FN]

Medicare and Medicaid Programs; Approval of the American Osteopathic Association for Deeming Authority for Ambulatory Surgical Centers

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

ACTION: Final notice.

SUMMARY: This final notice announces the approval of the American Osteopathic Association (AOA) for recognition as a national accreditation program for ambulatory surgical centers (ASCs) that request certification to participate in the Medicare or Medicaid programs. We have found that accreditation of ASCs by this organization will demonstrate that all Medicare ASC Conditions for Coverage are met or exceeded, and, thus, ASCs accredited by AOA will be granted deemed status to participate in the Medicare program.

EFFECTIVE DATE: This final notice is effective January 30, 2003.

FOR FURTHER INFORMATION CONTACT: Laura A. Weber, (410) 786–0227.

SUPPLEMENTARY INFORMATION: *Copies:* To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by

faxing to (202) 512–2250. The cost for each copy is $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 website address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Determining Compliance of Ambulatory Surgical Centers-Surveys and Deeming

Under the Medicare program, eligible beneficiaries may receive covered services in an ambulatory surgical center (ASC) provided that the ASC meets certain requirements. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) includes requirements that an ASC have an agreement in effect with the Secretary and that it meet health, safety, and other standards specified by the Secretary in regulations. Requirements concerning supplier agreements are located in 42 CFR part 489, and those pertaining to the survey and certification of facilities are set forth in 42 CFR part 488.

In 42 CFR part 416, we specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for facility services.

For an ASC to enter into an agreement, a State survey agency must first certify that the ASC complies with our conditions or requirements. Following that certification, the ASC is subject to routine monitoring by a State survey agency to ensure continuing compliance. As an alternative to surveys by State agencies, section 1865(b)(1) of the Act provides that, if the Secretary finds that, through accreditation by a national accreditation body, a provider entity demonstrates that all of our applicable conditions and requirements are met or exceeded, the Secretary will deem that the provider entity has met the applicable Medicare requirements.

In making our finding as to whether the accreditation organization demonstrates that all Medicare conditions or requirements are met or exceeded, we consider factors such as the organization's accreditation requirements, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for us in enforcement activities, its monitoring procedures for providers entities found to be out of compliance with conditions or requirements, and its ability to provide us with necessary data for validation.

It has been brought to our attention that some ASCs are under the mistaken impression that, once we have granted deeming authority to an accreditation organization, then ASCs must be accredited by such an organization to receive Medicare certification. Accreditation by an accreditation organization is voluntary, and we do not require that accreditation for Medicare certification.

The American Osteopathic Association (AOA) was the fourth accreditation organization to apply for deeming authority for ASCs. The three other accreditation organizations already granted deeming authority are the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association of Ambulatory Health Care (AAAHC), and The American Association for the Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF).

The AOA is defined as a national accrediting body in section 1865(b)(1) of the Act, and was granted deeming authority by us for hospitals (65 FR 8727, published February 22, 2000). This was taken into consideration in the evaluation of this application for ASC deeming authority.

The AOA previously applied to us for deeming authority, which we announced in the **Federal Register** on March 14, 2001 (66 FR 14906). However, the organization withdrew its application before a final decision was made. We received a revised complete application from AOA on April 18, 2002 and published notice of that receipt on May 24, 2002 (67 FR 36611).

II. Determining Compliance—Surveys and Deeming

A national accrediting organization may request the Secretary to recognize its program as employing standards that meet or exceed Medicare's standards. The Secretary then examines the national accreditation organization's requirements to determine if they meet or exceed Medicare standards. If the Secretary recognizes an accreditation organization in this manner, any provider accredited by the national accrediting body's program that we have approved for that service will be ''deemed'' to meet the Medicare Conditions for Coverage.

The regulations specifying the Medicare Conditions for Coverage for ASCs are located in 42 CFR part 416. These conditions implement section 1832(a)(2)(F)(i) of the Act, which provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures specified by the Secretary under section 1833(i)(1)(a) of the Act.

III. Provisions of the Proposed Notice

The proposed notice, published on May 24, 2002 (67 FR 36611), announced the application of AOA for deemed status for its accreditation program for ASCs. Under section 1865(b)(2) of the Act and our regulations in § 488.8 (Federal review of accreditation organizations), our review and evaluation of a national accreditation organization was conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of an accreditation organization's requirements for an entity to our comparable requirements for that entity.
- The organization's survey process to determine the following:

—The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

—The comparability of its processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

—The organization's procedures for monitoring providers or suppliers found by the organization to be out of compliance with program requirements. These monitoring procedures are used only when the organization identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified in § 488.7(d).

—The ability of the organization to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

—The ability of the organization to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of staff and other resources, and its financial viability.

—The organization's ability to provide adequate funding for performing required surveys.

—The organization's policies with respect to whether surveys are announced or unannounced.

- The accreditation organization's agreement to provide us with a copy of the most current accreditation survey together with any other information

related to the survey as we may require (including corrective action plans).

IV. Analysis of and Responses to Public Comments

We did not receive any comments to the proposed notice published in the **Federal Register** (67 FR 36611) on May 24, 2002.

V. Provisions of the Final Notice

A. Deeming Approval Review and Evaluation

We evaluated the AOA's standards and survey process to determine if facilities accredited by AOA met Medicare Conditions for Coverage. We did a standard-by-standard comparison of the applicable conditions or requirements to determine which of them met or exceeded Medicare requirements.

We compared the standards contained in the AOA's ''Ambulatory Surgical Center (ASC) Manual'' and its survey process in the ''Ambulatory Surgical Center Surveyor Handbook'' with the Medicare ASC Conditions for Coverage and our State and Regional Operations Manual. Our review and evaluation of AOA's deeming application, which were conducted as described in this notice, yielded the following clarifications:

- AOA provided an updated listing of its accredited ASC facilities.
- AOA adjusted language to refer consistently to the entities as ASCs as opposed to hospitals in its documents.
- AOA modified its standards to meet fully the requirements of the Medicare Conditions for Coverage.
- AOA modified its survey policy to ensure that ASC surveys are unannounced.
- AOA modified its requirements to indicate that any ASC seeking to participate in Medicare by virtue of an AOA accreditation must meet the ''Accreditation with Medicare Certification,'' which requires that all State licensure requirements are satisfied in addition to meeting all AOA standards.
- AOA adjusted its standards to require written confirmation of primary source verifications with regard to medical staff credentialing.
- AOA adjusted its standard to conform with all applicable requirements of each State Nurse Practice Act to specify what duties a registered nurse may be allowed to perform in the area of pharmaceutical services.
- AOA agrees to notify us of all accreditation decisions made.

Review of AOA's application raised issues concerning the comparability of the AOA's ASC accreditation standards with the Medicare Conditions for Coverage for ASCs. We requested that the AOA demonstrate compliance with the Medicare ASC Conditions for Coverage and submit supplemental information to clarify its policies and procedures. Upon our final review of this information, we have determined that the AOA's ASC accreditation program meets the Medicare Conditions for Coverage for ASCs.

B. Term of Approval

Based on the review and observations described in this final notice, we have determined that AOA's requirements for ASCs meet or exceed our requirements. We reserve the right to observe an AOA ASC survey to determine the compliance of AOA surveyors to the policies and procedures, as there were none scheduled during the review of this application. In addition, the AOA must seek approval of all standards pertaining to the Life Safety Code (LSC) when we move to the LSC 2000 Edition, which we intend to implement in Spring 2003. We therefore recognize the AOA as a national accreditation organization for ASCs that request participation in the Medicare program, effective for a 6-year period beginning January 30, 2003.

VI. Collection of Information Requirements

This final notice does not impose any information collection and record keeping requirements subject to the Paperwork Reduction Act (PRA). Consequently, it does not need to be reviewed by the Office of Management and Budget (OMB) under the authority of the PRA. The requirements associated with granting and withdrawal of deeming authority to national accreditation organizations, codified in 42 CFR part 488, ''Survey, Certification, and Enforcement Procedures,'' are currently approved by OMB under OMB approval number 0938–0690.

VII. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, 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).

The RFA requires agencies to analyze options for regulatory relief for small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million or less in any 1 year (for details, see the Small Business Administration's publication that set forth size standards for health care industries at 65 FR 69432). Approximately 73 percent of ASCs are considered small businesses with total revenues of $8.5 million or less according to the Small Business Administration's data. For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

This notice merely recognizes AOA as a national accreditation organization that has requested approval for deeming authority for ASCs that are participating in the Medicare program. Since these provider entities must be routinely monitored to determine compliance with Medicare requirements, we believe that this organization's accreditation program has the potential to reduce both the regulatory and administrative burdens associated with the Medicare program requirements.

This notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

Therefore, we have determined, and the Secretary certifies, that this final notice will not result in a significant impact on small entities and will not have an effect on the operations of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This

notice will have no consequential effect on State, local, or tribal governments. We believe the private sector costs of this notice will fall below this threshold as well.

In accordance with Executive Order 13132, this notice will not significantly affect the rights of States and will not significantly affect State authority.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Section 1865(b)(3)(A) of the Social Security Act (42 U.S.C. 1395bb(b)(3)(A)).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 7, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–27782 Filed 10–31–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: DHHS/ACF Rural Welfare-to-Work Strategies Demonstration Evaluation Project 18-Month Survey.

OMB No.: New Collection.

Description: the Rural Welfare-to-Work Strategies Demonstration Evaluation Project, which was developed and funded by the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS), is a national evaluation to determine the benefits and cost-effectiveness of methods designed to aid current or former Temporary Assistance for Needy Families (TANF) recipients or other low-income families as they transition from welfare to the employment arena. This evaluation chiefly attempts to address four research questions:

- What are the issues and challenges associated with operating the new welfare-to-work services and policy approaches being studied?
- How effective are the welfare-to-work programs under the project in increasing employment and earnings and in improving other measures?
- What are the net costs of the welfare-to-work programs, and do the programs' benefits outweigh the costs?
- What approaches should policymakers and program managers consider in designing strategies to improve the efficacy of welfare-to-work strategies for families in rural areas?

The evaluation employs a multi-pronged approach to answer the research questions. These approaches include: (1) An impact study, which will examine the differences between control and intervention groups with respect to factors such as employment rates, earnings, and welfare receipt; (2) a cost-benefit analysis, which will calculate estimates of net program cost-effectiveness; and (3) an in-depth process study, which will identify implementation issues and challenges, examine program costs, and provide details on how programs achieve observed results. The data collected during the conduct of this study will be used for the following purposes:

- To study rural welfare-to-work programs' effects on factors such as employment, earnings, educational attainment, family composition;
- To collect data on a wider range of outcome measures—such as job acquisition, retention, and advancement, job quality, educational attainment, and employment barriers—than is available through welfare or unemployment insurance records, in order to understand how individuals are being affected by the demonstration programs;
- To support research on the implementation of welfare-to-work programs across sites;
- To obtain program participation and service use information important to the evaluation's cost-benefit component; and
- To obtain contact information for a future follow-up survey that will be important to achieving high response rates for that survey.

Respondents: The respondents of the 18-month follow-up survey are current and former TANF recipients, or individuals in families at risk of needing TANF benefits (working poor, hard-to-employ) from the three states participating in the evaluation (Illinois, Nebraska, and Tennessee). The survey will be administered to both intervention and control groups in each participating site. The estimated sample size for the survey is 3,400 individuals, including projected samples of 2,200 in Tennessee, and 600 each in Illinois and Nebraska. The survey will be conducted primarily by telephone, with field interviews conducted with those individuals who cannot be interviewed by telephone.

Respondents of the process study data collection efforts (interviews, case studies, and focus groups) include State and local-level agency staff from welfare agencies and other organizations. These individuals include program directors and site managers, program line staff, workforce development staff, TANF agency staff, and community partners and employers. Approximately 105 staff members per site are expected to participate in semi-structured interviews, 21 in case conferences, and 108 in focus groups, across the three demonstration sites.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
18-Month Follow-up Survey	963	1	45 minutes or .75 hours	723
Process Study Data Collection Staff Interviews	105	1	75 minutes or 1.15 hours	120.8
Process Study Data Collection Staff Case Conferences	21	1	30 minutes or .5 hours	10.5
Process Study Data Collection Staff Focus Groups	108	1	90 minutes or 1.5 hours	162

Estimated Total Annual Burden Hours: 1016.3.

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Administration Office of Information Services, 370 L'Enfant Promenade, SW., Washington,

DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments 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) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: October 23, 2002.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 02–27759 Filed 10–31–02; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Women's Health Initiative Subcommittee of the Advisory Committee for Reproductive Health Drugs; Notice of Postponement of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is postponing the meeting of the Women's Health Initiative Subcommittee of the Advisory Committee for Reproductive Health Drugs scheduled for November 12 and 13, 2002. The meeting was announced in the **Federal Register** of October 21, 2002 (67 FR 64651). FDA's Center for Drug Evaluation and Research is going to evaluate additional data relevant to the topic. Future meeting dates will be announced in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Jayne E. Peterson, Center for Drug Evaluation and Research (HFD–21), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–7001, FAX 301–827–6776, or e-mail: *PETERSONJ@CDER.FDA.GOV*, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12537. Please call the Information Line for up-to-date information on this meeting.

Dated: October 24, 2002.

LaJuana D. Caldwell,

Acting Senior Associate Commissioner for External Relations.

[FR Doc. 02–27884 Filed 10–31–02; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 02D–0427]

Guidance for Industry on Antiretroviral Drugs Using Plasma Human Immunodeficiency Virus Ribonucleic Acid Measurements—Clinical Considerations for Accelerated and Traditional Approval; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a guidance for industry entitled ''Antiretroviral Drugs Using Plasma HIV RNA Measurements—Clinical Considerations for Accelerated and Traditional Approval.'' This guidance is intended to assist sponsors in the clinical development of drugs for the treatment of human immunodeficiency virus (HIV) infection. Specifically, this guidance addresses the agency's current thinking regarding designs of clinical trials that use HIV ribonucleic acid (RNA) measurements to support accelerated and traditional approvals of antiretroviral drug products.

DATES: Submit written or electronic comments on agency guidances at any time.

ADDRESSES: Submit written requests for single copies of this guidance to the Division of Drug Information (HFD–240), Center for Drug Evaluation and Research, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857. Send one self-addressed adhesive label to assist that office in processing your requests. Submit written comments on the guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to *http://www.fda.gov/dockets/ecomments*. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance document.

FOR FURTHER INFORMATION CONTACT: Jeffrey S. Murray, Center for Drug Evaluation and Research (HFD–530), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–2330.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a guidance for industry entitled ''Antiretroviral Drugs Using Plasma HIV RNA Measurements—Clinical Considerations for Accelerated and Traditional Approval.'' This guidance is intended to assist sponsors in the clinical development of drugs for the treatment of HIV infection. Specifically, this guidance addresses the agency's current thinking regarding designs of clinical trials that use HIV RNA measurements to support accelerated and traditional approvals of antiretroviral drug products. It is also intended to serve as a focus for continued discussions among the Division of Antiviral Drug Products (DAVDP), pharmaceutical sponsors, the academic community, and the public.

The draft version of this document, first issued in August 1999, was based on a DAVDP advisory committee meeting, convened in July 1997, to discuss the use of HIV RNA endpoints for traditional approval of antiretroviral drugs. This document has been updated to address public comments to the draft version and to include pertinent information from a DAVDP advisory committee meeting held in January 2001 that addressed issues relating to trial design in HIV-infected patients who have already been heavily treated for the disease. The guidance summarizes the rationale for using HIV RNA as a primary endpoint in clinical trials to support both accelerated and traditional approval. It describes the amount and type of safety and efficacy data recommended for new drug applications. The guidance also reviews pertinent clinical trial design issues including choice of control arms, study procedures, and statistical considerations. An appendix addresses the use of experimental HIV RNA assays in phase 3 studies.

This guidance does not address specific phase-1 and -2 development issues, development of alternate dosing regimens, or the use of HIV–1 resistance testing. These issues will be addressed in separate future guidance documents.

This guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The guidance represents the agency's current thinking on clinical considerations for accelerated and

traditional approval of antiretroviral drugs using plasma HIV RNA measurements. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may, at any time, submit written or electronic comments on the guidance to the Dockets Management Branch (see **ADDRESSES**). Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The guidance and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/cder/guidance/index.htm* or *http://www.fda.gov/ohrms/dockets/default.htm*.

Dated: October 28, 2002.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 02–27885 Filed 10–31–02; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 02D–0407]

Diagnostic X-Ray Field Size; Revocation of Compliance Policy Guide 7133.17; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; correction.

SUMMARY: The Food and Drug Administration is correcting a notice that appeared in the **Federal Register** of October 10, 2002 (67 FR 63108). The document revoked the compliance policy guide entitled ''Sec. 398.475 Minimum X-Ray Field Size for Spot-Film Operation of Fluoroscopic Systems with Fixed SID and Without Stepless Adjustment of the Field Size (CPG 7133.17).'' The document was published with an inadvertent error. This document corrects that error.

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

SUPPLEMENTARY INFORMATION: In FR Doc. 02–25881, appearing on page 63108 in the **Federal Register** of Thursday, October 10, 2002, the following correction is made:

1. On page 63108, in the third column, at the end of the document, the phrase ''Dated: October 1, 2022'' is corrected to read ''Dated: October 1, 2002''.

Dated: October 25, 2002.

John M. Taylor,

Senior Associate Commissioner for Regulatory Affairs.

[FR Doc. 02–27886 Filed 10–31–02; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 01D–0177]

Guidance for Industry on Immunotoxicology Evaluation of Investigational New Drugs; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a guidance for industry entitled ''Immunotoxicology Evaluation of Investigational New Drugs.'' This guidance provides recommendations for sponsors of investigational new drugs (INDs) on what parameters to routinely assess in toxicology studies to determine effects on immune function, when to conduct additional immunotoxicity studies, and when additional mechanistic information could better characterize a given effect on the immune system.

DATES: Submit written or electronic comments on agency guidances at any time.

ADDRESSES: Submit written requests for single copies of this guidance to the Division of Drug Information (HFD–240), Center for Drug Evaluation and Research, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857. Send one self-addressed adhesive label to assist that office in processing your requests. Submit written comments on the guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to http://www.fda.gov/dockets/ecomments. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance document.

FOR FURTHER INFORMATION CONTACT: Kenneth L. Hastings, Center for Drug Evaluation and Research (HFD–590), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–2489.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a guidance for industry entitled ''Immunotoxicology Evaluation of Investigational New Drugs.'' The human immune system is a complex set of cells and organs that can be adversely affected by drugs. Impairment of the immune system can result in increased susceptibility to infections and tumors, allergic responses to drugs, autoimmune reactions, or other forms of immune system disease. Immunotoxicology studies can be conducted in animals to determine the potential of an investigational drug to adversely affect the immune system. This guidance provides advice on: (1) When to conduct immunotoxicology studies, (2) what types of effects can be observed in standard nonclinical toxicology studies that would indicate that a drug has immunotoxic potential, and (3) what types of studies could be useful in determining the nature of the immunotoxicity. It is expected that this guidance will provide sponsors with useful information for proper assessment of the immunotoxic potential of drugs.

In the **Federal Register** of May 11, 2001 (66 FR 24145), FDA published a draft guidance entitled ''Immunotoxicology Evaluation of Investigational New Drugs.'' The notice gave interested persons an opportunity to submit comments. Based on the comments, FDA has revised the guidance.

This guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The guidance represents the agency's current thinking on immunotoxicology evaluation of INDs. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may, at any time, submit written comments on the guidance to the Dockets Management

Branch (see **ADDRESSES**). Two copies of mailed comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The guidance and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the document at either http://www.fda.gov/cder/guidance/index.htm or http://www.fda.gov/ohrms/dockets/default.htm.

Dated: October 28, 2002.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 02–27883 Filed 10–31–02; 8:45 am]

BILLING CODE 4160–01–S

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; Special Emphasis Panel to Review Two R25, Two K12 and One K23 Grant Applications.

Date: November 19, 2002.

Time: 3 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: 6116 Executive Blvd, Room 8137, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Raymond A. Petryshyn, PhD, Scientific Review Administrator, Grants Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6116 Executive Blvd., 8th Fl., Room 8109, Bethesda, MD 20892, 301/594–1216, *petryshr@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, Natural Institutes of Health, HHS)

Dated: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27754 Filed 10–31–02; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Eye 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 Eye Institute Special Emphasis Panel; NEI Clinical Applications (U10 clinical trials, R03, R01, R21, K08, K23).

Date: December 10, 2002.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency, One Bethesda Metro Center, Bethesda, MD 20814.

Contact Person: Anne E. Schaffner, PhD, Scientific Review Administrator, Division of Extramural Research, National Eye Institute, 6120 Executive Blvd., Suite 350, Bethesda, MD 20892, 301–451–2020.

(Catalogue of Federal Domestic Assistance Program Nos. 93.867, Vision Research, National Institutes of Health, HHS)

Dated: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27753 Filed 10–31–02; 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 pubic 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; Fragile X Research Center.

Date: November 18–29, 2002.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: The Madison Hotel, 15th and M Street, NW., Washington, DC 20005.

Contact Person: Norman Chang, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, National Institutes of Health, 6100 Executive Blvd., Room 5E03, Bethesda, MD 20892, (301) 496–1485.

(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: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27748 Filed 10–31–02; 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 Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice

is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 DD (02) Review Applications.

Date: November 12, 2002.

Time: 4:30 p.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: 6000 Executive Boulevard, Suite 409, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Sathasiva B. Kandasamy, PhD, Scientific Review Administrator, Extramural Project Review Branch, Office of Scientific Affairs, National Institute on Alcohol, Abuse and Alcoholism, 6000 Executive Blvd, Suite 409, Bethesda, MD 20892–7003, (301) 443–2926. *skandasa@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 FF (02) Review K05 Application.

Date: November 18, 2002.

Time: 9 a.m. to 10 a.m.

Agenda: To review and evaluate grant applications.

Place: Willco Building, Suite 409, 6000 Executive Boulevard, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Sean N. O'Rourke, Scientific Review Administrator, Extramural Project Review Branch, Office of Scientific Affairs, National Institute on Alcohol, Abuse and Alcoholism, Suite 409, 6000 Executive Blvd, Bethesda, MD 20892–7003, (301) 443–2861.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 FF (05) Review R21 Applications.

Date: November 19, 2002.

Time: 4 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Willco Building, Suite 409, 6000 Executive Boulevard, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Sean N. O'Rourke, Scientific Review Administrator, Extramural Project Review Branch, Office of Scientific Affairs, National Institute on Alcohol, Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Blvd, Bethesda, MD 20892–7003, (301) 443–2861.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 CC (02) Review of Application.

Date: November 26, 2002.

Time: 2 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: 6000 Executive Boulevard, Rockville, MD 20892 (Telephone Conference Call).

Contact Person: Sandra Camman, Grants Technical Assistant, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Boulevard, Bethesda, MD 20892, 301–443–9419, *scamman@wiilco.niaaa.nih.gov.*

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 FF (04) Review R03 Application.

Date: November 18, 2003.

Time: 2 p.m. to 3 p.m.

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.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel; ZAA1 FF (03) Review R01 Application.

Date: November 19, 2003.

Time: 11 a.m. to 11:45 a.m.

Agenda: To review and evaluate applications.

Place: Willco Building, Suite 409, 6000 Executive Boulevard, Rockville, MD 20892 (Telephone Conference Call).

Contact Person: Sean N. O'Rouke, 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.

(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: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27749 Filed 10–31–02; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Environmental Health Sciences; 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 Environmental Health Sciences Special Emphasis Panel; Review of P01 Supplemental Applications.

Date: November 14, 2002.

Time: 2 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: NIEHS-East Campus, 79 TW Alexander Drive, Building 4401, Room 3446, Research Triangle Park, NC 27709 (Telephone Conference Call).

Contact Person: Leroy Worth, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research and Training, Nat. Institute of Environmental Health Sciences, P.O. Box 12233, MD EC–30/Room 3171, Research Triangle Park, NC 27709, 919/541–0670, *worth@niehs.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Environmental Health Sciences Special Emphasis Panel; Review of P01 Supplemental Applications.

Date: November 14, 2002.

Time: 3 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: NIEHS-East Campus, 79 TW Alexander Drive, Building 4401, Room 3446, Research Triangle Park, NC 27709 (Telephone Conference Call).

Contact Person: Leroy Worth, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research and Training, Nat. Institute of Environmental Health Sciences, P.O. Box 12233, MD EC–30/Room 3171, Research Triangle Park, NC 27709, 919/541–0670, *worth@niehs.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing

limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Environmental Health Sciences Special Emphasis Panel; Review of Conference Grant Applications.

Date: December 10, 2002.

Time: 2 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: NIEHS, 79 T.W. Alexander Drive, Building 4401, Conference Room 122, Research Triangle Park, NC 27709 (Telephone Conference Call).

Contact Person: RoseAnne M McGee, Associate Scientific Review Administrator, Scientific Review Branch, Office of Program Operations, Division of Extramural Research and Training, Nat. Inst. of Environmental Health Sciences, P.O. Box 12233, MD EC–30, Research Triangle Park, NC 27709, 919/541–0752.

Name of Committee: National Institute of Environmental Health Sciences Special Emphasis Panel; Review of Grant Applications.

Date: December 10, 2002.

Time: 3 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: NIEHS, 79 T.W. Alexander Drive, Building 4401, Conference Room 122, Research Triangle Park, NC 27709 (Telephone Conference Call).

Contact Person: RoseAnne M McGee, Associate Scientific Review Administrator, Scientific Review Branch, Office of Program Operations, Division of Extramural Research and Training, Nat. Inst. of Environmental Health Sciences, P.O. Box 12233, MD EC–30, Research Triangle Park, NC 27709, 919/541–0752.

(Catalogue of Federal Domestic Assistance Program Nos. 93.113, Biological Response to Environmental Health Hazards; 93.114, Applied Toxicological Research and Testing; 93.115, Biometry and Risk Estimation—Health Risks from Environmental Exposures; 93.142, NIEHS Hazardous Waste Worker Health and Safety Training; 93.143, NIEHS Superfund Hazardous Substances—Basic Research and Education; 93.894, Resources and Manpower Development in the Environmental Health Sciences, National Institutes of Health, HHS)

Dated: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27750 Filed 10–31–02; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the Board of Scientific Counselors, National Institute of Mental Health. The meeting will be closed to the public as indicated below in accordance with the provisions set forth in section 552b(c)(6), Title 5 U.S.C., as amended for the review, discussion, and evaluation of individual intramural programs and projects conducted by the National Institute of Mental Health, including consideration of personnel qualifications and performance, and the competence of individual investigators, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Board of Scientific Counselors, National Institute of Mental Health.

Date: November 18, 2002.

Agenda: To review and evaluate personal qualifications and performance, and competence of individual investigators.

Place: National Institutes of Health, 9000 Rockville Pike, Building 36, Room 1B07, Bethesda, MD 20892.

Contact Person: Susan Koester, PhD, Executive Secretary, Associate Director for Science, Intramural Research Program, National Institute of Mental Health, NIH, Building 10, Room 4N222, MSC 1381, Bethesda, MD 20892–1381, 301–496–3501.

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 intramural research review cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27751 Filed 10–31–02; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; 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 General Medical Sciences Special Emphasis Panel; Predoctoral Research Training Grant Applications.

Date: November 14–15, 2002.

Time: 8:30 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: Chevy Chase Holiday Inn, 5520 Wisconsin Ave., Chevy Chase, MD 20815.

Contact Person: Laura K. Moen, PhD, Scientific Review Administrator, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, Natcher Building, Room 1AS–13H, Bethesda, MD 20892, (301) 594–3998, *moenl@nigms.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. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes, of Health, HHS)

Dated: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27755 Filed 10–31–02; 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, Special Emphasis Panel—Review Application—Dr. Ira B. Black.

Date: November 12, 2002.

Time: 1 p.m. to 4:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda Residence Inn, 7335 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Gopal M. Bhatnagar, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, National Institutes of Health, PHS, DHHS, 9000 Rockville Pike, 6100 Bldg., Room 5E01, Bethesda, MD 20892, (301) 496–1485.

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. 93.209, 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: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27756 Filed 10–31–02; 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, Special Emphasis Panel: Review Application—Dr. Hannah Kinney.

Date: November 12, 2002.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda Residence Inn, 7335 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Gopal M. Bhatnagar, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, National Institutes of Health, PHS, DHHS, 9000 Rockville Pike, 6100 Bldg., Room 5E01, Bethesda, MD 20892, (301) 496–1485.

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. 93.209, 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: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27757 Filed 10–31–02; 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; Immunology Small Business.

Date: November 12–13, 2002.

Time: 8:30 a.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: The River Inn, 924 Twenty-Fifth Street, NW., Washington, DC 20037.

Contact Person: Stephen M. Nigida, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4112, MSC 7812, Bethesda, MD 20892, (301) 435–3565.

Name of Committee: AIDS and Related Research Integrated Review Group; AIDS and Related Research 2.

Date: November 14, 2002.

Time: 8 a.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: Mayflower Hotel, 1127 Connecticut Avenue NW., Washington, DC 20036.

Contact Person: Abraham P. Bautista, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5102, MSC 7852, Bethesda, MD 20892, (301) 435–1506.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Occupational Safety and Health: Quorum.

Date: November 14–15, 2002.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Embassy Suites Hotel, 1900 Diagonal Road, Alexandria, VA 22314.

Contact Person: Charles N. Rafferty, PhD, NIOSH Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4114, MSC 7816, Bethesda, MD 20892, 301–435–3562, *raffertc@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Diagnosis and Treatment of Cancer.

Date: November 14–15, 2002.

Time: 8:30 a.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Georgetown, 2101 Wisconsin Avenue, NW., Washington, DC 20007.

Contact Person: Shen K. Yang, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4138, MSC 7804, Bethesda, MD 20892, (301) 435–1213, *yangsh@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 F09 (20) L Fellowships and AREA Oncological Sciences.

Date: November 14–15, 2002.

Time: 8:30 a.m. to 5 p.m.,

Agenda: To review and evaluate grant applications.

Place: St. Gregory Hotel, 2033 M Street, NW., Washington, DC 20036–3305.

Contact Person: Syed M. Quadri, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4144, MSC 7804, Bethesda, MD 20892, (301) 435–1211, *quadris@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG 1SSS–5 (10) Small Business Rehabilitation Medicine.

Date: November 14–15, 2002.

Time: 10 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Silver Spring, 8727 Colesville Road, Silver Spring, MD 20910.

Contact Person: Nancy Shinowara, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of

Health, 6701 Rockledge Drive, Room 4208, MSC 7814, Bethesda MD 20892–7814, (301) 435–1173, *shinowan@drg.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 BDCN 5 03M: Hippocampus.
Date: November 14, 2002.
Time: 11 a.m. to 11:45 a.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Sherry L. Stuesse, PhD, Scientific Review Administrator, Division of Clinical and Population-Based Studies, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5188, MSC 7846, Bethesda, MD 20892, (301) 435–1785, *stuesses@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Breast Cancer Biology.
Date: November 14, 2002.
Time: 1 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: Victor A. Fung, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4120, MSC 7804, Bethesda, MD 20814–9692, (301) 435–3504, *fungv@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 PTHB 02M: Member Conflict: Chemoprevention of Cancer.
Date: November 14, 2002.
Time: 1 p.m. to 3 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Martin L. Padarathsingh, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4146, MSC 7804, Bethesda, MD 20892, (301) 435–1717.

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 VACC 10—Small Business: Vaccines.
Date: November 14–15, 2002.
Time: 2 p.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: The Hyatt Regency Hotel, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Mary Clare Walker, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5104, MSC 7852, Bethesda, MD 20892, (301) 435–1165.

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 IFCN1 (2) Sleep, Stress & Feeding Behavior.
Date: November 14, 2002.
Time: 2 p.m. to 4:30 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Gamil C. Debbas, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5170, MSC 7844, Bethesda, MD 20892, (301) 435–1247, *eskayr@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Reproductive Behavior.
Date: November 14, 2002.
Time: 2 p.m. to 3 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Weijia Ni, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3190, MSC 7848 (for overnight mail use room # and 20817 zip), Bethesda, MD 20892, (301) 435–1507, *niw@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Behavioral Research on Smoking.
Date: November 14, 2002.
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: Weijia Ni, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3190, MSC 7848 (for overnight mail use room # and 20817 zip), Bethesda, MD 20892, (301) 435–1507, *niw@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 SSS2 (01) Syndecan-2 in Matrix Assembly.
Date: November 14, 2002.
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: Prabha L. Atreya, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5156, MSC 7842, Bethesda, MD 20892, (301) 435–8367, *atreyap@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Cancer Therapy.
Date: November 14, 2002.
Time: 3 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: Philip Perkins, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4148, MSC 7804, Bethesda, MD 20892, (301) 435–1718, *perkins@csr.nih,gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Cognitive Functioning in Parkinson's Disease.
Date: November 14, 2002.
Time: 3:15 p.m. to 5:15 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Jeffrey W. Elias, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3170, MSC 7848, Bethesda, MD 20892, (301) 435–0913, *eliasj@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Innovations Grants in AIDS Research and Human Immunology.
Date: November 14–15, 2002.
Time: 4:15 p.m. to 5 p.m.
Agenda: To review and evaluate grant applications.
Place: Mayflower Hotel, 1127 Connecticut Avenue NW., Washington, DC 20036.
Contact Person: Abraham P. Bautista, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5102, MSC 7852, Bethesda, MD 20892, (301) 435–1506. *bautista@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 GRM (04) Oral Biology.
Date: November 15, 2002.
Time: 1 p.m. to 2 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Jo Pelham, BA, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4102, MSC 7814, Bethesda, MD 20892, (301) 435–1786.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Cancer Genetics.
Date: November 15, 2002.
Time: 1 p.m. to 3 p.m.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).
Contact Person: Victor A. Fung, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4120, MSC 7804, Bethesda, MD 20814–9692, 301–435–3504, *fungv@csr,nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; SNEM 1—Member Applications.
Date: November 15, 2002.
Time: 1 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: Yvette M. Davis, VMD, MPH, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3152, MSC 7770, Bethesda, MD 20892, 301–435–0906.

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 HEM–1(02): Heart Development.
Date: November 15, 2002.
Time: 2 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: Robert T. Su, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4134, MSC 7802, Bethesda, MD 20892, (301) 435–1195, *sur@csr.nih.gov.*

Name of Committee: AIDS and Related Research Integrated Review Group, AIDS and Related Research 5.

Date: November 18–19, 2002.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Mayflower Hotel, 1127 Connecticut Avenue NW., Washington, DC 20036.

Contact Person: Abraham P. Bautista, PhD, Scientist Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5102, MSC 7852, Bethesda, MD 20892, (301) 435–1506, *bautista@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1: SSS–7(11): Small Business Applications on Imaging Technologies A.

Date: November 18, 2002.

Time: 8 a.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn—Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Contact Person: Tracy E. Orr, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., Room 5112, Bethesda, MD 20892, (301) 435–1259, *orrt@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Brain Disorders and Clinical Neuroscience/ZRG1 BDCN–2(12).

Date: November 18–19, 2002.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Ramada Inn Rockville, 1775 Rockville Pike, Rockville, MD 20852.

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.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1–F01–20–L Brain Disorders and Clinical Neurosciences Fellowships.

Date: November 18–19, 2002.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Monarch Hotel, 2400 M Street, NW., Washington, DC 20037.

Contact Person: Sherry L. Stuesse, PhD, Scientific Review Administrator, Division of Clinical and Population-Based Studies, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5188, MSC 7846, Bethesda, MD 20892, 301–435–1785, *stuesses@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Developmental Disabilities, Communication and Science Education.

Date: November 18–19, 2002.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Wyndam Washington Hotel, 1400 M Street NW., Washington, DC 20005–2750.

Contact Person: Thomas A. Tatham, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3114, MSC 7848, Bethesda, MD 20892, (301) 594–6836, *tathamt@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Cancer Molecular Pathobiology.

Date: November 18, 2002.

Time: 1 p.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Sharon K. Gubanich, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4140, MSC 7804, Bethesda, MD 20892, (301) 435–1767.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Pain: Cellular and Molecular Biology.

Date: November 18, 2002.

Time: 2 p.m. to 3:30 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: John Bishop, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5180, MSC 7844, Bethesda, MD 20892, (301) 435–1250.

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1 MEPO2M: DNA Replication & Repair.

Date: November 18, 2002.

Time: 4 p.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Angela Y. Ng, PhD, MBA, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4142, MSC 7804 (For courier delivery, use MD 20817), Bethesda, MD 20892, 301–435–1715, *nga@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; ZRG1: SSS–7 (50): BISTI Applications on Imaging Technologies.

Date: November 18, 2002.

Time: 4 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn—Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Contact Person: Tracy E. Orr, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., Room 5112, Bethesda, MD 20892, (301) 435–1259, *orrt@csr.nih.gov.*

(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: October 24, 2002.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 02–27752 Filed 10–31–02; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Department of Health and Human Services notifies Federal agencies of the laboratories currently certified to meet standards of Subpart C of Mandatory Guidelines for Federal Workplace Drug Testing Programs (59 FR 29916, 29925). A notice listing all currently certified laboratories is published in the **Federal Register** during the first week of each month. If any laboratory's certification is suspended or revoked, the laboratory will be omitted from subsequent lists until such time as it is restored to full certification under the Guidelines.

If any laboratory has withdrawn from the National Laboratory Certification Program during the past month, it will be listed at the end, and will be omitted from the monthly listing thereafter.

This notice is also available on the internet at the following Web sites: *http://workplace.samhsa.gov* and *http://www.drugfreeworkplace.gov.*

FOR FURTHER INFORMATION CONTACT: Mrs. Giselle Hersh or Dr. Walter Vogl, Division of Workplace Programs, 5600 Fishers Lane, Rockwall 2 Building, Room 815, Rockville, Maryland 20857; Tel.: (301) 443–6014, Fax: (301) 443–3031.

SUPPLEMENTARY INFORMATION: Mandatory Guidelines for Federal Workplace Drug Testing were developed in accordance with Executive Order 12564 and section 503 of Public Law 100–71. Subpart C of the Guidelines, ''Certification of Laboratories Engaged in Urine Drug Testing for Federal Agencies,'' sets strict standards which laboratories must meet in order to conduct urine drug testing for Federal

agencies. To become certified an applicant laboratory must undergo three rounds of performance testing plus an on-site inspection.

To maintain that certification a laboratory must participate in a quarterly performance testing program plus periodic, on-site inspections.

Laboratories which claim to be in the applicant stage of certification are not to be considered as meeting the minimum requirements expressed in the HHS Guidelines. A laboratory must have its letter of certification from SAMHSA, HHS (formerly: HHS/NIDA) which attests that it has met minimum standards.

In accordance with Subpart C of the Guidelines, the following laboratories meet the minimum standards set forth in the Guidelines:

ACL Laboratories
8901 W. Lincoln Ave.
West Allis, WI 53227
414–328–7840/800–877–7016
(Formerly: Bayshore Clinical Laboratory)

ACM Medical Laboratory, Inc.
160 Elmgrove Park
Rochester, NY 14624
716–429–2264

Advanced Toxicology Network
3560 Air Center Cove, Suite 101
Memphis, TN 38118
901–794–5770/888–290–1150

Aegis Analytical Laboratories, Inc.
345 Hill Ave.
Nashville, TN 37210
615–255–2400

Alliance Laboratory Services
3200 Burnet Ave.
Cincinnati, OH 45229
513–585–9000
(Formerly: Jewish Hospital of Cincinnati, Inc.)

American Medical Laboratories, Inc.
14225 Newbrook Dr.
Chantilly, VA 20151
703–802–6900

Associated Pathologists Laboratories, Inc.
4230 South Burnham Ave., Suite 250
Las Vegas, NV 89119–5412
702–733–7866/800–433–2750

Baptist Medical Center—Toxicology Laboratory
9601 I–630, Exit 7
Little Rock, AR 72205–7299
501–202–2783
(Formerly: Forensic Toxicology Laboratory Baptist Medical Center)

Clinical Reference Lab
8433 Quivira Rd.
Lenexa, KS 66215–2802
800–445–6917

Cox Health Systems, Department of Toxicology
1423 North Jefferson Ave.
Springfield, MO 65802
800–876–3652/417–269–3093
(Formerly: Cox Medical Centers)

Diagnostic Services Inc., dba DSI
12700 Westlinks Drive
Fort Myers, FL 33913
941–561–8200/800–735–5416

Doctors Laboratory, Inc.
P.O. Box 2658, 2906 Julia Dr.
Valdosta, GA 31602
912–244–4468

DrugProof, Divison of Dynacare
543 South Hull St.
Montgomery, AL 36103
888–777–9497/334–241–0522
(Formerly: Alabama Reference Laboratories, Inc.)

DrugProof, Division of Dynacare/Laboratory of Pathology, LLC
1229 Madison St., Suite 500, Nordstrom Medical Tower
Seattle, WA 98104
206–386–2672/800–898–0180
(Formerly: Laboratory of Pathology of Seattle, Inc., DrugProof, Division of Laboratory of Pathology of Seattle, Inc.)

DrugScan, Inc.
P.O. Box 2969, 1119 Mearns Rd.
Warminster, PA 18974
215–674–9310

Dynacare Kasper Medical Laboratories *
10150–102 Street, Suite 200
Edmonton, Alberta
Canada TJ5 5E2
780–451–3702 / 800–661–9876

ElSohly Laboratories, Inc.
5 Industrial Park Dr.
Oxford, MS 38655
662–236–2609

Express Analytical Labs
3405 7th Avenue, Suite 106
Marion, IA 52302
319–377–0500

Gamma-Dynacare Medical Laboratories *
A Division of the Gamma-Dynacare Laboratory Partnership
245 Pall Mall St.
London, ONT
Canada N6A 1P4
519–679–1630

General Medical Laboratories
36 South Brooks St.
Madison, WI 53715
608–267–6267

Kroll Laboratory Specialists, Inc.
1111 Newton St.
Gretna, LA 70053
504–361–8989 / 800–433–3823
(Formerly: Laboratory Specialists, Inc.)

LabOne, Inc.
10101 Renner Blvd.
Lenexa, KS 66219
913–888–3927 / 800–728–4064
(Formerly: Center for Laboratory Services, a Division of LabOne, Inc.)

Laboratory Corporation of America Holdings
7207 N. Gessner Road
Houston, TX 77040
713–856–8288 / 800–800–2387

Laboratory Corporation of America Holdings
69 First Ave.
Raritan, NJ 08869
908–526–2400 / 800–437–4986
(Formerly: Roche Biomedical Laboratories, Inc.)

Laboratory Corporation of America Holdings
1904 Alexander Drive
Research Triangle Park, NC 27709
919–572–6900 / 800–833–3984
(Formerly: LabCorp Occupational Testing Services, Inc., CompuChem Laboratories, Inc.; CompuChem Laboratories, Inc., A Subsidiary of Roche Biomedical Laboratory; Roche CompuChem Laboratories, Inc., A Member of the Roche Group)

Laboratory Corporation of America Holdings
10788 Roselle Street
San Diego, CA 92121
800–882–7272
(Formerly: Poisonlab, Inc.)

Laboratory Corporation of America Holdings
1120 Stateline Road West
Southaven, MS 38671
866–827–8042 / 800–233–6339
(Formerly: LabCorp Occupational Testing Services, Inc., MedExpress/National Laboratory Center)

Marshfield Laboratories
Forensic Toxicology Laboratory
1000 North Oak Ave.
Marshfield, WI 54449
715–389–3734 / 800–331–3734

MAXXAM Analytics Inc.*
5540 McAdam Rd.
Mississauga, ON
Canada L4Z 1P1
905–890–2555
(Formerly: NOVAMANN (Ontario) Inc.)

Medical College Hospitals Toxicology Laboratory, Department of Pathology
3000 Arlington Ave.
Toledo, OH 43699
419–383–5213

MedTox Laboratories, Inc.
402 W. County Rd. D
St. Paul, MN 55112
651–636–7466 / 800–832–3244

MetroLab-Legacy Laboratory Services
1225 NE 2nd Ave.
Portland, OR 97232
503–413–5295 / 800–950–5295

Minneapolis Veterans Affairs Medical Center
Forensic Toxicology Laboratory
1 Veterans Drive
Minneapolis, Minnesota 55417
612–725–2088

National Toxicology Laboratories, Inc.
1100 California Ave.
Bakersfield, CA 93304
661–322–4250 / 800–350–3515

Northwest Drug Testing, a division of NWT Inc.
1141 E. 3900 South
Salt Lake City, UT 84124
801–293–2300 / 800–322–3361
(Formerly: NWT Drug Testing, NorthWest Toxicology, Inc.)

One Source Toxicology Laboratory, Inc.
1705 Center Street
Deer Park, TX 77536
713–920–2559
(Formerly: University of Texas Medical Branch, Clinical Chemistry Division; UTMB Pathology-Toxicology Laboratory)

Oregon Medical Laboratories
P.O. Box 972, 722 East 11th Ave.
Eugene, OR 97440–0972
541–687–2134

Pacific Toxicology Laboratories
6160 Variel Ave.

Woodland Hills, CA 91367
818–598–3110 / 800–328–6942
(Formerly: Centinela Hospital Airport Toxicology Laboratory

Pathology Associates Medical Laboratories
110 West Cliff Drive
Spokane, WA 99204
509–755–8991 / 800–541–7891x8991

PharmChem Laboratories, Inc.
4600 N. Beach
Haltom City, TX 76137
817–605–5300
(Formerly: PharmChem Laboratories, Inc., Texas Division; Harris Medical Laboratory)

Physicians Reference Laboratory
7800 West 110th St.
Overland Park, KS 66210
913–339–0372 / 800–821–3627

Quest Diagnostics Incorporated
3175 Presidential Dr.
Atlanta, GA 30340
770–452–1590
(Formerly: SmithKline Beecham Clinical Laboratories, SmithKline Bio-Science Laboratories)

Quest Diagnostics Incorporated
4770 Regent Blvd.
Irving, TX 75063
800–842–6152
(Moved from the Dallas location on 03/31/01; Formerly: SmithKline Beecham Clinical Laboratories, SmithKline Bio-Science Laboratories)

Quest Diagnostics Incorporated
400 Egypt Rd.
Norristown, PA 19403
610–631–4600 / 877–642–2216
(Formerly: SmithKline Beecham Clinical Laboratories, SmithKline Bio-Science Laboratories)

Quest Diagnostics Incorporated
506 E. State Pkwy.
Schaumburg, IL 60173
800–669–6995 / 847–885–2010
(Formerly: SmithKline Beecham Clinical Laboratories, International Toxicology Laboratories)

Quest Diagnostics Incorporated
7600 Tyrone Ave.
Van Nuys, CA 91405
818–989–2520 / 800–877–2520
(Formerly: SmithKline Beecham Clinical Laboratories)

Scientific Testing Laboratories, Inc.
463 Southlake Blvd.
Richmond, VA 23236
804–378–9130

S.E.D. Medical Laboratories
5601 Office Blvd.
Albuquerque, NM 87109
505–727–6300 / 800–999–5227

South Bend Medical Foundation, Inc.
530 N. Lafayette Blvd.
South Bend, IN 46601
219–234–4176

Southwest Laboratories
2727 W. Baseline Rd.
Tempe, AZ 85283
602–438–8507 / 800–279–0027

Sparrow Health System
Toxicology Testing Center, St. Lawrence Campus
1210 W. Saginaw
Lansing, MI 48915
517–377–0520
(Formerly: St. Lawrence Hospital & Healthcare System)

St. Anthony Hospital Toxicology Laboratory
1000 N. Lee St.
Oklahoma City, OK 73101
405–272–7052

Sure-Test Laboratories, Inc.
2900 Broad Avenue
Memphis, Tennessee 38112
901–474–6028

Toxicology & Drug Monitoring Laboratory
University of Missouri Hospital & Clinics
2703 Clark Lane, Suite B, Lower Level
Columbia, MO 65202
573–882–1273

Toxicology Testing Service, Inc.
5426 N.W. 79th Ave.
Miami, FL 33166
305–593–2260

US Army Forensic Toxicology Drug Testing Laboratory
Fort Meade, Building 2490
Wilson Street
Fort George G. Meade, MD 20755–5235
301–677–7085

The following laboratory voluntarily withdrew from the National Laboratory Certification Program, on October 28, 2002:

Clinical Laboratory Partners, LLC
129 East Cedar St.
Newington, CT 06111
860–696–8115
(Formerly: Hartford Hospital Toxicology Laboratory)

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* The Standards Council of Canada (SCC) voted to end its Laboratory Accreditation Program for Substance Abuse (LAPSA) effective May 12, 1998. Laboratories certified through that program were accredited to conduct forensic urine drug testing as required by U.S. Department of Transportation (DOT) regulations. As of that date, the certification of those accredited Canadian laboratories will continue under DOT authority. The responsibility for conducting quarterly performance testing plus periodic on-site inspections of those LAPSA-accredited laboratories was transferred to the U.S. DHHS, with the DHHS' National Laboratory Certification Program (NLCP) contractor continuing to have an active role in the performance testing and laboratory inspection processes. Other Canadian laboratories wishing to be considered for the NLCP may apply directly to the NLCP contractor just as U.S. laboratories do.

Upon finding a Canadian laboratory to be qualified, the DHHS will recommend that DOT certify the laboratory (Federal Register, 16 July 1996) as meeting the minimum standards of the ''Mandatory Guidelines for Workplace Drug Testing'' (59 FR, 9 June 1994, Pages 29908–29931). After receiving the DOT certification, the laboratory will be included in the monthly list of DHHS certified laboratories and participate in the NLCP certification maintenance program.

Richard Kopanda,
Executive Officer, SAMHSA.

[FR Doc. 02–27785 Filed 10–31–02; 8:45 am]
BILLING CODE 4160–20–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4737–N–08]

Notice of Proposed Information Collection for Public Comment: Data Collection Techniques for Identifying the Housing Subsidy Status of Survey Respondents

AGENCY: Office of Policy Development and Research, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comment Due Date:* December 31, 2002.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Reports Liaison Officer, Office of Policy Development and Research, Department of Housing and Urban Development, 451 7th Street, Room 8228, SW., Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Harold R. Holzman, Program Evaluation Division, Office of Policy Development and Research, Department of Housing and Urban Development, 451 7th Street, SW., Room 8140, Washington, DC 20410, telephone 202–708–3700, extension 5709. This is not a toll-free number. E-mail: *Harold_R._Holman@hud.gov.* Copies of the proposed forms and other available documents may be obtained from Harold Holzman.

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This notice 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 functions to the agency, including if 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; (4) Minimize the burden of the collection of information on those who respond, including through the use of appropriate automated collection techniques or other forms of information technology that will reduce respondent burden (*e.g.,* permitting electronic submission of responses).

This notice also provides the following information:

Title of Proposal: Data Collection Techniques for Identifying the Housing Subsidy Status of Survey Respondents.

Description of the Need for Information and Proposed Use: The Department is conducting under contract a study to develop techniques to more accurately identify respondents' housing subsidy status in the American Housing Survey (AHS). The AHS provides information about the Nation's housing needs, with emphasis on the condition of the housing of low income households, as required by the Housing and Urban/Rural Recovery Act of 1983. The AHS data are also the basis of an annual report on housing quality that Congress requires of the President. Further, AHS data allow the Department to evaluate the housing needs of low-income families.

Accuracy of the results has been an issue in past versions of the AHS. Specifically, a substantial proportion of respondents misidentify their housing subsidy status in the survey. This threatens the accuracy of information that is reported to Congress, and it also can lead the Department to provide inadequate amounts of housing assistance to low-income families.

Some housing subsidy misidentifications in the AHS involve a 'false positive' pattern: individuals who do not receive a housing subsidy based on program records indicate that they do receive a subsidy in the AHS. The present investigation is an attempt to determine whether alternative survey questions would reduce the number of false positives in the AHS.

To identify false positives, it is necessary to first identify individuals who believe themselves in receipt of a housing subsidy, then use program records to determine whether they are actually receiving a subsidy. In the present study, screening interviews matched with program records will be used to identify individuals who fit the false positive pattern. Alternative questions designed to more effectively identify false positives will be tested in a second interview with a sample of such individuals.

Members of the Affected Public: (1) Randomly selected individuals will participate in screening interviews; and (2) a subset of the randomly selected individuals will participate in a second interview.

Estimation of the Total Number of Hours Needed With Those Surveyed to Conduct the Information Collection, Including Number of Respondents, Frequency of Response, and Hours of Response: The researchers will complete screening interviews with 800 individuals. The individuals will be interviewed by telephone, in their homes, or in another place that is convenient for them. The screening interviews will involve questions about housing subsidies, to identify individuals who believe themselves in receipt of a subsidy. Fifteen individuals who believe themselves in receipt of a subsidy but who are not according to program records will participate in a second interview. This second interview will test alternative questions designed to more accurately identify individuals' housing subsidy status.

Estimation of the Total Number of Hours Needed With Those Surveyed to Conduct the Information Collection, Including Number of Respondents, Frequency of Response, and Hours of Response:

Types of respondents	Number of respondents	Number of responses	Minutes per respondent	Total burden hours
Randomly selected individuals	800	1	5	67
Low-income individuals who incorrectly believe that they are receiving a housing subsidy	15	1	60	15
Total	815	.....	.....	82

Status of the Proposed Information Collection: Pending OMB for approval.

Authority: Section 3506 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35, as amended.

Dated: October 23, 2002.

Harold L. Bunce,

Deputy Assistant Secretary for Economic Affairs.

[FR Doc. 02–27747 Filed 10–31–02; 8:45 am]

BILLING CODE 4210–62–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4734–N–63]

Notice of Submission of proposed Information Collection to OMB: Public Housing Assessment System (PHAS) Management Operations Certification

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* December 2, 2002.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2535–0106) and should be sent to: Lauren Wittenberg, OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503; Fax number (202) 395–6974; E-mail *Lauren_Wittenberg@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; e-mail *Wayne_Eddins@HUD gov;* telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed

forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) The office of the agency to collect the information; (3) The OMB approval number, if applicable; (4) The description of the need for the information and its proposed use; (5) The agency form number, if applicable; (6) What members of the public will be affected by the proposal; (7) How frequently information submissions will be required; (8) An estimate of the total number of hours to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) Whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) The name and telephone number of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

This Notice also lists the following information:

Title of Proposal: Public Housing Assessment system (PHAS) Management Operations Certification.

OMB Approval Number: 2535–0106.

Form Numbers: HUD–50072.

Description of the Need for the Information and Its Proposed Use: Public Housing Assessment Systems (PHAS) indicators will be used to assess the management performance of PHAS designated troubled PHAs and troubled with respect to the program, for assistance from the Capital Fund.

Respondents: Not-for profit institutions, state, Local or Tribal Government.

Frequency of Submission: Annually.

	Number of respondents	x	Annual responses	x	Hours per response	=	Burden hours
Reporting Burden	3,169		1		1.95		6,202

Total Estimated Burden Hours: 6,202.

Status: Revision of a currently approved collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: October 22, 2002.

Wayne Eddins,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 02–27746 Filed 10–31–02; 8:45 am]

BILLING CODE 4210–72–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4730–N–44]

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 1, 2002.

FOR FURTHER INFORMATION CONTACT: Mark Johnston, 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: October 24, 2002.

John D. Garrity,

Director, Office of Special Needs Assistance Programs.

[FR Doc. 02–27536 Filed 10–31–02; 8:45 am]

BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Natural Gas Pipeline Right-of-Way Permit Application To Cross Roanoke River National Wildlife Refuge

AGENCY: Fish and Wildlife Service, Department of the Interior.

ACTION: Notice.

SUMMARY: This Notice advises the public that Eastern North Carolina Natural Gas, has applied for a right-of-way permit for the installation of a twelve (12)-inch outer-diameter natural gas pipeline across 8.5 acres of Roanoke River National Wildlife Refuge in Bertie County, North Carolina, described as follows: A right-of-way with a total width of twenty (20) feet on, over, across, and through that part of the Roanoke River National Wildlife lying and being in Bertie County, North Carolina. The proposed route is within the existing Department of Transportation right-of-way.

The proposed pipeline will cross approximately 3.5 miles of refuge lands between Windsor and Williamston, North Carolina. Commencing at the Northern entrance to the refuge running along the highway to the Roanoke River.

The purpose of the notice is to inform the public that the United States Fish and Wildlife Service is currently considering the merits of approving this application.

DATES: Interested persons desiring to comment on this application should do so within thirty (30) days following the date of publication of this notice.

ADDRESSES: If you wish to comment, you may submit comments by any one of several methods. You may mail comments to Regional Director, U.S. Fish and Wildlife Service, 1875 Century Boulevard, Room 400, Atlanta, Georgia 30345. You may also comment via the Internet to *Roger__Beckham@fws.gov.* Please submit Internet comments as an ASCII file avoiding the use of special characters and any form of encryption. Please also include ''Attn: Roger Beckham'' and your name and return address in your Internet message. If you do not receive a confirmation from the system that we have received your Internet message, contact us at U.S. Fish and Wildlife Service, Division of Realty, Roger Beckham, 1–800–419–9582. Finally, you may hand deliver comments to Regional Director, U.S. Fish and Wildlife Service, 1875 Century Boulevard, Suite 400, Atlanta, Georgia 30345. 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 rulemaking record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the rulemaking record a respondent's identity, as allowable by law. If you wish 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.

FOR FURTHER INFORMATION CONTACT: Roger Beckham, Chief, Realty Branch-East, at the above Atlanta, Georgia, address or call (404) 679–7204 or FAX (404) 679–7273.

Right-of-way applications are filed in accordance with section 28 of the Mineral Leasing Act of 1920 (41 Stat. 449:30 U.S.C. 185), as amended by Public Law 93–153. Additionally, 50 CFR 29.21–9f requires this Agency to publish Notices in the **Federal Register**.

Dated: October 15, 2002.

Sam D. Hamilton,

Regional Director.

[FR Doc. 02–27793 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–55–M

DEPARTMENT OF THE INTERIOR

Minerals Management Service

Agency Information Collection Activities: Proposed Collection, Comment Request

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Notice of an extension of a currently approved information collection (OMB Control Number 1010–0103).

SUMMARY: To comply with the Paperwork Reduction Act (PRA) of 1995, we are inviting comments on a collection of information that we will submit to the Office of Management and Budget (OMB) for review and approval. The information collection request (ICR) is titled ''30 CFR part 206, subpart E—Indian Gas (Form MMS–4411, Safety Net Report).''

DATES: Submit written comments on or before December 31, 2002.

ADDRESSES: Submit written comments to Sharron L. Gebhardt, Regulatory Specialist, Minerals Management Service, Minerals Revenue Management, PO Box 25165, MS 320B2, Denver, Colorado 80225. If you use an overnight courier service, our courier address is Building 85, Room A–614, Denver Federal Center, Denver, Colorado 80225. You may also email your comments to us at *mrm.comments@mms.gov.* Include the title of the information collection and the OMB control number in the ''Attention'' line of your comment. Also include your name and return address. Submit electronic comments as an ASCII file avoiding the use of special characters and any form of encryption. If you do not receive a confirmation we have received your email, contact Ms. Gebhardt at (303) 231–3211.

FOR FURTHER INFORMATION CONTACT: Sharron L. Gebhardt, telephone (303) 231–3211, FAX (303) 231–3385 or email *sharron.gebhardt@mms.gov.*

SUPPLEMENTARY INFORMATION: *Title:* 30 CFR part 206, subpart E—Indian Gas (Form MMS–4411, Safety Net Report).

OMB Control Number: 1010–0103.

Bureau Form Number: Form MMS–4411.

Abstract: The Department of the Interior (DOI) is responsible for matters relevant to mineral resource development on Federal and Indian lands and the Outer Continental Shelf (OCS). The Secretary of the Interior (Secretary) is responsible for managing the production of minerals from Federal and Indian lands and the OCS, collecting royalties from lessees who produce minerals, and distributing the funds collected in accordance with applicable laws. The Secretary has an Indian trust responsibility to manage Indian lands and seek advice and information from Indian beneficiaries. MMS performs the royalty management functions and assists the Secretary in carrying out DOI's Indian trust responsibility.

On August 10, 1999, MMS published in the **Federal Register** (64 FR 43506) a final rulemaking titled ''Amendments to Gas Valuation Regulations for Indian Leases,'' with an effective date of January 1, 2000. These regulations are codified at 30 CFR part 206, subpart E. Form MMS–4411, Safety Net Report, governs the valuation for royalty purposes of natural gas produced from Indian leases. In 30 CFR 206.172(e), MMS requires that lessees submit Form MMS–4411 when gas production from an Indian lease is sold beyond the first index pricing point. The gas regulations apply to all gas production from Indian (tribal or allotted) oil and gas leases (except leases on the Osage Indian Reservation).

Form MMS–4411 ensures Indian mineral lessors receive the maximum revenues from mineral resources on their land consistent with the Secretary's trust responsibility and lease terms. It permits lessees to comply with the regulatory requirements at the time that royalties are due.

The safety net calculation establishes the minimum value, for royalty purposes, of natural gas production from Indian leases. This reporting requirement will assist the Indian lessor in receiving all the royalties that are due and aid MMS in its compliance efforts. The safety net price is calculated using prices received for gas sold downstream of the first index pricing point. It will include only the lessee's or the lessee's affiliate's arm's-length sales price, and it will not require detailed calculations for the costs of transportation. By June 30 following any calendar year, the lessee calculates a safety net price for each month of the previous calendar year. Lessees must calculate the safety net prices for each index zone where the lessee has an Indian lease. The safety net price will capture the significantly higher values for sales occurring beyond the index point. The lessee will submit its safety net prices to MMS annually (by June 30) using Form MMS–4411.

We are also revising this ICR to include reporting requirements that were inadvertently overlooked when the final rule was published. See the chart below for these requirements and associated burden hours. These reporting requirements are rare and unusual circumstances where the standard valuation procedures set out in the Indian gas valuation rule are not appropriate.

MMS is requesting OMB's approval to continue to collect this information. Not collecting this information would limit the Secretary's ability to discharge his/her duties and may also result in loss of royalty payments to the Indian lessor due to royalties not being collected on prices received under higher priced long-term sales contracts. Proprietary information submitted is protected, and there are no questions of a sensitive nature included in this information collection.

We have also changed the title of this ICR from ''Safety Net Report'' to ''30 CFR part 206, subpart E—Indian Gas (Form MMS–4411, Safety Net Report),'' to clarify the regulatory language we are covering under 30 CFR part 206.

Frequency: Annually.

Estimated Number and Description of Respondents: 29 Indian lessees/lessors.

Estimated Annual Reporting and Record keeping ''Hour'' Burden: 1,012 hours.

The following chart shows the breakdown of the burden hours by CFR section and paragraph:

30 CFR section	Reporting requirement	Burden hours per response	Annual number of responses	Annual burden hours
206.172(e)(6)(i) and (iii)	You must report the safety net price for each index zone to MMS on Form MMS–4411, Safety Net Report, no later than June 30 following each calendar year * * * MMS may order you to amend your safety net price within one year from the date your Form MMS–4411 is due or is filed, whichever is later.	25	24	600
206.172(f)(1), (2), and (3)	An Indian tribe may ask MMS to exclude some or all of its leases from valuation under this section. . . . If an Indian tribe requests exclusion from an index zone for less than all of its leases, MMS will approve the request only if the excluded leases may be segregated into one or more groups based on separate fields within the reservation. . . . An Indian tribe may ask MMS to terminate exclusion of its leases from valuation under this section. . . . The Indian tribe's request to MMS under either paragraph (f)(1) or (2) of this section must be in the form of a tribal resolution.	40	1	40
206.174(f)	You may ask MMS for guidance in determining value. You may propose a valuation method to MMS. Submit all available data related to your proposal and any additional information MMS deems necessary.	40	1	40
206.175(d)(4)	You may request MMS approval of other methods for determining the quantity of residue gas and gas plant products allocable to each lease.	20	1	20
Transportation Allowances				
206.178(a)(1)(i)	You are required to submit to MMS a copy of your arm's-length transportation contract(s) and all subsequent amendments to the contract(s) within 2 months of the date MMS receives your report which claims the allowance on the Form MMS–2014.	8	2	16
206.178(a)(2)(ii)	As an alternative to paragraph (a)(2)(i) of this section, you may propose to MMS a cost allocation method based on the values of the products transported.	20	1	20
206.178(a)(3)(i) & (ii)	If your arm's-length transportation contract includes both gaseous and liquid products and the transportation costs attributable to each cannot be determined from the contract, you must propose an allocation procedure to MMS. You are required to submit all relevant data to support your allocation proposal.	40	1	40
206.178(b)(2)(iv)	After you have elected to use either method [depreciation with a return on under appreciated capital investment or a return on depreciable capital investment] for a transportation system, you may not later elect to change to the other alternative without MMS approval.	20	1	20
206.178(b)(2)(iv)(A)	Once you make an election [depreciation or unit of production method], you may not change methods without MMS approval.	20	1	20
206.178(b)(3)(I)	Except as provided in this paragraph, you may not take an allowance for transporting a product that is not royalty bearing without MMS approval.	40	1	40
206.178(b)(3)(ii)	As an alternative to the requirements of paragraph (b)(3)(i) of this section, you may propose to MMS a cost allocation method based on the values of the products transported.	See 206.178(a)(2)(ii)		
206.178(b)(5)	If you transport both gaseous and liquid products through the same transportation system, you must propose a cost allocation procedure to MMS. . . . You are required to submit all relevant data to support your proposal.	See 206.178(a)(3)(i)(ii) and		
Processing Allowances				
206.180(a)(1)(i)	You are required to submit to MMS a copy of your arm's-length processing contract(s) and all subsequent amendments to the contract(s) within 2 months of the date MMS receives your first report which deducts the allowance on the Form MMS–2014.	8	2	16
206.180(a)(3)	If your arm's-length processing contract includes more than one gas plant product and the processing costs attributable to each product cannot be determined from the contract, you must propose an allocation procedure to MMS. . . . You are required to submit all relevant data to support your proposal.	40	1	40
206.180(b)(2)(iv)	After you elect to use either method [depreciation with a return on undepreciable capital investment or a return on depreciable capital investment] for a processing plant, you may not later elect to change to the other alternative without MMS approval.	20	1	20
206.180(b)(2)(iv)(A)	Once you make an election, you may not change [depreciation or unit of production] methods without MMS approval.	20	1	20

30 CFR section	Reporting requirement	Burden hours per response	Annual number of responses	Annual burden hours
206.180(b)(3)	Your processing allowance under this paragraph (b) must be determined based upon a calendar year or other period if you and MMS agree to an alternative.	20	1	20
206.181(c)	A proposed comparable processing fee submitted to either the Tribe and MMS (for tribal leases) or MMS (for allotted leases) with your supporting documentation submitted to MMS. If MMS does not take action on your proposal within 120 days, the proposal will be deemed to be denied and subject to appeal to the MMS Director under 30 CFR part 290.	40	1	40
Total			41	1,012

Estimated Annual Reporting and Record keeping ''Non-hour Cost'' Burden: We have identified no ''non-hour'' cost burdens.

Comments: The PRA (44 U.S.C. 3501, *et seq.*) provides 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. Before submitting an ICR to OMB, PRA Section 3506(c)(2)(A) 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.

The PRA also requires agencies to estimate the total annual reporting ''non-hour cost'' burden to respondents or record keepers resulting from the collection of information. We have not identified non-hour cost burdens for this information collection. If you have costs to generate, maintain, and disclose this information, you should comment and provide your total capital and startup cost components or annual operation, maintenance, and purchase of service components. You should describe the methods you use to estimate major cost factors, including system and technology acquisition, expected useful life of capital equipment, discount rate(s), and the period over which you incur costs. Capital and startup costs include, among other items, computers and software you purchase to prepare for collecting information; monitoring, sampling, testing equipment; and record storage facilities. Generally, your estimates should not include equipment or services purchased: (i) Before October 1, 1995; (ii) to comply with requirements not associated with the information collection; (iii) for reasons other than to provide information or keep records for the Government; or (iv) as part of customary and usual business or private practices.

We will summarize written responses to this notice and address them in our ICR submission for OMB approval, including appropriate adjustments to the estimated burden. We will provide a copy of the ICR to you without charge upon request and the ICR will also be posted on our Web site at *http://www.mrm.mms.gov/Laws_R_D/FRNotices/FRInfColl.htm.*

Public Comment Policy: We will post all comments in response to this notice on our Web site at *http://www.mrm.mms.gov/Laws_R_D/FRNotices/FRInfColl.htm.* We will also make copies of the comments available for public review, including names and addresses of respondents, during regular business hours at our offices in Lakewood, Colorado. Individual respondents may request we withhold their home address from the public record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the rulemaking record a respondent's identity, as allowable by law. If you request that we withhold your name and/or address, 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: October 25, 2002.

Cathy J. Hamilton,

Acting Associate Director for Minerals Revenue Management.

[FR Doc. 02–27715 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF THE INTERIOR

National Park Service

Kaloko-Honokohau National Historical Park, Advisory Commission; Notice of Meeting

Notice is hereby given in accordance with the Federal Advisory Committee Act that a meeting of the Na Hoapili O Kaloko Honokohau, Kaloko-Honokohau National Historical Park Advisory Commission will be held at 9 a.m., November 16, 2002 at Kaloko-Honokohau National Historical Park headquarters, 73–4786 Kanalani St. Suite 14, Kailua-Kona, Hawaii.

The agenda will include Status on Park Brochure, Report on Alu Like Training Program, and FY2003 Budget Plans.

The meeting is open to the public. Minutes will be recorded for documentation and transcribed for dissemination. Minutes of the meeting will be available to the public after approval of the full Advisory Commission. Transcripts will be available after 30 days of the meeting.

For copies of the minutes, contact Kaloko-Honokohau National Historical Park at (808) 329–6881.

Dated: October 8, 2002.

Geraldine K. Bell,

Superintendent, Kaloko-Honokohau National Historical Park.

[FR Doc. 02–27878 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–70–M

DEPARTMENT OF THE INTERIOR

National Park Service

National Register of Historic Places; Notification of Pending Nominations

Nominations for the following properties being considered for listing in the National Register were received by the National Park Service before October 12, 2002. Pursuant to § 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded by the United States Postal Service, to the National Register Historic Places, National Park Service, 1849 C St. NW, NC400, Washington, DC 20240; by all other carriers, National Register of Historic Places, National Park Service,1201 Eye St. NW, 8th floor, Washington, DC 20005; or by fax, 202–343–1836. Written or faxed comments should be submitted by November 18, 2002.

Carol D. Shull,

Keeper of the National Register of Historic Places.

ARIZONA

Navajo County

Hubbell, Lorenzo, Trading Post and Warehouse, 523 W. Second St., Winslow, 02001383

Pinal County

Picacho Pass Skirmish Site—Overland Mail Co. Stage Station at Picacho Pass, 1 mi. NW of I–10, Interchange #219, Picacho, 02001384

CALIFORNIA

Modoc County

Nelson Springs, Address Restricted, Likely, 02001393

Mono County

Dry Lakes Plateau, Address Restricted, Bodie Hills, 02001394

Placer County

Stevens Trail, Roughly bounded by Iowa Hill, canyon of North fork of American R., until at Secret Ravine, top of ridge of Colfax, Colfax, 02001391

San Francisco County

Central Embarcadero Piers Historic District, Piers 1, 1½, 3 and 5, The Embarcadero, San Francisco, 02001390

Santa Barbara County

Point Sal Ataje, Address Restricted, Point Sal Highlands, 02001392

GEORGIA

Fulton County

Reynoldstown Historic District, Roughly bounded by the CSX rail line, Memorial Dr., Pearl St., and Moreland, Atlanta, 02001405

Putnam County

Rockville Academy and St. Paul Methodist Church Historic District, E of Eatonton and S of GA 16, Rockville Rd., Eatonton, 02001382

ILLINOIS

Cook County

Automatic Electric Company Building, 1001 W. Van Buren, Chicago, 02001386

Berwyn Health Center, 6600 W. 26th St., Berwyn, 02001352

Fuller Park, (Chicago Park District MPS) 331 W. 45th St., Chicago, 02001347

Maxwell—Briscoe Automobile Company Showroom, (Motor Row, Chicago, Illinois MPS) 1737 S. Michigan Ave., Chicago, 02001349

Motor Row Historic District, (Motor Row, Chicago, Illinois MPS) Roughly bounded by 22nd St., Indiana St., 24th Place, and Wabash St., Chicago, 02001387

Norwood Park Historical District, Roughly bounded by Harlem Ave., Nagle Ave., Bryn Mawr Ave., and Avondale St., Chicago, 02001350

Scoville Place, Jct. of Lake St. and Oak Park Ave., Oak Park, 02001351

Lake County

Waukegan Building, 4 S. Genesee St., Waukegan, 02001355

Madison County

Collins, Daniel Dove, House, 621 W. Main St., Collinsville, 02001385

Norodni Sin, 209–211 E. Vandalia, Edwardsville, 02001353

Ogle County

Buffalo Grove Lime Kiln, Galena Trail Rd., Polo, 02001348

Williamson County

Stotlar, Ed. M., House, 1304 W. Main St., Marion, 02001354

MISSISSIPPI

Greene County

Vernal Presbyterian Church, 455 McInnis—Vernal Rd., Lucedale, 02001389

Hinds County

Welty, Eudora, House, 1119 Pinehurst St., Jackson, 02001388

MISSOURI

Cole County

Kaullen Mercantile Company, 900 and 902 E. High St., Jefferson City, 02001402

Jackson County

Kansas City Club Building, 1228 Baltimore Ave., Kansas City, 02001401

TWA Corporate Headquarters' Building, 1735–1741 Baltimore Ave.—1740 Main St., Kansas City, 02001403

Marion County

Maple Avenue Historic District, Roughly bounded by Broadway and Center St., Alley to North St., Dulany to Section, Hannibal, 02001404

NEW YORK

Albany County

First Reformed Dutch Church of Bethlehem, US 9W, Bethlehem, 02001398

Delaware County

Congregation Bnai Israel Synagogue, Wagner Ave., Fleischmanns, 02001396

Queens County

Congregation Tifereth Israel, 109–18 and 109–20 54th Ave., Corona, 02001357

Rensselaer County

Lansingburgh Village Burial Ground, Third Ave. and 107th St., Troy, 02001358

Richmond County

Calvary Presbyterian Church, 909 Castleton Ave., Staten Island, 02001356

Schuyler County

Watkins Glen Grand Prix Course, 1948–1952, Franklin St., NY 329, NY 409, Watkins Glen, 02001397

Sullivan County

St. John's Episcopal Church and Rectory, 15 St. John's St., Monticello, 02001359

Ulster County

K. WHITTELSEY (Tugboat), 3 North St. at Rondout Creek, Kingston, 02001395

Ulster House Hotel, Main St. at Academy Rd., Pine Hill, 02001399

Westchester County

Peekskill Presbyterian Church, 705 South St., Peekskill, 02001400

OHIO

Cuyahoga County

Weizer Building, 11801 Buckeye Rd., Cleveland, 02001360

TENNESSEE

Madison County

New Souther Hotel, 112–120 E. Baltimore St., Jackson, 02001378

Rutherford County

Lytle Cemetery, 739 NW Broad St., Murfreesboro, 02001376

Shelby County

Martin Memorial Temple CME Church, 65 S. Parkway West, Memphis, 02001379

Warren County

City Cemetery, South High St., McMinnville, 02001377

VERMONT

Addison County

Brooksville Advent Church, (Religious Buildings, Sites and Structures in Vermont MPS) 1338 Dog Team Tavern Rd., New Haven, 02001380

Dog Team Tavern, 1338 Dog Team Tavern Rd., New Haven, 02001381

VIRGINIA

Augusta County

Bare House and Mill, 157 Wilda Rd., Stuarts Draft, 02001364

Carroll County

Carter Hydraulic Rams, Off Grayson St. and U.S. 221, Hillsville, 02001373

Franklin County

Bleak Hill, Address Restricted, Callaway, 02001374

Greene County

Powell—McMullan House, 233 McMullen Mill Rd., Stanardsville, 02001367

Hanover County

Hanover Wayside, 8225 Hanover Wayside Rd., Hanover, 02001365

Henry County

Old Turner Place, 7643 Henry Rd., Henry, 02001371

Lynchburg Independent city

Court House Hill—Downtown Historic District (Boundary Increase), Roughly along Madison St., Harrison St., 7th St., 6th St., Lynchburg (Independent City), 02001361

Page County

Wall Brook Farm, 967 Longs Rd., Luray, 02001375

Richmond Independent city

Bryan, Joseph, Park, 4308 Hermitage Rd., Richmond (Independent City), 02001369

Church of the Sacred Heart, 1401 Perry St., Richmond (Independent City), 02001368

New Pump House, 1708 Pump House Dr., Richmond (Independent City), 02001366

Rockbridge County

Hamilton Schoolhouse, VA 611, S. Buffalo Rd., Lexington, 02001372

Tazewell County

Moore, Capt. James, Homestead, VA 644, Boissevain, 02001363

Sanders, Walter McDonald, House, College Ave., Bluefield, 02001370

Wise County

Southwest Virginia Museum Historical State Park, 10 W. Street N, Big Stone Gap, 02001362

A request for REMOVAL has been made for the following resources:

IOWA

Washington County

Rubio Bridge, (Highway Bridges in Iowa MPD) Over Skunk R. Rubio vicinity, 98000471

PENNSYLVANIA

Lackawanna County

Dalton House E. Main St. Dalton, 78002410

[FR Doc. 02–27880 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

National Park Service

Information Quality Guidelines pursuant to Section 515 of the Treasury and General Government Appropriations Act for Fiscal Year 2001

AGENCY: Department of Interior, National Park Service.

ACTION: Notice of availability of Information Quality Guidelines.

SUMMARY: The National Park Service is announcing the availability of Information Quality Guidelines in order to comply with the guidelines issued by the Office of Management and Budget in the **Federal Register**, Vol., 2, No. 67, dated January 2, 2002, and reissued February 2, 2002, Vol., 67, No. 36, for implementing Section 515(a) of the Treasury and General Government Appropriations Act for Fiscal Year 2001 (Pub. L. 106–554; HR 5658).

FOR FURTHER INFORMATION CONTACT: Persons interested in reviewing the final Information Quality Guidelines are encouraged to access the guidelines at website *http://data2.itc.nps.gov/npspolicy/Dorders.cfm* Individuals are also encouraged to contact the National Park Service, Washington Administrative Program Center, (Attn: Deke Cripe) 1849 C Street, NW, Mail Stop 2605, Washington, DC 20240: Phone 202–354–1927.

SUPPLEMENTARY INFORMATION: The National Park Service disseminates a wide variety of information to the public, including organizational information, natural and cultural resource information, and budget information. Organizational information includes general descriptive information about the NPS and its component parks and offices. Examples include the parks' history, functions, and legislative authorities; organizational charts, the offices within the parks and their functions; the parks' strategic and performance plans and their budgetary information; and information pertaining to the parks' history, natural and cultural resources and administrative processes. This document is the basis for National Park Service policy to assure the quality of the information it disseminates.

Richard G. Cripe,

Manager, Washington Administrative Program Center.

[FR Doc. 02–27879 Filed 10–31–02; 8:45 am]

BILLING CODE 4310–70–P

INTERNATIONAL TRADE COMMISSION

[Investigations Nos. 701–TA–417–419 and 731–TA–953, 954, 956–959, 961, and 962 (Final)]

Carbon and Certain Alloy Steel Wire Rod From Brazil, Canada, Germany, Indonesia, Mexico, Moldova, Trinidad and Tobago, and Ukraine

Determinations

On the basis of the record [1] developed in the subject investigations, the United States International Trade Commission determines, pursuant to section 705(b) of the Tariff Act of 1930 (19 U.S.C. 1671d(b)) (the Act), that an industry in the United States is materially injured by reason of imports from Brazil and Canada of carbon and certain alloy steel wire rod [2] that have been found by the Department of Commerce (Commerce) to be subsidized by the Governments of Brazil and Canada. The Commission also determines, pursuant to section 735(b) of the Act (19 U.S.C. 1673d(b)), that an industry in the United States is materially injured by reason of imports from Brazil, Canada, Indonesia, Mexico, Moldova, Trinidad and Tobago, and Ukraine of carbon and certain alloy steel wire rod that have been found by Commerce to be sold in the United States at less than fair value (LTFV).[3]

[1] The record is defined in 207.2(f) of the Commission's Rules of Practice and Procedure (19 CFR 207.2(f)).

[2] The merchandise covered by these investigations is certain hot-rolled products of carbon steel and alloy steel, in coils, of approximately round cross section, 5.0 mm or more but less than 19.0 mm, in solid cross-sectional diameter. Specifically excluded are steel products possessing the above-noted physical characteristics and meeting the *Harmonized Tariff Schedule of the United States (HTS)* definitions for (a) stainless steel, (b) tool steel, (c) high nickel steel, (d) ball bearing steel, and (e) concrete reinforcing bars and rods. Also excluded are (f) free machining steel products (*i.e.*, products that contain by weight one or more of the following elements: 0.03 percent or more of lead, 0.05 percent or more of bismuth, 0.08 percent or more of sulfur, more than 0.04 percent of phosphorus, more than 0.05 percent of selenium, or more than 0.01 percent of tellurium). Also excluded from the scope are grade 1080 tire cord and tire bead quality wire rod that comport with the specifications, definitions, and applications set forth in Commerce's revised scope language (see, for example, Commerce's final determination of sales at LTFV concerning Canada, 67 FR 55782, August 30, 2002). All products meeting the physical description of subject merchandise that are not specifically excluded are included in the scope of these investigations. The subject merchandise is provided for in HTS subheadings 7213.91, 7213.99, 7227.20, and 7227.90.60.

[3] Chairman Deanna Tanner Okun determines that an industry in the United States is not materially injured or threatened with material injury, and the establishment of an industry in the United States is not materially retarded, by reason of imports from Trinidad and Tobago of carbon and certain alloy steel wire rod that have been found by Commerce to be sold in the United States at LTFV.

The Commission further determines, pursuant to section 771(24)(A) of the Act (19 U.S.C. 1677(24)(A)) that imports of carbon and certain alloy steel wire rod from Germany that have been found by Commerce to be subsidized by the Government of Germany and sold in the United States at LTFV are negligible, and its investigations with regard to that country are thereby terminated pursuant to sections 705(b) and 735(b) of the Act.[4] With regard to imports of the subject merchandise from Moldova and Ukraine that were subject to affirmative critical circumstances determinations by Commerce, the Commission determines that critical circumstances do not exist.[5]

Background

The Commission instituted these investigations effective August 31, 2001, following receipt of petitions filed with the Commission and Commerce by counsel on behalf of Co-Steel Raritan, Inc., Perth Amboy, NJ; GS Industries, Inc., Charlotte, NC; Keystone Consolidated Industries, Inc., Dallas, TX; and North Star Steel Texas, Inc., Edina, MN. The final phase of the investigations was scheduled by the Commission following notification of preliminary determinations by Commerce that imports of carbon and certain alloy steel wire rod from Canada and Germany were being subsidized within the meaning of section 703(b) of the Act (19 U.S.C. 1671b(b))[6] and imports of carbon and certain alloy steel wire rod from Brazil, Canada, Germany, Indonesia, Mexico, Moldova, Trinidad and Tobago, and Ukraine were being sold at LTFV within the meaning of section 733(b) of the Act (19 U.S.C. 1673b(b)). Notice of the scheduling of the final phase of the Commission's investigations and of a public hearing to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** of May 2, 2002 (67 FR 22105).[7] The hearing was held in Washington, DC, on August 27, 2002, and all persons who requested the opportunity were permitted to appear in person or by counsel.

The Commission transmitted its determinations in these investigations to the Secretary of Commerce on October 15, 2002. The views of the Commission are contained in USITC Publication 3546 (October 2002), entitled *Carbon and Certain Alloy Steel Wire Rod From Brazil, Canada, Germany, Indonesia, Mexico, Moldova, Trinidad and Tobago, and Ukraine: Investigations Nos. 701–TA–417–419 and 731–TA–953, 954, 956–959, 961, and 962 (Final).*

Issued: October 16, 2002.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 02–27860 Filed 10–31–02; 8:45 am]

BILLING CODE 7020–02–P

[4] Commissioner Lynn M. Bragg determines that an industry in the United States is threatened with material injury by reason of imports from Germany of carbon and certain alloy steel wire rod that have been found by Commerce to be subsidized by the Government of Germany and sold in the United States at LTFV.

[5] Commissioner Lynn M. Bragg makes affirmative determinations with regard to critical circumstances in the investigations concerning Germany, Moldova, and Ukraine.

[6] Although Commerce made a preliminary negative countervailing duty determination with respect to Brazil, it subsequently made a final affirmative countervailing duty determination with respect to that country.

[7] The Commission's schedule was subsequently revised on May 22, 2002 (67 FR 36022) and on September 12, 2002 (67 FR 57849).

INTERNATIONAL TRADE COMMISSION

[USITC SE–02–034]

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: International Trade Commission.

TIME AND DATE: November 14, 2002 at 10 a.m.

PLACE: Room 101, 500 E Street SW., Washington, DC 20436, Telephone: (202) 205–2000.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED:

1. *Agenda for future meeting:* none.
2. Minutes.
3. Ratification List.
4. Inv. No. 731–TA–1020 (Preliminary) (Barium Carbonate from China)—briefing and vote. (The Commission is currently scheduled to transmit its determination to the Secretary of Commerce on November 14, 2002; Commissioners' opinions are currently scheduled to be transmitted to the Secretary of Commerce on or before November 21, 2002).
5. *Outstanding action jackets:* none.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carrier over to the agenda of the following meeting.

Issued: October 29, 2002.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 02–27980 Filed 10–30–02; 11:19 am]

BILLING CODE 7020–02–M

DEPARTMENT OF JUSTICE

Office of the Attorney General; Certification of the Attorney General; Titus County, TX

In accordance with section 6 of the Voting Rights Act of 1965, as amended, 42 U.S.C. 1973d, I hereby certify that in my judgment the appointment of examiners is necessary to enforce the guarantees of the Fourteenth and Fifteenth Amendments of the Constitution of the United States in Titus County, Texas. This county is included within the scope of the determinations of the Attorney General and the Director of the Census made under section 4(b) of the Voting Rights Act of 1965 and published in the **Federal Register** on September 23, 1975 (40 FR 43746).

Dated: October 29, 2002.

John Ashcroft,

Attorney General of the United States.

[FR Doc. 02–27985 Filed 10–31–02; 8:45 am]

BILLING CODE 4410–13–M

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[DEA # 237P]

Controlled Substances: Proposed Aggregate Production Quotas for 2003

AGENCY: Drug Enforcement Administration (DEA), Justice.

ACTION: Notice of proposed year 2003 aggregate production quotas.

SUMMARY: This notice proposes initial year 2003 aggregate production quotas for controlled substances in Schedules I and II of the Controlled Substances Act (CSA).

DATES: Comments or objections must be received on or before November 22, 2002.

ADDRESSES: Send comments or objections to the Deputy Administrator, Drug Enforcement Administration, Washington, DC 20537, Attn.: DEA Federal Register Representative (CCR).

FOR FURTHER INFORMATION CONTACT: Frank L. Sapienza, Chief, Drug and Chemical Evaluation Section, Drug Enforcement Administration,

Washington, DC 20537, Telephone: (202) 307–7183.

SUPPLEMENTARY INFORMATION: Section 306 of the CSA (21 U.S.C. 826) requires that the Attorney General establish aggregate production quotas for each basic class of controlled substance listed in Schedules I and II. This responsibility has been delegated to the Administrator of the DEA by Section 0.100 of Title 28 of the Code of Federal Regulations. The Administrator, in turn, has redelegated this function to the Deputy Administrator, pursuant to § 0.104 of Title 28 of the Code of Federal Regulations.

The proposed year 2003 aggregate production quotas represent those quantities of controlled substances that may be produced in the United States in 2003 to provide adequate supplies of each substance for: The estimated medical, scientific, research, and industrial needs of the United States; lawful export requirements; and the establishment and maintenance of reserve stocks. These quotas do not include imports of controlled substances for use in industrial processes.

In determining the proposed year 2003 aggregate production quotas, the Deputy Administrator considered the following factors: Total actual 2001 and estimated 2002 and 2003 net disposals of each substance by all manufacturers; estimates of 2002 year-end inventories of each substance and of any substance manufactured from it and trends in accumulation of such inventories; product development requirements of both bulk and finished dosage form manufacturers; projected demand as indicated by procurement quota applications filed pursuant to Section 1303.12 of Title 21 of the Code of Federal Regulations; and other pertinent information.

Pursuant to Section 1303 of Title 21 of the Code of Federal Regulations, the Deputy Administrator of the DEA will, in early 2003, adjust aggregate production quotas and individual manufacturing quotas allocated for the year based upon 2002 year-end inventory and actual 2002 disposition data supplied by quota recipients for each basic class of Schedule I or II controlled substance.

Therefore, under the authority vested in the Attorney General by Section 306 of the CSA of 1970 (21 U.S.C. 826), and delegated to the Administrator of the DEA by § 0.100 of Title 28 of the Code of Federal Regulations, and redelegated to the Deputy Administrator pursuant to § 0.104 of Title 28 of the Code of Federal Regulations, the Deputy Administrator hereby proposes that the year 2003 aggregate production quotas for the following controlled substances, expressed in grams of anhydrous acid or base, be established as follows:

Basic class	Proposed year 2003 quotas
Schedule I	
2,5–Dimethoxyamphetamine	9,501,000
2,5–Dimethoxy-4-ethylamphetamine (DOET)	2
3–Methylfentanyl	4
3–Methylthiofentanyl	2
3,4–Methylenedioxyamphetamine(MDA)	15
3,4–Methylenedioxy-N-ethylamphetamine (MDEA)	10
3,4–Methylenedioxymethamphetamine (MDMA)	19
3,4,5–Trimethoxyamphetamine	2
4–Bromo-2,5–Dimethoxyamphetamine (DOB)	2
4–Bromo-2,5–Dimethoxyphenethylamine (2–CB)	2
4–Methoxyamphetamine	7
4–Methylaminorex	2
4–Methyl-2,5–Dimethoxyamphetamine (DOM)	2
5–Methoxy-3,4–Methylenedioxyamphetamine	2
Acetyl-alpha-methylfentanyl	2
Acetyldihydrocodeine	2
Acetylmethadol	2
Allylprodine	2
Alphacetylmethadol	7
Alpha-ethyltryptamine	2
Alphameprodine	2
Alphamethadol	2
Alpha-methylfentanyl	2
Alpha-methylthiofentanyl	2
Aminorex	17
Benzylmorphine	2
Betacetylmethadol	2
Beta-hydroxy-3-methylfentanyl	2
Beta-hydroxyfentanyl	2
Betameprodine	2
Betamethadol	2
Betaprodine	2
Bufotenine	2
Cathinone	12
Codeine-N-oxide	52
Diethyltryptamine	2
Difenoxin	9,000
Dihydromorphine	1,101,000
Dimethyltryptamine	3
Gamma-hydroxybutyric acid	45,566,000
Heroin	5
Hydromorphinol	2
Hydroxypethidine	2
Lysergic acid diethylamide (LSD)	61

Basic class	Proposed year 2003 quotas
Marihuana	840,000
Mescaline	7
Methaqualone	9
Methcathinone	9
Methyldihydromorphine	2
Morphine-N-oxide	52
N,N–Dimethylamphetamine	7
N–Ethyl-1–Phenylcyclohexylamine (PCE)	5
N–Ethylamphetamine	7
N–Hydroxy-3,4–Methylenedioxyamphetamine	2
Noracymethadol	2
Norlevorphanol	52
Normethadone	7
Normorphine	57
Para-fluorofentanyl	2
Phenomorphan	2
Pholcodine	2
Propiram	415,000
Psilocybin	2
Psilocyn	2
Tetrahydrocannabinols	131,000
Thiofentanyl	2
Trimeperidine	2
Schedule II	
1–Phenylcyclohexylamine	12
1–Piperidinocyclohexanecarbonitrile (PCC)	10
Alfentanil	700
Alphaprodine	2
Amobarbital	12
Amphetamine	10,987,000
Cocaine	171,000
Codeine (for sale)	43,494,000
Codeine (for conversion)	43,251,000
Dextropropoxyphene	167,365,000
Dihydrocodeine	741,000
Diphenoxylate	501,000
Ecgonine	31,000
Ethylmorphine	12
Fentanyl	733,000
Glutethimide	2
Hydrocodone (for sale)	29,243,000
Hydrocodone (for conversion)	3,800,000
Hydromorphone	1,409,000
Isomethadone	12
Levo-alphacetylmethadol (LAAM)	12
Levomethorphan	2
Levorphanol	8,600
Meperidine	9,649,000
Metazocine	1
Methadone (for sale)	11,657,000
Methadone Intermediate	14,693,000
Methamphetamine: 734,000 grams of levo-desoxyephedrine for use in a non-controlled, non-prescription product; 1,220,000 grams for methamphetamine for conversion to a Schedule III product; and 1,000 grams for methamphetamine (for sale)	1,955,000
Methylphenidate	20,967,000
Morphine (for sale)	18,218,000
Morphine (for conversion)	110,774,000
Nabilone	2
Noroxymorphone (for sale)	40,000
Noroxymorphone (for conversion)	4,400,000
Opium	700,000
Oxycodone (for sale)	34,482,000
Oxycodone (for conversion)	700,000
Oxymorphone	454,000
Pentobarbital	27,728,000
Phencyclidine	16
Phenmetrazine	2
Phenylacetone	21,975,000
Secobarbital	1,100
Sufentanil	2,000
Thebaine	43,292,000

The Deputy Administrator further proposes that aggregate production quotas for all other Schedules I and II controlled substances included in §§ 1308.11 and 1308.12 of Title 21 of the Code of Federal Regulations be established at zero.

All interested persons are invited to submit their comments and objections in writing regarding this proposal. A person may object to or comment on the proposal relating to any of the above-mentioned substances without filing comments or objections regarding the others. If a person believes that one or more of these issues warrant a hearing, the individual should so state and summarize the reasons for this belief.

In the event that comments or objections to this proposal raise one or more issues which the Deputy Administrator finds warrant a hearing, the Deputy Administrator shall order a public hearing by notice in the **Federal Register**, summarizing the issues to be heard and setting the time for the hearing.

The Office of Management and Budget has determined that notices of aggregate production quotas are not subject to centralized review under Executive Order 12866.

This action does not preempt or modify any provision of state law; nor does it impose enforcement responsibilities on any state; nor does it diminish the power of any state to enforce its own laws. Accordingly, this action does not have federalism implications warranting the application of Executive Order 13132.

The Deputy Administrator hereby certifies that this action will have no significant impact upon small entities whose interests must be considered under the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.* The establishment of aggregate production quotas for Schedules I and II controlled substances is mandated by law and by international treaty obligations. The quotas are necessary to provide for the estimated medical, scientific, research and industrial needs of the United States, for export requirements and the establishment and maintenance of reserve stocks. While aggregate production quotas are of primary importance to large manufacturers, their impact upon small entities is neither negative nor beneficial. Accordingly, the Deputy Administrator has determined that this action does not require a regulatory flexibility analysis.

This action meets the applicable standards set forth in Sections 3(a) and 3(b)(2) of Executive Order 12988 Civil Justice Reform.

This action will not result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more in any one year, and will not significantly or uniquely affect small governments. Therefore, no actions were deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

This action is not a major rule as defined by Section 804 of the Small Business Regulatory Enforcement Fairness Act of 1996. This action will not result in an annual effect on the economy of $100,000,000 or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign-based companies in domestic and export markets.

The Drug Enforcement Administration makes every effort to write clearly. If you have suggestions as to how to improve the clarity of this regulation, call or write Frank L. Sapienza, Chief, Drug and Chemical Evaluation Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, Telephone: (202) 307–7183.

Dated: October 28, 2002.

John B. Brown, III,

Deputy Administrator.

[FR Doc. 02–27882 Filed 10–31–02; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review; Comment Request

October 22, 2002.

The Department of Labor (DOL) has submitted the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of this ICR, with applicable supporting documentation, may be obtained by calling the Department of Labor. To obtain documentation contact Darrin King on 202–693–4129 or e-mail: *King-Darrin@dol.gov.*

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for ETA, Office of Management and Budget, Room 10235, Washington, DC 20503 (202–395–7316), within 30 days from the date of this publication in the **Federal Register**.

The OMB is particularly interested in comments which:

- 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;
- 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;
- Enhance the quality, utility, and clarity of the information to be collected; and
- 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 submission of responses.

Agency: Employment and Training Administration (ETA).

Type of Review: Extension of a currently approved collection.

Title: MIS Requirements for Youth Opportunity Grants.

OMB Number: 1205–0414.

Affected Public: State, Local, or Tribal Government and Not-for-profit institutions.

Type of Response: Reporting.

Cite/Reference	Total respondents	Frequency	Total responses	Average response time per form (hours)	Annual burden hours
ETA–9086	36	Monthly	432	104	44,928
ETA–9087	36	Quarterly	144	48	
					6,912

Cite/Reference	Total respondents	Frequency	Total responses	Average response time per form (hours)	Annual burden hours
Totals			576		51,840

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $0.

Description: The Department of Labor (DOL) has obligated roughly $750 million over the first three years on Youth Opportunity Grants and will spend approximately $250 million more over the remaining two years on the original 36 grants to high-poverty communities. To manage these grants both at the Federal and local levels and to report to OMB and Congress on the effective use of these funds, DOL will need to continue to collect information on characteristics of youth enrolled, services provided, and program outcomes. Further section 169 of the Workforce Investment Act requires the use of performance measures to evaluate the performance of Youth Opportunity Grantees.

Ira L. Mills,

Departmental Clearance Officer.

[FR Doc. 02–27866 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–30–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review; Comment Request

October 25, 2002.

The Department of Labor (DOL) has submitted the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of each individual ICR, with applicable supporting documentation, may be obtained by calling the Department of Labor. To obtain documentation contact Marlene Howze at (202) 693–4158 or e-mail *Howze-Marlene@dol.gov.*

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for ESA, Office of Management and Budget, Room 10235, Washington, DC 20503 ((202) 395–7316), within 30 days from the date of this publication in the **Federal Register**.

The OMB is particularly interested in comments which:

- 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;
- 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;
- Enhance the quality, utility, and clarity of the information to be collected; and 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 submission of responses.

Type of Review: Revision of a currently approved collection.

Agency: Employment Standards Administration (ESA).

Title: Application for Authority for an Institution of Higher Education to Employ Its Full-Time Students at Sub-minimum Wages Under Regulations Part 519.

OMB Number: 1215–0080.

Affected Public: Business or other-for-profit and individuals or households.

Frequency: Annually.

Estimated Time Per Response and Total Burden Hours:

Description	Total respondents	Total annual responses	Average minutes per response	Total burden (hours)
Initial Applications	2	2	30	1.00
Renewal Applications	13	13	15	3.25
Reporting Burden				4.25
Record-keeping	15	15	1	.25
Total Reporting and Record-keeping				5.00

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $0.

Description: Section 14(b)(3) of the Fair Labor Standards Act (FLSA) authorizes the Secretary of Labor to provide certificates authorizing the employment of full-time students at sub-minimum wages in institutions of higher education to the extent necessary in order to prevent curtailment of opportunities for employment. The WH–201 application form provides the information necessary to ascertain whether the requirements of section 14(b) have been met. If this information were not collected, it would be difficult to ensure that use of a certificate has not curtailed full-time employment opportunities for other workers.

Ira L. Mills,

Departmental Clearance Officer.

[FR Doc. 02–27867 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–27–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review; Comment Request

October 22, 2002.

The Department of Labor (DOL) has submitted the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork

Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35). A copy of each individual ICR, with applicable supporting documentation, may be obtained by calling the Department of Labor. To obtain documentation contact Marlene Howze at (202) 693–4158 or e-mail *Howze-Marlene@dol.gov.*

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for ESA, Office of Management and Budget, Room 10235, Washington, DC 20503 ((202) 395–7316), within 30 days from the date of this publication in the **Federal Register**.

The OMB is particularly interested in comments which:

• 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;

• 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;

• Enhance the quality, utility, and clarity of the information to be collected; and 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 submission of responses.

Type of Review: Extension of a currently approved collection.

Agency: Employment Standards Administration (ESA).

Title: Representative Fee Request.

OMB Number: 1215–0078.

Affected Public: Business or other-for-profit and individuals or households.

Frequency: On Occasion.

Estimated Time Per Response and Total Burden Hours:

Fee requests	Total respondents	Total annual responses	Minutes per response (average)	Estimated total burden (hours)
Longshore	9,700	9,700	30	4,850
FECA	3,000	3,000	60	3,000
Total	12,700	12,700		7,850

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $17,215.

Description: Individuals filing for compensation benefits with the Office of Workers' Compensation Programs (OWCP) may be represented by an attorney or other representative. The representative is entitled to request a fee for services under the Federal Employees' Compensation Act (FECA), Regulations 20 CFR 10.702, and under the Longshore and Harbor Workers' Compensation Act (LSHWC), 20 CFR 702.132. The fee must be approved by the OWCP before the representative can make any demand for payment. If the information were not collected, OWCP would be unable to properly evaluate applications for representatives' fees.

Ira L. Mills,

Departmental Clearance Officer.

[FR Doc. 02–27869 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–CH–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review; Comment Request

October 21, 2002.

The Department of Labor (DOL) has submitted the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35). A copy of each individual ICR, with applicable supporting documentation, may be obtained by calling the Department of Labor. To obtain documentation contact Marlene Howze at ((202) 693–4158) or e-mail *Howze-Marlene@dol.gov.*

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for PWBA, Office of Management and Budget, Room 10235, Washington, DC 20503 ((202) 395–7316), within 30 days from the date of this publication in the **Federal Register**.

The OMB is particularly interested in comments which:

• 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;

• 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;

• Enhance the quality, utility, and clarity of the information to be collected; and 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 submission of responses.

Type of Review: Extension of a currently approved collection.

Agency: Pension and Welfare Benefits Administration (PWBA).

Title: Furnishing Documents to the Secretary of Labor on Request under ERISA Section 104(a)(6).

OMB Number: 1210–0112.

Affected Public: Business or other for-profit; individuals or households; and not-for-profit institutions.

Frequency: On occasion.

Estimated Time Per Response: 30 minutes preparation and 5 minutes distribution.

Number of Respondents: 1,000.

Number of Annual Responses: 1,000.

Total Burden Hours: 95.

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $4,000.

Description: ERISA Section 104(a)(6) and related regulations at 29 CFR 2520.104a–8 require the administrator of an employee benefit plan covered by Title I of ERISA to furnish certain documents relating to the plan on request to the Secretary of Labor. The Department collects documents related to the establishment or operation of an employee benefit plan in order to provide participants with plan information that they have requested

and to which they are entitled under the disclosure requirements of ERISA.

Ira L. Mills,

Departmental Clearance Officer.

[FR Doc. 02–27870 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–27–M

DEPARTMENT OF LABOR

Employment Standards Administration

Proposed Collection; Comment Request

AGENCY: Employment Standards Adminstration, Labor.

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Employment Standards Administration is soliciting comments concerning the proposed collection: Work Experience and Career Exploration Programs (WECEP), Regulations, 29 CFR part 570.35a (Fair Labor Standards Act). A copy of the proposed information collection request can be obtained by contacting the office listed below in the addresses section of this Notice.

DATES: Written comments must be submitted to the office listed in the addresses section below on or before December 31, 2002.

ADDRESSES: Ms. Patricia A. Forkel, U.S. Department of Labor, 200 Constitution Ave., NW., Room S–3201, Washington, DC 20210, telephone (202) 693–0339, fax (202) 693–1451, e-mail *pforkel@fenix2.dol-esa.gov*. Please use only one method of transmission for comments (mail, fax, or e-mail).

SUPPLEMENTARY INFORMATION:

I. Background

Section (3)(1) of the Fair Labor Standards Act (FLSA) establishes a minimum age of 16 for most nonagricultural employment, but allows the employment of 14 and 15 year olds in occupations other than manufacturing and mining if the Secretary of Labor determines such employment is confined to periods which will not interfere with their health and well-being. Subpart C of Regulations, 29 CFR Part 570, Child Labor Regulations, Orders and Statements of Interpretation, sets forth the employment standards for 14 and 15 year olds (Child Labor Reg. 3). Section 570.35a of these regulations permits employment of 14 and 15 year olds under conditions otherwise prohibited by Child Labor Reg. 3 pursuant to a school-supervised and school-administered Work Experience and Career Exploration Program (WECEP) which meets the stated requirements. In order to utilize the WECEP provisions of Child Labor Reg. 3, section 570.35 of the regulations require a State Educational Agency to file an application for approval of a State WECEP program as one not interfering with schooling or with the health and well-being of the minors involved and therefore not constituting oppressive child labor. Section 57.35a(b)(vi) of the regulations requires each student participating in a WECEP to execute a written training agreement signed by the teacher-coordinator, the employer, and the student and signed or otherwise consented to by the student's parent or guardian. This information collection is currently approved for use through February 28, 2003.

II. Review Focus

The Department of Labor is particularly interested in comments which:

- 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;
- 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;
- Enhance the quality, utility and clarity of the information to be collected; and
- 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.

III. Current Actions

State educational agencies are required to file applications for WECEP which provide exceptions to the child labor regulations issued under the FLSA. State educational agencies are also required to maintain certain records with respect to approved WECEP programs. The Department of Labor seeks the extension of the collection of information in order to carry out its responsibility to determine that regulatory tests for approval of the program have been met, and to document the validity of the WECEP program as one which is structured to provide training for the student. There is no change in the substance or method of collection since the last OMB approval.

Type of Review: Extension.

Agency: Employment Standards Administration.

Title: Work Experience and Career Exploration Programs (WECEP), 29 CRF Part 570.35a.

OMB Number: 1215–0121.

Affected Public: State, Local or Tribal government, Individuals or households.

Total Respondents/Responses: 14,014.

Frequency: Recordkeeping, Biennial reporting.

Average Time per Response:

Reporting, WECEP Application—2 hours.

Reporting, Written Training Agreement—1 hour.

Recordkeeping, WECEP Program Information—1 hour.

Recordkeeping, Filing of WECEP Record and Training Agreement—one-half minute.

Total Burden Hours: 7,145.

Estimated Total Annual Reporting and Recordkeeping

Burden Cost (capital/startup): $0.

Total Burden Cost (operating/maintenance): $2.80.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: October 25, 2002.

Margaret J. Sherrill

Chief, Branch of Management Review and Internal Control, Division of Financial Management, Office of Management, Administration and Planning, Employment Standards Administration.

[FR Doc. 02–27868 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–27–P

DEPARTMENT OF LABOR

Employment Standards Administration Wage and Hour Division

Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR Part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of other Federal statutes referred to in 29 CFR part 1, Appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the payment of wages determined to be prevailing by the Secretary of Labor is 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 202010.

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

New Jersey
NJ020002 (Mar. 01, 2002)
NJ020003 (Mar. 01, 2002)

Volume II

Pennsylvania
PA020001 (Mar. 01, 2002)
PA020002 (Mar. 01, 2002)
PA020003 (Mar. 01, 2002)
PA020004 (Mar. 01, 2002)
PA020005 (Mar. 01, 2002)
PA020006 (Mar. 01, 2002)
PA020007 (Mar. 01, 2002)
PA020008 (Mar. 01, 2002)
PA020010 (Mar. 01, 2002)
PA020012 (Mar. 01, 2002)
PA020016 (Mar. 01, 2002)
PA020017 (Mar. 01, 2002)
PA020019 (Mar. 01, 2002)
PA020020 (Mar. 01, 2002)
PA020021 (Mar. 01, 2002)
PA020023 (Mar. 01, 2002)
PA020024 (Mar. 01, 2002)
PA020026 (Mar. 01, 2002)
PA020027 (Mar. 01, 2002)
PA020028 (Mar. 01, 2002)
PA020029 (Mar. 01, 2002)
PA020030 (Mar. 01, 2002)
PA020031 (Mar. 01, 2002)
PA020040 (Mar. 01, 2002)
PA020042 (Mar. 01, 2002)
PA020060 (Mar. 01, 2002)

Volume III

Alabama
AL020018 (Mar. 01, 2002)
Florida
FL020014 (Mar. 01, 2002)
FL020016 (Mar. 01, 2002)
FL020017 (Mar. 01, 2002)
FL020034 (Mar. 01, 2002)
FL020076 (Mar. 01, 2002)
FL020100 (Mar. 01, 2002)

Volume IV

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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 20402, (202) 512–1800.

When ordering hard-copy subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the six separate Volumes, arranged by State. Subscriptions include an annual edition (issued in January or February) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates will be distributed to subscribers.

Signed at Washington, D.C. this 24th day of October 2002.

Carl J. Poleskey,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 02–27652 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–27–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. ICR–1218–0096(2003)]

Temporary Labor Camps; Extension of the Office of Management and Budget's (OMB) Approval of the Information-Collection (Paperwork) Requirements

AGENCY: Occupational Safety and Health Administration, Labor.

ACTION: Request for comment.

SUMMARY: The Occupational Safety and Health Administration (OSHA) requests comments concerning the proposed extension of information-collection requirements contained in the Temporary Labor Camps Standard (29 CFR 1910.142).

DATES: Comments must be submitted by the following dates:

Hard copy: Your comments must be submitted (postmarked or sent) by December 31, 2002.

Facsimile and electronic transmission: Your comments must be sent by December 31, 2002.

(Please see the **SUPPLEMENTARY INFORMATION** below for additional information on submitting comments.)

ADDRESSES:

I. Submission of Comments

Regular mail, express delivery, hand-delivery, and messenger service: Submit your comments and attachments to the OSHA Docket Office, Docket No. ICR–1218–0096(2003), Room N–2625, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. OSHA Docket Office and Department of Labor hours of operation are 8:15 a.m. to 4:45 p.m., EST.

Facsimile: If your comments, including any attachments, are 10 pages or fewer, you may fax them to the OSHA Docket Office at (202) 693–1648. You must include the docket number of this document, Docket No. ICR–1218–0096(2003), in your comments.

Electronic: You may submit comments, but not attachments, through the Internet at *http://ecomments.osha.gov/.*

(Please see the **SUPPLEMENTARY INFORMATION** below for additional information on submitting comments.)

II. Obtaining Copies of Supporting Statement for the Information Collection

The Supporting Statement for the Information Collection is available for downloading from OSHA's Web site at *www.osha.gov.* The supporting statement is available for inspection and copying in the OSHA Docket Office, at the address listed above. A printed copy of the supporting statement can be obtained by contacting Todd Owen at (202) 693–1941.

FOR FURTHER INFORMATION CONTACT: Todd Owen, Directorate of Standards and Guidance, Occupational Safety and Health Administration, U.S. Department of Labor, Room N3631, 200 Constitution Avenue, NW., Washington, DC 20210, (202) 693–1941.

SUPPLEMENTARY INFORMATION:

I. Submission of Comments on This Notice and Internet Access to Comments and Submissions

You may submit comments in response to this document by (1) hard copy, (2) FAX transmission (facsimile), or (3) electronically through the OSHA webpage. Please note that you cannot attach materials such as studies or journal articles to electronic comments. If you have additional materials, you must submit three copies of them to the OSHA Docket Office at the address above. The additional materials must clearly identify your electronic comments by name, date, subject and docket number so we can attach them to your comments. Because of security-related problems there may be a significant delay in the receipt of comments by regular mail. Please contact the OSHA Docket Office at (202) 693–2350 for information about security procedures concerning the delivery of materials by express delivery, hand delivery and message service.

II. Background

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burdens, conducts a pre-clearance consultation program to provide the public with an opportunity to comment on proposed and continuing information collection requirements in accordance with the Paperwork Reduction Act of 1995 (PRA–95) (44 U.S.C. 3506(c)(2)(A)). OSHA will be requesting approval from the Office of Management and Budget (OMB) for certain information collection requirements contained in the Temporary Labor Camps Standard (29 CFR 1910.142). This notice initiates the process for OSHA to request OMB approval. The purpose of the Temporary Labor Camps Standards is to eliminate the incidence of communicable disease among temporary labor camp residents. The Standard requires camp superintendents to report immediately to the local health officer (1) the name and address of any individual in the camp known to have or suspected of having a communicable disease or suspected food poisoning, or (2) an unusual prevalence of any illness in which fever, diarrhea, sore throat, vomiting or jaundice is a prominent symptom.

III. Special Issues for Comment

OSHA has a particular interest in comments on the following issues:

- Whether the proposed collection of information is necessary for the proper performance of the Agency's functions, including whether the information will have practical utility;
- 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, especially the number of temporary labor camps in the United States; and
- The quality, utility, and clarity of the information on those who are to respond, including 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.

IV. Proposed Actions

OSHA proposes to extend OMB's approval of the collection of information requirements specified in 5 CFR

1320.8(d). OSHA will summarize the comments submitted in response to this notice, and will include this summary in its request to OMB to extend the approval of the information-collection requirements for the Temporary Labor Camps Standard.

Type of Review: Extension of a currently approved information-collection requirement.

Title: Temporary Labor Camps (29 CFR 1910.142).

OMB Number: 1218–0096.

Affected Public: Business or other for-profit; not-for-profit institutions; Federal government; State, local or tribal governments.

Number of Respondents: 838.

Frequency: On occasion.

Average time per Response: Five minutes response.

Estimating Total Burden Hours: 67 hours.

Authority and Signature

This document was prepared under the direction of John L. Henshaw, Assistant Secretary of Labor for Occupational Safety and Health, 200 Constitution Avenue, NW., Washington, DC 20210.

This action is taken pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3506(c)(2)(A)).

Signed at Washington, DC, this 28th day of October 2002.

John L. Henshaw,

Assistant Secretary of Labor.

[FR Doc. 02–27772 Filed 10–31–02; 8:45 am]

BILLING CODE 4510–26–M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–443]

North Atlantic Energy Service Corporation, et al.; (Seabrook Station, Unit No. 1); Order Approving Transfer of License and Conforming Amendment

I

Facility Operating License No. NPF–86 authorizes the operation of Seabrook Station, Unit No. 1 (Seabrook Station or the facility), at steady-state power levels not in excess of 3,411 megawatts thermal. The facility is located in Seabrook Township, Rockingham County, New Hampshire, on the southeast coast of the State of New Hampshire. The license authorizes North Atlantic Energy Service Corporation (NAESCO) to possess, use, and operate the facility, and certain other entities discussed below to possess the facility.

II

Under cover of a letter dated May 17, 2002, NAESCO, on its own behalf and on the behalf of certain licensees owning interests in Seabrook Station—North Atlantic Energy Corporation (NAEC), The United Illuminating Company, Great Bay Power Corporation, New England Power Company, The Connecticut Light and Power Company, Canal Electric Company, Little Bay Power Corporation, and New Hampshire Electric Cooperative, Inc.—and FPL Energy Seabrook, LLC (FPLE Seabrook) jointly submitted an application requesting approval of the transfer of Facility Operating License No. NPF–86 for Seabrook Station, to the extent held by the foregoing licensees, to FPLE Seabrook. The applicants also requested approval of a conforming amendment to reflect the transfer. The application was supplemented by submittals dated June 28, July 1, July 24, August 29, and October 11, 2002 (collectively referred to as the ''application'' herein unless otherwise indicated).

FPLE Seabrook is an indirect, wholly owned subsidiary of FPL Energy, LLC (FPLE), which is a wholly owned subsidiary of FPL Group Capital Inc., which, in turn, is a wholly owned subsidiary of FPL Group Inc. (FPL Group). According to the application, the current licensees owning interests in the facility listed above will sell their ownership interests in Seabrook Station to FPLE Seabrook. In addition, NAESCO will transfer its operating authority under the license to FPLE Seabrook which will assume title to the acquired interests in the facility and operate and maintain Seabrook Station. While the transfer of operating authority and the ownership interests identified in the application is expected to occur at one time, it is possible that certain ownership interests proposed to be transferred will be transferred in a second phase, depending upon the timing of the receipt of other regulatory approvals. Current licensees which own interests in Seabrook Station but are not involved in this license transfer are Massachusetts Municipal Wholesale Electric Company, Taunton Municipal Lighting Plant, and Hudson Light and Power Department, all of which will remain licensees.

The conforming license amendment would remove from the license references to NAESCO and the licensees transferring their interests in the facility and add references to FPL Energy Seabrook, LLC, as a licensee, and make other administrative changes to reflect the proposed transfer.

The application requested approval of the subject transfer of the license and a conforming license amendment pursuant to 10 CFR 50.80 and 50.90. Notice of the requests for approval and an opportunity to request a hearing or submit written comments was published in the **Federal Register** on June 14, 2002 (67 FR 40972). The Commission received no requests for hearing or written comments.

Under 10 CFR 50.80, no license, or any right thereunder, shall be transferred, directly or indirectly, through transfer of control of the license, unless the Commission shall give its consent in writing. After reviewing the information submitted in the application and other information before the Commission, and relying upon the representations and agreements contained in the application, the Nuclear Regulatory Commission (NRC) staff has determined that FPLE Seabrook is qualified to be the holder of the license to the extent proposed in the application, and that the transfer of the license to FPLE Seabrook is otherwise consistent with applicable provisions of law, regulations, and orders issued by the Commission, subject to the conditions set forth below. The NRC staff has further found that the application for the proposed license amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations set forth in 10 CFR Chapter I; the facility will operate in conformity with the application, the provisions of the Act, and the rules and regulations of the Commission; there is reasonable assurance that the activities authorized by the proposed license amendment can be conducted without endangering the health and safety of the public and that such activities will be conducted in compliance with the Commission's regulations; the issuance of the proposed license amendment will not be inimical to the common defense and security or the health and safety of the public; and the issuance of the proposed license amendment will be in accordance with 10 CFR part 51 of the Commission's regulations and all applicable requirements have been satisfied. The findings set forth above are supported by the staff's safety evaluation dated October 25, 2002.

III

Accordingly, pursuant to sections 161b, 161i, and 184 of the Atomic Energy Act of 1954, as amended, 42 U.S.C. 2201(b), 2201(i), and 2234; and 10 CFR 50.80, *it is hereby ordered* that

the transfer of the license as described herein to FPLE Seabrook is approved, subject to the following conditions:

(1) Before the transfer of operating authority and completion of the sale and transfer of any interest in Seabrook Station to FPLE Seabrook, FPLE Seabrook shall provide the Director of the Office of Nuclear Reactor Regulation satisfactory documentary evidence that FPLE Seabrook has obtained the appropriate amount of insurance required of licensees under 10 CFR part 140 of the Commission's regulations.

(2) On the closing date(s) of the transfer of any ownership interests in Seabrook Station covered by this Order, FPLE Seabrook shall obtain from each respective transferring owner all of the accumulated decommissioning trust funds for the facility, and ensure the deposit of such funds and additional funds, if necessary, into a decommissioning trust or trusts for Seabrook Station established by FPLE Seabrook, such that the amount of funds deposited meets or exceeds the amount required under 10 CFR 50.75 with respect to the interest in Seabrook Station FPLE Seabrook acquires on such dates(s).

(3) With respect to the decommissioning trust(s) established by FPLE Seabrook,

(i) The decommissioning trust agreement must be in a form acceptable to the NRC.

(ii) Investments in the securities or other obligations of FPL Group Inc. or its affiliates, successors, or assigns shall be prohibited. In addition, except for investments tied to market indexes or other non-nuclear-sector mutual funds, investments in any entity owning one or more nuclear power plants shall be prohibited.

(iii) The decommissioning trust agreement must provide that no disbursements or payments from the trust(s), other than for ordinary administrative expenses, shall be made by the trustee unless the trustee has first given the NRC 30 days prior written notice of payment. The decommissioning trust agreement shall further provide that no disbursements or payments from the trust(s) shall be made if the trustee receives prior written notice of objection from the Director of the Office of Nuclear Reactor Regulation.

(iv) The decommissioning trust agreement must provide that the agreement cannot be amended in any material respect without 30 days prior written notification to the Director of the Office of Nuclear Reactor Regulation.

(v) The appropriate section of the decommissioning trust agreement shall provide that the trustee, investment advisor, or anyone else directing the investments made in the trust(s) shall adhere to a ''prudent investor'' standard, as specified in 18 CFR 35.32(a)(3) of the Federal Energy Regulatory Commission's regulations.

(4) FPLE Seabrook shall take all necessary steps to ensure that the decommissioning trust(s) are maintained in accordance with the application and the requirements of this Order, and consistent with the safety evaluation supporting this Order.

(5) FPLE Seabrook shall take no action to cause FPL Group Capital, Inc. or its parent companies to void, cancel, or modify the Support Agreement to provide funding of up to $110 million for FPLE Seabrook as represented in the application without prior written consent of the Director of the Office of Nuclear Reactor Regulation.

(6) After receipt of all required regulatory approvals of the transfer of the subject interests in Seabrook Station, NAESCO and FPLE Seabrook shall inform the Director of the Office of Nuclear Reactor Regulation in writing of such receipt within 5 business days, and of the closing date(s) of the transfer no later than 2 business days prior to the date of closing. If the transfer of the license as approved by this Order is not completed by October 31, 2003, this Order shall become null and void, provided, however, on written application and for good cause shown, this date may be extended in writing.

It is further ordered that, consistent with 10 CFR 2.1315(b), changes to the license, as indicated in Enclosure 2 to the cover letter forwarding this Order, to conform the license to reflect the subject license transfer are approved. An amendment, or amendments should the transfer of the interests in Seabrook Station occur in more than one phase, incorporating the approved changes as appropriate to reflect the transfer of interests occurring, shall be issued and made effective at the time the proposed transfer of interests in the facility occurs.

This Order is effective upon issuance.

For further details with respect to this Order, see the initial application dated May 17, 2002, the supplemental letters dated June 28, July 1, July 24, August 29, and October 11, 2002, and the safety evaluation dated October 25, 2002, which are available for public inspection at the Commission's Public Document Room, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, and accessible electronically through the ADAMS Public Electronic Reading Room link at the NRC Web site (*http://www.nrc.gov*).

Dated at Rockville, Maryland, this 25th day of October 2002.

For the Nuclear Regulatory Commission.

Samuel J. Collins,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 02–27862 Filed 10–31–02; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 72–17]

Notice of Issuance of Amendment to Materials License SNM–2509 Trojan Independent Spent Fuel Storage Installation

The U.S. Nuclear Regulatory Commission (NRC or the Commission) has issued Amendment 2 to Materials License No. SNM–2509 held by Portland General Electric Company (PGE) for the receipt, possession, storage, and transfer of spent fuel at the Trojan Independent Spent Fuel Storage Installation (ISFSI), located in Columbia County, Oregon. The amendment is effective as of the date of issuance.

By application dated October 26, 2001, PGE requested an amendment to its ISFSI license to permit the use of the Holtec International Multi-Purpose Canister (MPC) to store spent fuel.

This amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment. An Environmental Assessment and Finding of No Significant Impact regarding this amendment has been issued (67 FR 63458, October 11, 2002).

In accordance with 10 CFR 72.46(b)(2), a determination has been made that the amendment does not present a genuine issue as to whether public health and safety will be significantly affected. Therefore, the publication of a notice of proposed action and an opportunity for hearing or a notice of hearing is not warranted. Notice is hereby given of the right of interested persons to request a hearing on whether the action should be rescinded or modified.

For further details with respect to this amendment, see the application dated October 26, 2001, which is available for

public inspection at the Commission's Public Document Room, One White Flint North Building, 11555 Rockville Pike, Rockville, MD or from the publicly available records component of NRC's Agencywide Documents Access and Management System (ADAMS) under Accession No. ML013060075. The NRC maintains ADAMS, which provides text and image files of NRC's public documents. These documents may be accessed through the NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/reading__rm/adams.html*. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC Public Document Room (PDR) Reference staff at 1–800–397–4209, 301–415–4737 or by email to *pdr@nrc.gov*.

Dated at Rockville, Maryland, this 23rd day of October 2002.

For the Nuclear Regulatory Commission.

E. William Brach,

Director, Spent Fuel Project Office, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 02–27863 Filed 10–31–02; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–335 and 50–389]

Florida Power and Light Co., St. Lucie, Units 1 and 2; Notice of Availability of the Draft Supplement 11 to the Generic Environmental Impact Statement and Public Meeting for the License Renewal of St. Lucie, Units 1 and 2

Notice is hereby given that the U.S. Nuclear Regulatory Commission (the Commission) has published a draft plant-specific supplement to the Generic Environmental Impact Statement (GEIS), NUREG–1437, regarding the renewal of operating licenses DPR–67 and NPF–16 for an additional 20 years of operation at St. Lucie, Units 1 and 2 (St. Lucie). St. Lucie nuclear power station is located on Hutchinson Island in St. Lucie County, Florida. Possible alternatives to the proposed action (license renewal) include no action and reasonable alternative energy sources.

The draft supplement to the GEIS is available for public inspection in the NRC Public Document Room (PDR) located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, or, electronically, from the Publicly Available Records (PARS) component of NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at *http://www.nrc.gov/reading-rm.html* (the Public Electronic Reading Room). Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS, should contact the NRC's PDR reference staff at 1–800–397–4209 or 301–415–4737, or by e-mail to *pdr@nrc.gov.* In addition, the Indian River Community College Library, located at 3209 Virginia Avenue, Ft. Pierce, Florida, has agreed to make the draft supplement to the GEIS available for public inspection.

Any interested party may submit comments on the draft supplement to the GEIS for consideration by the NRC staff. To be certain of consideration, comments on the draft supplement to the GEIS and the proposed action must be received by January 15, 2003. Comments received after the due date will be considered if it is practical to do so, but the NRC staff is able to assure consideration only for comments received on or before this date. Written comments on the draft supplement to the GEIS should be sent to: Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, Mailstop T–6D 59, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

Comments may be hand-delivered to the NRC's PDR, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, between 7:45 a.m. and 4:15 p.m. on Federal workdays. Submittal of electronic comments may be sent by Internet to the NRC at *StLucieDSEIS@nrc.gov.* All comments received by the Commission, including those made by Federal, State, and local agencies, Indian tribes, or other interested persons, will be made available electronically at the Commission's PDR in Rockville, Maryland, or from the PARS component of ADAMS.

The NRC staff will hold a public meeting to present an overview of the draft plant-specific supplement to the GEIS and to accept public comments on the document. The public meeting will be held at the Council Chambers, Port St. Lucie City Hall, 121 SW Port St. Lucie Boulevard, Port St. Lucie, Florida, on December 3, 2002. There will be two sessions to accommodate interested parties. The first session will commence at 1:30 p.m. and will continue until 4:30 p.m. The second session will commence at 7 p.m. and will continue until 10 p.m. Both meetings will be transcribed and will include: (1) A presentation of the contents of the draft plant-specific supplement to the GEIS, and (2) the opportunity for interested government agencies, organizations, and individuals to provide comments on the draft report. Additionally, the NRC staff will host informal discussions one hour prior to the start of each session at the Port St. Lucie City Hall. Persons may pre-register to attend or present oral comments at the meeting by contacting Dr. Michael T. Masnik by telephone at 1–800–368–5642, extension 1191, or by Internet to the NRC at *StLucieDSEIS@nrc.gov* no later than November 22, 2002. Members of the public may also register to provide oral comments within 15 minutes of the start of each session. Individual, oral comments may be limited by the time available, depending on the number of persons who register. If special equipment or accommodations are needed to attend or present information at the public meeting, the need should be brought to Dr. Masnik's attention no later than November 22, 2002, to provide the NRC staff adequate notice to determine whether the request can be accommodated.

For further information, contact: Dr. Michael T. Masnik, License Renewal and Environmental Impacts Program, Division of Regulatory Improvement Programs, U.S. Nuclear Regulatory Commission, Washington, DC 20555. Dr. Masnik may be contacted at the aforementioned telephone number or e-mail address.

Dated at Rockville, Maryland, this 2nd day of October, 2002.

For the Nuclear Regulatory Commission.

Pao-Tsin Kuo,

Program Director, License Renewal and Environmental Impacts Program, Division of Regulatory Improvement Programs, Office of Nuclear Reactor Regulation.

[FR Doc. 02–27864 Filed 10–31–02; 8:45 am]

BILLING CODE 7590–01–P

PENSION BENEFIT GUARANTY CORPORATION

Privacy Act of 1974; System of Records

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Notice of a new routine use of records for PBGC–6, Plan Participant and Beneficiary Data—PBGC.

SUMMARY: The Pension Benefit Guaranty Corporation is proposing a new routine use of records for a system of records maintained pursuant to the Privacy Act of 1974, as amended, entitled PBGC–6, Plan Participant and Beneficiary Data—PBGC. The new routine use permits PBGC to disclose to the Department of Treasury and the Department of Labor

the names, addresses, social security numbers, and dates of birth of eligible PBGC pension recipients to implement the income tax credit for health insurance costs and to implement the program for advance payment of the tax credit under the Trade Act of 2002, Pub. L. 107–210, 116 Stat. 933, 954 (Aug. 6, 2002).

DATES: Comments on the new routine use must be received by December 2, 2002. The new routine use will become effective December 3, 2002, without further notice, unless comments result in a contrary determination and a notice is published to that effect.

ADDRESSES: Comments may be mailed to the Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026, or delivered to Suite 340 at the above address. Comments also may be sent by Internet e-mail to *regcomments@pbgc.gov.* Copies of comments may be obtained by writing to the PBGC's Communications and Public Affairs Department at Suite 240 at the above address or by visiting that office or calling 202–326–4040 during normal business hours.

FOR FURTHER INFORMATION CONTACT: D. Bruce Campbell, Attorney, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4016, 202–326–4020 (extension 3672). (TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4020.)

SUPPLEMENTARY INFORMATION: The Trade Act of 2002 amended the Internal Revenue Code to create an income tax credit for health insurance costs of eligible individuals. Pub. L. 107–210, sec. 201, 116 Stat. 933, 954 (Aug. 6, 2002) (to be codified at 26 U.S.C. 35). The legislation also requires the Department of Treasury to establish a program for making advance payment to eligible individuals of the income tax credit. Pub. L. No. 107–210, sec. 202, 116 Stat. at 960 (to be codified at 26 U.S.C. 7527). The income tax credit and advance payment program are open to, among others, any individual who is an ''eligible PBGC pension recipient.'' 26 U.S.C. 35(c) and 26 U.S.C. 7527(d)(2). An eligible PBGC pension recipient is defined to mean, with respect to any month, an individual ''who has attained age 55 as the first day of such month, and * * * is receiving a benefit for such month any portion of which is paid by the (PBGC).'' 26 U.S.C. 35(c)(4).

The income tax credit and advance payment program are also open to any individual who is an ''eligible TAA recipient'' 26 U.S.C. 35(c) and 26 U.S.C. 7527(d)(2). The term eligible TAA recipient is defined to include, for any month, an individual who is receiving ''a trade readjustment allowance under * * * the Trade Act of 1974.'' The Department of Labor, with the states, is responsible for implementing the trade readjustment assistance program for eligible workers. 19 U.S.C. 2271–2296. The Trade Act of 2002 also amended the Workforce Investment Act of 1988 to permit a state to use funds made available by the Department of Labor to provide qualified health insurance assistance to eligible individuals and to pay the administrative expenses associated with implementing the income tax credit and advance payment program. Pub. L. 107–210, sec. 203, 116 Stat. 933, 963 (to be codified at 29 U.S.C. 2918(a) and (f)).

The new routine use permits the PBGC to disclose the names, addresses, social security numbers, and dates of birth of eligible PBGC pension recipients to the Department of Treasury and the Department of Labor to implement the income tax credit for health insurance costs and the advance payment program for eligible individuals.

For the convenience of the public, PBGC–6, as amended, is published in full below with new routine 14 italicized.

Issued in Washington, DC, this 30th day of October, 2002.

Steven A. Kandarian,

Executive Director, Pension Benefit Guaranty Corporation.

PBGC–6

SYSTEM NAME:

Plan Participant and Beneficiary Data—PBGC.

SECURITY CLASSIFICATION:

Not applicable.

SYSTEM LOCATION:

Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026 and/or field benefit administrator, plan administrator, and paying agent worksites.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Participants and beneficiaries in terminating and terminated pension plans covered by Title IV of the Employee Retirement Income Security Act of 1974, as amended (''ERISA'').

CATEGORIES OF RECORDS IN THE SYSTEM:

Names, addresses, telephone numbers, sex, social security numbers and other Social Security Administration information, dates of birth, dates of hire, salary, marital status, domestic relations orders, time of plan participation, eligibility status, pay status, benefit data, health-related information, insurance information where plan benefits are provided by private insurers, initial and final PBGC determinations (29 CFR § 4003.21 and 4003.59). The records listed herein are included only as pertinent or applicable to the individual plan participant or beneficiary.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

29 U.S.C. 1055, 1056(d)(3), 1302, 1321, 1322, 1322a, 1341, 1342 and 1350.

PURPOSE(S):

This system of records is maintained for use in determining whether participants and beneficiaries are eligible for benefits under plans covered by Title IV of ERISA, the amounts of benefits to be paid, making benefit payments, and collecting benefit overpayments. Names, addresses, and telephone numbers are used to survey customers to measure their satisfaction with the PBGC 's benefit payment services and to track (for follow up) those who do not respond to surveys.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

1. A record from this system of records may be disclosed to third parties, such as banks, insurance companies, or trustees, to make benefit payments to plan participants and beneficiaries.

2. A record from this system of records may be disclosed, in furtherance of proceedings under Title IV of ERISA, to a contributing sponsor (or other employer who maintained the plan), including any predecessor or successor, and any member of the same controlled group.

3. A record from this system of records may be disclosed, upon request for a purpose authorized under Title IV of ERISA, to an official of a labor organization recognized as the collective bargaining representative of the individual about whom a request is made.

4. Names, addresses, and telephone numbers of participants and beneficiaries and information pertaining to debts owed by such participants and beneficiaries to the PBGC may be disclosed to a debt collection agency or firm to collect a claim. Disclosure shall be made only under a contract that binds any such contractor or employee of such contractor to the criminal penalties of the Privacy Act. The

information so disclosed shall be used exclusively pursuant to the terms and conditions of such contract and shall be used solely for the purposes prescribed therein. The contract shall provide that the information so disclosed shall be returned at the conclusion of the debt collection effort.

5. The name and social security number of a participant employed or formerly employed as a pilot by a commercial airline may be disclosed to the Federal Aviation Administration (''FAA'') to obtain information relevant to the participant's eligibility or continued eligibility for disability benefits.

6. Names and social security numbers of plan participants and beneficiaries may be disclosed to the Internal Revenue Service (''IRS'') to obtain current addresses from tax return information and to the Social Security Administration (''SSA'') to obtain current addresses. Such information will be disclosed only if the PBGC has no address for an individual or if mail sent to the individual at the last known address is returned as undeliverable.

7. Names and last known addresses may be disclosed to an official of a labor organization recognized as the collective bargaining representative of participants for posting in union halls or for other means of publication to obtain current addresses of participants and beneficiaries. Such information will be disclosed only if the PBGC has no address for an individual or if mail sent to the individual at the last known address is returned as undeliverable.

8. Names, social security numbers, last known addresses, and dates of birth and death may be disclosed to private firms and agencies that provide locator services, including credit reporting agencies and debt collection firms or agencies, to locate participants and beneficiaries. Such information will be disclosed only if the PBGC has no address for an individual or if mail sent to the individual at the last known address is returned as undeliverable. Disclosure shall be made only under a contract that binds the firm or agency providing the service and its employees to the criminal penalties of the Privacy Act. The information so disclosed shall be used exclusively pursuant to the terms and conditions of such contract and shall be used solely for the purposes prescribed therein. The contract shall provide that the information so disclosed shall be returned at the conclusion of the locating effort.

9. Names and last known addresses may be disclosed to licensees of the United States Postal Service (''USPS'') to obtain current addresses under the USPS's National Change of Address Program. Such information will be disclosed only if the PBGC has no address for an individual or if mail sent to the individual at the last known address is returned as undeliverable. Disclosure shall be made only under a contract that binds the licensee of the Postal Service and its employees to the criminal penalties of the Privacy Act. The information so disclosed shall be used exclusively pursuant to the terms and conditions of such contract and shall be used solely for the purposes prescribed therein. The contract shall provide that the information so disclosed shall be returned at the conclusion of the locating effort.

10. Names and last known addresses may be disclosed to other participants in, and beneficiaries under, a pension plan to obtain the current addresses of individuals. Such information will be disclosed only if the PBGC has no address for an individual or if mail sent to the individual at the last known address is returned as undeliverable.

11. Names and last known addresses of participants and beneficiaries, and the names and addresses of participants' former employers, may be disclosed to the public to obtain current addresses of the individuals. Such information will be disclosed to the public only if the PBGC is unable to make benefit payments to the participants and beneficiaries because the address it has does not appear to be current or correct.

12. The name of a participant's pension plan, the actual or estimated amount of a participant's benefit under Title IV of ERISA, the form(s) in which the benefit is payable, and whether the participant is currently receiving benefit payments under the plan or (if not) the earliest date(s) such payments could commence may be disclosed to the participant's spouse, former spouse, child, or other dependent solely to obtain a qualified domestic relations order under 29 U.S.C. 1056(d) and 26 U.S.C. 414(p). The PBGC will disclose the information only upon the receipt of a notarized, written request by a prospective alternate payee that describes the requester's relationship to the participant and states that the information will be used solely to obtain a qualified domestic relations order under state domestic relations law. The PBGC will notify the participant of any information disclosed to a prospective alternate payee under this routine use. Any person who knowingly and willfully requests or obtains any record concerning an individual under false pretenses is subject to a criminal penalty under 5 U.S.C. 552a(i)(3).

13. Information from a participant's initial determination under 29 CFR 4003.1(b) (excluding the participant's address, telephone number, social security number, and any sensitive medical information) may be disclosed to a participant's spouse, former spouse, child, or other dependent who is an alternate payee under a qualified domestic relations order issued pursuant to 29 U.S.C. 1056(d) and 26 U.S.C. 414(p) to explain how the PBGC determined the benefit due the alternate payee so that the alternate payee can pursue an administrative appeal of the benefit determination under 29 CFR 4003.51. The PBGC will notify the participant of the information disclosed to an alternate payee under this routine use.

14. *The names, addresses, social security numbers, and dates of birth of eligible PBGC pension recipients may be disclosed to the Department of Treasury and the Department of Labor to implement the income tax credit for health insurance costs under 26 U.S.C. 35 and the program for advance payment of the tax credit under 26 U.S.C. 7527.*

General Routine Uses G1 and G4 through G7 (see Prefatory Statement of General Routine Uses) apply to this system of records.

DISCLOSURE TO CONSUMER REPORTING AGENCIES:

Information may be disclosed to a consumer reporting agency in accordance with 31 U.S.C. 3711(f) (5 U.S.C. 552a(b)(12)).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Records are maintained in paper and electronic form.

RETRIEVABILITY:

Records are indexed by plan and participant and/or beneficiary name. Customer satisfaction survey responses are aggregated for statistical purposes after they have been received by the PBGC and are not retrievable by a participant or beneficiary's name or other assigned identifier.

SAFEGUARDS:

Paper records are kept in file folders in areas of restricted access that are locked after office hours. Electronic records are stored on computer networks and protected by assigning user identification numbers to individuals needing access to the records and by passwords set by authorized users that must be changed periodically.

RETENTION AND DISPOSAL:

Records for plan participants are transferred to the Washington National Federal Records Center 6 months after either the final payment to a participant and/or beneficiary or the PBGC's final determination that a participant or beneficiary is not entitled to any benefits and are destroyed 7 years after such payment or determination.

SYSTEM MANAGER(S) AND ADDRESS:

Director, Insurance Operations Department, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026.

NOTIFICATION PROCEDURE:

Procedures are detailed in the PBGC's regulations: 29 CFR part 4902.

RECORD ACCESS PROCEDURES:

Same as notification procedure.

CONTESTING RECORDS PROCEDURE:

Same as notification procedure.

RECORD SOURCE CATEGORIES:

Plan administrators, participants and beneficiaries, the FAA, the SSA, labor organization officials, firms or agencies providing locator services, and USPS licensees.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 02–27991 Filed 10–31–02; 8:45 am]

BILLING CODE 7708–01–P

SECURITIES AND EXCHANGE COMMISSION

Existing Collection; Comment Request

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520), the Securities and Exchange Commission (the ''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget (''OMB'') for extension and approval.

Rule 17a–7 [17 CFR 270.17a–7] under the Investment Company Act of 1940 (the ''Act'') is entitled ''Exemption of certain purchase or sale transactions between an investment company and certain affiliated persons thereof.'' It provides an exemption from section 17(a) of the Act for purchases and sales of securities between registered investment companies, which are affiliated persons or affiliated persons of affiliated persons of each other, or between a registered investment company and an affiliated person or an affiliated person of an affiliated person, when the affiliation arises solely because of a common adviser, director, or officer. Rule 17a–7 requires investment companies to keep various records in connection with purchase or sale transactions affected by the rule. The rule requires the board of directors of an investment company to establish procedures reasonably designed to ensure that all conditions of the rule have been satisfied. If an investment company enters into a purchase or sale transaction with an affiliated person, the rule requires the investment company to compile and maintain written records of the transaction.[1] In addition, under the rule, the board is required to determine, at least on a quarterly basis, that all affiliated transactions made during the preceding quarter were made in compliance with these established procedures. The Commission's examination staff uses these records to evaluate transactions between affiliated investment companies for compliance with the rule.

The Commission estimates that approximately 1,000 investment companies enter into transactions affected by rule 17a–7 each year and, therefore, are subject to the rule's information collection requirements.[2] The average annual burden for rule 17a–7 is estimated to be approximately two burden hours per respondent, for an annual total of 2,000 burden hours for all respondents. The estimates of burden hours are made solely for the purposes of the Paperwork Reduction Act, and are not derived from a comprehensive or even a representative survey or study of the costs of Commission rules.

Written comments are invited on: (a) Whether the collections of information are necessary for the proper performance of the functions of the Commission, including whether the information has practical utility; (b) the accuracy of the Commission's estimate of the burdens of the collections of information; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burdens of the collections of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Kenneth A. Fogash, Acting Associate Executive Director, Office of Information Technology, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549.

Dated: October 24, 2002.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27775 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[1] The written records are required to set forth a description of the security purchased or sold, the identity of the person on the other side of the transaction, and the information or materials upon which the board of directors' determination that the transaction was in compliance with the procedures was made.

[2] These estimates are based on conversations with the examination and inspections staff of the Commission and fund representatives. Based on these conversations, the Commission staff estimates that most investment companies (4,000 of the estimated 4,500 registered investment companies) have adopted procedures for compliance with rule 17a–7. Of these 4,000 investment companies, the Commission staff estimates that each year approximately 25% (1,000) enter into transactions affected by rule 17a–7.

SECURITIES AND EXCHANGE COMMISSION

[Release No. 35–27586]

Filings Under the Public Utility Holding Company Act of 1935, as Amended (''Act'')

October 25, 2002.

Notice is hereby given that the following filing has been made with the Commission pursuant to provisions of the Act and rules promulgated under the Act. All interested persons are referred to the application/declaration for a complete statements of the proposed transaction summarized below. The application/declaration is available for public inspection through the Commission's Branch of Public Reference.

Interested persons wishing to comment or request a hearing on the application/declaration should submit their views in writing by November 18, 2002, to the Secretary, Securities and Exchange Commission, Washington, DC 20549–0609, and serve a copy on the relevant applicant/declarant at the address specified below. Proof of service (by affidavit or, in the case of an attorney at law, by certificate) should be filed with the request. Any request for hearing should identify specifically the issues of facts or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After November 18, 2002, the application/declaration, as filed or as amended, may be granted and/or permitted to become effective.

Ameren Corporation, et al. (70–10078)

Ameren Corporation (''Ameren''), a registered public utility holding company, Ameren Energy Fuels and Services Company (''Ameren Fuels''), Ameren's indirect wholly owned nonutility subsidiary, both located at 1901 Chouteau Avenue, St. Louis, Missouri 63103; and CILCORP Inc. (''CILCORP''), an exempt holding company under section 3(a)(1) of the Act and a wholly owned subsidiary of The AES Corporation (''AES''), an exempt holding company under section 3(a)(5) of the Act, CILCORP's direct wholly owned public utility subsidiary, Central Illinois Light Company (''CILCO''), and CILCO's wholly owned nonutility subsidiary, Central Illinois Generation, Inc. (''CIGI''), all located at 300 Liberty Street, Peoria, Illinois 61602 (collectively, and together with Ameren and Ameren Fuels, ''Applicants''), have filed an application-declaration under sections 3(a)(1), 6(a), 7, 8, 9(a), 9(c)(3), 10, 11(b), 12(b), 12(c), 12(d), 12(f), 13(b) and 32 of the Act and rules 45, 46, 51, 54, 87, 90 and 91 under the Act (''Application'').

I. Introduction

Applicants request authority for the acquisition of CILCORP by Ameren and associated transactions (collectively, ''Transaction''). The Transaction will be effected through a stock purchase agreement (''Stock Purchase Agreement'') entered into by Ameren and The AES Corporation (''AES''), CILCORP's parent company, under which Ameren has agreed to purchase, for cash, all of the issued and outstanding shares of common stock of CILCORP. As a result of the Transaction, Ameren will indirectly acquire all of the common stock of CILCO and CIGI, which will become additional public utility subsidiaries of Ameren,[1] and the nonutility subsidiaries and investments held directly and indirectly by CILCORP. The Transaction is subject to, among other usual and customary conditions precedent, receipt by the parties of approvals by the Commission as well as the FERC and the Illinois Commerce Commission (''ICC'') and filing of pre-merger notification statements under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the expiration or termination of the according statutory waiting period.

In conjunction with the Transaction, Ameren states that it has also agreed to purchase from AES all of the membership interests in AES Medina Valley (No. 4), LLC, which indirectly through intermediate subsidiaries holds all of the membership interests of AES Medina Valley Cogen, L.L.C. (''AES Medina Valley''), an EWG. AES Medina Valley owns a 40 MW gas-fired cogeneration facility in Mossville, Illinois that produces electricity, steam and chilled water that is sold to CILCO for resale to CILCO's largest customer, Caterpillar Inc.

II. Summary of Requests

In addition to authorization of the Transaction, CILCORP, CILCO and CIGI are requesting authorization through March 31, 2006 (''Authorization Period'') for a program of long-term and short-term financing. CILCORP is requesting authorization to issue guarantees and provide other forms of credit support on behalf of its subsidiaries, and to pay dividends out of capital and unearned surplus, subject to certain limitations. Applicants are requesting authorization to permit Ameren Services to enter into separate service agreements with CILCORP, CILCO, CIGI and certain of CILCORP's other subsidiaries. Ameren Fuels is requesting authorization to enter into a fuel services agreement with CILCO and CIGI. Ameren is requesting authority to retain certain of CILCORP's nonutility subsidiaries and investments. To the extent required, Applicants are requesting authorization to maintain in place a tolling agreement with AES Medina Valley, a fuel supply and services agreement between a gas marketing subsidiary of CILCORP and AES Medina Valley and a FERC-approved interconnection agreement between CILCO and AES Medina Valley. Finally, CILCORP and CILCO are requesting an order granting to each of them an exemption under section 3(a)(1) of the Act.

III. Parties to the Transaction

A. Ameren

Ameren's primary operating subsidiaries are AmerenCIPS and AmerenUE, which are electric and gas utility companies, and Ameren Energy Generating Company (''Ameren Energy Generating''), which is an EWG. Together, AmerenCIPS and AmerenUE provide electric service to approximately 1.5 million customers in Missouri and Illinois and natural gas service to approximately 300 customers, also in Missouri and Illinois. Ameren Energy Generating, an indirect wholly owned subsidiary of Ameren, was organized to facilitate the restructuring of AmerenCIPS in accordance with the Illinois Electric Service Customer Choice and Rate Relief Law of 1997 (''Customer Choice Law''). In May 2000, Ameren Energy Generating acquired all of the existing generating assets of AmerenCIPS.

AmerenUE and Ameren Energy Generating together own and operate about 12,600 MW of electric generating capacity, all of which is located in Missouri and Illinois. As of December 31, 2001, AmerenUE and AmerenCIPS owned and operated, or partially owned, a total of approximately 5,400 circuit miles of electric transmission lines and approximately 7,800 miles of natural gas transmission and distribution mains, substantially all of which are located in Missouri and Illinois.

Ameren's directly owns CIPSCO Investment Company, Ameren Services Company (''Ameren Services''), Ameren Energy, Inc., Ameren Development Company and Ameren Energy Resources Company, all nonutility subsidiaries. CIPSCO Investment Company holds various nonutility businesses, including passive investments in low income housing projects and investments in equipment leases. Ameren Services is a service company subsidiary that provides administrative, accounting, legal, engineering, executive, and other corporate support services to Ameren and its associate companies. Ameren Energy, Inc. is an energy-related company under rule 58 that primarily serves as the short-term energy trading and marketing agent for AmerenUE and Ameren Energy Generating and provides a range of energy and risk management services. Ameren Development Company is an intermediate nonutility holding company that directly and indirectly owns all of the outstanding stock of two energy-related companies under rule 58 (Ameren ERC, Inc., which provides energy management services, and Missouri Central Railroad, a fuel transportation subsidiary) and of Ameren Energy Communications, Inc., an exempt telecommunications company within the meaning of section 34 of the Act. Ameren Energy Resources Company, also an intermediate nonutility holding company, holds all of the outstanding common stock of Ameren Energy Development Company, an EWG, as well as of two energy-related companies under rule 58, Ameren Energy Marketing Company, a power marketer, and Ameren Fuels, which brokers and markets energy

[1] Applicants state CIGI, which has been determined by the Federal Energy Regulatory Commission (''FERC'') to be an ''exempt wholesale generator'' (''EWG''), as defined under section 32 of the Act, will relinquish its EWG status upon completion of Ameren's acquisition of CILCORP. Accordingly, in the Application, Ameren is treating CIGI as a public utility company for all purposes under the Act.

commodities and owns and manages fuel procurement and delivery assets. Ameren Energy Generating is a wholly owned subsidiary of Ameren Energy Development Company.

In addition, Ameren indirectly owns 60% of the common stock of Electric Energy, Inc. (''EEI''), an EWG. EEI owns and/or operates electric generation and transmission facilities in Illinois that supply electric power primarily to a uranium enrichment plant located in Paducah, Kentucky.[2]

Ameren also indirectly owns all of the common stock of Ameren Fuels, an ''energy-related company'' under rule 58 that brokers and markets energy commodities and owns and manages fuel procurement and delivery assets.

For the twelve months ended December 31, 2001, Ameren reported total operating revenues of $4,505,867,000, operating income of $664,987,000, and net income of $468,545,000. On a consolidated basis, approximately 92.2% of Ameren's 2001 operating revenues were derived from sales of electricity, 7.6% from sales of gas and gas transportation service, and .2% from other sources. At December 31, 2001, Ameren had $10,400,575,000 in total assets, including net property and plant of $8,426,562,000. As of August 9, 2002, Ameren had issued and outstanding 144,946,829 shares of common stock, $.01 par value. Ameren's common stock is listed and traded on the New York Stock Exchange.

B. CILCORP, CILCO and CIGI

CILCORP, an Illinois corporation, directly owns all of the issued and outstanding common stock of CILCO, its predominant subsidiary. CILCO is engaged in the generation, transmission, distribution and sale of electric energy in an area of approximately 3,700 square miles in central and east-central Illinois, and the purchase, distribution, transportation and sale of natural gas in an area of approximately 4,500 square miles in central and east-central Illinois. CILCO furnishes electric service to approximately 201,000 retail customers in 136 Illinois communities (including Peoria, East Peoria, Pekin, Lincoln and Morton). CILCO owns and operates two coal-fired base load generating plants, a natural gas-fired cogeneration plant, two natural gas combustion turbine generators and 16 diesel-fueled power modules and leases 14 diesel-fueled power modules, all of which are located in Illinois. These facilities had an available summer capability of 1,172 MW in 2001 and 1,197 MW in 2002. CILCO's transmission system (all of which is located in Illinois) includes approximately 285 circuit miles operating at 138 kV, 48 circuit miles operating at 345 kV and 18 principal substations with an installed capacity of approximately 3,724 megavolt-amperes. CILCO's electric distribution system (all of which is located in Illinois) includes approximately 6,516 circuit miles of overhead pole and tower lines and 1,933 miles of underground distribution cables. The distribution system also includes approximately 108 substations with an installed capacity of 1,766 megavolt-amperes.

CILCO has a power purchase agreement with AmerenCIPS for the purchase of 100 MW of capacity and firm energy for the months of June through September through 2003. The agreement also provides for CILCO to purchase 100 MW of firm energy for the month of January through 2003. CILCO and Ameren also make short-term sales of power to each other from time to time under market-based rate tariffs as authorized by the FERC.

Applicants state that CILCO intends to transfer substantially all of its generating assets and certain associated transmission facilities to CIGI in exchange for all of CIGI's common stock and CIGI's assumption of certain liabilities.[3] Applicants expect to complete this transfer prior to the closing of the Transaction, but state that the transfer could possibly be delayed until after closing. The transferred assets will remain subject to the lien of CILCO's Indenture of Mortgage and Deed of Trust, which secures CILCO's first mortgage bonds (''CILCO Mortgage'').[4] This choice of reorganization is being undertaken pursuant to the Customer Choice Law. CILCO will retain all of its other electric transmission and distribution assets and operations. As part of this reorganization, CILCO and CIGI will also enter into a power supply agreement and an interconnection agreement under which CIGI will supply the full requirements of CILCO's customers through at least December 31, 2004.

CILCO's electric service territory is adjacent to AmerenCIPS' service territory. The transmission systems of the two companies are directly interconnected via a 345 kV line that runs approximately 21.3 miles between CILCO's Duck Creek station, which is southwest of Peoria, to a 345/138 kV transformer owned by AmerenCIPS near Ipava, Illinois.

CILCO also provides gas service to approximately 204,000 customers in 128 Illinois communities (including Peoria, East Peoria, Pekin, Lincoln and Springfield). CILCO's gas system includes approximately 3,632 miles of transmission and distribution mains (all of which are located in Illinois) and associated gas storage facilities.

CILCO is regulated by the ICC with respect to retail electric and gas rates and other matters and by the FERC with respect to the transmission service and wholesale electric rates. CIGI is not a public utility company under the laws of Illinois and is therefore not subject to regulation by the ICC. However, CIGI is subject to regulation by the FERC with respect to wholesale electric rates and other matters.

CILCORP directly owns all of the common stock of three nonutility subsidiaries: CILCORP Investment Management Inc., CILCORP Ventures Inc., and QST Enterprises Inc. The assets of these companies consist primarily of investments in affordable housing projects that qualify for federal tax credits and in leveraged leases of equipment and commercial real estate. Applicants maintain that other direct and indirect subsidiaries of CILCORP provide energy-related services. CILCO's nonutility subsidiaries engage in the exploration and development of gas, oil, coal and other mineral resources and research and development activities relating to new sources of energy, including the conversion of coal and other minerals into gas. With certain exceptions, Ameren is requesting approval to retain CILCORP's nonutility subsidiaries and investments.

[2] Applicants state the remaining 40% of the stock of EEI is held equally by two unaffiliated electric utility companies.

[3] Applicants state CILCO will transfer generating facilities representing 1,136 MW of its total generating capacity. These include the Duck Creek and E.D. Edwards coal-fired units and certain peaking units. CILCO will continue to own and maintain a natural gas-fired cogeneration plant and 26 MW of capacity provided by 16 diesel-fueled power modules located at various substations, which will be managed by CIGI.

[4] Applicants state CILCO does not have sufficient unfunded property additions at this time to obtain a complete release of the generation assets under the CILCO Mortgage. Under the CILCO Mortgage, CILCO does not require the trustee's approval to transfer the generating assets to CIGI (although CILCO has notified the trustee of its intent to do so) and also would not require the trustee's approval to transfer CIGI's common stock to CILCORP or another subsidiary of Ameren after the Transaction closes. In general, the CILCO Mortgage permits CILCO to transfer a portion of its assets, subject to the lien. However, even after the transfer of the assets to CIGI, CILCO will continue to have certain ongoing obligations with respect to the transferred property, such as ensuring that the lien is maintained, taxes are paid and the property is insured. The trustee under the CILCO Mortgage will continue to have recourse against the transferred assets in the event of a CILCO default under the CILCO Mortgage.

For the twelve months ended December 31, 2001, CILCORP reported consolidated revenues of $814,870,000, of which $391,811,000 (48.1%) were derived from sales of electricity, $271,434,000 (33.3%) from sales of gas and gas transportation service, and $151,625,000 (18.6%) from CILCORP's nonutility operations. At December 31, 2001, CILCORP had $1,811,698,000 in total assets, including total net property, plant and equipment of $857,987,000.

IV. The Transaction

Applicants request approval for the acquisition by Ameren of all of the issued and outstanding common stock of CILCORP pursuant to the Stock Purchase Agreement. Under the Stock Purchase Agreement, Ameren will pay AES, in consideration for all of the issued and outstanding common stock of CILCORP, cash in an amount equal to $1,340,000,000, less certain ''assumed obligations'' [5] (which includes long-term debt, short-term debt and preferred stock of CILCORP and its subsidiaries), increased or decreased, as appropriate, by the amount, if any, by which ''working capital'' [6] of CILCORP as of the closing date exceeds or is less than the ''base working capital'' [7] of CILCORP, and increased or decreased, as appropriate, by the amount of the ''cap ex adjustment,'' [8] the net amount of the foregoing being the ''purchase price.'' Applicants state if the closing date under the Stock Purchase Agreement had occurred on March 31, 2002, and assuming no change in the base working capital amount and no cap ex adjustment amount, the cash paid by Ameren at closing for the common stock of CILCORP would have been approximately $522 million. Ameren states that it will finance the cash portion of the purchase price using cash on hand and/or proceeds of debt and/or equity financings previously authorized in SEC File No. 70–9877.[9]

The Stock Purchase Agreement further provides that, in the event that the closing date does not occur by the ''Trigger Date,'' then the

''purchase price'' shall be increased by $33,699 per day from the Trigger Date through the closing date, subject to certain limitations. The Trigger Date is the later of (a) December 31, 2002, (b) the date on which AES is capable (without further action by any third party) of completing performance in all material respects of its obligations required to be performed on or prior to closing, and (c) the date which is 90 days following the date on which the ICC grants its approval of the Transaction. Subject to certain limitations and exceptions, either party may terminate the Stock Purchase Agreement if closing has not occurred by March 27, 2003.

Following the acquisition of CILCORP, Ameren proposes to retain

CILCORP as a direct subsidiary for the foreseeable future, and CILCORP will continue to own all of the common stock of CILCO. CILCO, in turn, will continue to hold all of the common stock of CIGI for the foreseeable future. CILCO will maintain its headquarters in Peoria for a period of at least five years and will maintain a local management team and adequate staffing levels to operate its utility system. CILCO will continue to operate as a separate control area. CILCO's generating plants (which CILCO intends to transfer to CIGI by the time of the closing) will not be jointly dispatched with the generating plants owned by AmerenUE and Ameren Energy Generating.

V. Agreements for Sale of Goods and Services

Applicants state that Ameren Services intends to enter into separate service agreements with CILCORP, CILCO, CIGI and certain of CILCORP's other subsidiaries that are identical in all material respects with an existing general service agreement between Ameren Services, Ameren, AmerenUE, AmerenCIPS and certain other associate companies. Thus, Ameren Services will provide to the new client companies the same administrative, management, and technical services that it now provides to Ameren system companies under the general services agreement, utilizing the same work order procedures and the same methods of allocating costs that are specified in that agreement. In connection with the Transaction, certain employees of CILCORP and its subsidiaries may be transferred to and become employees of Ameren Services.

Applicants state that historically, CILCO has provided certain administrative, management and technical services at cost to CILCORP and all of its other associate companies under a service agreement that has been approved by the ICC.[10] Although Applicants expect Ameren Services will assume the responsibility for providing these services after the Transaction closes under new service agreements, there may be a period, not to exceed two years, during the transition in which CILCO will continue to provide certain corporate support services, such as accounting, tax, cash management and billing and sales services, to the same associate companies to which these services were provided prior to the Transaction. In addition, following the transfer of its generating assets to CIGI, CILCO and CIGI request authorization to provide to each other, on a permanent basis, certain technical services relating to the operation and maintenance of generating assets located at CILCO substations and the equipment connecting CIGI's generation facilities with CILCO's transmission facilities. Applicants state that all of these services will be performed at cost in accordance with rules 90 and 91 under a services and facilities agreement to be executed when the generating assets are transferred to CIGI.

To the extent required, Applicants request authorization to maintain in place (a) a tolling agreement under which AES Medina Valley sells electricity, steam and chilled water to CILCO, (b) a fuel supply and services agreement between CILCORP Energy Services Inc. (''CESI''), a nonutility gas marketing subsidiary of CILCORP, and AES Medina Valley, under which CESI supplies AES Medina Valley's gas requirements and also provides certain ancillary services relating to the supply of gas to the Mossville facility, and (c) a FERC-approved interconnection agreement between CILCO and AES Medina Valley, under which CILCO provides metering and other ancillary services to AES Medina Valley, at cost.

In addition, Ameren Fuels requests authorization to enter into separate fuel services agreements with CILCO and CIGI under which Ameren Fuels will manage gas supply resources for CILCO

[5] Applicants state the term ''assumed obligations'' means the amounts required to be included on CILCORP's balance sheet as of the closing date as long-term debt (including the current portion), short-term debt, capital lease obligations, preferred stock of subsidiaries, and other obligations for borrowed money.

[6] Applicants state the term ''working capital'' means the current assets of CILCORP less current liabilities (not counting in current liabilities any short-term debt or current maturity of long-term debt that is included in Assumed Obligations) as of the closing date.

[7] Applicants state that, as agreed to in the Stock Purchase Agreement, ''base working capital'' is $75 million.

[8] Applicants state the term ''cap ex adjustment'' amount represents the amount, if any, by which expenditures by CILCORP for certain capital improvements prior to closing are less or greater than the amounts agreed to under the Stock Purchase Agreement.

[9] See, Ameren Corporation, HCAR No. 27449 (Oct. 5, 2001). On September 10, 2002, Ameren sold 8.05 million new shares of common stock in a public offering at $42.00 per share. Net proceeds (after underwriting discount) to Ameren were $327 million.

[10] Applicants state that, with one exception, CILCO's nonutility associate companies do not have employees of their own.

and manage fuel procurement for CIGI. These services will be provided at cost, in accordance with rule 90 and 91.[11]

VI. Financing by CILCORP, CILCO and CIGI

The existing equity and long-term and short-term debt securities of CILCORP, CILCO and CIGI will remain outstanding after the Transaction closes.[12] In addition, CILCORP, CILCO and CIGI are requesting authority, to the extent these transactions are not exempt, to engage in certain ongoing external and intrasystem financing transactions from time to time during the Authorization Period. Any securities issued by CILCORP, CILCO or CIGI to third parties may be issued directly, or may be issued indirectly through one or more special purpose entities formed solely for this purpose (''Financing Subsidiaries'').

A. Financing Parameters

The financing authorizations requested in the Application will be subject to the following parameters:

• CILCORP, CILCO and CIGI state that they will not engage in any financing transactions for which approval is sought unless, on a pro forma basis to take into account the amount and types of the financing and the subsequent application of the proceeds, common equity as a percentage of capitalization (including short-term debt and current maturities of long-term debt) of each company is at least 30%;

• Except in accordance with a further order of the Commission in this proceeding, CILCORP and CIGI will not publicly issue any Long-term Securities (defined below) unless the securities are rated at the investment grade level as established by at least one nationally recognized statistical rating organization, as that term is used in paragraphs (c)(2)(vi)(E), (F) and (H) of Rule 15c3–1 under the Securities Exchange Act of 1934.

• The effective cost of money on all external short-term borrowings by CILCORP will not exceed at the time of issuance the greater of (1) 300 basis points over the six-month London Interbank Offered Rate (''LIBOR''), or (2) a gross spread over LIBOR that is consistent with similar securities of comparable credit quality and maturities issued by other companies;

• The maturity date of any new series of long-term notes issued by CILCORP will be not later than October 15, 2029, which is the maturity date of the longest of the two series of outstanding Senior Notes;

• Any new long-term notes issued by CILCORP in a refinancing transaction will bear interest at a rate not to exceed at the time of issuance the greater of (1) 500 basis points over the yield to maturity of a U.S. Treasury security having a remaining term equal to the average life of the new notes (or, if no such Treasury security is outstanding, then the yield to maturity of a 30-year U.S. Treasury Bond), or (2) a gross spread over U.S. Treasuries that is consistent with similar securities of comparable credit quality and maturities issued by other companies;

• The effective cost of money on all external short-term borrowings by CILCO and CIGI will not exceed at the time of issuance the greater of (1) 300 basis points over the six-month LIBOR, or (2) a gross spread over LIBOR that is consistent with similar securities of comparable credit quality and maturities issued by other companies;

• Any preferred stock or other types of preferred securities issued by CIGI will be redeemed no later than 50 years after issuance;

• The dividend rate on any series of preferred stock or other preferred securities issued by CIGI will not exceed at the time of issuance the greater of (1) 700 basis points over the yield to maturity of a U.S. Treasury security having a remaining term equal or closest to the term of the securities (or, if no such Treasury security is outstanding, then the yield to maturity of a 30-year U.S. Treasury Bond), or (2) a gross spread over U.S. Treasuries that is consistent with similar securities of comparable credit quality and maturities issued by other companies;

• Long-term debt issued by CIGI will have a maturity ranging from one to 50 years; and

• Long-term debt issued by CIGI will bear interest at a rate not to exceed at the time of issuance the greater of (1) 600 basis points over the yield to maturity of a U.S. Treasury security having a remaining term equal or closest to the average life of the series (or, if no such U.S. Treasury security is outstanding, then the yield to maturity of a 30-year U.S. Treasury Bond), or (2) a gross spread over U.S. Treasuries that is consistent with similar securities of comparable credit quality and maturities issued by other companies.

B. External Financing Transactions

1. CILCORP

(a) Short-Term Debt

CILCORP requests authorization to issue and sell commercial paper and/or establish and make unsecured short-term borrowings (*i.e.*, less than one year) under credit facilities with banks or other institutional lenders on terms that are generally available to borrowers with a comparable credit rating as CILCORP as CILCORP deems appropriate in light of its needs and existing market conditions, provided that the aggregate amount of borrowings by CILCORP at any time outstanding under all credit facilities, when added to the amount of any direct short-term borrowings by CILCORP from Ameren will not exceed $250 million.

(b) Refinancing of CILCORP Senior Notes

CILCORP also requests authorization to issue, in one or more transactions from time to time during the Authorization Period, long-term notes for the purpose of refinancing or acquiring $475 million principal amount of senior notes (''Senior Notes'') that are currently outstanding at or prior to their scheduled maturity. The principal amount of any new long-term notes issued will not exceed the unpaid principal amount of the Senior Notes, plus any ''make whole'' premium required to be paid in connection with any prepayment and/or the premium, if any, that is paid in connection with any acquisition of the Senior Notes in open market purchases. In connection with any issuance, Ameren requests authorization to guaranty any new CILCORP notes issued in a refinancing transaction or to issue a guarantee of the outstanding CILCORP Senior Notes in order to obtain a termination and release of the pledge of CILCO's common stock[13] or for other corporate purposes.

[11] By order dated April 5, 2001 in File No. 70–9775 (HCAR No. 27374), the Commission authorized Ameren Fuels to provide AmerenUE and AmerenCIPS with the same fuel management services that Ameren Fuels is now proposing to provide to CILCO and CIGI.

[12] CILCORP currently has issued and outstanding 1,000 shares of common stock, no par value, all held by AES. In addition, CILCORP has outstanding $225 million of 8.7% senior notes, due 2009, and $250 million of 9.375% senior notes, due 2029 (the ''Senior Notes''), which are secured by a pledge of the common stock of CILCO. CILCORP also had committed bank lines totaling $35 million at December 31, 2001, under which it had outstanding borrowings of $20 million.

At March 31, 2002, CILCO had issued and outstanding 13,563,871 shares of common stock, no par value, all of which are held by CILCORP; 191,204 shares of cumulative preferred stock, $100 par value, and 220,000 shares of Class A preferred stock, no par value, totaling $41,120,000; and $242,250,000 of long-term debt. In addition, at December 31, 2001, CILCO had issued and outstanding $43,000,000 of commercial paper, and had in place bank lines totaling $100,000,000 which are used to backstop its commercial paper.

[13] Applicants state CILCORP has outstanding $225 million of 8.7% senior notes, due 2009, and

Continued

2. CILCO and CIGI

(a) Short-Term Debt

CILCO and CIGI are requesting authorization to issue commercial paper and establish and make unsecured short-term borrowings (*i.e.*, less than one year) under credit lines from time to time during the Authorization Period, provided that the aggregate amount of external short-term borrowings by CILCO at any time outstanding under all credit facilities, when added to the amount of any direct short-term borrowings by CILCO from Ameren (see part VI.C.1., ''Intrasystem Financing Transactions'' below), will not exceed $250 million, and that the aggregate amount of borrowings by CIGI at any time outstanding under all credit facilities, when added to the amount of any direct short-term borrowings by CIGI from Ameren (see part VI.C.1., ''Intrasystem Financing Transactions'' below), will not exceed $250 million.

(b) Long-Term Securities of CIGI

CIGI is also requesting authorization to issue and sell from time to time during the Authorization Period long-term securities consisting of any combination of preferred stock or other forms of preferred securities and long-term debt (''Long-term Securities''). Preferred stock or other types of preferred securities may be issued in one or more series with rights, preferences, and priorities as may be designated in the instrument creating each series provided that the aggregate amount of all such securities at any time outstanding, when added to the amount of any direct long-term borrowings by CIGI from Ameren (see part VI.C.1., ''Intrasystem Financing Transactions'' below), will not exceed $500 million.

Long-term debt of a particular series (i) may be secured or unsecured, (ii) may be subject to optional and/or mandatory redemption, in whole or in part, at par or at various premiums above the principal amount, (iii) may be entitled to mandatory or optional sinking fund provisions, (iv) may provide for reset of the coupon under a remarketing or auction arrangement, and (v) may be called from existing investors by a third party.

CILCORP and CIGI request authority to issue Long-term Securities that are rated below investment grade. Applicants request the Commission reserve jurisdiction over CILCORP and CIGI in connection with the issuance of any Long-term Securities that are rated below investment grade.

3. Interest Rate and Anticipatory Hedging Transactions

To the extent not exempt under rule 52, CILCORP, CILCO and CIGI also request authorization to enter into interest rate hedging transactions with respect to outstanding indebtedness (''Interest Rate Hedges''), subject to certain limitations and restrictions, in order to reduce or manage the effective interest rate cost. In no case will the notional amount of any Interest Rate Hedge exceed the principal amount of the underlying debt instrument. Transactions will be entered into for a fixed or determinable period. Thus, the applicants will not engage in speculative transactions. Interest Interest Rate Hedges would only be entered into with counterparties (''Approved Counterparties'') whose senior debt ratings, or the senior debt ratings of any credit support providers who have guaranteed the obligations of the Approved Counterparties, as published by S&P, are equal to or greater than BBB, or an equivalent rating from Moody's or Fitch, Inc. In addition, CILCORP, CILCO and CIGI request authorization to enter into interest rate hedging transactions with respect to anticipated debt offerings (the ''Anticipatory Hedges''), subject to certain limitations and restrictions.

Applicants state that Each Interest Rate Hedge and Anticipatory Hedge will qualify for hedge accounting treatment under the current Financial Accounting Standards Board (''FASB'') guidelines in effect and as determined at the time entered into. Further, the Applicants will comply with the Statement of Financial Accounting Standards (''SFAS'') 133 (''Accounting for Derivatives Instruments and Hedging Activities'') and SFAS 138 (''Accounting for Certain Derivative Instruments and Certain Hedging Activities'') or other standards relating to accounting for derivative transactions as are adopted and implemented by the FASB.[14]

C. Intrasystem Financing Transactions

1. Long-Term and Short-Term Securities of CILCORP, CILCO and CIGI

Ameren may from time to time during the Authorization Period acquire additional shares of CILCORP's common stock, make additional capital contributions or non-interest bearing cash advances to CILCORP, and/or make loans to CILCORP, CILCO and CIGI (and acquire unsecured promissory notes of CILCORP, CILCO and CIGI evidencing the loans) in order to enable CILCORP to fund additional investments in CILCO and its other existing subsidiaries, to redeem or retire the outstanding Senior Notes, and to fund working capital. Accordingly, CILCORP requests authority to issue, and Ameren requests authority to acquire, from time to time during the Authorization Period, (a) up to $1 billion at any time outstanding of additional common stock and/or promissory notes having maturities of one year or more, and (b) up to $250 million at any time outstanding of promissory notes having maturities of less than one year. Any promissory note issued by CILCORP to Ameren evidencing a loan will be unsecured and will bear interest at a rate and have a maturity date designed to parallel the effective cost of capital and maturity date of a similar debt instrument issued by Ameren.

Ameren requests authorization to make long-term and short-term loans to CIGI (and acquire promissory notes of CIGI evidencing the loans) in order to fund CIGI's capital improvements and working capital requirements. Accordingly, CIGI requests authority to issue, and Ameren requests authority to acquire, from time to time during the Authorization Period, (a) up to $500 million at any time outstanding of promissory notes having maturities of one year or more, and (b) up to $250 million at any time outstanding of promissory notes having maturities of less than one year.

Ameren requests authorization to make short-term loans to CILCO (and acquire promissory notes of CILCO evidencing the loans) in order to fund CILCO's capital improvements and working capital requirements. Accordingly, CILCO requests authority to issue, and Ameren requests authority to acquire, from time to time during the Authorization Period, up to $250 million at any time outstanding of promissory notes having maturities of less than one year.

2. Guarantees Issued by CILCORP and Its Subsidiaries

CILCORP and certain of its nonutility subsidiaries request authorization to maintain, renew and extend all guarantees and other forms of credit support that they have issued and which are outstanding at the time that the Transaction closes. In addition, CILCORP requests authorization to provide additional guarantees and other forms of credit support (collectively, ''Guarantees'') from time to time during the Authorization Period on behalf of or for the benefit of any of its subsidiaries,

$250 million of 9.375% senior notes, due 2029 that are secured by a pledge of the common stock of CILCO

[14] Applicants state the authority sought for interest rate hedging transactions in this Application is identical to the authorization previously granted to Ameren in SEC File No. 70–9877.

provided that the aggregate amount of all CILCORP guarantees at any time outstanding shall not exceed $500 million. Any Guarantee outstanding on March 31, 2006 will expire or terminate in accordance with its terms.

D. Organization and Acquisition of Financing Subsidiaries

In connection with the issuance of any securities for which authorization is requested in the application/declaration, or (in the case of CILCO) under rule 52(a), CILCORP, CILCO and CIGI request authorization to acquire, directly or indirectly, the common stock or other equity securities of one or more entities (each a ''Financing Subsidiary'') formed exclusively for the purpose of facilitating the issuance of long-term debt and/or preferred securities and the loan or other transfer of the proceeds to the parent company of a Financing Subsidiary. The proceeds of any financing carried out through a Financing Subsidiary will be counted against the limits proposed in the Application for the securities issued by CILCORP or CIGI, as the case may be, and the terms, conditions and other limitations applicable to any securities issued by a Financing Subsidiary will conform to those proposed for the specified type of security (*e.g.*, long-term debt, preferred securities, etc.). In connection with any of these financing transactions, CILCORP or CIGI, as the case may be, may enter into one or more guarantees or other credit support agreements in favor of its Financing Subsidiary. CILCORP, CILCO and CIGI also request authorization to enter into an expense agreement with its respective Financing Subsidiary, under which each company would agree to pay all expenses of the Financing Subsidiary.

In addition, CILCORP and CIGI also request authority to issue and sell to any Financing Subsidiary, at any time or from time to time in one or more series, unsecured debentures, unsecured promissory notes or other unsecured debt instruments (individually, a ''Note'' and, collectively, the ''Notes'') governed by an indenture or indentures or other documents, and the Financing Subsidiary will apply the proceeds of any external financing by the Financing Subsidiary plus the amount of any equity contribution made to it from time to time to purchase Notes. The terms (*e.g.*, interest rate, maturity, amortization, prepayment terms, default provisions, etc.) of any Notes would generally be designed to parallel the terms of the securities issued by the Financing Subsidiary to which the Notes relate. The principal amount of Notes issued to a Financing Subsidiary by its parent will not be counted against the limits proposed in this Application on securities issued by CILCORP or CIGI to third parties or to Ameren.[15]

Applicants state that any Financing Subsidiary organized under the authority granted by the Commission in this proceeding shall be organized only if, in management's opinion, the creation and utilization of a Financing Subsidiary will likely result in tax savings, increased access to capital markets and/or lower cost of capital for CILCORP, CILCO or CIGI, as applicable.[16]

E. Payment of Dividends by CILCORP Out of Capital Surplus

CILCORP requests authorization to declare and pay dividends on its common stock and/or redeem or repurchase its outstanding shares of common stock from time to time through the Authorization Period out of capital surplus (including revaluation reserve) to the extent permitted under applicable corporate law and the terms of any applicable covenants in its financing documents (including the CILCORP Indenture) in an amount equal to CILCORP's retained earnings at the time that the Transaction is consummated plus the amount, if any, recorded as an impairment to goodwill on the books of CILCORP in accordance with SFAS Nos. 141 and 142.[17]

VII. Exemption of CILCORP and CILCO as Holding Companies

Finally, in its capacity as a holding company over CILCO and CIGI, CILCORP states that it will continue to be entitled to an exemption under section 3(a)(1) because CILCORP, CILCO and CIGI are all incorporated in Illinois, the state in which all of CILCO's and CIGI's public utility operations are conducted. Likewise, Applicants state that CILCO will be entitled to an exemption under section 3(a)(1) by nature of its capacity as a holding company over CIGI. Accordingly, CILCORP and CILCO request that the Commission issue an order exempting them from the registration requirements of section 5 under section 3(a)(1).

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

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[15] ''Mirror image'' Notes issued by CILCO to any Financing Subsidiary will be exempt under rule 52(a) if the conditions of rule 52(a) are satisfied.

[16] Applicants state the creation of any Financing Subsidiary, issuance of securities through these entities, and the use of financing proceeds to make investments will be subject to a comprehensive set of formal internal controls that Ameren has adopted. These include delegation of authority limits on expenditures, board of director budget approvals and comparison of budgets against actual financial results on a monthly basis, daily reconciliations of disbursements from major accounts by the Treasurer's group, monthly review of financial statements of each legal entity in the Ameren system by Ameren's Accounting Manager, Controller and Vice President of Finance, external auditor review of financial statements for each legal entity filing reports under the Securities Exchange Act of 1934 on a quarterly basis, internal audits, and corporate compliance procedures that are applicable to all management employees.

[17] See, E.ON AG, *et al.*, HCAR No. 27539 (June 14, 2002).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 35–27587]

Filings Under the Public Utility Holding Company Act of 1935, as Amended (''Act'')

October 28, 2002.

Notice is hereby given that the following filing(s) has/have been made with the Commission pursuant to provisions of the Act and rules promulgated under the Act. All interested persons are referred to the application(s) and/or declaration(s) for complete statements of the proposed transaction(s) summarized below. The application(s) and/or declaration(s) and any amendment(s) is/are available for public inspection through the Commission's Branch of Public Reference.

Interested persons wishing to comment or request a hearing on the application(s) and/or declaration(s) should submit their views in writing by November 22, 2002, to the Secretary, Securities and Exchange Commission, Washington, DC 20549–0609, and serve a copy on the relevant applicant(s) and/or declarant(s) at the address(es) specified below. Proof of service (by affidavit or, in the case of an attorney at law, by certificate) should be filed with the request. Any request for hearing should identify specifically the issues of facts or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After November 22, 2002, the application(s) and/or declaration(s), as filed or as amended, may be granted and/or permitted to become effective.

Great Plains Energy Incorp., et al. (70–10064)

Great Plains Energy Incorporated (''GPE''), a registered holding company;

Kansas City Power & Light Company (''KCPL''), an electric utility company and a wholly-owned subsidiary of GPE; and Great Plains Energy Services Incorporated (''GPES''), a to-be formed service company subsidiary, all located at 1201 Walnut, Kansas City, Missouri 64106; and Wolf Creek Nuclear Operating Corporation (''WCNOC''), 1550 Oxen Lane N.E., Burlington, Kansas 66839, a nonutility subsidiary of KCPL, which provides goods and services to the owners of Wolf Creek Generating Station; (collectively, ''Applicants'') have filed an application-declaration under sections 6(a), 7, 9(a), 10, 12(b), and 13(b) under the Act and rules 45, 88, 90 and 91 under the Act.

I. Prior Authorizations

By Commission order dated September 7, 2001 (HCAR No. 27436) (''September Order'') GPE was authorized, among other things, to effectuate a reorganization by GPE forming another Missouri subsidiary and merging KCPL into the Missouri subsidiary that resulted in KCPL becoming a wholly owned subsidiary of GPE. In addition, financing was authorized for the new system. Specifically, related to the intrasystem provision of services, KCPL and GPE were given until April 30, 2002 to file an application-declaration seeking authority to create a service company and implement the final support service structure for the new GPE holding company system (''Service Company Application''). Until the Service Company Application is made effective, KCPL and GPE requested authority under section 13(b) and the rules for an interim period (''Interim Period'') for KCPL and the nonutility subsidiaries to provide support services and to sell goods to each other and to GPE. Existing and future nonutility, intermediate subsidiaries of GPE were also authorized during the Interim Period to provide management, administrative, project development and operating services at fair market prices to certain classes of nonutility subsidiaries.

II. Request to Form the Service Company and Provide Services

A. Summary of Requests

Applicants filed the Service Company Application by April 30, 2002, as directed by the Commission in September Order. The Service Company Application seeks the authorization and approval by the Commission of the provision of intrasystem services and goods following the expiration of the Interim Period, under section 13 of Act and the rules. Applicants request that the Commission: (1) Approve the designation of GPES as a subsidiary service company in accordance with the provisions of rule 88 under the Act and find that GPES is so organized and will conduct its operations so as to meet the requirements of section 13 and the rules under the Act; (2) approve the service agreement (as attached in S.E.C. File No. 70–10064, Exhibit B–1 filed April 19, 2002) (''Service Agreement''); (3) authorize to the extent not exempt under rules 81 and 87, for GPE's subsidiaries to provide certain services and goods to each other and to GPE; and (4) authorize extensions of credit or guarantees under section 12(b) and rule 45 for GPES or KCPL to assume responsibility to counterparties in leases, licenses, or other arrangements for the associates' compliance under those leases, licenses, or other arrangements.

B. Services provided by GPES

GPE requests authorizations with respect to the activities of GPES, which will be incorporated in Missouri as a wholly-owned subsidiary of GPE to serve as the service company for the GPE system. GPES will:

- Have a minimal equity capitalization of not more than 1,000 shares with total equity capitalization of not more than $10,000.
- Finance it business through the issuance of debt securities exempted under rule 52(b) to associate companies or unaffiliated parties or as otherwise authorized by the Act, rules, and Commission orders.
- Provide companies [1] in the GPE system with a variety of administrative, management and support services.
- Be staffed by a transfer of personnel from KCPL, and in addition, KCPL will transfer personal property from KCPL to GPES.[2]
- Be assigned certain leases and licenses currently held by KCPL, or in the alternative the leases and licenses may continue to be held by KCPL and a portion of the goods and services may be provided to other system companies. (To the extent that current leases, licenses, and other arrangements respecting goods and services used by KCPL and one or more associate companies cannot be reasonably transferred to GPES, or in situations in which KCPL is the predominant user of such goods and services, or in the event Missouri Public Service Commission approval of the proposed asset transfer is not obtained before the establishment of GPES,[3] KCPL may make available a portion of the associated goods and services to associate companies through leases, licenses or similar arrangements.)
- Be responsible to counterparties of the underlying leases, licenses, or other arrangements for the associates' compliance with the terms and conditions of those agreements.
- Comply with the Commission's standards for cost allocation methods and procedures for service companies in registered holding company systems;
- Use the Commission's ''Uniform System of Accounts for Mutual Service Companies and Subsidiary Service Companies'' for GPES's billing system.
- Provide classes of services through departments and more than one class of services. Both corporate services and shared services may be offered. Corporate services are required, but shared services will be a choice subject to the terms and conditions of the service agreement.
- Provide all services by GPES to affiliated companies on an ''at cost'' basis as determined by rules 90 and 91 of the Act, except as permitted by the Act or the Commission.

C. Services Provided by the Subsidiaries

1. KCPL

KCPL may provide to associate companies services incidental to its utility business, including but not limited to leases [4] or subleases of office or other space with associate companies, services of personnel with specialized expertise and usage of KCPL's integrated voice and data communications system. In addition, to

[1] GPE currently has four direct subsidiaries: KCPL; Innovative Energy Consultants, Inc.; KLT, Inc.; and Great Plains Power Incorporated (''GPP''). KCPL is the only public utility company in the GPE system, and provides electricity at retail in portions of Kansas and Missouri and at wholesale.

[2] The net book value of the property proposed to be transferred to GPES is approximately $4.9 million. Of this amount, approximately $815,000 is related to leasehold improvements in leased office space which will be occupied by GPES. Approximately $2.9 million of this amount is related to general office equipment (such as chairs, desks, furniture, cubicle partitions and other items) which will be used by GPES employees. The remainder is related to the capitalized costs of software which will be used by GPES in providing services to its Clients. GPES will pay to KCPL the net book value of the property, under rule 90. The payment by GPES to KCPL for the transferred property may be in the form of either cash or a promissory note in the principal amount of the purchase price, bearing interest at the effective cost of capital of KCPL. Applicants represent that none of the property proposed to be transferred constitutes ''utility assets'' as defined by section 2(18) of the Act, and to the extent the property constitutes ''goods'' of KCPL, the Applicants state the transfer is permitted by rule 87(b)(4).

[3] Section 393.190, RSMo.

[4] KCPL leases transmission facilities and railcars, and has entered into lease arrangements for five combustion turbines.

the extent that current leases, licenses and other arrangements respecting goods and services used by KCPL and one or more associate companies cannot be reasonably transferred to GPES, or in situations in which KCPL is the predominant user of such goods and services, or in the event Missouri Public Service Commission approval of the proposed asset transfer is not obtained before the establishment of GPES, KCPL may make available a portion of the associated goods and services to associate companies through leases, licenses or similar arrangements. All such goods and services will be provided to associate companies in accordance with rules 87, 90 and 91. To the extent such matters do not fall within the exception provided in rule 87(a)(3), Applicants request authorization for KCPL to engage in such activities.

KCPL may have responsibility for GPES's compliance under assigned leases, licenses, and other arrangements. In situations where KCPL makes available goods and services to associate companies under leases, licenses, or other arrangements between KCPL and third parties, KCPL may have responsibility for those associate companies' compliance with such leases, licenses, or other arrangements. To the extent such responsibility is deemed to be an extension of credit or guaranty by KCPL under section 12(b) of the Act, Applicants request authority for KCPL to incur such responsibility.

2. WCNOC

Applicants request authorization for WCNOC, as a nonutility subsidiary of KCPL, to provide services and goods to the owners of Wolf Creek Generating Station at cost under existing agreements (as attached in S.E.C. File No. 70–10064, Exhibit B–3) (''WCNOC Existing Agreements''). Applicants also request authorization for KCPL to provide goods and services to WCNOC at cost under WCNOC Existing Agreements. WCNOC, KCPL, and Kansas Gas and Electric Company (an owner of Wolf Creek Generating Station) also have entered into a service reciprocity agreement dated June 20, 1986 (as attached in S.E.C. File No. 70–10064, Exhibit B–6) (''Service Reciprocity Agreement''), providing for the recognition of pension service credits earned by employees who transfer to or from WCNOC. To the extent the Service Reciprocity Agreement may be deemed jurisdictional, Applicants request authorization for KCPL and WCNOC to continue with such agreement.

D. Request for an Exemption From At Cost

Applicants request that GPES and all other nonutility subsidiaries of GPE be authorized to enter into agreements to provide construction, goods or services to certain associate companies enumerated below at fair market prices determined without regard to cost, and request an exemption (to the extent that rule 90(d) of the Act does not apply) under section 13(b) from the cost standards of rules 90 and 91:

- A foreign utility company (''FUCO'') or foreign exempt wholesale generator that derives no part of its income, directly or indirectly, from the generation, transmission or distribution of electric energy for sale within the United States;
- An exempt wholesale generator (EWG) that sells electricity at market-based rates which have been approved by the Federal Energy Regulatory Commission (''FERC''), provided that the purchaser is not KCPL;
- A ''qualifying facility'' (''QF'') within the meaning of the Public Utility Regulatory Policies Act of 1978, as amended (''PURPA'') that sells electricity exclusively (i) at rates negotiated at arms' length to one or more industrial or commercial customers purchasing the electricity for their own use and not for resale, and/or (ii) to an electric utility company at the purchaser's ''avoided cost'' as determined in accordance with the regulations under PURPA;
- A domestic EWG or QF that sells electricity at rates based upon its cost of service, as approved by FERC or any state public utility commission having jurisdiction, provided that the purchaser is not KCPL; or
- A rule 58 subsidiary or any other nonutility subsidiary that (i) is partially-owned, directly or indirectly, by GPE, provided that the ultimate purchaser of such goods or services is not KCPL (or any other entity that GPE may form whose activities and operations are primarily related to the provision of goods and services to KCPL), (ii) is engaged solely in the business of developing, owning, operating and/or providing services or goods to nonutility subsidiaries described in clauses (a) through (e) immediately above, or (iii) does not derive, directly or indirectly, any material part of its income from sources within the United States and is not a public utility company operating within the United States.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46729; File No. S7–24–89]

Joint Industry Plan; Order Granting Partial Temporary Approval of Amendment No. 13 of the Reporting Plan for Nasdaq-Listed Securities Traded on Exchanges on an Unlisted Trading Privilege Basis, Submitted by the National Association of Securities Dealers, Inc., the Boston Stock Exchange, Inc., the Chicago Stock Exchange, Inc., the Cincinnati Stock Exchange, Inc., the Pacific Exchange, Inc., the American Stock Exchange LLC, and the Philadelphia Stock Exchange, Inc.

October 25, 2002.

I. Introduction

On May 31, 2002, the Cincinnati Stock Exchange, Inc. (''CSE'') on behalf of itself and the National Association of Securities Dealers, Inc. (''NASD''), the American Stock Exchange LLC (''Amex''), the Boston Stock Exchange, Inc. (''BSE''), the Chicago Stock Exchange, Inc. (''CHX''), the Pacific Exchange, Inc. (''PCX''), and the Philadelphia Stock Exchange, Inc. (''PHLX'') (hereinafter referred to collectively as ''Participants''),[1] as members of the operating committee (''Operating Committee'' or ''Committee'')[2] of the Plan submitted to the Securities and Exchange Commission (''SEC'' or ''Commission'') a proposal to amend the Plan, pursuant to Rule 11Aa3–1 and Rule 11Aa3–2 [3] under the Securities Exchange Act of 1934 (''Act'' or ''Exchange Act''). The proposal represents the 13th amendment (''13th Amendment'') made

[1] The CSE was elected chair of the Operating Committee for the Joint Self-Regulatory Organization Plan Governing the Collection, Consolidation and Dissemination of Quotation and Transaction Information for Nasdaq-Listed Securities Traded on Exchanges on an Unlisted Trading Privilege Basis (''Nasdaq UTP Plan'' or ''Plan'') by the Participants.

[2] Among other things, the 13th Amendment proposes to add the Nasdaq Stock Market, Inc. (''Nasdaq'') as a Participant. The Committee is made up of all the Participants. As discussed below, the Category 1 amendments of the 13th Amendment propose adding Nasdaq as a Participant and this approval order does not take action with respect to the Category 1 amendments.

[3] 17 CFR 240.11Aa3–1 and 17 CFR 240.11Aa3–2.

to the Plan and reflects changes unanimously adopted by the Committee. Notice of the proposed 13th Amendment was published in the **Federal Register** on July 5, 2002.[4]

Through the 13th Amendment Notice, the Commission granted temporary summary effectiveness to a portion of the 13th Amendment, granted an exemption under Rule 11Aa3–2(f)[5] from compliance with Section VI.C.1. of the Plan as required by Rule 11Aa3–2(d),[6] and published the 13th Amendment Notice to solicit comments from interested persons. The Commission received one comment on the proposed 13th Amendment.[7]

As discussed in the 13th Amendment Notice, proposed amendments to the Plan have been segregated into four categories: (1) Category 1, ''Effective Upon Nasdaq's Exchange Registration;'' (2) Category 2, ''Effective Upon Launch of the Internal SIP;'' (3) Category 3, ''Effective Upon End of Parallel Period—Elimination of the Legacy SIP;'' and (4) Category 4, ''Timing Not An Issue.'' The amendments detailed in Category 2 were granted summary effectiveness through the 13th Amendment Notice so as to allow the target launch date for the new Internal Securities Information Processor (''SIP'') data feeds to be met.[8] The summary effectiveness expires on October 26, 2002.[9]

In addition, the Commission granted partial temporary approval to the 13th Amendment only with respect to extension of the expiration date of the Plan itself. The partial temporary approval extended the expiration date of the Plan through August 19, 2003.[10] As explicitly noted in the Date Extension Approval Order, the Commission was not approving the Category 1, 2, 3, or 4 amendments, but would address such amendments through separate action.

This order approves the amendments detailed in Categories 2, 3, and 4 on a pilot basis through August 19, 2003 to be coterminous with the expiration date set by the Date Extension Approval Order. In addition, this order continues the exemption under Rule 11Aa3–2(f)[11] from compliance with Section VI.C.1. of the Plan as required by Rule 11Aa3–2(d),[12] which exemption was granted through the 13th Amendment Notice.

This order does not approve those amendments detailed in Category 1. The Commission intends to address those amendments detailed in Category 1 through separate action when the Commission acts on the Nasdaq exchange registration application.[13]

II. Background

The Plan governs the collection, consolidation, and dissemination of quotation and transaction information for Nasdaq/National Market (''Nasdaq/NM'') and Nasdaq SmallCap securities listed on Nasdaq and traded on an exchange pursuant to unlisted trading privileges (''UTP'').[14] The Plan provides for the collection from Plan Participants, and the consolidation and dissemination to vendors, subscribers and others, of quotation and transaction information in ''eligible securities.'' The Plan contains various provisions concerning its operation, including: Implementation of the Plan; Manner of Collecting, Processing, Sequencing, Making Available and Disseminating Last Sale Information; Reporting Requirements (including hours of operation); Standards and Methods of Ensuring Promptness, Accuracy and Completeness of Transaction Reports; Terms and Conditions of Access; Description of Operation of Facility Contemplated by the Plan; Method and Frequency of Processor Evaluation; Written Understandings of Agreements Relating to Interpretation of, or Participation in, the Plan; Calculation of the Best Bid and Offer (''BBO''); Dispute Resolution; and Method of Determination and Imposition, and Amount of Fees and Charges.

The Commission originally approved the Plan on a pilot basis on June 26, 1990.[15] The parties did not begin trading until July 12, 1993, accordingly, the pilot period commenced on July 12, 1993. The Plan has since been in operation on an extended pilot basis.[16]

III. Description and Purpose of the Category 2, 3, and 4 Amendments

The complete text of the Plan, as amended, was published in the **Federal Register**.[17] The following is a summary of the changes made by the 13th Amendment to the Plan by the Category 2, 3, and 4 amendments. As discussed above, only those amendments described in Categories 2, 3, and 4 are being approved on a pilot basis by this order.

Category 2 Amendments: Effective Upon Launch of the Internal SIP

1. Section III.I. of the Plan, which defines ''UTP Quote Data Feed,'' is amended to reflect that the Processor will replace the Level 1 Service as it currently exists. In its place, the

[4] Securities Exchange Act Release No. 46139 (June 28, 2001 [sic]), 67 FR 44888 (''13th Amendment Notice'').

[5] 17 CFR 240.11Aa3–2(f).

[6] 17 CFR 240.11Aa3–2(d).

[7] *See* letter from Sam Guidetti, Senior Vice President & Chief Compliance Officer, BrokerageAmerica, to Jonathan Katz, Secretary, Commission, dated September 17, 2002.

[8] In November of 2001, Nasdaq began implementing the ''Internal SIP'' project. The Internal SIP is a separate technology infrastructure within Nasdaq that will perform the functions of the SIP for Nasdaq-listed securities. When the Internal SIP is in place, Nasdaq will be able to separate its functions as a stock market from its functions as a SIP for the Plan.

[9] Pursuant to Rule 11Aa3–2(c)(4), 17 CFR 240.11Aa3–2(c)(4), summary effectiveness granted to national market system plans (or provisions thereof) may not exceed 120 days in length.

[10] Securities Exchange Act Release No. 46381 (August 19, 2002), 67 FR 54687 (August 23, 2002) (''Date Extension Approval Order'').

[11] 17 CFR 240.11Aa3–2(f).

[12] 17 CFR 240.11Aa3–2(d).

[13] Pursuant to Rule 11Aa3–2(c), 17 CFR 240.11Aa3–2(c), the Commission must take action within 120 days of the date of publication of notice of filing of amendment in the **Federal Register** unless the sponsors of such amendment consent to an extension. The Commission notes that the sponsors of the 13th Amendment have given such consent with respect to amendment Category 1 based upon the Category 1 amendments being contingent upon a subsequent trigger event. *See* letter from Jeffrey T. Brown, Chairman, Operating Committee, to Jonathan G. Katz, Secretary, Commission, dated May 30, 2002 (''13th Amendment Filing'').

[14] Section 12 of the Act generally requires an exchange to trade only those securities that the exchange lists, except that Section 12(f) of the Act permits UTP under certain circumstances. For example, Section 12(f) of the Act, among other things, permits exchanges to trade certain securities that are traded over-the-counter (''OTC/UTP''), but only pursuant to a Commission order or rule. For a more complete discussion of the Section 12(f) requirement, *see* November 1995 Extension Order, *infra* note 16.

[15] *See* Securities Exchange Act Release No. 28146, 55 FR 27917 (July 6, 1990) (''1990 Plan Approval Order'').

[16] *See* Securities Exchange Act Release Nos. 34371 (July 13, 1994), 59 FR 37103 (July 20, 1994); 35221 (January 11, 1995), 60 FR 3886 (January 19, 1995); 36102 (August 14, 1995), 60 FR 43626 (August 22, 1995); 36226 (September 13, 1995), 60 FR 49029 (September 21, 1995); 36368 (October 13, 1995), 60 FR 54091 (October 19, 1995); 36481 (November 13, 1995), 60 FR 58119 (November 24, 1995) (''November 1995 Extension Order''); 36589 (December 13, 1995), 60 FR 65696 (December 20, 1995); 36650 (December 28, 1995), 61 FR 358 (January 4, 1996); 36934 (March 6, 1996), 61 FR 10408 (March 13, 1996); 36985 (March 18, 1996), 61 FR 12122 (March 25, 1996); 37689 (September 16, 1996), 61 FR 50058 (September 24, 1996); 37772 (October 1, 1996), 61 FR 52980 (October 9, 1996); 38457 (March 31, 1997), 62 FR 16880 (April 8, 1997); 38794 (June 30, 1997), 62 FR 36586 (July 8, 1997); 39505 (December 31, 1997), 63 FR 1515 (January 9, 1998); 40151 (July 1, 1998), 63 FR 36979 (July 8, 1998); 40896 (December 31, 1998), 64 FR 1834 (January 12, 1999); 41392 (May 12, 1999), 64 FR 27839 (May 21, 1999) (''May 1999 Approval Order''); 42268 (December 23, 1999), 65 FR 1202 (January 6, 2000); 43005 (June 30, 2000), 65 FR 42411 (July 10, 2000); 44099 (March 23, 2001), 66 FR 17457 (March 30, 2001); 44348 (May 24, 2001), 66 FR 29610 (May 31, 2001); 44552 (July 13, 2001), 66 FR 37712 (July 19, 2001); 44694 (August 14, 2001), 66 FR 43598 (August 20, 2001); 44804 (September 17, 2001), 66 FR 48299 (September 19, 2001); 45081 (November 19, 2001), 66 FR 59273 (November 27, 2001).

[17] *See* 13th Amendment Notice, *supra* note 4.

Processor will disseminate a data feed containing the National Best Bid and Offer quotations, size and market center identifier, as well as the Best Bid and Offer quotations, size and market center identifier from each individual Participant in Eligible Securities.

2. Section III.N. of the Plan defines the ''OTC Montage Data Feed,'' which will be launched as a new data feed for the dissemination of NASD ADF Participant quotations with the launch of the Internal SIP. However, as stated above in Category 1.7, NQDS will not be fully eliminated as a data feed disseminated by the Processor until Nasdaq is registered as an exchange.

3. Section III.K. of the Plan changes the name of the Nasdaq Last Sale Information Service to ''UTP Trade Data Feed,'' but makes no changes to the data elements contained in that data feed. While this change was effective upon launch of the Internal SIP, the Processor continues to disseminate the current Nasdaq Last Sale Information Service for a three-month parallel period to enable market data vendors to have a smooth transition to the new feed.[18]

4. Section III.R. of the Plan, which defines ''Quotation Information'' is amended to reflect that the NASD ADF will send individual market participant information to the Processor. It is also amended to clarify that only displayed quotation sizes are included in the definition and that market center identifiers are also included.

5. Section VI.B. (Collection and Consolidation of Information) has been amended to clarify the devices available for sending information to the Processor and the data feeds which the Processor shall disseminate, for as long as Nasdaq remains the Processor. While this change was effective upon launch of the Internal SIP, the Processor will continue to disseminate the legacy data feeds for a three-month parallel period to enable market data vendors to have a smooth transition to the new feed.[19]

6. Section VI.C. (Dissemination of Information) has been amended to identify the data feeds that the Processor shall disseminate. While this change was effective upon launch of the Internal SIP, the Processor continues to disseminate the current data feeds to enable market data vendors to have a smooth transition to the new feed.[20] In addition, the Processor will continue to disseminate Nasdaq individual market center quotes until Nasdaq registers as an exchange.

7. Section VI.C.1. (Best Bid and Offer) is amended to change the method of calculating the national best bid and offer from price/time/size to price/size/time and to establish a precise methodology for calculation.

8. Section VI.C.3. is renamed ''Quotation Data Stream,'' and amended to reflect the change in definition of the UTP Quote Data Feed contained in Section III.I. of the Plan. While this change was effective upon launch of the Internal SIP, the Processor continues to disseminate the current Level 1 service (''Legacy SIP'') to enable market data vendors to have a smooth transition to the new feed.[21]

9. Section VI.C.4. (Transaction Reports) is amended to reflect the change in name of the UTP Trade Data Feed contained in Section III.K. of the Plan.

10. Section XI (Hours of Operation) has been amended to change the reporting procedures for Participants that execute transactions in Eligible Securities outside of the normal trading hours of 9:30 a.m. to 4:00 p.m. EST.

Category 3: Effective Upon End of Parallel Period—Elimination of the Legacy SIP

1. Section VI.C.1. is amended to reflect that the Processor shall no longer carry quotation information from one trading day to the next, and that the Processor shall not calculate the best bid and offer for any individual Participant, including the NASD.

2. Section VI.C.1. is also amended to reflect that the Processor shall disseminate an internally locked or crossed quotation submitted by a single Participant.

3. Section XVIII.D.3, regarding Price Checks, is eliminated to reflect the Operating Committee's agreement that the Processor should no longer perform these functions.

4. Plan Exhibit 1, Paragraph 3(d)(5) is eliminated to reflect that MarketWatch costs are no longer eligible Processor Operating Costs, contingent upon the elimination of the Processor's ability to perform price checks on Participant's trade reports.

Category 4: Timing Not an Issue

1. Section III.S. of the Plan, which defines ''Regulatory Halt,'' is amended to include halts that are called for regulatory problems relating to an Eligible Security that should be clarified before trading therein is permitted to continue.

2. Section IV.A. (Operating Committee: Composition) has been amended to permit entities that are actively pursuing registration as a national securities exchange to participate in Operating Committee meetings in limited capacities.

3. Section IV.C. (Operating Committee: Voting) has been amended to eliminate references to events and contingencies that occurred when the Plan was first adopted. It also is clarified to reflect the Participants' agreement that neither the Plan nor the Operating Committee shall have authority in any respect over any Participant's proprietary systems.

4. Section IV.D. (Operating Committee: Meetings) will permit the Operating Committee to waive the advance notice requirement contained therein.

5. Section IV.E. has been added to establish an Advisory Committee and to define its composition and authority.

6. Section V.A. (Selection and Evaluation of the Processor: Generally) has been amended to eliminate references to events and contingencies that occurred when the Plan was first adopted.

7. Section VI.C. is amended to eliminate references to agreements between the NASD and certain foreign exchanges.

8. Section VI.D. (Immediate Hard Copy Confirmations) is eliminated and the remaining subsections of Section VI. are re-lettered.

9. Section VIII.B. (Transaction Reports) is amended to clarify that this Section applies only to transactions between Plan Participants pursuant to the Plan, and to eliminate reference to shared computer-to-computer interfaces.

10. Section X. is amended to include halts that are called for regulatory problems relating to an Eligible Security that should be clarified before trading therein is permitted to continue and to state that during a halt the Processor shall collect and disseminate Transaction Information but shall cease collection and dissemination of all Quotation Information.

11. Section XI.C. is amended to reflect that late trades can be reported between the hours of 8:00 a.m. and 6:30 p.m. on the same trading day that the transaction occurred.

12. Section XI.E. governing changes to operating hours, is eliminated.

13. Section XIII (Undertakings by NASD) is eliminated, and subsequent sections re-numbered.

14. Section XXI (Depth of Book Display) is added to reflect the Operating Committee's determination that the entity that succeeds Nasdaq as the Processor, upon certain specific conditions being met through a further

[18] *See* note 24 *infra.*

[19] *Id.*

[20] *Id.*

[21] *Id.*

Plan amendment should have the ability to collect, consolidate, and disseminate quotations at multiple price levels beyond the best bid and best offer from any Participant that voluntarily chooses to submit such quotations. Section XXI states that implementing the depth of book display functionality will require a plan amendment that addresses all pertinent issues.

15. Within the body of the 13th Amendment, there are numerous ''house-keeping'' corrections, including punctuation and renumbering changes.

IV. Summary of Comments

The Commission received one comment letter on the 13th Amendment from BrokerageAmerica (''BA'').[22] BA raised several concerns regarding the current Plan-mandated access requirements for Nasdaq market makers attempting to access the quotes of exchange specialists trading Nasdaq securities pursuant to UTP. BA generally stated its belief that exchange specialists trading Nasdaq securities pursuant to UTP should be required to provide the same level of connectivity as that provided among Nasdaq market makers—electronic auto-execution. To support that main point, BA noted five reasons why the Plan-mandated connectivity dichotomy is deficient.

First, BA stated that the connectivity dichotomy between Nasdaq market makers and exchange specialists causes fragmentation and inefficiencies that conflict with Congress' intent in establishing the national market system (''NMS''). Second, BA argued that the dichotomy results in unfair and disorderly functioning of the NMS with respect to Nasdaq securities. Third, BA averred that the use of multiple execution functionalities for the trading of Nasdaq securities (*i.e.*, the Plan-mandated telephone access and Nasdaq's proprietary system, SuperSOES) conflicts with the unification of the NMS as desired by Congress. Fourth, BA argued that the human element in the auction market format causes delays in quote updating, which increase Nasdaq market makers' market exposure. Finally, BA contended that exchange specialists that trade pursuant to UTP are not consistently subject to the Firm Quote Rule.[23] Further, BA argued that, because such specialists are not subject to automatic execution, they will act in a manner that disrupts the fair and orderly market for trading NNM securities by causing extended locked and crossed markets. BA generally states that such specialists have the capacity to and as a matter of rational market behavior will act in such a disruptive manner.

V. Discussion

The Commission finds that the Category 2, 3,[24] and 4 amendments of the 13th Amendment are consistent with the requirements of the Act and the rules and regulations thereunder, and, in particular, Section 11A(a)(1)[25] of the Act and Rules 11Aa3–1 and 11Aa3–2 thereunder.[26] Section 11A of the Act directs the Commission to facilitate the development of a national market system for securities, ''having due regard for the public interest, the protection of investors, and the maintenance of fair and orderly markets,'' and cites as an objective of that system the ''fair competition . . . between exchange markets and markets other than exchange markets.''[27] When the Commission first approved of the Plan on a pilot basis, it found that the Plan ''should enhance market efficiency and fair competition, avoid investor confusion, and facilitate surveillance of concurrent exchange and OTC trading.''[28]

The Commission finds that amending the Plan to incorporate the amendments detailed in Categories 2, 3, and 4 above furthers these goals. The Commission believes the Category 2 and 3 amendments should, among other things, further the satisfaction of requirements of the SuperMontage approval order[29] by establishing an Internal SIP that is distinct from Nasdaq's other proprietary systems.

The SuperMontage Approval Order imposed certain requirements upon the Participants in order for the Commission to extend the Plan. Specifically, the Participants were charged with engaging in good faith negotiations to revise the Plan to provide for (i) a fully viable alternative exclusive SIP for all Nasdaq securities, or (ii) a fully viable alternative non-exclusive SIP.

Moreover, the Commission imposed a presumption that, if the revised Plan provided for an exclusive consolidating SIP, such SIP should not be a Plan Participant. The Commission stated that, if a Plan Participant were selected to operate such exclusive SIP, there should be a further presumption that the Participant-operated SIP must operate completely separate from any order matching facility operated by that Participant. Such an order matching facility must interact with the exclusive SIP on the same terms and conditions as any other market center trading Nasdaq listed securities.

The Commission understands that the Participants are negotiating to select a non-Participant technology vendor to serve as an alternative exclusive SIP. In the event that a non-Participant technology vendor is selected, the Commission notes that the Plan may require further amendment.

The Commission also believes that the Category 4 amendments further the goals of the Act by making clarifying changes, deleting provisions that no longer apply, and making certain ''house-keeping'' corrections. Moreover, the Commission believes that the Category 4 amendments should further the satisfaction of requirements of the SuperMontage approval order by establishing an Advisory Committee. Finally, the Commission believes that the Depth of Book Display provision added by the Category 4 amendments is a beneficial addition to the Plan as it would increase the amount of data disseminated by the SIP for the benefit of investors generally.

The Commission has carefully considered all the issues raised by the sole commenter, BA, and is not persuaded. BA essentially argued the point that there are fundamental differences between the trading of Nasdaq securities by Nasdaq market makers and by human exchange specialists trading pursuant to UTP in the traditional auction format. BA generally argued that exchange specialists trading Nasdaq securities pursuant to UTP should be required to provide the same level of connectivity as that provided among Nasdaq market makers—electronic automatic execution. To support its main argument, BA described why it perceives the Plan-mandated telephone connectivity as being deficient and detrimental to the operation of the NMS.

The Commission notes that a market participant providing automatic execution against that market

[22] *See* note 7 *supra*.

[23] 17 CFR 240.11Ac1–1.

[24] Nasdaq plans to sunset the current SIP application (''Legacy SIP''), which will trigger specific technical changes in the operation of the Internal SIP and the resulting data feeds. At such time, the Legacy SIP will no longer function and the Internal SIP will be the sole remaining SIP. *See* 13th Amendment Filing. This order approves the Category 3 amendments, but such amendments will not be effective and operative until such time as the Legacy SIP is no longer operative and the Internal SIP becomes the sole remaining SIP. The Commission understands that Nasdaq expects to end the parallel period no later than January 5, 2003.

[25] 15 U.S.C. 78k–1(a)(1).

[26] 17 CFR 240.11Aa3–1 and 17 CFR 240.11Aa3–2.

[27] 15 U.S.C. 78k–1(a).

[28] 1990 Plan Approval Order, *see supra* note 17.

[29] Securities Exchange Act Release No. 43863 (January 19, 2001), 66 FR 8020 (January 26, 2001) (File No. SR–NASD–99–53) (''SuperMontage Approval Order'').

participant's quote is not (and has never been) a requirement for exchanges to trade Nasdaq issues. Moreover, the Commission has not required competitors to participate in a Nasdaq trading facility or required Nasdaq to provide access to its trading facilities to its competitors. Each of the UTP participants has independently decided whether to participate in Nasdaq's automatic execution facility. The Commission also notes that providing automatic executions—rather than operating an auction market—is not a precondition to competing in Nasdaq securities. The very essence of UTP is to permit competition among markets and market structures. Requiring one market structure for trading Nasdaq securities would defeat this purpose.

BA argued that the trading of Nasdaq securities pursuant to UTP by exchange specialists causes inconsistent application of the Firm Quote Rule, 11Ac1–1.[30] While compliance with the Firm Quote Rule is easier to monitor in an automatic execution environment, the Firm Quote Rule does not require market participants to be subject to automatic execution. Indeed, the Firm Quote Rule has always applied to exchange trading as well as over-the-counter trading, and exchanges must monitor and enforce compliance with the Firm Quote Rule.

BA also argued that the delay in updating quotes by human UTP exchange specialists causes UTP exchange specialists' quotes to be ''not real'' when compared to the quotes of Nasdaq market makers that are subject to automatic execution and electronic quote updating. The Commission notes that UTP exchange specialists must comply with the Firm Quote Rule. It may take longer to receive a fill from an exchange specialist trading pursuant to UTP and for such specialist's quote to be updated than it takes to receive a fill from a Nasdaq member that is subject to automatic execution and for the Nasdaq member's quote to be updated. This does not, however, make trading pursuant to UTP under the Plan impermissible under the Act and the rules and regulations thereunder.

VI. Conclusion

It is therefore ordered, pursuant to Section 11A of the Act[31] and paragraph (c)(2) of Rule 11Aa3–2,[32] thereunder, that those amendments to the Plan detailed in Category 2, Category 3, and Category 4 above be, and hereby are, approved on a pilot basis until August 19, 2003. The Commission also has determined to continue the exemption from Rule 11Aa3–2,[33] regarding the dissemination of multiple BBOs from a single Plan Participant[34] until such time as Nasdaq is registered as a national securities exchange.[35]

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[36]

Margaret H. McFarland,

Deputy Secretary.

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[30] 17 CFR 240.11Ac1–1.

[31] 15 U.S.C. 78k-1.

[32] 17 CFR 240.11Aa3–2(c)(2).

[33] 17 CFR 240.11Aa3–2.

[34] *See* 13th Amendment Notice for a more detailed discussion of the referenced exemption.

[35] The Commission notes that it is not continuing the exemption provided under Rule 11Ac1–2, 17 CFR 240.11Ac1–2, regarding calculation of the BBO in the 12th Amendment approval order because the 13th Amendment has converted the method of calculation of the BBO by the Plan SIP from price/time/size to price/size/time methodology consistent with Rule 11Ac1–2, 17 CFR 240.11Ac1–2.

[36] 17 CFR 200.30–3(a)(27).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46719; File No. SR–CBOE–2002–41]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of a Proposed Rule Change and Amendment No. 1 Thereto by the Chicago Board Options Exchange, Inc. Relating to an Interpretation of Paragraph (b) of Article Fifth of Its Certificate of Incorporation and an Amendment to Rule 3.16(b)

October 25, 2002.

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 July 29, 2002, the Chicago Board Options Exchange, Inc. (''CBOE'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the CBOE. On September 20, 2002, the CBOE filed an amendment to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons, and to approve the proposed rule change, as amended, on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change consists of an interpretation of paragraph (b) of Article Fifth of the Certificate of Incorporation of the CBOE (''Article Fifth (b)'') pertaining to the right of 1,402 full members of the Board of Trade of the City of Chicago (''CBOT'') to become members of CBOE without having to purchase a CBOE membership (the ''Exercise Right''). This provision has previously been interpreted by the CBOE, including an interpretation reflected in an agreement between the CBOE and CBOT dated September 1, 1992 (the ''1992 Agreement'').[4] The interpretation provided, among other things, that in order to become a member of the CBOE pursuant to the Exercise Right, a full member of the CBOT must be in possession of all the trading rights and privileges appurtenant to a CBOT full membership.

It has recently come to the attention of the CBOE that starting in 1999, the CBOT implemented expedited membership approval procedures applicable only to those individuals who wished to become CBOE members pursuant to the Exercise Right, but did not wish to trade as members on the CBOT itself. Under the rules of the CBOT, individuals approved for CBOT membership pursuant to these expedited procedures do not have any rights to trade as members on the CBOT, and thus the CBOE believes that these individuals do not satisfy the interpretation reflected in the 1992 Agreement as described above.

On April 17, 2002, the CBOE informed the CBOT that individuals approved for CBOT membership pursuant to these expedited procedures are not entitled to become exerciser members of the CBOE. In response, on April 22, 2002, the CBOT began advising applicants for membership on the CBOT for the purpose of becoming exerciser members of the CBOE that such individuals must complete regular CBOT membership approval procedures. All individuals exercising since that date have complied with this requirement. The CBOE represents that during the several years that CBOT's

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from Arthur B. Reinstein, Deputy General Counsel, CBOE, to Elizabeth King, Associate Director, Division of Market Regulation, Commission, dated September 19, 2002 (''Amendment No. 1''). Amendment No. 1 designates the proposed rule change as filed pursuant to Section 19(b)(2) of the Act. 15 U.S.C. 78s(b)(2). The CBOE also requests that the proposed rule change be given accelerated effectiveness, pursuant to 19(b)(2) of the Act. 15 U.S.C. 78s(b)(2).

[4] The CBOE believes that the 1992 Agreement and an amendment to Rule 3.16 referring to the 1992 Agreement were approved by the Commission. *See* Securities Exchange Act Release No. 32430 (June 8, 1993), 58 FR 32969 (June 14, 1993).

expedited membership approval procedures were in place, many individuals that were approved as CBOT members under expedited procedures did in fact exercise to become members of the CBOE. According to the CBOE, approximately 330 such individuals are currently engaged in activities as exerciser members of the CBOE. If the CBOE were now to revoke the good standing of these individuals, unless and until they are re-approved as CBOT members under regular procedures, this would be likely to impose significant hardships on these individuals and cause disruption to the CBOE's market.

To avoid these results, the CBOE now proposes a further interpretation of its prior interpretation of the Exercise Right as reflected in the 1992 Agreement to provide that each individual who would have been a member in good standing of the CBOE on April 17, 2002, pursuant to the Exercise Right, but for the fact that he or she was approved as a CBOT full member or full member delegate under expedited procedures and therefore does not possess the trading rights of a full member of CBOT, will nevertheless be recognized as a member of the CBOE in good standing, so long as that individual would possess all trading rights and privileges appurtenant to a CBOT full membership upon satisfaction of the CBOT's regular (not expedited) application process. Satisfaction of CBOT full membership would also include examination and approval requirements necessary for an individual to be in actual possession of all trading rights and privileges appurtenant to a CBOT full membership as defined in the 1992 Agreement.

Any CBOE member in good standing who subsequently ceases to be a CBOE member in good standing for any reason and who thereafter reapplies to become a CBOE member pursuant to the Exercise Right, and any other individual who applies to become a member of CBOE pursuant to the Exercise Right after April 17, 2002, will be required to satisfy all applicable CBOT application, examination and approval requirements necessary for such individual to be in actual possession of all trading rights and privileges appurtenant to a CBOT full membership as defined in the 1992 Agreement. Notwithstanding the foregoing, if a CBOE exerciser member in good standing subsequently ceases to be a member of the CBOE in good standing, and he or she reapplies to become a member of the CBOE pursuant to the Exercise Right within six months of the date he or she ceased to a CBOE exerciser member, the individual may be reinstated as a member of the CBOE in good standing without having to satisfy the requirements of the CBOT necessary for such individual to be in actual possession of all trading rights and privileges appurtenant to a CBOT full membership as defined in the 1992 Agreement. The CBOE intends to provide a limited exception to the CBOE Rule 3.16(b). The proposed interpretation, together with a proposed amendment to CBOE Rule 3.16 (b), constitutes the proposed rule change that is the subject of this filing. Below is the text of the proposed rule change. Additions are *italicized*.

* * * * *

Rule 3.16 Special Provisions Regarding Chicago Board of Trade Exerciser Memberships

(a) *Termination of Nontransferable Memberships.* [No change]

(a) *Board of Trade Exercisers.* For the purpose of entitlement to membership on the Exchange in accordance with Paragraph (a) of Article Fifth of the Certificate of Incorporation of the Exchange (''Article Fifth(b)'') the term ''member of the Board of Trade of the City of Chicago'' (the ''CBOT''), as used in Article Fifth(b), is interpreted to mean an individual who is either an ''Eligible CBOT Full Member'' or an ''Eligible CBOT Full Member Delegate,'' as those terms are defined in the Agreement entered into on September 1, 1992 (the ''*1992* Agreement'') between the CBOT and the Exchange, *as further interpreted in accordance with that certain proposed rule change filed with the Securities and Exchange Commission as File No. SR–CBOE–2002–41*, and shall not mean any other person. In order to permit Eligible CBOT Full Members and Eligible CBOT Full Member Delegates to participate in an offer, distribution or redemption of the kind referred to in the last two sentences of Paragraph 3(a) of the *1992* Agreement, and solely for such purpose, the Exchange agrees to waive all membership dues, fees and other charges and all qualification requirements, other than those that may be imposed by law, that may be applicable to the application for membership on the Exchange of each Eligible CBOT Full Member and Eligible CBOT Full Member Delegate who wishes to exercise the Exercise Right during the period commencing on the date the Exchange gives notice to the CBOT pursuant to Paragraph 3(b) of the *1992* Agreement and ending on the date such individual participates in such offer, distribution or redemption (as the case may be); provided, however, that (i) no Exerciser Member (as defined in the *1992* Agreement) for whom dues, fees and other charges and qualification requirements are waived in accordance with the foregoing shall have any rights as a member of the Exchange other than to participate in such offer, distribution or redemption, and (ii) the membership on the Exchange of each such Exerciser Member shall terminate immediately following the time such individual participates in such offer, distribution or redemption.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CBOE included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The CBOE has prepared summaries set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to provide a further interpretation of a prior interpretation of Article Fifth (b). Article Fifth (b) governs the right of all 1,402 full members of the CBOT to become members of the CBOE without having to purchase a separate CBOE membership. Article Fifth (b) has previously been interpreted on several occasions, including an interpretation made pursuant to an agreement between the CBOT and CBOE dated September 1, 1992. According to the CBOE, the 1992 Agreement states that only an individual who is an ''Eligible CBOT Full Member'' or an ''Eligible CBOT Full Member Delegate'' constitutes a CBOT member within the meaning of Article Fifth (b) and thus would be eligible to have an Exercise Right—that is, a right to be an exerciser member of the CBOE.

The 1992 Agreement defines the terms ''Eligible CBOT Full Member'' and ''Eligible CBOT Full Member Delegate'' to require in each case that the individual must be in possession of ''all trading rights and privileges appurtenant to such CBOT Full Membership.''[5] The 1992 Agreement

[5] According to the CBOE, the reference to ''such'' CBOT Full Membership describes the CBOT Full Membership owned or leased by the individual.

defines the term ''all trading rights and privileges appurtenant to such CBOT Full Membership'' to mean ''(1) the rights and privileges of a CBOT Full Membership which entitle a holder or delegate to trade as principal and broker for others in all contracts traded on the CBOT, whether by open outcry, by electronic means, or otherwise, during any segment of a trading day when trading is authorized; and (2) every trading right or privilege granted, assigned or issued by CBOT after the effective date of this Agreement to holders of CBOT Full Memberships, as a class, but excluding any right or privilege which is the subject of an option granted, assigned or issued by CBOT to a CBOT Full Member and which is not exercised by such CBOT Full Member.''

These provisions of the 1992 Agreement are reflected in the CBOT's rules and were adopted by the CBOT as required by the 1992 Agreement (referred to in that Agreement as the ''CBOT Rule Change''). The CBOT Rule Change may not be amended without the consent of CBOE. The CBOT Rule Change has not been amended, and is currently set forth in CBOT Rules 210.00 and 221.00(g).

In 1999, without the knowledge or approval of the CBOE, the CBOT implemented certain expedited membership approval procedures applicable to those individuals who wished to become CBOT members for the sole purpose of exercising the right to become members of the CBOE pursuant to the Exercise Right, but who did not wish to be able to trade as members on the CBOT itself. Under these expedited procedures, the CBOT waived its normal application procedures and examination requirements for these individuals, and has relied on special delegated authority to approve their membership applications. Individuals approved for CBOT membership pursuant to these expedited procedures do not have any rights to trade as a member of the CBOT in any of the contracts traded on that exchange. Accordingly, such individuals cannot qualify as Eligible CBOT Full Members or Full Member Delegates for purposes of the interpretation of the Exercise Right reflected in the 1992 Agreement, and thus are not eligible to become exerciser members of the CBOE.

The CBOE did not become aware of the expedited membership approval procedures until late 2001. On April 17, 2002, the CBOE informed the CBOT that individuals approved for CBOT membership pursuant to these expedited procedures would not be entitled to become exerciser members of the CBOE because they did not satisfy the requirements of Article Fifth(b) as it had previously been interpreted under the 1992 Agreement. In response, on April 22, 2002, the CBOT began advising individuals who apply to become members of CBOT for the purpose of exercising to be members of the CBOE that such individuals must complete regular CBOT membership approval procedures in order to be able to exercise. The CBOE believes that all individuals exercising since that date have complied with this requirement.

During the several years that the CBOT's expedited membership approval procedures were in place, many CBOT members, pursuant to the expedited procedures, exercised to become members of the CBOE. Without the CBOE having been aware of the adoption of these expedited membership procedures by the CBOT or having focused on the fact that these individuals did not meet the requirements of a valid exercise, these individuals were then approved by the CBOE as exerciser members. According to the CBOE, approximately 330 individuals who were approved as CBOT members under expedited procedures are currently engaged in conducting business as exerciser members of the CBOE. If the CBOE now refused to recognize these individuals as members of the CBOE in good standing, unless and until they are re-approved as CBOT members under procedures that give them full trading rights on the CBOT, the result would impose significant hardships on these individuals. Likewise, the CBOE believes that the removal of these individuals from the CBOE trading floor, even if only for a temporary period while they are re-approved as members of the CBOT, would be disruptive to the CBOE itself.

To avoid these harmful results, the CBOE has determined to interpret its prior interpretation of Article Fifth (b) of its Certificate of Incorporation so as to allow each individual who would have been an exerciser member in good standing of the CBOE on April 17, 2002, but for the fact that he or she was approved as a CBOT member or delegate under expedited procedures, to be recognized as a member of CBOE in good standing so long as that individual would be able to have all trading rights and privileges appurtenant to a CBOT membership, including satisfying full CBOT membership or delegate application, examination and approval requirements. Any such individual who subsequently ceases to be an exerciser member in good standing for any reason and who thereafter reapplies to become an exerciser member, and any other individual who applies to become an exerciser member of the CBOE after April 17, 2002, as a condition of becoming an exerciser member of the CBOE, will be required to satisfy all applicable CBOT application, examination and approval requirements necessary for such individual to be in actual possession of ''all trading rights and privileges appurtenant to such CBOT Full Membership'' as defined in the 1992 Agreement. Notwithstanding the foregoing, if an individual who was an exerciser member of the CBOE in good standing pursuant to the first sentence of this paragraph subsequently ceases to be an exerciser member in good standing, and if the same individual reapplies to become an exerciser member of the CBOE within six months of the date he or she ceased to be an exerciser member in good standing, the individual may be reinstated as an exerciser member in good standing without having to satisfy the requirements of the CBOT necessary for such individual to be in actual possession of all trading rights and privileges appurtenant to a CBOT full membership as defined in the 1992 Agreement.

This interpretation will provide a limited exception to the requirement of the interpretation reflected in the 1992 Agreement that all exercisers must be in possession of ''all trading rights and privileges appurtenant to such CBOT Full Membership.'' It has the effect of ''grandfathering'' those individuals who were exerciser members of the CBOE in good standing on April 16, 2002, to the extent described above, notwithstanding that they were approved as members of the CBOT under expedited procedures and thus do not possess the right to trade as members on the CBOT. The CBOE represents that this interpretation will have no effect on the application of the requirements of the 1992 Agreement to individuals who were not exerciser members on April 17, 2002, and who seek to become exerciser members after that date.

2. Statutory Basis

The CBOE believes that the proposed rule change is consistent with and furthers the objectives of section 6(b)(5) of the Act[6] in particular, in that it constitutes an interpretation of and an amendment to the rules of the Exchange that are designed to promote just and equitable principles of trade, to perfect the mechanisms of a free and open

[6] 15 U.S.C. 78f(b)(5).

market, and to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The CBOE does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Exchange Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act.

Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW, Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the CBOE. All submissions should refer to File No. SR–CBOE–2002–41 and should be submitted by November 22, 2002.

IV. Commission's Findings and Order Granting Accelerated Approval of Proposed Rule Change

After careful review, the Commission finds that the proposed rule change is consistent with the requirements of section 6(b)(5) of the Act,[7] and the rules and regulations thereunder applicable to a national securities exchange.[8] Specifically, the Commission believes that this proposal, which provides a further interpretation of the Exercise Right, as provided in Article Fifth (b) and CBOE Rule 3.16(b), should clarify that the approximately 330 exerciser members of the CBOE, who became CBOT members pursuant to the CBOT's expedited membership approval procedures, will continue to be recognized by the CBOE as exerciser members in good standing of the CBOE, so long as these exerciser members would posses all trading rights and privileges appurtenant to a CBOT membership, including satisfying full CBOT membership or delegate application, examination, and approval requirements. Further, the Commission believes that the proposal also clarifies that the CBOE will reinstate as an exerciser member in good standing any CBOE exerciser member, who became a CBOT member by the CBOT's expedited membership approval procedures and who subsequently ceases to be an exerciser member in good standing for any reason but thereafter reapplies to become an exerciser member of the CBOE, pursuant to the Exercise Right within six months of the date he or she ceased to be a CBOE exerciser member.

The Commission notes that this proposed interpretation as described above by the CBOE provides a limited exception to CBOE Rule 3.16(b), which interprets Article Fifth (b) to include ''Eligible CBOT Full Member[s]'' and ''Eligible CBOT Full Member Delegate[s],'' as defined in the 1992 Agreement between the CBOE and CBOT. The Commission believes that the proposed interpretation has no investor protection implications because all CBOE members, including exerciser members, must nevertheless comply with the requirements of the Act and CBOE rules in order to utilize their trading privileges on the CBOE floor. Also, although the CBOT granted expedited approval to these 330 individuals, the CBOE conducted a full review of these 330 members before they were permitted to trade on the CBOE. In addition, the Commission believes that refusing to recognize these certain individuals as exerciser members of the CBOE in good standing unless and until they were re-approved as CBOT members under its regular membership procedures would impose significant hardship on these individuals and cause disruption to the CBOE itself. In order to avoid such harmful results, the Commission believes that the proposed interpretation described herein and the proposed rule change are appropriate, in that the CBOE is interpreting its requirements for certain CBOT members (exerciser members) to become and remain members of the CBOE. For these reasons, the Commission finds good cause for approving the proposed rule change, as amended, prior to the thirtieth day after the date of publication of notice in the **Federal Register**.

It is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[9] that the proposed rule change (SR–CBOE–2002–41), as amended, is approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to the delegated authority.[10]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27805 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[7] 15 U.S.C. 78f(b)(5).

[8] In approving this rule, the Commission notes that it has also considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[9] 15 U.S.C. 78s(b)(2).

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46727; File No. SR–CBOE–2002–44]

Self-Regulatory Organizations; Order Approving Proposed Rule Change by the Chicago Board Options Exchange, Incorporated To Amend Its Rules To Eliminate the ''Book Indicator''

October 25, 2002.

On August 19, 2002, the Chicago Board Options Exchange, Incorporated (''CBOE'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'' or ''SEC'') pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend its rules to eliminate the ''Book Indicator.''[3] The proposed rule change was published for comment in the **Federal Register** on August 28, 2002.[4] The Commission received no comments on the proposed rule change.

The Commission has reviewed carefully the CBOE's proposed rule change and finds that the proposal is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange,[5] and with the requirements of section 6(b).[6] In particular, the Commission finds the

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] This indicator is affixed to the CBOE disseminated quotation when an order in the Exchange's book represents the best bid or offer on the Exchange.

[4] *See* Securities Exchange Act Release No. 46397 (August 21, 2002), 67 FR 55443 (August 29, 2002).

[5] In approving this rule proposal, the Commission notes that it has also considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[6] 15 U.S.C. 78f(b).

proposed is consistent with section 6(b)(5)[7] of the Act in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

The Commission notes that the Book Indicator was adopted as part of the CBOE's initiative to provide split-price Retail Automatic Execution System (''RAES'') executions for incoming customer orders when the prevailing best bid (offer) is generated by a existing customer order in the CBOE book.[8] At the time split-price execution functionality was adopted, CBOE's disseminated quote did not display size. Thus, the Book Indicator served to alert a customer that a RAES eligible order might not be executed in its entirety at CBOE's displayed price, and that he might receive a split-price execution. Now that CBOE disseminates quotes with size, the Commission believes that the Book Indicator is no longer necessary. Therefore, the Commission believes that it is appropriate for the Exchange to eliminate the Book Indicator, and remove all references to the Book Indicator from the CBOE rules. The Commission believes that the proposed rule change will streamline and clarify the Exchange rules by eliminating reference to an indicator that no longer is necessary.

It is therefore ordered, pursuant to section 19(b)(2) of the Act,[9] that the proposed rule change (SR–CBOE–2002–44) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[10]

Margaret H. McFarland,

Secretary.

[FR Doc. 02–27808 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[7] 15 U.S.C. 78f(b)(5).

[8] *See* Securities Exchange Act Release No. 43932 (February 6, 2001), 66 FR 10332 (February 14, 2001).

[9] 15 U.S.C. 78s(b)(2).

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46723; File No. SR–ISE–2002–24]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change by the International Securities Exchange, Inc. Relating to Quotation Size

October 25, 2002.

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 11, 2002, the International Securities Exchange, Inc. (''ISE'' or ''Exchange'') 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 ISE. 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 that all ISE's quotations would be firm for all incoming orders for their full disseminated size. The ISE would retain a one-contract minimum size for quotations when they interact with quotations entered by other ISE market makers. The proposed rule change would be implemented when the Commission approves the proposal and grants the Exchange an exemption from Rule 11Ac1–1 (the ''Firm Quote Rule'') under the Act, and when the Exchange implements technical enhancements to its system necessary to support this change. Below is the text of the proposed rule change. Additions are italicized. Brackets indicate deletions.

* * * * *

Rule 804.—Market Maker Quotations

(a) Options Classes. A quotation only may be entered by a market maker, and only in the options classes to which the market maker is appointed under Rule 802.

(b) Size Associated with Quotes. A market maker's bid and offer for a series of options contracts shall be accompanied by the number of contracts at that price the market maker is willing to buy [from] or sell *(i) upon receipt of an order (''Order Execution Size'') and (ii) upon interaction with a quotation entered by another market maker on the Exchange (''Quotation Execution Size'')* [to (i) Public Customers (the ''Public Customer Size'') and (ii) Non-Customers (the ''Non-Customer Size'')]. Unless the Exchange has declared a fast market pursuant to Rule 704, a market maker may not initially enter *an Order Execution Size* [a bid or offer with a Public Customer] of less than ten (10) contracts. Where the size associated with a market maker's bid or offer falls below ten (10) contracts due to executions at that price and consequently the size of the best bid or offer on the Exchange would be for less than ten (10) contracts, the market maker shall enter a new bid or offer for at least ten (10) contracts, either at the same or a different price. Every market maker bid or offer must have a *Quotation Execution* [a Non-Customer] Size of at least one (1) contract.

(c) Two-Sided Quotes. A market maker that enters a bid (offer) on the Exchange must enter an offer (bid) within the spread allowable under Rule 803(b)(4).

(d) Firm Quotes. (1) Market maker bids and offers are firm for *orders and Exchange market maker quotations* [Public Customer Orders and Non-Customer Orders] both under this Rule and Rule 11Ac1–1 under the Exchange Act (''Rule 11Ac1–1'') for the number of contracts specified [for each] according to the requirements of paragraph (b) above. Market maker bids and offers are not firm under this Rule and Rule 11Ac1–1 if:

(i) a system malfunction or other circumstance impairs the Exchange's ability to disseminate or update market quotes in a timely and accurate manner;

(ii) the level of trading activities or the existence of unusual market conditions is such that the Exchange is incapable of collecting, processing, and making available to quotation vendors the data for the option in a manner that accurately reflects the current state of the market on the Exchange, and as a result, the market in the option is declared to be ''fast'' pursuant to Rule 704;

(iii) during trading rotations; or

(iv) any of the circumstances provided in paragraph (c)(3) of Rule 11Ac1–1 exist.

(2) Within thirty seconds of receipt of *an order* [a Public Customer Order (Non-Customer Order)] to buy or sell an option in an amount greater than the *Order Execution Size, or within thirty seconds of another Exchange market maker entering a quotation at a price executable against the market maker's quotation* [Public Customer Size (Non-Customer Size)], that portion of the order equal to the *Order Execution Size, or the Quotation Execution Size, as the case may be*, [Public Customer Size

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

(Non-Customer Size)] will be executed and the bid or offer price will be revised.

[Supplementary Material to Rule 804

.01 Notwithstanding the provisions of paragraph (b), for the ''Enhanced Size Pilot'' described in .02 below, a Primary Market Maker may not initially enter a bid or offer for a Public Customer of less than 100 contracts, and a bid or offer for Non-Customers (except for other market makers) of less than 50 contracts. Also for the purposes of the Enhanced Size Pilot, a Competitive Market Maker may not initially enter a bid or offer for a Public Customer of less than 50 contracts, and a bid or offer for Non-Customers (except for other market makers) of less than 25 contracts. Where the size associated with a market maker's bid or offer falls below such specified size, the market maker shall enter a new bid or offer for at least the specified size, either at the same or a different price.

.02 The Enhanced Size Pilot shall operate as follows:

(1) The Enhanced Size Pilot shall operate until October 31, 2002;

(2) Securities included in the Enhanced Size Pilot are options on: Nasdaq 100 Trust; Sun Microsystems; EMC Corp.; Qualcomm; Wells Fargo &Co.; Oracle; Lucent; Juniper Networks; Intel; AOL Time Warner; Tyco; Citigroup; Cisco; Applied Materials; Microsoft; General Electric; Broadcom; Nokia; Siebel Systems; Banc of America; Ciena; Dell; Fannie Mae; Motorola; Merrill Lynch; Nvidia; Xilinx; Amazon.com; Halliburton; Nextel Communications; J.P. Morgan Chase; ADC Telecommunication; Best Buy; Calpine; General Motors; and Hewlett Packard; and

(3) The size requirements in the Enhanced Size Pilot will not apply:

(a) To options that expire beyond the nearest three expiration months;

(b) To ''Deep-in-the-Money'' options; or

(c) On an option's last three trading days prior to expiration.

03. For the purpose of this Rule, ''Deep-in-the-Money'' means all options with strike prices that are in the money by 12 percent or more in relation to the at-the-money strike price.]

* * * * *

Rule 805.—Market Maker Orders

* * * * *

(c) *Limitations on Orders. A market maker shall not enter more than one order every fifteen (15) seconds for its own account in options on the same underlying security; provided, however, that this shall not apply to multiple orders in different series of options on the same underlying security if such orders are part of a spread.*

[Exemptive Authority. Until the earlier of (1) one year from the date on which the Exchange commences operations or (2) the date on which the Exchange opens all options Groups for trading, an Exchange official designated by the Board may grant market makers exemptions from the requirements of subparagraphs (b)(2) and (3) of this rule, subject to the following:

(1) If a market maker has only one Membership, and thus is assigned to only one Group, any exemption would end when the assigned Group is open for trading, regardless of the number of options classes that begin trading in the assigned Group;

(2) If a market maker has multiple Memberships, and thus is assigned to trading in more than one Group, the exemption would end when all the market maker's Groups are open for trading, again regardless of the number of options classes that begin trading in the assigned Groups; as the market maker's assigned Groups open for trading, the amount of trading the market maker would be permitted to execute outside of its assigned Groups would be reduced;

(3) Any exemption would be conditioned on the member performing market maker functions in the classes they trade;

(4) An exemption could be revoked by the Exchange at any time if the market maker is not acting in accordance with the terms of the exemption; and

(5) No exemption would have a term of more than one month, but would be renewable on a monthly basis until the market maker's group(s) was open for trading.]

* * * * *

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 ISE 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 ISE 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 this proposed rule change is to provide that all ISE quotations would be firm for all incoming orders for their full disseminated size. This would be the first time that any options exchange provides non-customers (that is, broker-dealers) with full access to the entire disseminated size of the exchange's quotations for all their orders. The specifics of the proposal are as follows:

- Each ISE Primary Market Maker and Competitive Market Maker would enter a quotation with a single size, available in full for all incoming orders, whether from customers, broker-dealers, ISE market makers or market makers on other exchanges.
- Each market maker also would be able to establish a second quotation size that would be available when its quotation interacts with another ISE market maker quotation. This would limit an ISE market maker's exposure when it establishes a quotation at the same price as an existing ISE market maker quotation in the system. While this interaction of quotations is beneficial from a price-discovery standpoint, there is significant risk in this situation because execution can occur simultaneously in multiple series. While market makers would be able to limit this risk by setting their size to a smaller number of at least one contract, ISE market makers would be able to access the full size of another market maker's quotation by sending an order in that series.[3]
- The ISE also proposes to prohibit market makers from sending more than one order every 15 seconds in options on the same underlying security. ISE Rule 717(h) currently imposes this limitation on orders that Electronic Access Members send to the Exchange. This limitation reduces a market maker's exposure across multiple series of options.[4] This restriction, however, does not currently apply to market maker orders since market makers generally have established nominal

[3] Implementing this aspect of the proposal would require the Commission to grant an exemption from the Firm Quote Rule. While that rule permits market makers to set smaller sizes for all non-customer orders, it does not permit different quotation sizes for different categories of professionals. Simultaneously with submitting this proposed rule change, the ISE submitted a separate exemption request.

[4] *See* Securities Exchange Act Release No.44017 (February 28, 2001), 66 FR 13820 (March 7, 2001) (File No. SR–ISE–2000–20).

quotations for other market makers. Because ISE market makers now would be able to enter orders accessing another market maker's full size, ISE proposes to extend this 15-second limitation to ISE market maker orders.

• Finally, the ISE proposes two technical ''clean up'' changes to its rules. First, the Exchange proposes to delete language from Rule 804 regarding the ''enhanced size pilot'' that would expire on October 31, 2002. Second, the Exchange proposes to delete language from Rule 805 regarding limited exemptive authority that expired a year after the Exchange commenced trading.

2. Statutory Basis

The basis for this proposed rule change is the requirement under section 6(b)(5) of the Act [5] to remove impediments to and perfect the mechanism for a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The ISE believes that the proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization 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 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 also will be available for inspection and copying at the principal office of the ISE. All submissions should refer to File No. SR–ISE–2002–24 and should be submitted by November 22, 2002.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[6]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27809 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[5] 15 U.S.C. 78f(b)(5).

[6] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46732; File No. SR–NASD–2002–137]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change and Amendment No. 1 Thereto by the National Association of Securities Dealers, Inc. Relating to Technical Corrections to the Trade or Move Process in the Nasdaq Order Collection and Display Facility (''SuperMontage'')

October 28, 2002.

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 October 4, 2002, the National Association of Securities Dealers, Inc. (''NASD''), through its subsidiary, the Nasdaq Stock Market, Inc. (''Nasdaq''), submitted to 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 Nasdaq. On October 21, 2002, Nasdaq filed an amendment to the proposed rule change.[3] The proposed rule change, as amended, has been filed by Nasdaq as a ''non-controversial'' rule change under Rule 19b–4(f)(6) [4] under the Act. 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

Nasdaq is filing with the Commission technical rule changes to NASD Rule 4613(e)(1) to harmonize the language with recent approved rule proposals.

The text of the proposed rule change is available at the Office of the Secretary, the Nasdaq and at 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, Nasdaq 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. Nasdaq 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

Nasdaq has filed numerous rule proposals relating to NASD Rule 4613(e), and also has filed numerous rule proposals relating to SuperMontage. In the process of compiling the changes to Rule 4613(e), Nasdaq has discovered several

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from Jeffrey S. Davis, Associate General Counsel, Nasdaq to Terri Evans, Assistant Director, Division of Market Regulation, Commission dated October 18, 2002 (''Amendment No. 1''). In Amendment No. 1, Nasdaq redesignated certain provisions in NASD Rule 4613(e)(1) to correct erroneous references to NASD Rule 4613(e)(2). In addition, the rule text was amended to replace all uses of the word ''message'' with the word ''order'' to eliminate inadvertent inconsistencies within Rule 4613(e)(1).

[4] 17 CFR 240.19b–4(f)(6). For purposes of determining the effective date and calculating the 60-day period within which the Commission may summarily abrogate the proposed rule change under Section 19(b)(3)(C) of the Act, the Commission considers that period to commence on October 21, 2002, the date Nasdaq filed Amendment No. 1. *See* 15 U.S.C. 78s(b)(3)(C).

grammatical and technical errors in Rule 4613(e) that must be fixed.

First, Nasdaq is changing the acronym ''MMID'' to ''MPID'' to be consistent with its use of those terms throughout the rules governing usage of the SuperMontage system. Second, Nasdaq is replacing references to ''messages'' to ''orders'' or ''Directed Orders,'' as appropriate. This change makes consistent the use of such terms across NASD Rule 4613(e)(1). In addition, Nasdaq is adding the word ''for'' when describing the minimum number of shares for which a Trade or Move Directed Order is required to be sent. Finally, Nasdaq is changing Rule 4613(e)(1)(c)(ii)(a) to reflect that an ECN that wishes to lock or cross the market between 9:20:00 and 9:29:29 must send a Trade or Move Directed Order. The current rule language erroneously indicates that ECNs are obligated to send such Directed Orders up until 9:29:59. This technical change conforms the rule to the clear intent of SR–NASD–2002–56, which was approved on August 23, 2002.[5]

2. Statutory Basis

Nasdaq believes that the proposed rule change, as amended, is consistent with section 15A of the Act in general,[6] and section 15A(b)(6) of the Act in particular,[7] in that the proposal is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. Nasdaq believes that the proposed rule change, as amended, should enhance the interaction of the Trade or Move Rule with the SuperMontage opening, and that such enhancements would ensure a smooth opening of daily trading for the ultimate benefit of investors.

B. Self-Regulatory Organization's Statement on Burden on Competition

Nasdaq does not believe that the proposed rule change, as amended, will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were either solicited or received.

[5] *See* Securities Exchange Act Release No. 46410 (August 23, 2002), 67 FR 55897 (August 30, 2002).

[6] 15 U.S.C. 78*o*–3.

[7] 15 U.S.C. 78*o*–3(b)(6).

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

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) by its terms, does not become operative until 30 days from the date on which it was filed, or such shorter time as the Commission may designate. The proposed rule change, as amended, has therefore become effective pursuant to section 19(b)(3)(A) of the Act[8] and Rule 19b–4(f)(6)[9] thereunder.

Nasdaq has requested that the Commission waive the usual five-day notice and 30-day pre-operative waiting periods. The Commission believes that it is consistent with the protection of investors and the public interest to accelerate the operative date and to waive the five-day notice period since the proposed rule change, as amended, makes only technical corrections to the rule text. For these reasons, the Commission designates the proposal, as amended, to be effective and operative upon filing with the Commission.[10]

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.[11]

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 NASD. All submissions should refer to File No. SR–NASD–2002–137 and should be submitted by November 22, 2002.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[12]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27804 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[8] 15 U.S.C. 78s(b)(3)(A).

[9] 17 CFR 240.19b–4(f)(6).

[10] For purposes of determining the effective date and calculating the 60-day period within which the Commission may summarily abrogate the proposed rule change under Section 19(b)(3)(C) of the Act, the Commission considers that period to commence on October 21, 2002, the date Nasdaq filed Amendment No. 1. *See* 15 U.S.C. 78s(b)(3)(C). 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).

[11] 17 CFR 240.19b–4(f)(6).

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46720; File No. SR–NSCC–2002–03]

Self-Regulatory Organizations; National Securities Clearing Corporation; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Revising the Fee Schedule

October 25, 2002.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on May 30, 2002, the National Securities Clearing Corporation (''NSCC'') 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 primarily by NSCC. 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 proposed rule change will establish a base participation fee for NSCC participants using NSCC's Mutual Fund Services Profile service.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NSCC included statements concerning the purpose of and basis for the

[1] 15 U.S.C. 78s(b)(1).

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. NSCC has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.[2]

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The purpose of the proposed rule change is to establish a base participation fee for NSCC participants using NSCC's Mutual Fund Services Profile service (''Profile service'').[3] The Profile service was introduced in 1997 and in 2000 was made accessible through the internet via NSCC's PC WebDirect system. Since its introduction, NSCC has provided the service without charge.

However, consistent with its goal to align fees with costs and to reflect the numerous enhancements that NSCC has made to the service, NSCC is establishing a Profile membership fee payable by the users of the service. Accordingly, participating settling members and fund members will now be charged a $325 monthly membership fee to use the Profile service, regardless of usage.[4] This fee was effective July 1, 2002.

NSCC believes that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder because it provides for the equitable allocation of dues, fees, and other charges among NSCC's participants.

B. Self-Regulatory Organization's Statement on Burden on Competition

NSCC does not believe that the proposed rule change will have an impact on or impose a 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 relating to the proposed rule change have been solicited or received. NSCC has notified participants who use the Profile service of the new fee charges and will notify the Commission of any written comments it receives.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to section 19(b)(3)(A)(ii) of the Act[5] and Rule 19b–4(f)(2)[6] thereunder because the proposed rule change is changing a due, fee, or other charge. At any time within sixty days of the filing of such 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, U.S. 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 rule proposal that are filed with the Commission, and all written communications relating to the rule proposal 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 in Washington, DC. Copies of such filing will also be available for inspection and copying at NSCC's principal office. All submissions should refer to File No. SR–NSCC–2002–03 and should be submitted by November 22, 2002.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[7]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27803 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[2] The Commission has modified the text of the summaries prepared by NSCC.

[3] The Profile service is a data base system that enables mutual fund industry participant to exchange accurate and timely information on daily prices and dividend rates, firm and fund members, individual security identifications and processing capabilities, and projected and actual distribution declarations.

[4] Because the Profile service is not a transaction-based execution system but rather an informational data base resource, NSCC believes that a monthly usage fee is the most practical way to allocate the costs of the service.

[5] 15 U.S.C. 78s(b)(3)(A)(ii).

[6] 17 CFR 240.19b–4(f)(2).

[7] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–46721; File No. SR–Phlx–2002–63]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the Philadelphia Stock Exchange, Inc. To Increase Maintenance and Transfer Registration Fees for Registered Representatives

October 25, 2002.

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 October 15, 2002, the Philadelphia Stock Exchange, Inc. (''Exchange'' or ''Phlx'') submitted to 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 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, pursuant to Section 19(b)(1) of the Act[3] and Rule 19b–4 thereunder,[4] proposes to amend its schedule of dues, fees and charges to increase from $50.00 to $55.00 both the maintenance and transfer registration fees for registered representatives.[5] The initial registered representative registration fee will remain at $55.00.[6] In addition, the Exchange proposes to make a minor change to its schedule of dues, fees and charges by changing the word ''Maintenance'' that appears under Registered Representative Registration to ''Renewal.''

The proposed fee of $55.00 for maintenance and transfer registration for registered representatives will apply to 2003 registered representative registrations.[7] Consistent with current

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(1).

[4] 17 CFR 240.19b–4.

[5] These fees are not eligible for the monthly credit of up to $1,000 to be applied against certain fees, dues and charges and other amounts owed to the Exchange by certain members. *See* Securities Exchange Act Release No. 44292 (May 11, 2001), 66 FR 27715 (May 18, 2001) (SR–Phlx–2001–49).

[6] *See* Securities Exchange Act Release No. 44947 (October 17, 2001), 66 FR 53822 (October 24, 2001) (SR–Phlx–2001–90).

[7] Registered representative categories include registered options principals, general securities representatives, general securities sales supervisors and United Kingdom-limited general securities registered representatives.

practice, the Phlx intends that, on its behalf, the National Association of Securities Dealers, Inc. (''NASD'') will bill for year 2003 registered representative renewal registration fees in November, 2002 and will thereafter collect the maintenance fee for the Exchange.[8]

The text of the proposed rule is available at the Office of the Secretary, 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 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 generate additional revenue for the Exchange by increasing the maintenance (renewal) and transfer registered representative registration fees from $50.00 to $55.00.[9] In addition, the Exchange believes that this fee increase is warranted based upon the Exchange's increased costs relating to its regulatory oversight and enforcement programs.

The Exchange is also amending its schedule of dues, fees and charges by changing the word ''Maintenance'' that appears under Registered Representative Registration to ''Renewal.'' The Exchange believes that the word ''Renewal'' more readily reflects how the fee is implemented.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with Section 6(b) of the Act[10] in general, and Section 6(b)(4) of the Act[11] in particular, in that the proposal is designed to provide for the equitable allocation of reasonable dues, fees, and other charges among Exchange members.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Phlx 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 establishes or changes a due, fee or other charge, it has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act[12] and subparagraph (f)(2) of Rule 19b–4[13] thereunder. 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 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 Exchange. All submissions should refer to File No. SR–Phlx–2002–63 and should be submitted by November 22, 2002.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 02–27810 Filed 10–31–02; 8:45 am]

BILLING CODE 8010–01–P

[8] In addition, the Exchange intends that, on its behalf, the NASD will bill and collect the initial and transfer fees in 2003, consistent with current practice.

[9] Two other exchanges recently increased their maintenance (also referred to as ''annual'') and transfer registration fees for registered representatives. *See* Securities Exchange Act Release Nos. 46266 (July 25, 2002), 67 FR 49969 (August 1, 2002) (SR–CBOE–2002–37) and 46239 (July 19, 2002), 67 FR 48962 (July 26, 2002) (SR–PCX–2002–38).

[10] 15 U.S.C. 78f(b).

[11] 15 U.S.C. 78f(b)(4).

[12] 15 U.S.C. 78s(b)(3)(A)(ii).

[13] 17 CFR 240.19b–4(f)(2).

[14] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

Public Federal Regulatory Enforcement Fairness Hearing; Small Business Administration Region IX Regulatory Fairness Board

The Small Business Administration Region IX Regulatory Fairness Board and the SBA Office of the National Ombudsman will hold a Public Hearing on Tuesday, November 12, 2002 at 1 p.m. at the Small Business Administration, District Office Training Room, 455 Market Street, 6th Floor, San Francisco, CA 94105, to receive comments and testimony from small business owners, small government entities, and small non-profit organizations concerning regulatory enforcement and compliance actions taken by federal agencies.

Anyone wishing to attend or to make a presentation must contact Judy Ishizu in writing or by fax, in order to be put on the agenda. Judy Ishizu, U.S. Small Business Administration, San Francisco District Office, 455 Market Street, 6th floor, Suite 2200, San Francisco, CA 94105, phone (415) 744–6801, fax (415) 744–6812, e-mail *judy.ishizu@sba.gov*.

For more information, see our Web site at *http://www.sba.gov/ombudsman.*

Dated: October 23, 2002.

Michael L. Barrera,

National Ombudsman.

[FR Doc. 02–27794 Filed 10–31–02; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Public Federal Regulatory Enforcement Fairness Roundtable; Small Business Administration Region VII Regulatory Fairness Board

The Small Business Administration Region VII Regulatory Fairness Board and the SBA Office of the National Ombudsman will hold a Public Roundtable on Thursday, November 7, 2002 at 9 a.m. at the Exchange Bank, 132 E. High Street, Jefferson City, MO 65102, to provide small business owners and representatives of trade associations

with an opportunity to share information concerning the federal regulatory enforcement and compliance environment.

Anyone wishing to attend or to make a presentation must contact Rose Garland in writing or by fax, in order to be put on the agenda. Rose Garland, U.S. Small Business Administration, St. Louis District Office, 815 Olive Street, Room 242, St. Louis, MO 63101, phone (314) 539–6600 ext. 232, fax (314) 539–3785, e-mail: *rose.garland@sba.gov.*

For more information, see our Web site at *http://www.sba.gov/ombudsman.*

Dated: October 23, 2002.

Michael L. Barrera,

National Ombudsman.

[FR Doc. 02–27795 Filed 10–31–02; 8:45 am]

BILLING CODE 8025–01–P

OFFICE OF SPECIAL COUNSEL

SES Performance Review Board

AGENCY: U.S. Office of Special Counsel

ACTION: Notice.

SUMMARY: Notice is hereby given of the appointment of a member of the OSC Performance Review Board. The following person has been appointed to the SES Performance Review Board in the U.S. Office of Special Counsel: Bernestine Allen, Director, Office of International Transportation and Trade, Department of Transportation.

FOR FURTHER INFORMATION CONTACT: M. Marie Glover, Director of Human Resources, U.S. Office of Special Counsel, 1730 M Street, NW., Suite 218, Washington, D.C. 20036–4505, (202) 653–9485.

SUPPLEMENTARY INFORMATION:

Section 4314(c)(1) through (5) of Title 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 reviews and evaluates the initial appraisal of a senior executive's performance by the supervisor, and considers recommendations to the appointing authority regarding the performance of the senior executive.

Dated: October 25, 2002.

Elaine D. Kaplan,

Special Counsel.

[FR Doc. 02–27763 Filed 10–31–02; 8:45 am]

BILLING CODE 7405–01–S

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Generalized System of Preferences (GSP); Deadline for Submission of Petitions for the 2002 Annual GSP Product and Country Eligibility Practices Review and Status of 2001 Annual GSP Review

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: This notice announces the initiation of the 2002 Annual GSP Product and Country Eligibility Practices Review and sets the deadline for the submission of petitions on December 2, 2002. The notification of which petitions have been accepted for the 2002 and 2001 Annual GSP Reviews and other relevant dates will be issued in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Contact the GSP Subcommittee, Office of the United States Trade Representative (USTR), 1724 F Street, NW., Room F–220, Washington, DC 20508. The telephone number is (202) 395–6971 and the facsimile number is (202) 395–9481.

SUPPLEMENTARY INFORMATION: The GSP provides for the duty-free importation of designated articles when imported from designated beneficiary developing countries. The GSP is authorized by title V of the Trade Act of 1974 (19 U.S.C. 2461, *et seq.*), as amended (the ''Trade Act''), and is implemented in accordance with Executive Order 11888 of November 24, 1975, as modified by subsequent Executive Orders and Presidential Proclamations.

2002 Annual GSP Review

The GSP regulations (15 CFR Part 2007) provide the schedule of dates for conducting an annual review unless otherwise specified by a **Federal Register** notice. Notice is hereby given that, in order to be considered in the 2002 Annual GSP Product and Country Eligibility Practices Review, all petitions to modify the list of articles eligible for duty-free treatment under GSP or to review the GSP status of any beneficiary developing country must be received by the GSP Subcommittee of the Trade Policy Staff Committee no later than 5 p.m., December 2, 2002. Petitions submitted after the deadline will not be considered for review.

Interested parties or foreign governments may submit petitions to: (1) Designate additional articles as eligible for GSP; (2) withdraw, suspend or limit GSP duty-free treatment accorded either to eligible articles under the GSP or to individual beneficiary developing countries with respect to specific GSP eligible articles; (3) waive the ''competitive need limits'' for individual beneficiary developing countries with respect to specific GSP eligible articles; and (4) otherwise modify GSP coverage. As specified in 15 CFR 2007.1, all product petitions must include a detailed description of the product and the subheading of the Harmonized Tariff Schedule (HTS) of the United States under which the product is classified.

Interested parties may also submit petitions to have the GSP status of any eligible beneficiary developing country reviewed with respect to any of the designation criteria listed in sections 502(b) or 502(c) of the Trade Act (19 U.S.C. 2462(b) and (c)). Such petitions must comply with the requirements of 15 CFR 2007.0(b).

Requirements for Submissions

All such submissions must conform to the GSP regulations set forth at 15 CFR part 2007, except as modified below. These regulations are also included in ''A Guide to the U.S. Generalized System of Preferences (GSP)'' (August 1991) (''GSP Guidebook''), available at *www.ustr.gov.* Petitioners are strongly advised to review the GSP regulations. Submissions that do not provide all information required by sections 2007.0 and 2007.1 of the GSP regulations will not be accepted for review, except upon a detailed showing in the submission that the petitioner made a good faith effort to obtain the information required. Petitions with respect to waivers of the ''competitive need limitations'' must meet the information requirements for product addition requests in section 2007.1(c) of the GSP regulations. A model petition format is available from the GSP Subcommittee and is included in the GSP Guide. Petitioners are requested to use this model petition format so as to ensure that all information requirements are met. Furthermore, interested parties submitting petitions that request action with respect to specific products should list on the first page of the petition the following information: (1) The requested action; (2) the United States HTS subheading in which the product is classified; and (3) if applicable, the beneficiary country.

Petitions and requests must be submitted, in English, to the Chairman of the GSP Subcommittee, Trade Policy Staff Committee and must be received no later than December 2, 2002. Submissions in response to this notice will be subject to public inspection by appointment with the staff of the USTR

Public Reading Room, except for information granted ''business confidential'' status pursuant to 15 CFR 2003.6. If the submission contains business confidential information, a non-confidential version of the submission must also be submitted that indicates where confidential information was redacted by inserting asterisks where material was deleted. In addition, the confidential submission must be clearly marked ''BUSINESS CONFIDENTIAL'' at the top and bottom of each and every page of the document. The public version which does not contain business confidential information must also be clearly marked at the top and bottom of each and every page (either ''PUBLIC VERSION'' or ''NON-CONFIDENTIAL'').

In order to facilitate prompt consideration of submissions, USTR strongly urges and prefers electronic e-mail submissions in response to this notice. In the event that an e-mail submission is impossible, submissions should be made by facsimile. These submissions should be single copy transmissions in English with the total submission not to exceed 50 single-spaced pages and 3 megabytes as a digital file attached to an e-mail transmission. Persons making submissions by e-mail should use the following subject line: ''2002 Annual GSP Review—Petition.'' Documents must be submitted as either WordPerfect (''.WPD''), MSWord (''.DOC''), or text (''.TXT'') files. Documents should not be submitted as electronic image files or contain imbedded images (for example, ''.JPG'', ''PDF'', ''.BMP'', or ''.GIF'') as these type files are generally excessively large. E-mail submissions containing such files may not be accepted. Supporting documentation submitted as spreadsheets are acceptable as Quattro Pro or Excel, pre-formatted for printing on 8½ x 11 inch paper. To the extent possible, any data attachments to the submission should be included in the same file as the submission itself, and not as separate files. Facsimile submissions should include, among other identifying information specified in the regulations, the following information at the top of the first page: ''2002 Annual GSP Review.''

For any document containing business confidential information submitted as an electronic attached file to an e-mail transmission, the file name of the business confidential version should begin with the characters ''BC-'', and the file name of the public version should begin with the characters ''P-''. The ''P-'' or ''BC-'' should be followed by the name of the party (government, company, union, association, etc.) which is submitting the petition. Parties who make submissions by e-mail should not provide separate cover letters or messages in the message area of the e-mail; information that might appear in any cover letter should be included directly in the attached file containing the submission itself. The e-mail address for these submissions is *FR0052@USTR.GOV.* Documents not submitted in accordance with these instructions might not be considered in this review.

Public versions of all documents relating to this review will be available for review approximately three weeks after the due date by appointment in the USTR Public Reading Room, 1724 F Street NW., Washington, DC. Availability of documents may be ascertained, and appointments may be made from 9:30 a.m. to noon and 1 p.m. to 4 p.m., Monday through Friday, by calling (202) 395–6186.

Status of 2001 Annual GSP Review

The GSP program expired on September 30, 2001, and was not reauthorized until August 6, 2002. Consequently, the announcement of which petitions were to be accepted for the 2001 Annual GSP Review was not made, except for the announcement in the August 28, 2002 **Federal Register** of those petitions accepted for the Special Three Country Review for Argentina, the Philippines and Turkey. Because of this delay, the schedule for completing the 2002 and 2001 Annual GSP Reviews will be merged to the extent practicable. The notification of which petitions have been accepted for the 2002 and 2001 Annual GSP Reviews and other relevant dates, including the review schedule, will be issued in the **Federal Register**.

Steven Falken,

Executive Director for GSP, Chairman, GSP Subcommittee.

[FR Doc. 02–27773 Filed 10–31–02; 8:45 am]

BILLING CODE 3901–01–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Request for Public Comment With Respect to the Annual National Trade Estimate Report on Foreign Trade Barriers

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: Pursuant to section 303 of the Trade and Tariff Act of 1984, as amended, USTR is required to publish annually the National Trade Estimate Report on Foreign Trade Barriers (NTE). With this notice, the Trade Policy Staff Committee (TPSC) is requesting interested parties to assist it in identifying significant barriers to U.S. exports of goods, services and overseas direct investment for inclusion in the NTE. Particularly important are impediments materially affecting the actual and potential financial performance of an industry sector. The TPSC invites written comments that provide views relevant to the issues to be examined in preparing the NTE. In order to ensure the most timely processing of submissions, the Department of Commerce will receive comments in response to this Notice. Commenters should review carefully the written comments section of this Notice for special procedures for filing comments this year.

DATES: Public comments are due not later than Friday, December 13, 2002. This deadline is firm. No submissions will be accepted after December 13.

ADDRESSES: *Paper submissions:* NTE Comments, Office of Trade and Economic Analysis, Room H–2815, U.S. Department of Commerce, Washington, DC 20230.

Submissions by electronic mail: ntecomments@ita.doc.gov.

FOR FURTHER INFORMATION CONTACT: Procedural questions about transmitting comments or viewing public submissions should be directed to Ms. Marva Thompson (202–482–2185) or Mr. Howard Schreier (202–482–4180), U.S. Department of Commerce. Questions regarding the report or its subject matter should be directed to Ms. Gloria Blue, Office of Policy Coordination, Office of the United States Trade Representative (202–395–3475).

SUPPLEMENTARY INFORMATION: Last year's report may be found on USTR's Internet Home Page (*www.ustr.gov*) under the section on Reports. In order to ensure compliance with the statutory mandate for reporting foreign trade barriers that are significant, we will focus particularly on those restrictions where there has been active private sector interest.

The information submitted should relate to one or more of the following ten categories of foreign trade barriers:

(1) Import policies (*e.g.*, tariffs and other import charges, quantitative restrictions, import licensing, and customs barriers);

(2) Standards, testing, labeling, and certification (including unnecessarily restrictive application of phytosanitary standards, refusal to accept U.S. manufacturers' self-certification of

conformance to foreign product standards, and environmental restrictions);

(3) Government procurement (*e.g.*, ''buy national'' policies and closed bidding);

(4) Export subsidies (*e.g.*, export financing on preferential terms and agricultural export subsidies that displace U.S. exports in third country markets);

(5) Lack of intellectual property protection (*e.g.*, inadequate patent, copyright, and trademark regimes);

(6) Services barriers (*e.g.*, limits on the range of financial services offered by foreign financial institutions, regulation of international data flows, restrictions on the use of data processing, quotas on imports of foreign films, and barriers to the provision of services by professionals (*e.g.*, lawyers, doctors, accountants, engineers, nurses, etc.);

(7) Investment barriers (*e.g.*, limitations on foreign equity participation and on access to foreign government-funded R&D consortia, local content, technology transfer and export performance requirements, and restrictions on repatriation of earnings, capital, fees and royalties);

(8) Anticompetitive practices with trade effects tolerated by foreign governments (including anticompetitve activities of both state-owned and private firms that apply to services or to goods and that restrict the sale of U.S. products to any firm, not just to foreign firms that perpetuate the practices);

(9) Trade restrictions affecting electronic commerce (*e.g.*, tariff and non-tariff measures, burdensome and discriminatory regulations and standards, and discriminatory taxation); and

(10) Other barriers (*i.e.*, barriers that encompass more than one category, *e.g,* bribery and corruption, or that affect a single sector).

As in the case of last year's NTE, we are asking that particular emphasis be placed on any practices that may violate U.S. trade agreements. We are also interested in receiving any new or updated information pertinent to the barriers covered in last year's report as well as new information. Please note that the information not used in the NTE will be maintained for use in future negotiations.

It is most important that your submission contain estimates of the potential increase in exports that would result from the removal of the barrier, as well as a clear discussion of the method(s) by which the estimates were computed. Estimates should fall within the following value ranges: Less than $5 million; $5 to $25 million; $25 million to $50 million; $50 million to $100 million; $100 million to $500 million; or over $500 million. Such assessments enhance USTR's ability to conduct meaningful comparative analyses of a barrier's effect over a range of industries.

Please note that interested parties discussing barriers in more than one country should provide a separate submission (*i.e.*, one that is self-contained) for each country.

Written Comments: In order to ensure the most timely receipt and consideration of comments submitted in response to this Notice, the following guidelines and special procedures have been established:

(1) All comments will be received at the U.S. Department of Commerce rather than the Office of the United States Trade Representative;

(2) The Department of Commerce has arranged to accept non-confidential, public submissions by electronic mail (e-mail). An automatic reply confirming receipt of e-mail submissions will be sent. E-mail submissions in Microsoft Word or Corel WordPerfect are preferred. If a word processing application other than those two is used, please advise us in your submission of the specific application used;

(3) In order to facilitate prompt processing of submissions, the Department of Commerce strongly urges and prefers e-mail submission of non-confidential, public comments;

(4) To ensure security, submissions containing business confidential information should not be sent by e-mail, but via the U.S. Postal Service or commercial express delivery (see paragraph 6 and 7 below for special requirements applying to such submissions). If a submission contains business confidential information, a non-confidential public version must also be submitted along with the business confidential version.

(5) Business-confidential submissions must be accompanied by a justification as to why the information contained in the submission should be treated confidentially. In addition, any submissions containing business confidential information must be clearly marked ''Confidential'' at the top and bottom of the cover page (or letter) and of each succeeding page of the submission. The version that does not contain confidential information should also be clearly marked, at the top and bottom of each page, ''public version'' or ''non-confidential''.

(6) When comments are submitted using the U.S. Postal Service or commercial couriers, it is strongly recommended that submitters notify the Department of Commerce by e-mail as to the date of transmittal and method of delivery (U.S. Postal Service or name of courier company).

(7) All submissions must be in English and should conform to the information requirements of 15 CFR 2003. If submissions are made via U.S. Postal Service or commercial express delivery, a party must provide five copies of its submission and the submission should be accompanied by a computer disk containing a machine-readable version. The disk should have a label identifying the software used, the submitter and the title of the submission. In addition, business confidential and public or non-confidential submissions should be submitted on separate disks which are clearly marked ''business confidential'' or ''non-confidential'', as appropriate.

Submissions must be received at the Department of Commerce no later than Friday, December 13, 2002.

Written comments submitted in connection with this request, except for information granted ''business confidential'' status pursuant to 15 CFR 2003.6, will be available for public inspection shortly after the filing deadline in the Foreign Trade Reference Room (Room 2233) in the U.S. Department of Commerce. The Department of Commerce is located at 14th St. and Constitution Ave., NW., in Washington, DC. Customary hours of operation for the Foreign Trade Reference Room are from 9 a.m. to 4 p.m., Monday through Friday. Call (202) 482–2185 to confirm. Questions regarding the operation of the Reference Room should be directed to Ms. Marva Thompson at 202–482–2185. Non-proprietary public comments will also be available for review on the web at: *http://web.ita.doc.gov/otea/ntecomments.nsf.*

Carmen Suro-Bredie,

Chairman, Trade Policy Staff Committee.

[FR Doc. 02–27744 Filed 10–31–02; 8:45 am]

BILLING CODE 3190–01–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Privacy Act of 1974: System of Records

AGENCY: Office of the Secretary, DOT.

ACTION: Notice to establish a system of records.

SUMMARY: DOT intends to establish a system of records under the Privacy Act of 1974.

EFFECTIVE DATE: December 11, 2002. If no comments are received, the proposal will become effective on the above date. If comments are received, the comments will be considered and, where adopted, the documents will be republished with changes.

FOR FURTHER INFORMATION CONTACT: Yvonne L. Coates, Department of Transportation, Office of the Secretary, 400 7th Street, SW., Washington, DC 20590, (202) 366–6964 (telephone), (202) 366–7024 (fax), *Yvonne.Coates@ost.dot.gov* (Internet address).

SUPPLEMENTARY INFORMATION: The Department of Transportation system of records notice subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended, has been published in the **Federal Register** and is available from the above mentioned address.

DOT/ALL 014

SYSTEM NAME:

Docket Management System (DMS).

SECURITY CLASSIFICATION:

Unclassified, non-sensitive.

SYSTEM LOCATION:

The system is located in Department of Transportation (DOT), Dockets and Media Management Center, Transportation Administrative Service Center, 400 7th Street, SW., Room PL–401, Washington, DC, 20590.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals who participate in proceedings at the DOT that are covered by the Administrative Procedure Act (APA), and who provide information about their identities.

CATEGORIES OF RECORDS IN THE SYSTEM:

DOT rulemaking and related documents issued in informal rulemakings, and public comments thereon; non-rulemaking and related documents, and public comments thereon; in formal rulemakings, motions, petitions, complaints, and related documents and formal responses thereto.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 551 et seq.

PURPOSE(S):

To facilitate involvement of the public in APA and related proceedings.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

See Prefatory Statement of General Routine Uses.

DISCLOSURE TO CONSUMER REPORTING AGENCIES:

None.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Electronically on a publicly-accessible website.

RETRIEVABILITY:

Documents are retrievable through DMS by name and by docket number.

SAFEGUARDS:

Records are freely available to anyone.

RETENTION AND DISPOSAL:

Paper copies are returned to the originating office upon transfer to electronic medium. Electronic version is retained indefinitely at the discretion of the DOT.

SYSTEM MANAGER(S) AND ADDRESS:

U.S. Department of Transportation, Chief, Dockets and Media Management Center (SVC–124), 400 7th Street, SW., Room PL–401, Washington, DC 20590.

NOTIFICATION PROCEDURE:

Same as ''System Manager.''

RECORD ACCESS PROCEDURES:

Same as ''System Manager.''

CONTESTING RECORD PROCEDURES:

Same as ''System Manager.''

RECORD SOURCE CATEGORIES:

Individuals participating in DOT APA proceedings.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

Dated: October 18, 2002.

Yvonne L. Coates,

Privacy Act Coordinator.

[FR Doc. 02–27168 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Summary Notice No. PE–2002–62]

Petitions for Exemption; Summary of Petitions Received

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of petition for exemption received.

SUMMARY: Pursuant to FAA's rulemaking provisions governing the application, processing, and disposition of petitions for exemption, part 11 of Title 14, Code of Federal Regulations (14 CFR), this notice contains a summary of a certain petition seeking relief from specified requirements of 14 CFR. The purpose of this notice is to improve the public's awareness of, and participation in, this aspect of FAA's regulatory activities. Neither publication of this notice nor the inclusion or omission of information in the summary is intended to affect the legal status of any petition or its final disposition.

DATES: Comments on petitions received must identify the petition docket number involved and must be received on or before November 21, 2002.

ADDRESSES: Send comments on the petition to the Docket Management System, U.S. Department of Transportation, Room Plaza 401, 400 Seventh Street, SW., Washington, DC 20590–0001. You must identify the docket number FAA–2002–13062 at the beginning of your comments. If you wish to receive confirmation that the FAA received your comments, include a self-addressed, stamped postcard.

You may also submit comments through the Internet to *http://dms.dot.gov*. You may review the public docket containing the petition, any comments received, and any final disposition in person in the Dockets Office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Dockets Office (telephone 1–800–647–5527) is on the plaza level of the NASSIF Building at the Department of Transportation at the above address. Also, you may review public dockets on the Internet at *http://dms.dot.gov*.

FOR FURTHER INFORMATION CONTACT: Susan Boylon (425–227–1152), Transport Airplane Directorate (ANM–113), Federal Aviation Administration, 1601 Lind Ave. SW., Renton, WA 98055–4056; or Vanessa Wilkins (202–267–8029), Office of Rulemaking (ARM–1), Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591.

This notice is published pursuant to 14 CFR 11.85 and 11.91.

Issued in Washington, DC, on October 29, 2002.

Donald P. Byrne,

Assistant Chief Counsel for Regulations.

Petitions for Exemption

Docket No.: FAA–2002–13062.

Petitioner: Lockheed Martin Aircraft.

Section of 14 CFR Affected: SFAR 88.

Description of Relief Sought: To permit Lockheed Model L–11011–385

airplanes to operate without meeting the requirements of SFAR–88.

[FR Doc. 02–27845 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Rule on Application To Impose and Use the Revenue From a Passenger Facility Charge (PFC) at Brownsville/South Padre Island International Airport, Brownsville, TX

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of intent to rule on application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Brownsville/South Padre Island International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101–508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before December 2, 2002.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate copies to the FAA at the following address: Mr. G. Thomas Wade, Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–611, Fort Worth, Texas 76193—0610.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Mr. Larry Brown, Acting Manager of Brownsville/South Padre Island International Airport at the following address: Mr. Larry Brown, Acting Manager, Brownsville/South Padre International Airport, 700 S. Minnesota Avenue, Brownsville, TX 78521.

Air carriers and foreign air carriers may submit copies of the written comments previously provided to the Airport under section 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: Mr. G. Thomas Wade, Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–611, Fort Worth, Texas 76193–0610, (817) 222–5613.

The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Brownsville/South Padre Island International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Pub. L. 101–508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On October 25, 2002, the FAA determined that the application to impose and use the revenue from a PFC submitted by the Airport was substantially complete within the requirements of § 158.25 of part 158. The FAA will approve or disapprove the application, in whole or in part, no later than February 20, 2003.

The following is a brief overview of the application.

Level of the proposed PFC: $4.50.

Proposed charge effective date: May 1, 2003.

Proposed charge expiration date: June 1, 2008.

Total estimated PFC revenue: $1,421,192.

PFC application number: 03–02–C–BRO.

Brief description of proposed project(s):

Projects To Impose and Use PFC's

1. Acquire and Install Two Loading Bridges and an Aircraft Loading Walkway
2. Construct ARFF Facility and Acquire Two ARFF Vehicles
3. Acquire Security Access Control System with Finger Print Equipment
4. Conduct Planning Studies
5. Reconstruct Taxiway H
6. Reconstruct and Expand Terminal Apron
7. Rehabilitate Taxiways B, D and E Edge Lighting
8. Expand Cargo Apron
9. Seal Coat Taxiways B, D, E, E–1 and G
10. Drainage Improvements
11. Acquire Land
12. PFC Application and Administrative Fees

Proposed class or classes of air carriers to be exempted from collecting PFC's: None.

Any person may inspect the application in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT** and at the FAA regional Airports office located at: Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–610, 2601 Meacham Blvd., Fort Worth, Texas 76137–4298.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at Brownsville/South Padre Island International Airport.

Issued in Fort Worth, Texas, on October 25, 2002.

William J. Flanagan,

Acting Manager, Airports Division.

[FR Doc. 02–27846 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Opportunity To Participate, Criteria Requirements and Change of Application Procedure for Participation in the Military Airport Program (MAP)

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of criteria and application procedure for designation or redesignation, for the fiscal year 2003 MAP.

SUMMARY: This notice announces the criteria, application procedures and schedule to be applied by the Secretary of Transportation in designating or redesignating, and funding capital development annually for 15 current (joint-use) or former military airports seeking designation or redesignation to participate in the MAP. This Notice reflects and incorporates changes made to MAP in the Wendell H. Ford Aviation Investment and Reform Act for the 21st Century.

The MAP allows the Secretary to designate current (joint-use) or former military airports for which grants may be made under the Airport Improvement Program (AIP). The Secretary is authorized to designate an airport (other than an airport so designated before August 24, 1994) if: (1) The airport is a former military installation closed or realigned under the Title 10 U.S.C. 2687 announcement of closures of large Department of Defense installations after September 30, 1977, or under section 201 or 2905 of the Defense Authorization Amendments and Base Closure and Realignment Acts; or (2) the airport is a military installation with both military and civil aircraft operations. The Secretary shall consider for designation only those current or former military airports, at least partly converted to civilian airports as part of the national air transportation system, that will reduce delays at airports with more than 20,000 hours of annual delays in commercial passenger aircraft takeoffs and landings, or will enhance

airport and air traffic control system capacity in metropolitan areas or reduce current and projected flight delays (49 U.S.C. 47118(c)).

DATES: Airport sponsors should address written applications for new designation and redesignation in the MAP to the FAA Regional Airports Division or Airports District Office that serves the airport. That office of the FAA must receive applications on or before December 6, 2002.

ADDRESSES: Submit an original and two copies of Standard Form (SF) 424, ''Application for Federal Assistance,'' prescribed by the Office of Management and Budget Circular A–102, available at *http://www.whitehouse.gov/OMB/grants/index.html,* along with any supporting and justifying documentation. Applicant should specifically request to be considered for designation or redesignation to participate in the fiscal year 2003 MAP. Submission should be sent to the Regional FAA Airports Division or Airports District Office that serves the airport. Applicants may find the proper office on the FAA web site *http://www.faa.gov/arp/arphome.htm* or may contact the office below.

FOR FURTHER INFORMATION CONTACT: Mr. Murdock (*oliver.murdock@faa.gov*) or Leonard C. Sandelli (*len.sandelli@faa.gov*), Military Airport Program Branch (APP–420), Office of Airport Planning and Programming, Federal Aviation Administration (FAA), 800 Independence Avenue, SW., Washington, DC, 20591, (202) 267–8244, or (202) 267–8785, respectively.

SUPPLEMENTARY INFORMATION:

General Description of the Program

The MAP provides capital development assistance to civil airport sponsors of designated current (joint-use) military airfields or former military airports that are included in the FAA's National Plan of Integrated Airport Systems (NPIAS). Airports designated under the program may obtain funds from a set-aside (currently four percent) of AIP discretionary funds to undertake eligible airport development, including certain types of projects not otherwise eligible for AIP assistance. Such airports may also be eligible to receive grants from other categories of AIP funding.

Number of Airports

A maximum of 15 airports per fiscal year may participate in the MAP at any time. There are 5 slots available for designation or redesignation in FY 2003. One airport may be designated as a general aviation airport.

Term of Designation

The maximum period of eligibility for any airport to participate in the MAP is five fiscal years following designation. An airport sponsor having previously been in the program may apply for redesignation and, if found to satisfy the designation criteria upon reapplication, may have the opportunity to participate for subsequent periods, each not to exceed five fiscal years. The FAA can designate airports for a period less than five years. The FAA will evaluate the conversion needs of the airport in its five-year capital development plan to determine the appropriate length of designation.

Redesignation

Title 49 of the United States Code 47118(d), permits previously designated airports to apply for redesignation. Applicants reapplying need to meet current eligibility criteria set forth at 49 U.S.C. 47118(a). Redesignation will be considered largely in terms of warranted projects fundable under AIP solely through the MAP, such as utility systems, surface parking, hangars, fuel farms, and air cargo terminals up to 50,000 square feet. The airport must have MAP eligible projects and the airport must continue to satisfy the designation criteria for the MAP. The FAA will carefully scrutinize applications for redesignation, since redesignation candidates tend to have lesser conversion needs than new candidates. The FAA desires that MAP airports graduate to regular AIP participation.

Eligible Projects

In addition to other eligible AIP projects, passenger terminal facilities, fuel farms, utility systems, surface automobile parking lots, hangars, and air cargo terminals up to 50,000 square feet of floor space are all eligible to be funded from the MAP. Designated or redesignated military airports can receive not more than $7,000,000 each fiscal year for projects to construct, improve, or repair terminal building facilities. Also, designated or redesignated military airports can receive not more than a total of $7,000,000 for MAP eligible projects that include hangars, cargo facilities, fuel farms, automobile surface parking, and utility work.

Designation Considerations

In making designations of new candidate airports, the Secretary of Transportation may only designate an airport (other than an airport so designated before August 24, 1994) if it meets the following general requirements:

(I)(1) The airport is a former military installation closed or realigned under—

(A) Section 2687 of title 10;

(B) Section 201 of the Defense Authorization Amendments and Base Realignment and Closure Act (BRAC) (10 U.S.C. 2687 note); or

(C) Section 2905 of the Defense Base Realignment and Closure Act of 1990 (10 U.S.C. 2687 note); or

(2) The airport is a military installation with both military and civil aircraft operations.

(II) The airport is classified as a commercial service or reliever airport in the NPIAS. One of the designated airports, if included in the NPIAS, may be a general aviation (GA) airport (public airport other than an air carrier airport, 14 CFR 152.3) that was a former military installation closed or realigned under BRAC, as amended, or 10 U.S.C. 2687 (49 U.S.C. 47118(g)). A general aviation airport must qualify under (1) above.

(III) In designating new candidate airports, the Secretary shall consider if a grant would:

(1) Reduce delays at an airport with more than 20,000 hours of annual delays in commercial passenger aircraft takeoffs and landings; or

(2) Enhance airport and air traffic control system capacity in a metropolitan area or reduce current and projected flight delays.

The application for new designations will be evaluated in terms of how the proposed airport and associated projects would contribute to congestion relief and/or how the airport would enhance air traffic or airport system capacity and provide adequate user services.

Project Evaluation

Recently approved Base Realignment and Closure Acts or Title 10 U.S.C. 2678 military airports as well as active military airfields with new joint use agreements will be in the greatest need of funding to convert to or to incorporate civil airport operations successfully. Newly converted airports and new joint-use locations frequently have minimal capital development resources and will therefore receive priority consideration for designation and MAP funding. The FAA will evaluate the need for eligible projects based upon information in the candidate airport's five year Airport Capital Improvement Plan (ACIP). Of particular concern is whether these projects are related to development of that airport and/or the air traffic control system. It is the intent of the Secretary of Transportation to fund those airport

projects where the benefits to the capacity of the air traffic control or airport systems can be maximized, and/or where the contribution to reducing congestion can be maximized.

1. The FAA will evaluate the candidate airports and/or the airports such candidate airports would relieve based on the following specific factors:

- Compatibility of airport roles and the ability of the airport to provide an adequate airport facility;
- The capability of the candidate airport and its airside and landside complex to serve aircraft that otherwise must use the relieved airport;
- Landside surface access;
- Airport operational capability, including peak hour and annual capacities of the candidate airport;
- Potential of other metropolitan area airports to relieve the congested airport;
- Ability to satisfy, relieve or meet air cargo demand within the metropolitan area;
- Forecasted aircraft and passenger levels, type of commercial service anticipated, *i.e.*, scheduled and/or charter commercial service;
- Type and capacity of aircraft projected to serve the airport and level of operations at the relieved airport and the candidate airport;
- The potential for the candidate airport to be served by aircraft or users, including the airlines, serving the congested airport;
- Ability to replace an existing commercial service or reliever airport serving the area; and
- Any other documentation to support the FAA designation of the candidate airport.

2. The FAA will evaluate the development needs that, if funded, would make the airport a viable civil airport that will enhance system capacity or reduce delays. Newly closed installations or airport sponsors with new joint-use agreements with existing military aviation facilities will be strongly considered for designation since they tend to have the greatest conversion needs.

Application Procedures and Required Documentation

Airport sponsors applying for designation or redesignation must complete and submit an SF 424, ''Application for Federal Assistance,'' and supporting documentation to the appropriate FAA office serving that airport. In Item 15a of the SF 424, the applicant must indicate the total amount of funding requested from the MAP during the entire term for which it is applying. The SF 424 must indicate whether it is an initial application or reapplication for the MAP, and must be accompanied by the documentation and justification listed below:

(A) Identification as Current or Former Military Airport

The application must identify the airport as either a current or former military airport and indicate whether it was:

(1) Closed or realigned under section 201 of the Defense Authorization Amendments and Base Realignment and Closure Act, and/or section 2905 of the Defense Base Realignment and Closure Act of 1990 (Installations Approved for Closure by the Defense Base Realignment and Closure Commissions), or

(2) Closed or realigned pursuant to 10 U.S.C. 2687 as excess property (bases announced for closure by DOD pursuant to this title after September 30, 1977 (this is the date of announcement for closure and not the date of the deed to the airport sponsor)), or

(3) A military installation with both military and civil aircraft operations. The general aviation airport may be joint use but must qualify under (1) or (2) above.

(B) Qualifications for MAP

For (1) through (7) below the applicant does not need to resubmit any unchanged documentation that has been previously submitted to the Regional Airports Division or Airports District Office.

(1) Documentation that the airport meets the definition of a ''public airport'' as defined in 49 U.S.C. 47102(16).

(2) Documentation indicating that the required environmental review process for civil reuse or joint-use of the military airfield has been completed. This environmental review need not include review of the individual projects to be funded by the MAP. Rather, the documentation should reflect that the environmental review necessary to convey the property, enter into a long-term lease, or sign a joint use agreement has been completed. The military department conveying or leasing the property, or entering into a joint use agreement, generally has the lead responsibility for this environmental review. The environmental review and approvals must indicate that the operator or owner of the airport has good title, satisfactory to the Secretary, or gives assurance that good title will be acquired, to meet AIP requirements.

(3) In the case of a former military airport, documentation that the eligible airport sponsor holds or will hold satisfactory title, a long-term lease in furtherance of conveyance of property for airport purposes, or a long-term interim lease for 25 years or more, to the property on which the civil airport is being located. Documentation that an application for surplus or BRAC airport property has been accepted by the Government is sufficient to indicate the eligible airport sponsor holds or will hold adequate title or a long-term lease.

(4) In the case of a current military airport documentation that the airport sponsor has an existing joint-use agreement with the military department having jurisdiction over the airport. This is necessary so the FAA can legally issue grants to the sponsor. In (3) and (4) above, the airport must possess the necessary property rights in order to accept a grant for its proposed projects during FY 2003.

(5) Documentation that the airport is classified as a ''commercial service airport'' or a ''reliever airport'' as defined in 49 U.S.C. 47102(7) and 47102(18), unless it is applying for the general aviation slot.

(6) Documentation that the airport owner is an eligible airport ''sponsor'' as defined in 49 U.S.C. 47102(19).

(7) Documentation that the airport has an approved airport layout plan (ALP) and a five-year Airport Capital Improvement Program (ACIP) indicating all eligible grant projects proposed to be funded either from the MAP or other portions of the AIP.

(8) Information identifying the existing and potential levels of visual or instrument operations and aeronautical activity at the current or former military airport and, if applicable, the relieved airport. Also, if applicable, information on how the airport contributes to air traffic system or airport system capacity. If served by commercial air carriers, the revenue passenger and cargo levels should be provided.

(9) A description of the airport's projected civil role and development needs for transitioning from use as a military airfield to a civil airport, including how development projects would serve to reduce delays at an airport with more than 20,000 hours of annual delays by commercial passenger aircraft takeoffs and landings or enhance capacity in a metropolitan area.

(10) A description of the existing airspace capacity. Describe how anticipated new operations would affect the surrounding airspace and air traffic flow patterns in the metropolitan area in or near which a current or former military airport is located. Include a discussion of the level to which operations at this airport create airspace conflicts that may cause congestion or

whether air traffic works into the flow of other air traffic in the area.

(11) A description of the airport's five-year ACIP, including a discussion of major projects, their priorities, projected schedule for project accomplishment, and estimated costs. The ACIP must specifically identify the safety, capacity and conversion related projects, associated costs, and projected five-year schedule of project construction, including those requested for consideration for MAP funding.

(12) A description of those projects that are consistent with the role of the airport and effectively contribute to the joint use or conversion of the airfield to a civil airport. The projects can be related to various improvement categories depending on what is needed to convert from military to civil airport use, to meet required civil airport standards, and/or to provide capacity to the airport and/or airport system. The projects selected; *i.e.*, safety-related, conversion-related, and/or capacity-related, must be identified and fully explained based on the airport's planned use. Those projects that may be eligible under MAP, if needed for conversion or capacity-related purposes, must be clearly indicated, and include the following information:

Airside

- Modification of airport or military airfield for safety purposes, including airport pavement modifications (*i.e.* widening), marking, lighting, strengthening, drainage or modifying other structures or features in the airport environs to meet civil standards for airport imaginary surfaces as described in 14 CFR part 77.
- Construction of facilities or support facilities such as passenger terminal gates, aprons for passenger terminals, taxiways to new terminal facilities, aircraft parking, and cargo facilities to accommodate civil use.
- Modification of airport or military utilities (electrical distribution systems, communications lines, water, sewer, storm drainage) to meet civil standards. Also, modifications that allow utilities on the civil airport to operate independently, where other portions of the base are conveyed to entities other than the airport sponsor or retained by the Government.
- Purchase, rehabilitation, or modification of airport and airport support facilities and equipment, including snow removal, aircraft rescue, fire fighting buildings and equipment, airport security, lighting vaults, and reconfiguration or relocation of eligible buildings for more efficient civil airport operations.
- Modification of airport or military airfield fuel systems and fuel farms to accommodate civil aviation use.
- Acquisition of additional land for runway protection zones, other approach protection, or airport development.
- Cargo facility requirements.
- Modifications which will permit the airfield to accommodate general aviation users.

Landside

- Construction of surface parking areas and access roads to accommodate automobiles in the airport terminal and air cargo areas and provide an adequate level of access to the airport.
- Construction or relocation of access roads to provide efficient and convenient movement of vehicular traffic to, on, and from the airport, including access to passenger, air cargo, fixed base operations, and aircraft maintenance areas.
- Modification or construction of facilities such as passenger terminals, surface automobile parking lots, hangars, air cargo terminal buildings, and access roads to cargo facilities to accommodate civil use.

(13) An evaluation of the ability of surface transportation facilities (road, rail, high-speed rail, maritime) to provide intermodal connections.

(14) A description of the type and level of aviation and community interest in the civil use of a current or former military airport.

(15) One copy of the FAA-approved ALP for each copy of the application. The ALP or supporting information should clearly show capacity and conversion related projects. Also, other information such as project costs, schedule, project justification, other maps and drawings showing the project locations, and any other supporting documentation that would make the application easier to understand should be included. These maps and ALP's should be cross-referenced with the project costs and project descriptions.

Redesignation of Airports Previously Designated and Applying for up to an Additional Five Years in the Program

Airports applying for redesignation to the Military Airport Program should submit the same information required by new candidate airports applying for a new designation. On the SF 424, Application for Federal Assistance, prescribed by the Office of Management and Budget Circular A–102, airports must indicate their application is for redesignation to the MAP. In addition to the above information, they must explain:

(1) Why a redesignation and additional MAP eligible project funding is needed to accomplish the conversion to meet the civil role of the airport and the preferred time period for redesignation;

(2) Why funding of eligible work under other categories of AIP or other sources of funding would not accomplish the development needs of the airport;

(3) Why, based on the previously funded MAP projects, the projects and/or funding level were insufficient to accomplish the airport conversion needs and development goals; and

(4) The term of the redesignation, not to exceed five years, for which the airport is applying.

This notice is issued pursuant to Title 49 U.S.C. 47118.

Issued in Washington, DC, on October 24, 2002.

Benito De Leon,

Deputy Director, Office of Airport Planning and Programming.

[FR Doc. 02–27726 Filed 10–31–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 34262]

Illinois Indiana Development Company, LLC—Acquisition and Operation Exemption—Chicago SouthShore & South Bend Railroad Co.

Illinois Indiana Development Company, LLC (IIDC), a Class III carrier, has filed a verified notice of exemption under 49 CFR 1150.41 to acquire and operate approximately 6.2 miles of rail line from Chicago SouthShore & South Bend Railroad Co. (CSS). The rail line extends approximately from 115th Street in Chicago, IL (milepost 0.0) to the Illinois-Indiana state line in Burnham, IL, opposite Hammond, IN (milepost 6.2). IIDC certifies that its projected revenues as a result of this transaction will not result in the creation of a Class II or Class I rail carrier.

The transaction was scheduled to be consummated on or after October 9, 2002, the effective date of the exemption (7 days after the exemption was filed).

This transaction is related to STB Finance Docket No. 34263, *Chicago SouthShore & South Bend Railroad Co.—Operation Exemption—Illinois Indiana Development Company, LLC,* wherein CSS has concurrently filed a verified notice of exemption to conduct

freight operations over the line being acquired by IIDC.[1]

If the verified notice contains false or misleading information, the exemption is void *ab initio*. Petitions to revoke the exemption under 49 U.S.C. 10502(d) may be filed at any time. The filing of a petition to revoke will not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 34262, must be filed with the Surface Transportation Board, 1925 K Street, NW., Washington, DC 20423–0001. In addition, one copy of each pleading must be served on Rose-Michele Weinryb, Weiner Brodsky, Sidman Kider, PC, 1300 19th Street, NW., 5th Floor, Washington, DC 20036.

Board decisions and notices are available on our Web site at ''*www.stb.dot.gov.*''

Decided: October 24, 2002.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 02–27582 Filed 10–31–02; 8:45 am]

BILLING CODE 4915–00–P

[1] The parties state that CSS will have a nonexclusive right to conduct freight operations over the described line, and that IIDC will retain the right to operate over the line contemporaneously with CSS.

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 34263]

Chicago SouthShore & South Bend Railroad Co.—Operation Exemption—Illinois Indiana Development Company, LLC

Chicago SouthShore & South Bend Railroad (CSS), a Class III rail carrier, has filed a verified notice of exemption under 49 CFR 1150.41 to operate approximately 6.2 miles of rail line from Illinois Indiana Development, LLC (IIDC). The line extends approximately from 115th Street in Chicago, IL (milepost 0.0) to the Illinois-Indiana state line in Burnham, IL, opposite Hammond, IN (milepost 6.2). CSS certifies that its projected revenues as a result of this transaction will not result in the creation of Class II or Class I rail carrier.

The transaction was scheduled to be consummated on or after October 9, 2002, the effective date of the exemption (7 days after the exemption was filed).

This transaction is related to a concurrently filed verified notice of exemption in STB Finance Docket No. 34262, *Illinois Indiana Development Company, LLC—Acquisition and Operation Exemption—Chicago SouthShore & South Bend Railroad Co.,* wherein IIDC seeks to acquire and operate the above-described line.[1]

If the verified notice contains false or misleading information, the exemption is void *ab initio*. Petitions to revoke the exemption under 49 U.S.C. 10502(d) may be filed at any time. The filing of a petition to revoke will not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 34263, must be filed with the Surface Transportation Board, 1925 K Street, NW., Washington, DC 20423–0001. In addition, one copy of each pleading must be served on Rose-Michele Weinryb, Weiner Brodsky, Sidman Kider, PC, 1300 19th Street, NW., 5th Floor, Washington, DC 20036.

Board decisions and notices are available on our Web site at ''*www.stb.dot.gov.*''

Decided: October 24, 2002.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 02–27583 Filed 10–31–02; 8:45 am]

BILLING CODE 4915–00–P

[1] CSS will have a nonexclusive right to operate over the line. IIDC will retain the right over the line as well.

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Additional Designations of Terrorism-Related Blocked Persons

AGENCIES: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The Treasury Department's Office of Foreign Assets Control is publishing the name of one additional person whose property and interests in property has been blocked pursuant to Executive Order 13224 of September 23, 2001, pertaining to persons who commit, threaten to commit, or support terrorism.

DATES: The designation by the Secretary of the Treasury of the one additional person identified in this notice whose property and interests in property have been blocked pursuant to Executive Order 13224 is effective as of September 6, 2002.

FOR FURTHER INFORMATION CONTACT: Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220, *tel.:* (202) 622–2520.

SUPPLEMENTARY INFORMATION:

Electronic and Facsimile Availability

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Background

On September 23, 2001, President Bush issued Executive Order 13224 (the ''Order'') imposing economic sanctions on persons who commit, threaten to commit, or support certain acts of terrorism. In an annex to the Order, President Bush identified 12 individuals and 15 entities whose assets are blocked pursuant to the Order (66 FR 49079, September 25, 2001). Additional persons have been blocked pursuant to authorities set forth in the Order since that date and notice of such blockings have been published in the **Federal Register**.

Further Designation. On September 6, 2002, the Secretary of the Treasury, in consultation with the Secretary of State and the Attorney General, acting pursuant to authorities set forth in the Order designated one additional person whose property and interests in property are blocked. The name of this additional person is set forth below. Persons, and their known aliases, will be added to appendix A to 31 CFR chapter V, through a separate **Federal Register** document, as ''specially designated global terrorists'' identified by the initials ''[SDGT]''. Appendix A lists the names of persons with respect to whom transactions are subject to the various economic sanctions programs administered by the Office of Foreign Assets Control.

The designation by the Secretary of the Treasury pursuant to Executive Order 13224 of this additional person listed below is effective on September 6,

2002. All property and interests in property of any designated person, including but not limited to all accounts, that are or come within the United States or that are or come within the possession or control of United States persons, including their overseas branches, are blocked and may not be transferred, paid, exported, withdrawn, or otherwise dealt in, and all transactions or dealings by U.S. persons or within the United States in property or interests in property of any designated person are prohibited, unless licensed by the Office of Foreign Assets Control or exempted by statute.

In Section 10 of the Order, the President determined that because of the ability to transfer funds or assets instantaneously, prior notice to persons listed in the Annex to, or determined to be subject to, the Order who might have a constitutional presence in the United States, would render ineffectual the blocking and other measures authorized in the Order. The President further determined that no prior notification of a determination need be provided to any person who might have a constitutional presence in the United States. In furtherance of the objectives of the Order, the Secretary of the Treasury has determined that no prior notice should be afforded to the subjects of the determinations reflected in this notice because to do so would give the subjects the opportunity to evade the measures described in the Order and, consequently, render those measures ineffectual toward addressing the national emergency declared in the Order.

The additional designation follows:

JULAIDAN, Wa'el Hamza (a.k.a. ''Abu Al-Hasan al Madani;'' a.k.a. JALADIN, Wa'el Hamza; a.k.a. JALADIN, Wa'il Hamza; a.k.a. JALAIDAN, Wa'el Hamza; a.k.a. JALAIDAN, Wa'il Hamza; a.k.a. JULAIDAN, Wa'il Hamza; a.k.a. JULAYDAN, Wa'el Hamza; a.k.a. JULAYDAN, Wa'il Hamza); DOB 22 Jan 1958; POB Al-Madinah, Saudi Arabia; Passport No. A–992535 (Saudi Arabia) (individual) [SDGT]

Dated: September 13, 2002.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: October 10, 2002.

Kenneth Lawson,

Assistant Secretary (Enforcement), Department of the Treasury.

[FR Doc. 02–27813 Filed 10–31–02; 8:45 am]

BILLING CODE 4810–25–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Additional Designations of Terrorism-Related Blocked Persons

AGENCIES: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The Treasury Department's Office of Foreign Assets Control is publishing the names of 25 additional persons whose property and interests in property have been blocked pursuant to Executive Order 13224 of September 23, 2001, pertaining to persons who commit, threaten to commit, or support terrorism.

DATES: The designations by the Secretary of the Treasury of additional persons identified in this notice whose property and interests in property have been blocked pursuant to Executive Order 13224 are effective on August 29, 2002.

FOR FURTHER INFORMATION CONTACT: Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220, tel.: 202/622–2520.

SUPPLEMENTARY INFORMATION:

Electronic and Facsimile Availability

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Background

On September 23, 2001, President Bush issued Executive Order 13224 (the ''Order'') imposing economic sanctions on persons who commit, threaten to commit, or support certain acts of terrorism. In an annex to the Order, President Bush identified 12 individuals and 15 entities whose assets are blocked pursuant to the Order (66 FR 49079, September 25, 2001). Additional persons have been blocked pursuant to authorities set forth in the Order since that date and notice of these additional blockings have been published in the **Federal Register**.

Further Additional Designations. On August 29, 2002, the Secretary of the Treasury, in consultation with the Secretary of State and the Attorney General, acting pursuant to authorities set forth in the Order designated 25 additional persons whose property and interests in property are blocked. The names of these additional persons are set forth in the list below. Persons, and their known aliases, will be added to appendix A to 31 CFR chapter V, through a separate **Federal Register** document, as ''specially designated global terrorists'' identified by the initials ''[SDGT]''. Appendix A lists the names of persons with respect to whom transactions are subject to the various economic sanctions programs administered by the Office of Foreign Assets Control.

The designations by the Secretary of the Treasury pursuant to Executive Order 13224 of these additional persons listed below are effective on August 29, 2002. All property and interests in property of any designated person, including but not limited to all accounts, that are or come within the United States or that are or come within the possession or control of United States persons, including their overseas branches, are blocked and may not be transferred, paid, exported, withdrawn, or otherwise dealt in, and all transactions or dealings by U.S. persons or within the United States in property or interests in property of any designated person are prohibited, unless licensed by the Office of Foreign Assets Control or exempted by statute.

In Section 10 of the Order, the President determined that because of the ability to transfer funds or assets instantaneously, prior notice to persons listed in the Annex to, or determined to be subject to, the Order who might have a constitutional presence in the United States, would render ineffectual the blocking and other measures authorized in the Order. The President further determined that no prior notification of a determination need be provided to any person who might have a constitutional presence in the United States. In furtherance of the objectives of the Order, the Secretary of the Treasury has determined that no prior notice should be afforded to the subjects of the determinations reflected in this notice because to do so would give the subjects the opportunity to evade the measures described in the Order and,

consequently, render those measures ineffectual toward addressing the national emergency declared in the Order.

The list of additional designations follow:

1. Adel Ben Soltane, Via Latisana n. 6, Milan, Italy, DOB: July 14, 1970; POB: Tunis, Tunisia; Italian Fiscal Code: BNSDLA70L14Z352B
2. Nabil Benattia, DOB: May 11, 1966; POB: Tunis, Tunisia
3. Yassine Chekkouri, DOB: October 6, 1966; POB: Safi, Morocco
4. Riadh Jelassi, DOB: December 15, 1970; POB: Tunisia
5. Mehdi Kammoun, Via Masina n.7, Milan, Italy; DOB: April 3, 1968; POB: Tunis, Tunisia; Italian Fiscal Code: KMMMHD68D03Z352N
6. Samir Kishk, DOB: May 14, 1955; POB: Gharbia, Egypt
7. Tarek Ben Habib Maaroufi, DOB: November 23, 1965; POB: Ghardimaou, Tunisia
8. Abdelhalim Remadna, DOB: April 2, 1966; POB: Bistra, Algeria
9. Mansour Thaer, DOB: March 21, 1974; POB: Baghdad, Iraq
10. Lazhar Ben Mohammed Tlili, Via Carlo Porta n. 97, Legnano, Italy; DOB: March 26, 1969; POB: Tunis, Tunisia; Italian Fiscal Code: TLLLHR69C26Z352G
11. Habib Waddani, Via unica Borighero n. 1, San Donato M.se (MI), Italy; DOB: June 10, 1970; POB: Tunis, Tunisia; Italian Fiscal Code: WDDHBB70H10Z352O
12. AKIDA BANK PRIVATE LIMITED, (f.k.a. AKIDA ISLAMIC BANK INTERNATIONAL LIMITED); (f.k.a. IKSIR INTERNATIONAL BANK LIMITED); c/o Arthur D. Hanna & Company; 10 Deveaux Street, Nassau, Bahamas; PO Box N–4877, Nassau, Bahamas
13. AKIDA INVESTMENT CO. LTD., (a.k.a. AKIDA INVESTMENT COMPANY LIMITED); (f.k.a. AKIDA BANK PRIVATE LIMITED); c/o Arthur D. Hanna & Company; 10 Deveaux Street, Nassau, Bahamas; PO Box N–4877, Nassau, Bahamas
14. NASREDDIN GROUP INTERNATIONAL HOLDING LIMITED, (a.k.a. NASREDDIN GROUP INTERNATIONAL HOLDINGS LIMITED); c/o Arthur D. Hanna & Company; 10 Deveaux Street, Nassau, Bahamas; PO Box N–4877, Nassau, Bahamas
15. NASCO NASREDDIN HOLDING A.S., Zemin Kat, 219 Demirhane Caddesi, Zeytinburnu, Istanbul, Turkey
16. NASCOTEX S.A., (a.k.a. INDUSTRIE GENERALE DE FILATURE ET TISSAGE); (a.k.a. INDUSTRIE GENERALE DE TEXTILE); KM 7 Route de Rabat, BP 285, Tangiers, Morocco; KM 7 Route de Rabat, Tangiers, Morocco
17. NASREDDIN FOUNDATION, (a.k.a. NASREDDIN STIFTUNG); c/o Rechta Treuhand-Anstalt, Vaduz, Liechtenstein
18. BA TAQWA FOR COMMERCE AND REAL ESTATE COMPANY LIMITED, Vaduz, Liechtenstein; (formerly c/o Asat Trust reg.)
19. MIGA-MALAYSIAN SWISS, GULF AND AFRICAN CHAMBER, (f.k.a. GULF OFFICE ASSOC. PER LO SVILUPPO COMM. IND. E TURIS. FRA GLI STATI ARABI DEL GOLFO E LA SVIZZERA); Via Maggio 21, 6900 Lugano TI, Switzerland
20. GULF CENTER S.R.L., Corso Sempione 69, 20149 Milan, Italy; Fiscal Code: 07341170152; V.A.T. Number: IT 07341170152
21. NASCOSERVICE S.R.L., Corso Sempione 69, 20149 Milan, Italy; Fiscal Code: 08557650150; V.A.T. Number: IT 08557650150
22. NASCO BUSINESS RESIDENCE CENTER SAS DI NASREDDIN AHMED IDRIS EC, Corso Sempione 69, 20149 Milan, Italy; Fiscal Code: 01406430155; V.A.T. Number: IT 01406430155
23. NASREDDIN COMPANY NASCO SAS DI AHMED IDRIS NASREDDIN EC, Corso Sempione 69, 20149 Milan, Italy; Fiscal Code: 03464040157; V.A.T. Number: IT 03464040157
24. NADA INTERNATIONAL ANSTALT, Vaduz, Liechtenstein; (formerly c/o Asat Trust reg.)
25. NASREDDIN INTERNATIONAL GROUP LIMITED HOLDING, (a.k.a. NASREDDIN INTERNATIONAL GROUP LTD. HOLDING); c/o Rechta Treuhand-Anstalt, Vaduz, Liechtenstein; Corso Sempione 69, 20149, Milan, Italy

Dated: September 9, 2002.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: October 10, 2002.

Kenneth Lawson,

Assistant Secretary (Enforcement), Department of the Treasury.

[FR Doc. 02–27814 Filed 10–31–02; 8:45 am]

BILLING CODE 4810–25–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Additional Designations of Terrorism-Related Blocked Persons

AGENCIES: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The Treasury Department's Office of Foreign Assets Control is publishing the names of four additional persons whose property and interests in property have been blocked pursuant to Executive Order 13224 of September 23, 2001, pertaining to persons who commit, threaten to commit, or support terrorism.

DATES: The designations by the Secretary of the Treasury of additional persons identified in this notice whose property and interests in property have been blocked pursuant to Executive Order 13224 are effective on September 30, 2002.

FOR FURTHER INFORMATION CONTACT: Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220, tel.: 202/622–2520.

SUPPLEMENTARY INFORMATION:

Electronic and Facsimile Availability

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Background

On September 23, 2001, President Bush issued Executive Order 13224 (the ''Order'') imposing economic sanctions on persons who commit, threaten to commit, or support certain acts of terrorism. In an annex to the Order, President Bush identified 12 individuals and 15 entities whose assets are blocked pursuant to the Order (66 FR 49079, September 25, 2001). Additional persons have been blocked pursuant to authorities set forth in the Order since that date and notice of these additional blockings have been published in the **Federal Register**.

Additional Designations. On September 30, 2002, the Secretary of the

Treasury, in consultation with the Secretary of State and the Attorney General, acting pursuant to authorities set forth in the Order designated four additional persons whose property and interests in property are blocked. The names of these additional persons are set forth in the list below. Persons, and their known aliases, will be added to appendix A to 31 CFR chapter V, through a separate Federal Register document, as ''specially designated global terrorists'' identified by the initials ''[SDGT]''. Appendix A lists the names of persons with respect to whom transactions are subject to the various economic sanctions programs administered by the Office of Foreign Assets Control.

The designations by the Secretary of the Treasury pursuant to Executive Order 13224 of these additional persons listed below are effective on September 30, 2002. All property and interests in property of any designated person, including but not limited to all accounts, that are or come within the United States or that are or come within the possession or control of United States persons, including their overseas branches, are blocked and may not be transferred, paid, exported, withdrawn, or otherwise dealt in, and all transactions or dealings by U.S. persons or within the United States in property or interests in property of any designated person are prohibited, unless licensed by the Office of Foreign Assets Control or exempted by statute.

In Section 10 of the Order, the President determined that because of the ability to transfer funds or assets instantaneously, prior notice to persons listed in the Annex to, or determined to be subject to, the Order who might have a constitutional presence in the United States, would render ineffectual the blocking and other measures authorized in the Order. The President further determined that no prior notification of a determination need be provided to any person who might have a constitutional presence in the United States. In furtherance of the objectives of the Order, the Secretary of the Treasury has determined that no prior notice should be afforded to the subjects of the determinations reflected in this notice because to do so would give the subjects the opportunity to evade the measures described in the Order and, consequently, render those measures ineffectual toward addressing the national emergency declared in the Order.

The list of additional designations follow:

1. BAHAJI, Said, Bunatwiete 23, 21073 Hamburg, Germany; DOB 15 Jul 1975; POB Haselunne, Lower Saxony, Germany (individual).
2. BINALSHIBH, Ramzi Mohammed Abdullah (a.k.a. BIN AL SHIBH, Ramzi; a.k.a. BINALSHEIDAH, Ramzi Mohamed Abdullah; a.k.a. OMAR, Ramzi Mohammed Abdellah), Schleemer Ring 2, 22117 Hamburg, Germany; DOB 1 May 1972; POB Hadramawt, Yemen (individual).
3. EL MOTASSADEQ, Mounir, Goschenstasse 13, 21073 Hamburg, Germany; DOB 3 Apr 1974; POB Marrakesh, Morocco (individual).
4. ESSABAR, Zakarya (a.k.a. ESSABAR, Zakariya), Dortmunder Strasse 38, 22419 Hamburg; DOB 3 Apr 1977; POB Essaouria, Morocco (individual).

Dated: October 9, 2002.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: October 15, 2002.

Kenneth Lawson,

Assistant Secretary (Enforcement), Department of the Treasury.

[FR Doc. 02–27815 Filed 10–31–02; 8:45 am]

BILLING CODE 4810–25–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0121]

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 the insured's eligibility for continued disability insurance benefits.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before December 31, 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. 2900–0121'' 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: Obtaining Supplemental Information from Hospital or Doctor, VA FL 29–551b.

OMB Control Number: 2900–0121.

Type of Review: Extension of a currently approved collection.

Abstract: This form letter is used to request medical evidence from an insured's attending physician or hospital in connection with continuing disability insurance benefits.

Affected Public: Individuals or households.

Estimated Annual Burden: 61 hours.

Estimated Average Burden Per Respondent: 15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 244.

Dated: October 22, 2002.

By direction of the Secretary.

Ernesto Castro,

Director, Records Management Service.

[FR Doc. 02–27777 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0132]

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 specially adapted housing or for a special home adaptation grant.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before December 31, 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. 2900–0132'' 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: Veteran's Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant, VA Form 26–4555.

OMB Control Number: 2900–0132.

Type of Review: Extension of a currently approved collection.

Abstract: The form is used to gather the necessary information to determine the veteran's eligibility for specially adapted housing or the special home adaptation grant.

Affected Public: Individuals or households.

Estimated Annual Burden: 250 hours.

Estimated Average Burden Per Respondent: 10 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 1,500.

Dated: October 22, 2002.

By direction of the Secretary.

Ernesto Castro,

Director, Records Management Service.

[FR Doc. 02–27778 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0004]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 2, 2002.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030, FAX (202) 273–5981 or e-mail: *denise.mclamb@mail.va.gov.* Please refer to ''OMB Control No. 2900–0004.''

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0004'' in any correspondence.

SUPPLEMENTARY INFORMATION:

Title: Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable), VA Form 21–534.

OMB Control Number: 2900–0004.

Type of Review: Extension of a currently approved collection.

Abstract: VA Form 21–534 is used to gather the necessary information to determine the spouse's and/or children's eligibility, dependency and income, as applicable, for death benefit sought.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on August 23, 2002, at page 54697.

Affected Public: Individuals or households.

Estimated Annual Burden: 79,125 hours.

Estimated Average Burden Per Respondent: 1 hour and 15 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 63,300.

Dated: October 22, 2002.

By direction of the Secretary.

Ernesto Castro,

Director, Records Management Service.

[FR Doc. 02–27779 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0016]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995

(44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 2, 2002.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Records Management Service (005E3), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030, FAX (202) 273–5981 or e-mail: *denise.mclamb@mail.va.gov.* Please refer to ''OMB Control No. 2900–0016.''

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0016'' in any correspondence.

SUPPLEMENTARY INFORMATION:

Title: Claim for Disability Insurance Benefits, Government Life Insurance, VA Form 29–357.

OMB Control Number: 2900–0016.

Type of Review: Extension of a currently approved collection.

Abstract: VA Form 29–357 is used by policyholder to claim disability insurance on National Service Life Insurance and the United States Government Life Insurance policies. The information collected is used to determine the insured person's eligibility for disability insurance benefits.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on August 23, 2002, at pages 54696–54697.

Affected Public: Individuals or households.

Estimated Annual Burden: 14,175 hours.

Estimated Average Burden Per Respondent: 1 hour and 45 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 8,100.

Dated: October 22, 2002.

By direction of the Secretary.

Ernesto Castro,

Director, Records Management Service.

[FR Doc. 02–27780 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

Privacy Act of 1974; System of Records

AGENCY: Department of Veterans Affairs (VA).

ACTION: Notice of establishment of new system of records.

SUMMARY: The Privacy Act of 1974 (5 U.S.C. 552(e) (4)) requires that all agencies publish in the **Federal Register** a notice of the existence and character of their systems of records. Notice is hereby given that the Department of Veterans Affairs (VA) is establishing a new system of records entitled ''Employee Incentive Scholarship Program—VA'' (110VA10).

DATES: Comments on the establishment of this system of records must be received no later than December 2, 2002. If no public comment is received, the new system will become effective December 2, 2002.

ADDRESSES: You may mail or hand-deliver written comments concerning the proposed new system of records to the Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420; or fax comments to (202) 273–9289; or email comments to *OGCRegulations@mail.va.gov.* All relevant material received before December 2, 2002 will be considered. 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 Proposed System of Records

The Employee Incentive Scholarship Program (EISP) allows VA to award scholarships to employees pursuing degrees or training leading to appointment or retention in the following health professions: physician, dentist, podiatrist, pharmacist, licensed practical/vocational nurse, expanded-function dental auxiliary, registered nurse, certified registered nurse anesthetist, physician assistant, optometrist, physical therapist, occupational therapist, certified respiratory therapy technician, and registered respiratory therapist. The purpose of the program is to help VA meet its needs for qualified healthcare staff.

The Employee Incentive Scholarship Program—VA (110VA10) system of records contains personal identification information related to the application material, to award processes, to employment status, and to obligated service such as name, address, Social Security number, employing facility name, job title, grade, education level, degree sought, award amounts, obligated service incurred, and name and address of the educational institution. It also contains individual information about applicants who have been denied scholarships, program participants who have been terminated from VA employment, program participants who have breached their program contracts and any amount of indebtedness arising from a scholarship and owed back to VA. Additionally, it may contain information about why an applicant declined to accept a scholarship if the applicant furnished such information. Since applicants typically are denied scholarships because they do not meet the eligibility requirements to participate in the program, the specific nature of an applicant's ineligibility would be another element of information contained in the system of records. Scholarship recipients may request that a payment or service obligation be waived or suspended if circumstances beyond their control make it impossible to comply with the terms and conditions of the educational assistance program. The system of records would include information about the specific nature of the request and the related decision.

Any information in this system may be used by local VA supervisory officials and program coordinators to ensure that individual data in the system of records is accurate and up to date and that award recipients are in compliance with the terms of the scholarship program contract. Data about individual award recipients may change (e.g., adjustments to academic course load) and could impact certain terms of their scholarships such as the amounts of the awards and/or the beginning and ending dates of their periods of obligated service. Data changes may also impact assessments of the effectiveness of the scholarship

program. Accordingly, local supervisory officials and program coordinators must periodically review individual data in the system of records to ensure its accuracy.

The information in this system of records is maintained in electronic and hard copy format and is periodically updated through recurring reports, provided by local VA facilities, about the progress of their program participants. This information is necessary to effectively administer the scholarship program. It is used to determine and document individual applicants' initial eligibility for scholarship awards, calculate the service commitments for scholarship recipients, ensure program financial accountability which means that award amounts are consistent with applicable law, regulations and policy, monitor individual applicant educational progress, monitor the employment status of scholarship recipients during their periods of obligated service, and evaluate and report program results and effectiveness. The information would be used to determine the financial liability of individuals who breach their EISP contracts.

II. Proposed Routine Use Disclosures of Data in the System

We are proposing to establish the following routine use disclosures of information which will be maintained in the system:

• Any information in this system that is necessary to verify accuracy and completeness of the application information may be disclosed to educational institutions and other relevant organizations or individuals.

Employees must meet certain requirements to be eligible to participate in the scholarship program. For example, the applicants must have been formally accepted to or enrolled in authorized education or training programs as of the date that they submit their official applications for scholarship awards. Some schools may offer students who do not meet all of the requirements for formal (unconditional) acceptances into their academic programs (typically, Grade Point Average (GPA) or standardized test scores that are below established cutoff points), conditional acceptances. These students may be granted formal or unconditional acceptances once they meet certain requirements such as completing specified coursework and earning a minimum GPA. Students who have been conditionally or informally accepted into an academic program are not eligible to participate in the EISP. VA may need to disclose applicant information in order to verify that candidates for scholarship awards meet applicable program requirements.

• Any information in this system may be disclosed to a Federal agency in order to determine if an applicant has an obligation for service under another Federal program, thus rendering the applicant ineligible for a VA Employee Incentive Scholarship Program Award.

Scholarship program participants are required to serve a period of obligated service after completing their VA-sponsored courses of education or training. Employees are ineligible to receive scholarships if their VA periods of obligated service conflict with obligations to perform service under any other Federal educational program(s). VA may need to disclose applicant information to other Federal agencies to verify that employees do not have obligations to perform service that would render them ineligible to participate in the scholarship program.

• Any information in the system may be used to evaluate and report program results and effectiveness to appropriate officials including members of Congress on a routine and ad hoc basis.

The purpose of the scholarship program is to assist in meeting the staffing needs of VHA for health professional occupations for which recruitment or retention of qualified personnel is difficult. Top-level VA officials and Congress must have access to information from the system to assess how effectively the program accomplishes its purpose and to support decisions to continue, to modify or curtail its use.

• 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 record 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.

• Disclosure of information may be made to the National Archives and Record 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; they are responsible 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.

• Disclosure of information to the Federal Labor Relations Authority (FLRA) (including its General Counsel) when requested in connection with the investigation and resolution of allegations of unfair labor practices, in connection with the resolution of exceptions to arbitrator awards when a question of material fact is raised, in connection with matters before the Federal Service Impasses Panel, and to investigate representation petitions and conduct or supervise representation elections.

The release of information to FLRA from this Privacy Act system of records is necessary to comply with the statutory mandate under which FLRA operates.

• Disclosure may be made to officials of labor organizations recognized under 5 U.S.C. chapter 71 when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.

• Disclosure may be made to the VA-appointed representative of an employee, including all notices, determinations, decisions, or other written communications issued to the employee in connection with an examination ordered by VA under medical evaluation (formerly fitness-for-duty) examination procedures or Department-filed disability retirement procedures.

• Disclosure may be made to officials of the Merit Systems Protection Board, including the Office of the Special Counsel, when requested in connection with appeals, special studies of the civil service and other merit systems, review of rules and regulations, investigation of alleged or possible prohibited personnel practices, and such other functions, promulgated in 5 U.S.C. 1205 and 1206, or as may be authorized by law.

• Disclosure may be made to the Equal Employment Opportunity Commission when requested in connection with investigations of alleged or possible discrimination practices, examination of Federal affirmative employment programs, compliance with the Uniform Guidelines of Employee Selection Procedures, or other functions vested in the Commission by the President's Reorganization Plan No. 1 of 1978.

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 we collected the information. In all of the routine use disclosures described above, either the recipient of the information will use the information in connection with a matter relating to one of VA's programs, will use the information to provide a benefit to VA, or disclosure is 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: October 21, 2002.

Anthony J. Principi,

Secretary of Veterans Affairs.

110VA10

SYSTEM NAME:

Employee Incentive Scholarship Program (EISP)–VA.

SYSTEM LOCATION:

Active records will be maintained at the Health Care Staff Development and Retention Office (HCSDRO/10A2D), Veterans Health Administration (VHA), Department of Veterans Affairs (VA), 1555 Poydras Street, Suite 1971, New Orleans, Louisiana 70112; the Austin Automation Center (AAC), Department of Veterans Affairs, 1615 East Woodward Street, Austin, Texas 78772; and the VA healthcare facilities and VISN offices where scholarship recipients are employed. Address locations for VA healthcare facilities are listed in VA Appendix 1 of the Biennial Publication of Privacy Act Issuances. Complete records will be maintained only at the HCSDRO address.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

VA employees who apply for and are denied or granted educational assistance awards under the provisions of the VA Employee Incentive Scholarship Program (EISP) in a field leading to appointment or retention in a position listed in 38 U.S.C., Section 7401.

CATEGORIES OF RECORDS IN THE SYSTEM:

Records (or information contained in records) in this system may include personal identification information related to the application material, to award processes, to employment, to obligated service, and to requests for waivers or suspensions of obligated service or financial indebtedness to VA such as (1) name, (2) employing facility number, (3) telephone number(s), (4) Social Security number, (5) award amount, (6) obligated service incurred, and (7) name and address of the educational institution; or any amount of indebtedness (accounts receivable) arising from the scholarship and owed to VA. The application for an EISP award includes the applicant's full name, employing facility number, home and work telephone numbers, Social Security number, job title, current education level, degree sought, description of the academic program covered by the scholarship, the starting and completion dates of the employee's academic program, the name and address of the academic institution, the number of credits in the student's academic program plan and the cost of the education covered by the academic program plan. Records may include memoranda submitted by the employees, calculations for the service obligations, copies of letters and/or memoranda from employees making the requests and in correspondence to employees and appropriate local program officials delineating the decisions on such requests.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Title 38, U.S.C., Sections 501, 503, 7451, 7452, and 7431–7440.

PURPOSE(S):

The records and information may be used for determining and documenting individual applicant eligibility for scholarship awards, calculating the service commitments for scholarship recipients, ensuring program financial accountability, monitoring individual applicant educational progress, monitoring the employment status of scholarship recipients during their periods of obligated service, terminating the employee from the program, and evaluating and reporting program results and effectiveness. The information would be used to determine the financial liability of individuals who breach their EISP contracts.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

1. Disclosure of any information in this system that is necessary to verify authenticity and completeness of the application may be made to educational institutions and other relevant organizations or individuals.

2. Disclosure of any information in this system may be made to a Federal agency in order to determine if an applicant has an obligation for service under another Federal program, thus rendering the applicant ineligible for a VA Employee Incentive Scholarship Program Award.

3. Disclosure of any information in this system may be made to the local supervisory officials and program coordinators to ensure that individual data in the system of records is up to date and that award recipients are in compliance with the terms of the scholarship program contract.

4. Any information in the system may be used to evaluate and report program results and effectiveness to appropriate officials including members of Congress on a routine and ad hoc basis.

5. Disclosure of information in this system may be made 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.

6. Disclosure of information may be made to the National Archives and Record Administration (NARA) in records management inspections conducted under authority of Title 44, United States Code.

7. Disclosure of information to the FLRA (including its General Counsel) when requested in connection with the investigation and resolution of allegations of unfair labor practices, in connection with the resolution of exceptions to arbitrator awards when a question of material fact is raised, in connection with matters before the Federal Service Impasses Panel, and to investigate representation petitions and conduct or supervise representation elections.

8. Disclosure may be made to officials of labor organizations recognized under 5 U.S.C. chapter 71 when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting working conditions.

9. Disclosure may be made to officials of the Merit Systems Protection Board, including the Office of the Special Counsel, when requested in connection with appeals, special studies of the civil service and other merit systems, review of rules and regulations, investigation of alleged or possible prohibited personnel practices, and such other functions, promulgated in 5 U.S.C. 1205 and 1206, or as may be authorized by law.

10. Disclosure may be made to the Equal Employment Opportunity Commission when requested in connection with investigations of alleged or possible discrimination practices, examination of Federal affirmative employment programs, compliance with the Uniform Guidelines of Employee Selection Procedures, or other functions vested in the Commission by the President's Reorganization Plan No. 1 of 1978.

DISCLOSURE TO CONSUMER REPORTING AGENCIES:

Pursuant to 5 U.S.C. 552a(b)(12), VA may disclose records from this system to consumer reporting agencies as defined in the Fair Credit Reporting Act (15 U.S.C. 1681a(f)) or the Federal Claims Collection Act of 1966 (31 U.S.C. 3701(a)(3)).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Records are maintained on paper, electronic media and computer printouts.

RETRIEVABILITY:

Records are retrieved by use of the award number or an equivalent participant account number assigned by HCSDRO, social security number and the name of the individual.

SAFEGUARDS:

Access to the basic file in HCSDRO is restricted to authorized VA employees and vendors. Access to the office spaces where electronic media is maintained within HCSDRO is further restricted to specifically authorized employees and is protected by contracted building security services. Records (typically computer printouts) at HCSDRO will be kept in locked files and made available only to authorized personnel on a need-to-know basis. During non-working hours the file is locked and the building is protected by contracted building security services. Records stored on electronic media are maintained on a VA-approved and managed, password-protected, secure local area network (LAN) located within HCSDRO office spaces and safeguarded as described above. Records stored on electronic media at Veterans Integrated Service Network (VISN) Offices, VA healthcare facilities, and the AAC in Austin, Texas are provided equivalent safeguards subject to local policies mandating protection of information subject to federal safeguards.

RETENTION AND DISPOSAL:

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:

Director, Health Care Staff Development and Retention Office (10A2D), Veterans Health Administration, Department of Veterans Affairs, 1555 Poydras Street, Suite 1971, New Orleans, Louisiana 70112.

NOTIFICATION PROCEDURE:

Any individual who wishes to determine whether a record is being maintained in this system under his or her name or other personal identifier, or wants to determine the contents of such records, should submit a written request or apply in person to the Director, Health Care Staff Development and Retention Office, Veterans Health Administration, Department of Veterans Affairs, 1555 Poydras Street, Suite 1971, New Orleans, Louisiana 70112.

RECORD ACCESS PROCEDURES:

Individuals seeking information regarding access to and contesting of VA records in this system may write, call or visit the Director, Health Care Staff Development and Retention Office (10A2D), Veterans Health Administration, Department of Veterans Affairs, 1555 Poydras Street, Suite 1971, New Orleans, Louisiana 70112. The telephone number is (504) 589–5267.

CONTESTING RECORD PROCEDURES:

(*See Records Access Procedures* above.)

RECORD SOURCE CATEGORIES:

Information contained in the records is obtained from the individual, references given in application material, educational institutions, VA medical facilities, the VA AAC, other Federal agencies, State agencies and consumer reporting agencies.

[FR Doc. 02–27876 Filed 10–31–02; 8:45 am]

BILLING CODE 8320–01–P

Federal Register

Friday,
November 1, 2002

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405 and 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405 and 419

[CMS–1206–FC and CMS–1179–F]

RIN 0938–AL19 and 0938–AK59

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes are applicable to services furnished on or after January 1, 2003. This rule also allows the Secretary to suspend Medicare payments ''in whole or in part'' if a provider fails to file a timely and acceptable cost report.

In addition, this rule responds to public comments received on the November 2, 2001 interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payment under the Medicare's hospital outpatient prospective payment system. Finally, this rule responds to public comments received on the August 9, 2002 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (67 FR 52092). CMS finds good cause to waive proposed rulemaking for the assignment of new codes to Ambulatory Payment Classifications and for the payment of influenza and pneumococcal vaccines under reasonable cost; justification for the waiver will follow in a subsequent **Federal Register** notice.

DATES: *Effective date:* This final rule is effective January 1, 2003.

Comment date: We will consider comments on the ambulatory payment classification assignments of Healthcare Common Procedure Coding System codes identified in Addendum B with condition code NI, and on § 419.23(d)(3), if we receive them at the appropriate address, as provided below, no later than 5 pm on December 31, 2002.

FOR FURTHER INFORMATION CONTACT: Anita Heygster, (410) 786–0378—outpatient prospective payment issues; Lana Price, (410) 786–4533—partial hospitalization and end-stage renal disease issues; Gerald Walters, (410) 786–2070—payment suspension 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 toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Offi ce. The Web site address is: *http://www.access.gpo.gov/nara/index.html*. To assist readers in referencing sections contained in this document, we are providing the following table of contents.

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Alphabetical List of Acronyms Appearing in the Final Rule

ACEP—American College of Emergency Physicians
AMA—American Medical Association
APC—Ambulatory payment classification
AWP—Average wholesale price
BBA—Balanced Budget Act of 1997
BIPA—Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA—Balanced Budget Refinement Act of 1999
CCR—Cost center specific cost-to-charge ratio
CMHC—Community mental health center
CMS—Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT (Physician's) Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CSW Clinical social worker
CY Calendar year
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ERCP Endoscopic retrograde cholangiopancreatography
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HIPAA Health Insurance Portability and Accountability Act of 1996
ICU Intensive care unit
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
LTC Long Term Care
MedPAC Medicare Payment Advisory Commission
MDH Medicare Dependent Hospital
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
OT Occupational therapist
PHP Partial hospitalization program
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
RVUs Relative value units
SCH Sole Community Hospital
TEFRA Tax Equity and Fiscal Responsibility Act
USPDI United States Pharmacopoeia Drug Information

I. Background

A. Authority for the Outpatient Prospective Payment System (OPPS)

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. The OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking for the Outpatient Prospective Payment System

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services. On 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 18434) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419.

• 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. We implemented the OPPS on 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 implemented the 2001 OPPS on January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.

• On August 24, 2001, we published a proposed rule (66 FR 44672) that would revise the OPPS to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2002 (BIPA) and changes arising from our continuing experience with this system. It also described proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the PPS. The changes applied to services furnished on or after January 1, 2002.

• On November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year 2002. In addition, it described the Secretary's estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.

• On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.

• On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. It addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.

• On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.

• On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.

• On August 9, 2002, we published a proposed rule (67 FR 52092) that would revise the OPPS to implement applicable statutory requirements and changes arising from our continuing experience with this system. The changes would be applicable to services furnished on or afterJanuary 1, 2003. This rule also proposed to allow the Secretary to suspend Medicare payments ''in whole or in part'' if a provider fails to file a timely and acceptable cost report.

C. Authority for Payment Suspensions for Unfiled Cost Reports

Authority for the provision regarding payment suspensions for unfiled cost reports is contained within the authority for subpart C of 42 CFR part 405, that is, sections 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

D. Summary of Changes in the August 9, 2002 Proposed Rule

1. Changes Relating to the OPPS

On August 9, 2002, we published a proposed rule (67 FR 52092) that set forth proposed changes to the Medicare hospital OPPS and CY 2003 payment rates including changes used to determine these payment rates. The following is a summary of the major changes that we proposed and the issues we addressed in the August 9, 2002 proposed rule.

a. *Changes Required By Statute*

We proposed the following changes to implement statutory requirements:

• Add APCs, delete APCs, and modify the composition of some existing APCs.

• Recalibrate the relative payment weights of the APCs.

• Update the conversion factor and the wage index.

• Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.

• Cease transitional pass-through payments for drugs and biologicals (including blood and blood products) and devices (including brachytherapy), that will, on January 1, 2003, have been paid under transitional pass-through methodology for at least 2 years.

b. *Additional Changes to OPPS*

We proposed the following additional changes to the OPPS and Payment Suspension Provisions:

• Creation of new evaluation and management service codes for outpatient clinic and emergency department encounters for implementation no earlier than January 1, 2004.

• Changes to the list of services that we do not pay in outpatient departments because we define them as inpatient only procedures.

• Changes to our policy of nonpayment for procedures on the inpatient only list in special cases involving death or transfer before inpatient admission.

• Changes to our policy governing observation in cases of direct admission to observation.

• Changes to status indicators for Healthcare Common Procedure Coding System (HCPCS) codes.

• Changes to our policies governing dialysis for end-stage renal disease (ESRD) patients and regarding partial hospitalization.

C. Changes to the Regulations Text

A. We proposed to make the following changes to our regulations:

Amend § 419.66(c)(1) to specify that we must establish a new category for a medical device if it is not described by any category previously in effect as well as an existing category.

2. Changes Relating to Payment Suspension for Unfiled Cost Reports

We proposed to revise § 405.371(c) to specify that we may suspend Medicare payments ''in whole or in part'' if a provider has failed to timely file an acceptable cost report. This provision is consistent with the existing provisions in § 405.371(a) governing the suspension of Medicare payments ''in whole or in part'' under certain conditions. We believe the Medicare program would benefit because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients.

E. Summary of the November 2, 2001 Interim Final Rule with Comment Period

On November 2, 2001, we published an interim final rule with comment period in the **Federal Register** (66 FR 55850) that set forth the criteria for establishing new categories of medical devices eligible for transitional pass-through payments under Medicare's hospital OPPS as required by section 1833(t)(6)(B)(ii) of the Act, as amended by BIPA.

In the April 7, 2000 final rule with comment period (65 FR 18480), we defined new or innovative devices using eight criteria, three of which were revised in our August 3, 2000 interim final rule with comment period (65 FR 47673–74). These criteria remained applicable when defining a new category for devices, (that is, devices to be included in a category must meet all previously established applicable criteria for a device eligible for transitional pass-through payments) but we revised the definition of an eligible device to conform the requirements of amended section 1833(t)(6)(B)(ii) of the Act.

We also clarified our criterion that states that a device must be approved or cleared by the Food and Drug Administration (FDA).

In establishing the criteria for establishing additional categories, the Act mandates that new categories be established for devices that were not being paid for as an outpatient hospital service as of December 31, 1996 and for which no categories in effect (or previously in effect) are appropriate, in such a way that no device is described by more than one category and the average cost of devices to be included in the category is not insignificant in relation to the APC payment amount for the associated service. Based on these requirements, we used the following criteria to establish a category of devices:

- *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established categories or other available treatments, as described in regulations at new § 419.66(c)(1).
- *Cost.* We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures.

We received five timely items of correspondence on the November 2, 2001 interim final rule with comment period. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule with comment period.

F. Public Comments and Responses to the August 9, 2002 Proposed Rule

We received approximately 1,000 timely items of correspondence containing multiple comments on the August 9, 2002 proposed rule. Of that total, we received eight comments relating to the payment suspension provision described in section I.D.2. Summaries of the public comments received on other provisions and our responses to those comments are provided below in section I.F.2 of this preamble.

1. OPPS

We received comments from various sources including but not limited to health care facilities, physicians, drug and device manufacturers, and beneficiaries. Hospital associations and the Medicare Payment Advisory Commission (MedPAC) generally supported our proposed approach to revising the relative weights and incorporating the drugs and devices into payment for APCs. Pharmaceutial and medical device manufacturers and some individual hospitals that furnish particular devices or drugs were concerned with the proposed reductions in payment for medical devices and drugs. We received many thoughtful comments from a wide range of commenters with regard to methodological issues in OPPS. In addition, several comments provided data to support their assertions. The following are the major OPPS related issues addressed by the commenters:

- Expiration of pass-through payment for most devices and drugs/biologicals.
- Extent of reduction in payments for devices compared to payments in 2002.
- Potential impact on access to care of proposed payments.
- The proposal to package drugs with a per line cost less than $150 and to pay separately for others.
- Assignment and reassignment of codes to APCs (including assignments to procedural APCs from new tech APCs).
- Quality, quantity and content of claims data used to set payment weights.
- Continuation of a list of procedures that are not paid under OPPS because we believe that they should be performed as inpatient services.
- Policy on payment for outpatient observation care.
- Creation of evaluation and management codes for OPPS use.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate headings of this final rule with comment period.

2. Payment Suspension for Unfiled Cost Reports

Comments and Responses

Comment: All of the commenters stated that the rule provides for increased flexibility and a reduction in the financial impact of payment suspensions on providers. They indicated the increased flexibility would allow providers to receive partial payments from Medicare, which would lessen the financial impact of payment suspensions.

Response: We appreciate the hospital associations supporting this change.

Comment: One commenter suggested that payment suspension be limited to those payments directly determined by the cost report.

Response: We believe that immediate suspension of all payments when a cost report is not filed timely may not always be the appropriate response. However, if we require a provider to file a cost report, it is important for the cost report to be filed in a timely manner regardless of the amount of payment that is determined based on the cost report. We need flexibility in determining the amount of a provider's payments to suspend if its cost report is not filed timely. This could include the potential suspension of payments that are not determined by the cost report. Thus, we will retain § 405.371 of the regulation as set forth in the proposed rule.

II. Changes to the Ambulatory Payment Classification (APC) Groups and Relative Weights

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median

hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 601, Mid-Level Clinic Visits. The APC weights are scaled to APC 601 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 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 payment weights.

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median or mean cost item or service in the group is more than 2 times greater than the lowest median 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 purposes of the proposed rule and for this final rule with comment period, 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, requires that we consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights. The Act 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 (Pub. L. 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, we chose 15 highly qualified individuals to serve on the Panel. The first APC Panel meeting was held on February 27, February 28, and March 1, 2001, to discuss the 2001 APCs in anticipation of the 2002 OPPS.

We published a notice in the **Federal Register** on December 14, 2001, to announce the location and time of the second 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 on our Web site. We convened the second meeting of the Panel on January 22 through January 24, 2002.

2. General Issues Considered by the Advisory Panel

In the proposed rule, we summarized the Panel's discussion of a recommendation by the Panel's Research Subcommittee concerning the format of written submissions and oral presentations to the Panel and of several general OPPS payment issues.

Content for Future Presentations to the Panel

During the 2001 meeting, the Panel members felt that requiring consistency for all presentations with regard to format, data submission, and general information would assist them in analyzing the submissions and presentations and making recommendations. Therefore, upon the Panel's recommendation, the Research Subcommittee was established during the 2001 meeting.

The Panel began its 2002 meeting by considering the Research Subcommittee's recommendation to the Panel on requirements for written submissions and oral presentations. The Research Subcommittee recommended that all future oral presentations and written submissions contain the following:

- Name, address, and telephone number of the proposed presenter.
- Financial relationship(s), if any, with any company whose products, services, or procedures are under consideration.
- CPT codes involved.
- APC(s) affected.
- Description of the issue.
- Clinical description of the service under discussion, with comparison to other services within the APC.
- Description of the resource inputs associated with the service under discussion, with a comparison to resource inputs for other services within the APC.
- Recommendations and rationale for change.
- Expected outcome of change and potential consequences of no change.

The Panel adopted the Subcommittee s recommendation. Presentations for the 2003 meeting must contain, at a minimum, this information.

Inpatient Only List

At its February 2001 meeting, the Panel discussed the existence of the inpatient list. The Panel favored its elimination. At the January 2002 meeting, Panel members noted that hospitals receive no payment for a service performed in an outpatient department that appears on the inpatient list, even though the physician performing that service will receive payment for his or her services. The Panel believes the physician should determine what procedure to perform and that both the hospital and the physician should receive payment for the procedure. We continue to disagree with the position taken by the Panel regarding the inpatient list for reasons that we discuss in detail in the April 7, 2000 final rule (65 FR 18456).

Prior to the 2002 Panel meeting, we received requests from hospital and surgical associations and societies to remove certain procedures from the inpatient list. We reviewed those requests and presented to the Panel the requests for which we were unable to make a determination based on the information submitted with the request.

The Panel considered removing the following procedures from the inpatient list:

CPT	Description
21390	Treat eye socket fracture
27216	Treat pelvic ring fracture
27235	Treat thigh fracture

CPT	Description
32201	Drain, precut, lung lesion
33967	Insert a precut device
47490	Incision of gallbladder
62351	Implant spinal canal cath
64820	Remove sympathetic nerves
92986	Revision of aortic valve
92987	Revision of mitral valve
92990	Revision of pulmonary valve
92997	Pul art balloon repr, precut
92998	Pul art balloon repr, precut

As the Panel recommended, we solicited comments and additional information from hospitals and medical specialty societies that have an interest in these procedures. At their 2003 meeting, the Panel also recommended that we present to them any such comments that we receive to assist in their evaluation of whether to recommend removing the codes from the inpatient list.

The Panel did recommend that we remove from the inpatient list CPT code 47001, Biopsy of liver, needle; when done for indicated purpose at time of other major procedure. We agreed with the Panel's recommendation and we proposed to remove 47001 from the inpatient list. We further proposed to assign it status indicator ''N'' so that costs associated withCPT code 47001 would be packaged into the APC payment for the primary procedure performed during the same operative session.

In section II.B.5 of the proposed rule, we discussed additional procedures, which were not considered by the Panel, that we proposed to remove from the inpatient list. We discussed in detail our reasons for proposing these additional changes, and we proposed two new criteria that we would adopt in the future when evaluating whether to make a procedure on the inpatient list payable under the OPPS. Table 6 in section II.B.5 of the proposed rule lists all the procedures we proposed to remove from the inpatient list, including those discussed by the Panel. We considered the removal of CPT code 33967, Insertion of intra-aortic balloon assist device, percutaneous from the inpatient list, but did not include it in Table 6. The Panel considered this code for removal from the inpatient list and had concerns about whether performing this procedure in an outpatient setting is appropriate. Further, we were not able to confirm that this procedure is being performed on Medicare beneficiaries in an outpatient setting. We solicited comments, including clinical data and specific case reports, which would support payment for CPT 33967 under the OPPS.

Our discussion of the comments we received on this issue, our response and the statement of final action regarding what services to remove from the inpatient list is contained in section II.B.5.

Multiple Bills

During its February 2001 meeting, the Panel received oral testimony identifying CMS exclusive use of single procedure claims to set relative weights for APCs as a potential problem in setting appropriate payment rates for APCs. Therefore, the panel asked its Research Subcommittee to work with CMS staff, using the Endoscopic Retrograde Cholangiopancreatography (ERCP) code family as a case study, to explore the use of multiple procedure claims data for setting relative weights.

The Subcommittee made the following recommendations to the Panel, which the Panel approved:

- We should continue to explore the use of multiple procedure claims data for setting payment rates but should continue to use only single procedure claims data to determine relative payment weights for CY 2003.
- We should work with the APC Panel to explore the use of multiple claims data drawn from OPPS claims for services such as radiation oncology in time for the next APC Panel meeting.
- We should educate hospitals on appropriate coding and billing practices to ensure that claims with multiple procedures are properly coded and that costs are properly allocated to each procedure.

One presenter to the panel suggested a method to increase the number of claims that could be considered as single claims. Currently, we consider any claim submitted with two or more primary codes (that is, a code assigned to an APC for separate payment) to be a multiple procedure claim. When these claims contain line items for revenue centers without an accompanying Healthcare Common Procedure Coding System (HCPCS) code there is no way to determine the appropriate primary code with which to package the revenue center. The presenter suggested that we consider all claims where every line contains a separately payable HCPCS code as a single procedure claim, reasoning that on such claims we do not have to determine how and where to ''package'' line items not identified by a separately payable HCPCS code. Where every line item contains a separately payable HCPCS code, every cost can easily be allocated to a separately payable HCPCS code on the line item and all costs for each HCPCS code can then be accurately and completely determined.

We agreed with that suggestion. In section II.B.4 of the proposed rule, we described how we determined the number of single claims used to set the APC relative weights proposed for 2003 using this methodology. We requested comments on our methodology.

Discussion of the comments we received on this issue, our responses, and the statement of final action are contained in section III.A.

Packaging

We sought the Panel's guidance on whether we should package the costs of HCPCS codes for radiologic guidance and radiologic supervision and interpretation services whose descriptors require that they only be performed in conjunction with a surgical procedure.

In the proposed rule, we discussed why we package the costs of certain procedures. We specified for example, that ''add-on'' procedures and radiologic guidance procedures should never be billed on a claim without the code for an associated procedure. A facility should not submit a claim for ultrasound guidance for a biopsy unless the claim also includes the biopsy procedure, because the guidance is necessary only when a biopsy is performed. A claim for a packaged guidance procedure (or a supervision and interpretation procedure whose descriptor requires it be performed in association with a surgical procedure)

would be returned to the provider for correction and resubmission.

Also, we explained that we use packaging because billing conventions allow hospitals to report costs for certain services using only revenue center codes (that is, hospitals are not required to specify HCPCS codes for certain services). Packaging allows these costs to be captured in the data used to calculate median costs for services with an APC.

After hearing the requests of several presenters, (details discussed at 66 FR 52098 of the proposed rule) the Panel concluded that, even though we could be setting relative weights based on error claims, we should not package additional radiologic guidance and supervision and interpretation procedures and should continue to explore methodologies that would allow these procedures to be recognized for separate payment. The Panel also recommended that radiology guidance codes that were in APC 268 for CY 2001 but that were designated with status indicator ''N'' as packaged services in 2002, be restored as separately payable services for CY 2003. The Panel requested that this topic be placed on the agenda for the next Panel meeting.

Our discussion of the comments we received on this issue, our responses and a statement of final action is contained in section III.B.

Add-On Codes

As discussed in the proposed rule (66 FR 52098), we presented for the Panel's consideration several options for payment of add-on codes, including assignment of status indicator ''N'' to package them into the payment for the base procedure. After thorough review, the Panel concluded that we should continue to pay for add-on codes separately, setting relative weights with the use of single procedure claims in spite of the fact that these were error claims. The Panel asked us to continue exploring ways to most appropriately pay for these services. They requested that this item also be placed on the agenda for the next Panel meeting.

We proposed to accept the recommendations of the APC Panel both for packaging radiology guidance and supervision and interpretation codes and for payment of add-on codes. We proposed to pay separately in 2003 for radiology guidance codes that were paid in APC 268 in CY 2001 but that were packaged in 2002.

3. 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 most recent data available for the Panel to review in considering specific APC groupings were the 1999–2000 pre-OPPS claims data that were the basis of the CY 2002 relative payment weights. In the proposed rule, we provided a detailed summary of the Panel discussion and recommendations (67 FR 52098–52102). See the proposed rule for more details regarding these discussions. The APC titles are shown in this discussion of the APC Panel recommendations as they existed when the APC Panel met in January 2002. In a few cases the APC titles were changed for the proposed 2003 OPPS and therefore some APCs do not have the same title in Addendum A as they have in this section.

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.B.1 of this preamble, we discuss our proposals regarding the 2 times rule based on the CY 2001 data we are using to recalibrate the 2003 APC relative weights. Section II.B.1 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 2001 and 2002. We refer to the exceptions as ''violations of the 2 times'' rule in the following discussion.

APC 215: Level I Nerve and Muscle Tests
APC 216: Level III Nerve and Muscle Tests
APC 218: Level II Nerve and Muscle Tests

We presented this agenda item because APC 215 appeared to violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider the following changes:

- Move CPT codes 95858, 95921, and 95922 from APC 215 to APC 218.
- Move CPT code 95930 from APC 216 to APC 218.
- Move CPT code 92275 from APC 216 to APC 231.
- Move CPT code 95920 from APC 218 to APC 216.

The Panel recommended that the changes we asked them to consider be made, that is, to move CPT codes 95921 and 95922 to APC 218. However, if the calendar year 2001 data support a move of 95921 to APC 216, the Panel recommended that we consider that move.

APC 600: Low Level Clinic Visits
APC 601: Mid Level Clinic Visits
APC 602: High Level Clinic Visits
APC 610: Low Level Emergency Visits
APC 611: Mid Level Emergency Visits
APC 612: High Level Emergency Visits

We discussed the Panel's recommendations related to facility coding for clinic and emergency department visits are discussed below, in (section X.A of this rule).

APC 296: Level I Therapeutic Radiologic Procedures
APC 297: Level II Therapeutic Radiologic Procedures
APC 263: Level I Miscellaneous Radiology Procedures
APC 264: Level II Miscellaneous Radiology Procedures

APCs 296, 263, and 264 appear to violate the 2 times rule. We asked the Panel to consider three options for reconfiguring these APCs so that they would conform with the 2 times rule.

Option 1: Create a new APC, Level III Therapeutic Radiology Procedures, by moving CPT code 75984 from APC 296 and 74475 from APC 297. Also, move CPT codes 76101, 70390, and 71060 from APC 263 to APC 264 and move CPT code 75980 from APC 297 to APC 296.

Option 2: Move CPT codes 76101, 703690, and 71060 from APC 263 to APC 264 and move CPT code 75984 from APC 296 to APC 264. Move CPT code 75980 from APC 297 to APC 296.

Option 3: Create a new APC, Level III Miscellaneous Radiology

Procedures, by moving CPT codes 76080, 7036736, 76101, 70390, 74190, and 71060 from APC 263. Move CPT code 74327 from APC 296 to APC 263 and move CPT code 75980 from APC 297 to APC 296. APC 264 remains unchanged.

The Panel noted that none of the options that we presented resolve all of the 2 times violations. However, the Panel agreed that Option 2 would create more clinically coherent APCs without creating a new APC based on anticipated device costs that would be billed in 2002. In addition, the Panel invited the American College of Radiology and other interested parties to proposed further changes for the Panel's consideration next year.

We proposed to accept the Panel's recommendations that option 2 be implemented.

APC 230: Level I Eye Tests and Treatments
APC 231: Level III Eye Tests and Treatments
APC 232: Level I Anterior Segment Eye Procedures
APC 233: Level II Anterior Segment Eye Procedures
APC 234: Level III Anterior Segment Eye Procedures

APC 235: Level I Posterior Segment Eye Procedures
APC 236: Level II Posterior Segment Eye Procedures
APC 237: Level III Posterior Segment Eye Procedures
APC 238: Level I Repair and Plastic Eye Procedures
APC 239: Level II Repair and Plastic Eye Procedures
APC 240: Level III Repair and Plastic Eye Procedures
APC 241: Level IV Repair and Plastic Eye Procedures
APC 242: Level V Repair and Plastic Eye Procedures
APC 247: Laser Eye Procedures Except Retinal
APC 248: Laser Retinal Procedures
APC 698: Level II Eye Tests and Treatments
APC 699: Level IV Eye Tests and Treatments

We asked the Panel to review these APCs to address clinical inconsistencies and violations of the 2 times rule. We suggested creating a new level for posterior segment eye procedures and other changes in order to make the groups more clinically coherent, as follows:

- Move CPT codes 65260 and 67218 from APC 237 to 236.
- Create a new APC (Level IV Posterior Segment Eye Procedures) by moving CPT codes 67107, 67112, 67040, and 67108 from APC 237.
- Move CPT codes 67145, 67105, and 67210 from APC 247 to APC 248.
- Move CPT code 66999 from APC 247 to APC 232.
- Move CPT code 67299 from APC 248 to APC 235.
- Move CPT codes 65855, 66761, and 66821 from APC 248 to APC 247.
- Move CPT code 67820 from APC 698 to APC 230.
- Move CPT code 67208 from APC 231 to APC 235.
- Move CPT codes 92226, 92284, 65205, 92140 from APC 231 to APC 698.
- Move CPT code 92235 from APC 231 to APC 699.
- Move CPT code 68100 from APC 233 to APC 232.
- Move CPT code 65180 from APC 233 to APC 234.
- Create a new APC (Level IV Anterior Segment Eye Procedures) by moving CPT codes 66172, 66185, 66180, 66225 from APC 234.
- Move CPT code 92275 from APC 216 to APC 231.

No presenters commented on these APCs, and, after brief discussion, the Panel recommended concurrence with our suggested changes. We proposed to accept the Panel's recommendations. We noted in the proposed rule that when we were able to use 2001 claims data to re-evaluate the changes recommended by the Panel for these APCs, we found violations of the 2 times rule in the reconfigured APCs. Nonetheless, we proposed to accept the Panel's recommendations because they result in more clinically coherent APCs. We solicited comments on further changes that would address the violations of the 2 times rule.

APC 110: Transfusion
APC 111: Blood Product Exchange
APC 112: Apheresis, Photopheresis, and Plasmapheresis

We presented these APCs to the Panel in 2001 because of their low payment rates and concern that our cost data were inaccurate. These APCs were on the 2002 agenda in order to obtain further comment on our cost data. We suggested no changes in the structure of these APCs.

The Panel recommended that plasma derivatives be placed in their own APCs and classified in the same manner as whole blood products. In addition, the Panel observed that hospitals incur additional costs with each unit of blood product transfused and, therefore, recommended that APC 110 be revised to allow for the costs of additional units of blood product and clinical services.

In section IV.D of this rule, we discussed our payment proposals for drugs and biologicals for which pass-through payments are scheduled to expire in 2003. Those proposals would affect payment for blood and blood products. We proposed not to accept the Panel's recommendation to change current OPPS payment policy for transfusions.

Panel Recommendations to Defer Changes Pending Availability of 2001 Claims Data

Regarding the remaining APC groups that are addressed below, the Panel recommended that we make no changes until data from claims billed in 2001 under the OPPS become available for analysis. The Panel further requested that we place the APC groups in this section on the agenda for consideration at its meeting in 2003. The changes that we proposed for the APCs in this section are based upon our review of the 2001 claims data, which did not become available until March 2002.

APC 203: Level V Nerve Injections
APC 204: Level VI Nerve Injections
APC 206: Level III Nerve Injections
APC 207: Level IV Nerve Injections

Several presenters to the Panel suggested changes in the configuration of these APCs because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in the APCs. Several of these APCs include procedures associated with drugs or with device categories for which pass-through payments are scheduled to expire in 2003. The Panel recommended that we not change the structure of these APCs at this time. Because the structure of these APCs was substantially changed for 2002, and 2002 cost data was not yet available, the Panel felt it would be appropriate to review 2002 cost data prior to making further structural changes to these APCs. We proposed to accept the Panel's recommendation.

We will place these APCs on the Panel's agenda when 2002 cost data becomes available.

APC 43: Closed Treatment Fracture Finger/Toe/Trunk
APC 44: Closed Treatment Fracture/Dislocation, Except Finger/Toe/Trunk

On the basis of 1999–2000 claims data, these APCs violate the 2 times rule. The Panel reviewed these APCs and recommended no changes.

Our subsequent review of 2001 OPPS cost data shows continuing violations of the 2 times rule and that costs within these APCs are virtually identical. Therefore, we proposed to combine APCs 43 and 44 into APC 43. The procedures in the consolidated APC are clinically homogeneous.

APC 58: Level I Strapping and Cast Application
APC 59: Level II Strapping and Cast Application

The Panel reviewed these APCs and recommended that no changes be made pending analysis of 2001 claims data. The Panel did recommend that billing instructions be developed on the appropriate use of the codes in these APCs. We agreed with the Panel's recommendation regarding the need for billing instructions, and we expect to develop such instructions for hospitals to use in 2003.

Our subsequent review of 2001 claims data reveals that, in some cases, costs for short casts and splints are greater than costs for long casts and splints. Moreover, the proposed payments for these two APCs, based on 2001 OPPS data, would not differ significantly from each other. Therefore, we proposed to combine the codes in APC 58 and APC 59 into a single APC, APC 58. Combining these APCs does not compromise clinical homogeneity. The relative weight of the proposed single APC is virtually identical to the relative weight of each of the two current APCs. We proposed to continue to work with hospitals to develop appropriate coding

for these services and will review the appropriate APC structure for these services next year.

APC 279: Level I Angiography and Venography Except Extremity
APC 280: Level II Angiography and Venography Except Extremity

Without the benefit of 2001 OPPS claims data, it was difficult for the Panel to determine whether the apparent violation of the 2 times rule in APCs 279 and 280 was attributable to underreporting of procedures or inaccurate coding. Therefore, the Panel recommended no changes pending the availability of the more recent claims data. After subsequently reviewing the 2001 claims data, we proposed to move CPT codes 75978, Transluminal balloon angioplasty, venous, radiological supervision and interpretation, and 75774, Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation, to new APC 0668. This would resolve violations of the 2 times rule and result in clinically coherent APCs.

APC 115: Cannula/Access Device Procedures

We proposed to move CPT code 36860, External Cannula Declotting; without balloon catheter, to APC 103, Miscellaneous Vascular Procedures. We believe this makes both APC 115 and APC 103 more clinically homogeneous and it resolves a violation of the 2 times rule in APC 115 that was caused by the presence of CPT code 36860.

APC 93: Vascular Repair/Fistula Construction
APC 140: Esophageal Dilation without Endoscopy
APC 141: Upper GI Procedures
APC 142: Small Intestine Endoscopy
APC 143: Lower GI Endoscopy
APC 144: Diagnostic Anoscopy
APC 145: Therapeutic Anoscopy
APC 146: Level I Sigmoidoscopy
APC 147: Level II Sigmoidoscopy
APC 148: Level I Anal/Rectal Procedure
APC 149: Level II Anal/Rectal Procedure

Our subsequent review of 2001 claims data suggests that the cost data for APCs 144 and 145 are aberrant. The cost data for these APCs yield relative weights and payments that are significantly higher than the relative weights for APCs 146 and 147, which consist of similar procedures performed through a sigmoidoscope rather than an anoscope. As currently arranged, the APC configuration for these services could provide a financial incentive for hospitals to perform unnecessary anoscopic procedures, either alone or with a sigmoidoscopy. To rectify this problem, we proposed to move the procedures in APCs 144 and 145 to APC 147 with the exception of CPT code 46600, Anoscopy; diagnostic, which we proposed to assign to APC 340, Minor Ancillary procedures. We believe these changes would result in clinically coherent APCs with appropriate relative weights and payment rates.

APC 363: Otorhinolaryngologic Function Tests

Based on 2001 claims data, we proposed to move CPT codes 92543, 92588, 92520, 92546, 92516, 92548, and 92584 to new APC 0660 (Level III Otorhinolaryngolgic Function Tests). This change would resolve a 2 times rule violation and create clinically coherent APCs.

APC 96: Non-Invasive Vascular Studies
APC 265: Level I Diagnostic Ultrasound Except Vascular
APC 266: Level II Diagnostic Ultrasound Except Vascular
APC 267: Vascular Ultrasound
APC 269: Level I Echocardiogram Except Transesophageal
APC 270: Transesophageal Echocardiogram

The APC Panel recommended making no changes in the configuration of these APCs. Based on 2001 claims data, we proposed to make several changes in order to resolve 2 times rule violations and to make these APCs more clinically coherent. Specifically, we proposed to move CPT code 43499 from APC 0140 to APC 141; CPT code 93721 from APC 0096 to APC 368; CPT code 93740 from APC 0096 to APC 367; CPT code 93888 from APC 0267 to APC 266; and CPT code 93931 from APC 0267 to APC 266. We also proposed to move CPT codes 78627, 76825, and 93320 from APC 0269 to new APC 0671 to achieve more clinical coherence. We also proposed to create new APC 0670 for intravascular ultrasound and intracardiac echocardiography consisting of CPT codes 37250, 37251, 92978, 92979, and 93662.

APC 291: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 292: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

Subsequent to the APC Panel meeting, we received comments on these APCs from the Nuclear Medicine Task Force. After a thorough review of that proposal within the context of the 2001 claims data, we proposed to accept the recommendations of the Nuclear Medicine Task Force, which would result in a complete reconfiguration of APCs 290, 291, and 292. Although the reconfiguration would create violations of the 2 times rule, we agree with the Task Force that the reconfigured APCs are more clinically coherent. We note that APCs 290, 291, and 292 as currently configured would also violate the 2 times rule. Therefore, we solicited comments on the proposed reconfiguration of APCs 290, 291, and 292 and on alternative groupings that would achieve clinical coherence without violating the 2 times rule.

APC 274: Myleography
APC 179: Urinary Incontinence Procedures
APC 182: Insertion of Penile Prosthesis
APC 19: Level I Excision/Biopsy
APC 20: Level II Excision/Biopsy
APC 21: Level IV Excision/Biopsy
APC 22: Level V Excision/Biopsy
PC 694: Level III Excision/Biopsy

Based on 2001 claims data, we proposed to move several codes from APC 19 to APC 20 and several codes from ACP 20 to APC 21. Additionally, we proposed to move CPT codes 11770, 54105, and 60512 to APC 22. We also proposed to move CPT code 58999 to APC 191 and CPT code 37799 to APC 35. These changes would result in clinically coherent APCs that do not violate the 2 times rule.

APC 24: Level I Skin Repair
APC 25: Level II Skin Repair
APC 26: Level III Skin Repair
APC 27: Level IV Skin Repair
APC 686: Level V Skin Repair

Based on 2001 claims data, we proposed to move CPT code 43870 from APC 0025 to APC 141; and CPT codes with high costs from APC 26 to APC 27. We also proposed to move the codes remaining in APC 26 to APC 25. APC 26 would then be deleted. These changes would result in a more compact APC structure without compromising the clinical homogeneity of the reconfigured APCs and without violating the 2 times rule. See Table 1 for the final list of codes to be moved from APC 26 to APC 25 or APC 27.

TABLE 1.—HCPCS CODES TO BE MOVED FROM APC 26 INTO APC 25 OR APC 27

2002 APC 26	2003 APC 25	2003 APC 27
11960		11960
11970		11970
12037	12037	
12047	12047	
12057	12057	
13150	13150	
13160		13160
14000		14000
14001		14001

TABLE 1.—HCPCS CODES TO BE MOVED FROM APC 26 INTO APC 25 OR APC 27—Continued

2002 APC 26	2003 APC 25	2003 APC 27
14020		14020
14021		14021
14040		14040
14041		14041
14060		14060
14061		14061
14300		14300
14350		14350
15000	15000	
15001	15001	
15050	15050	
15101		15101
15120		15120
15121		15121
15200		15200
15201	15201	
15220		15220
15221	15221	
15240		15240
15241	15241	
15260		15260
15261	15261	
15351		15351
15400	15400	
15401	15401	
15570		15570
15572		15572
15574		15574
15576		15576
15600		15600
15610		15610
15620		15620
15630		15630
15650		15650
15775	15775	
15776	15776	
15819	15819	
15820		15820
15821		15821
15822		15822
15823		15823
15825		15825
15826		15826
15829		15829
15835	15835	
20101		20101
20102		20102
20910		20910
20912		20912
20920		20920
20922		20922
20926		20926
23921	23921	
25929		25929
33222		33222
33223		33223
44312		44312
44340		44340
15580—Code Deleted		
15625—Code Deleted		

APC 77: Level I Pulmonary Treatment
APC 78: Level II Pulmonary Treatment
APC 251: Level I ENT Procedures
APC 252: Level II ENT Procedures
APC 253: Level III ENT Procedures
APC 254: Level IV ENT Procedures
APC 256: Level V ENT Procedures

Based on 2001 claims data, we proposed to address violations of the 2 times rule by moving CPT codes 40812, 42330, and 21015 from APC 0252 to APC 253 and by moving CPT codes 41120 and 30520 to APC 254.

We are adopting the changes discussed in the proposed rule as final except as noted in our discussion of specific APC changes in section II.B, below.

B. Other Changes Affecting Ambulatory Payment Classification (APC) Assignments

1. 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 statute authorizes the Secretary to 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.

Taking into account the APC changes discussed in relation to the APC panel recommendations in this section of this preamble and the use of 2001 claims data to calculate the median cost of procedures classified to APCs, we reviewed all 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).

We received several comments on this proposal. A summary of these comments and our responses are provided below.

Comment: One commenter recommended that we move CPT code 47556 (Biliary endoscopy with dilation of biliary stricture with stent) from APC 0152 to APC 0153 because its placement in APC 0152 violated the 2 times rule.

Response: We will not make any changes at this time, but we will present this issue to the APC Advisory Panel. We do not use low-volume procedures in determining whether an APC violates the 2 times rule because there is a high potential for miscoding of such procedures and because our cost data is less reliable. The cost data that we do have for CPT 47556 indicates that APC 0152 is appropriate.

Comment: Several commenters thanked us for creating a separate APC for Computed Tomographic Angiography (CTA) but requested that we not use claims data to develop a payment rate. These commenters asserted that our claims data was faulty because hospitals had not developed specific charges for CTA and were using charges for other Computed Tomography (CT) when billing for CTA. They recommended that we use either the relative ratio of charges from hospitals that billed CTA at a higher rate than CT and use that ratio to determine a payment rate for CTA, or use a proxy model that the commenter had developed.

Response: Our payment rates for CT and CTA are different and our claims data indicates that CTA costs more than CT. Using claims data only from hospitals that charge more for CTA than CT is inappropriate, and the proxy model has not been validated. Therefore, we will update our payment for CTA next year based on 2002 claims data.

Table 2 contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally accepted 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.

The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http://www.cms.hhs.gov.*

TABLE 2.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE

APC	Description
0012	Level I Debridement & Destruction
0019	Level I Excision/ Biopsy
0020	Level II Excision/ Biopsy
0025	Level II Skin Repair
0032	Insertion of Central Venous/Arterial Catheter
0043	Closed Treatment Fracture Finger/ Toe/Trunk
0046	Open/Percutaneous Treatment Fracture or Dislocation

TABLE 2.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE—Continued

APC	Description
0058	Level I Strapping and Cast Application
0074	Level IV Endoscopy Upper Airway
0080	Diagnostic Cardiac Catheterization
0081	Non-Coronary Angioplasty or Atherectomy
0093	Vascular Repair/Fistula Construction
0097	Cardiac and Ambulatory Blood Pressure Monitoring
0099	Electrocardiograms
0103	Miscellaneous Vascular Procedures
0105	Revision/Removal of Pacemakers, AICD, or Vascular
0121	Level I Tube changes and Repositioning
0140	Esophageal Dilation without Endoscopy
0147	Level II Sigmoidoscopy
0148	Level I Anal/Rectal Procedure
0155	Level II Anal/Rectal Procedure
0165	Level III Urinary and Anal Procedures
0170	Dialysis
0179	Urinary Incontinence Procedures
0191	Level I Female Reproductive Proc
0192	Level IV Female Reproductive Proc
0203	Level VI Nerve Injections
0204	Level I Nerve Injections
0207	Level III Nerve Injection
0218	Level II Nerve and Muscle Tests
0225	Implantation of Neurostimulator Electrodes
0230	Level I Eye Tests & Treatments
0231	Level III Eye Tests & Treatments
0233	Level II Anterior Segment Eye Procedures
0235	Level I Posterior Segment Eye Procedures
0238	Level I Repair and Plastic Eye Procedures
0239	Level II Repair and Plastic Eye Procedures
0252	Level II ENT Procedures
0260	Level I Plain Film Except Teeth
0274	Myelography
0286	Myocardial Scans
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
0294	Level I Therapeutic Nuclear Medicine
0297	Level II Therapeutic Radiologic Procedures
0303	Treatment Device Construction
0304	Level I Therapeutic Radiation Treatment Preparation
0330	Dental Procedures
0345	Level I Transfusion Laboratory Procedures
0354	Administration of Influenza/Pneumonia Vaccine
0356	Level II Immunizations
0367	Level I Pulmonary Test
0368	Level II Pulmonary Tests
0370	Allergy Tests
0373	Neuropsychological Testing
0600	Low Level Clinic Visits

TABLE 2.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE—Continued

APC	Description
0602	High Level Clinic Visits
0660	Level III Otorhinolaryngologic Function Tests
0692	Electronic Analysis of Neurostimulator Pulse Generators
0694	Mohs Surgery
0698	Level II Eye Tests & Treatments

2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule, we made final our proposal to change the period of time during which a service may be paid under a new technology APC (66 FR 59903), initially established in the April 7, 2000 final rule. That is, beginning in 2002, we will retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

Effective in 2003, we will move several procedures from new technology APCs to clinical APCs. Those procedures and the clinical APCs to which we are assigning the procedures for payment in 2003 are identified in Table 3. Based upon our review of the 2001 outpatient prospective payment system (OPPS) claims data, we believe that we have sufficient information upon which to base assignment of these procedures to clinical APCs. In making this determination, we reviewed both single and multiple procedure claims. In the proposed rule at 67 FR 52103, we discuss the procedures that we followed to make this determination. In some cases we proposed classification of a new technology procedure in an APC with procedures that are similar both clinically and in terms of resource consumption. In other cases, we proposed to create a new APC for a new technology procedure because we do not believe any of the existing APCs contain procedures that are clinically similar and similar in terms of resource consumption. We solicited comments on our proposed reassignment of the new technology procedures listed in Table 3 of the proposed rule (67 FR 52103–52104).

We received several comments on this proposal which are summarized below.

Comment: Several commenters brought to our attention that, as a result of moving codes for proton beam radiation therapy out of APC 0710 and APC 0712 (new technology codes) and into APC 0664 (Proton beam radiation therapy), simple treatments would receive a higher payment while intermediate and complex treatments would receive a lower payment. Commenters requested that these codes remain in APCs 0710 and 0712 or be split into separate APCs.

Response: We thank the commenters for bringing this to our attention, and we agree that codes for simple proton beam radiation therapy (CPT 77522 and CPT 77520) should be placed in a different APC than codes for intermediate (CPT 77523) and complex (CPT 77525) radiation therapy. However, it would be inappropriate to return these codes to their previous new technology APCs (0712 and 0712) due to our having sufficient claims data to place them in their own APCs. Therefore, we will place codes for simple radiation therapy (CPTs 77522 and 77520) in APC 0664 and codes for intermediate (CPT 77523) and complex (CPT 77525) therapy in the newly created APC 0650.

Comment: Numerous commenters expressed concern over the movement of HCPC G0173 (Stereo radiosurgery, complete) from APC 0721 (New Technology Level XV $5,000–$6,000) to APC 0663 (Stereotactic radiosurgery), resulting in lower payment. Commenters requested that HCPCS G0173 be returned to APC 0721 (New Technology Level XV $5,000–$6,000) because our current data includes both linear accelerator and multi source treatments.

Response: We agree with commenters and have returned HCPC G0173 (Stereotactic radiosurgery, complete) to APC 0721 (New Technology Level XV $5,000–$6,000). We will review our claims data for next year's proposed rule to determine appropriate placement for all stereotactic radiosurgery procedures.

Comment: Many commenters brought to our attention that G0251 (Stereotactic radiotherapy, multisession) was erroneously omitted from the proposed rule. Commenters asserted that G0251 differs substantially from G0173 and G0243, and they requested that G0251 be reinstated and placed in an APC that pays more than APC 0721 (New Technology Level XV $5,000–$6,000).

Response: We thank the commenters for bringing this to our attention, and we agree that the elimination of G0251 in the proposed rule was in error. However, we do not agree with the

placement of G0251 in an APC that pays more than APC 0721 (New Technology Level XV $5,000–$6,000). Although there are significant fixed costs for all stereotactic radiosurgery procedures, our review of cost data does not show that our current APC assignment for G0251 (APC 713) is inappropriate. We will review the APC assignments for all stereotactic radiosurgery procedures next year when we have 2002 claims data available.

Comment: A commenter expressed concern over the bundling of payments for CPT 77370 (Special medical radiation physics consultation) and CPT 77336 (Continuing medical physics consultation) into code G0242 (Multisource photon stereotactic plan) based on the understanding that G0242 is unrelated to CPT 77370 and CPT 77336. The commenter requested that CPT 77370 and CPT 77336 be unbundled from G0242.

Response: We want hospitals to bill all resources associated with G0242 in one code. G0242 includes the work of a physicist and other staff, therefore it is appropriate that the resources used for CPT 77370 and CPT 77336 remain bundled with G0242. Separate payment for 77370 and 77336 would result in duplicate payment.

Comment: Many commenters expressed concern that FDG PET procedures are moving to a new clinical APC 0667 (Nonmyocardial positron emission tomography) with a payment of $971—a reduction of $404. The commenters asserted that although the proposed rule would continue separate pass-through payment for FDG (in APC 1775), the proposed new payment would not cover the cost of the PET procedure and would undermine access to care.

Response: We agree that our claims data may not accurately reflect the cost of FDG PET procedures.

On June 29, 2001, CMS announced its intention to issue a national coverage determination (NCD) limiting the type of technology that can be used to perform Medicare-covered PET scans. This NCD became effective January 1, 2002. We believe that our claims data includes a significant number of PET scans performed on coincidence cameras that are no longer covered by Medicare. This could have the effect of lowering the median cost as compared to our future claims data that will reflect (due to the NCD) only the use of full-ring or partial-ring PET scanners. For this reason, until we are confident that our claims data reflects the predominant use of dedicated PET scanners, we will continue to pay for FDG PET in APC 714 (New Technology—Level IX $1250–$1500) until further review of claims data for the 2004 final rule.

Comment: A commenter expressed concern about our proposal to reassign digital mammography from New Technology APC 0707 to a clinical APC (0699). Commenters recommended that we retain the assignment to New Technology APC 0707 for 1 more year until further data analysis can be performed.

Response: We disagree with the commenter. Hospitals billed for approximately 7,000 occurrences of digital mammography in 2001, providing us with sufficient data upon which to calculate a median cost.

New Technology APC Issues

Comment: A manufacturer was pleased that we designated endometrial cryoablation as eligible for new technology service APC payment, but was displeased at the delay in reaching our decision as well as the specific new technology service APC in which the service was placed. We proposed to place endometrial cryoablation into new technology service APC 980, which has a payment rate of $1,875. The commenter contended that endometrial cryoablation has similar resource costs as cryoablation of the prostate and should be assigned to new technology service APC 984, at $4,250, which would cover the cost of a cryoablation probe also. It provided a brief cost analysis from a single major medical center.

Response: We assigned endometrial cryoablation into new technology service APC 980 based on cost data submitted.

New Technology APC for Preview Planning Software

Comment: A manufacturer commented on our proposal to reassign the procedure related to Preview Treatment Planning Software (C9708) from its current APC 975, which pays $625, to APC 973, which pays $250. The manufacturer of Preview asserted that its sales records, which it provided, demonstrate that the cost to hospitals of providing Preview support the assignment of APC 975. It contended that we must have based the new APC assignment on faulty claims data.

Response: For the final rule, we had access to a larger number of claims for C9708, and we have moved it back to APC 975.

Comment: A manufacturer was pleased that we designated endometrial cryoablation as eligible for new technology service APC payment, but was displeased at the delay in reaching our decision as well as the specific new technology service APC in which the service was placed. We proposed to place endometrial cryoablation into new technology service APC 980, which has a payment rate of $1,875. The commenter contended that endometrial cryoablation has similar resource costs as cryoablation of the prostate and should be assigned to new technology service APC 984, at $4,250, which would cover the cost of a cryoablation probe also. It provided a brief cost analysis from a single major medical center.

Response: We assigned endometrial cryoablation into new technology service APC 980 based on cost data submitted.

Table 3 below is the final list of Healthcare Common Procedure Coding System (HCPCS) reassignments of new technology procedures.

TABLE 3.—CHANGES IN HCPCS ASSIGNMENTS FROM NEW TECHNOLOGY APCS TO PROCEDURE APCS FOR 2003

HCPCS	Description	2002 SI	2003 SI	2002 APC	2003 APC
19103	Bx breast precut w/device	S	T	0710	0658
33282	Implant pat-active ht record	S	S	0710	0680
36550	Declot vascular device	T	T	0972	0677
53850	Prostatic microwave thermotx	T	T	0982	0675
53852	Prostatic rf thermotx	T	T	0982	0675
55873	Cryoablate prostate	T	T	0982	0674
76075	Dual energy x-ray study	S	S	0707	0288
76076	Dual energy x-ray study	S	S	0707	0665
77520	Proton trmt, simple w/o comp	S	S	0710	0664
77522	Proton trmt, simple w/comp	S	S	0710	0664

TABLE 3.—CHANGES IN HCPCS ASSIGNMENTS FROM NEW TECHNOLOGY APCS TO PROCEDURE APCS FOR 2003—Continued

HCPCS	Description	2002 SI	2003 SI	2002 APC	2003 APC
77523	Proton trmt, intermediate	S	S	0712	0664
77525	Proton treatment, complex	S	S	0712	0664
92586	Auditor evoke potent, limit	S	S	0707	0218
95965	Meg, spontaneous	T	S	0972	0717
95966	Meg, evoked, single	T	S	0972	0714
95967	Meg, evoked, each addl	T	S	0972	0712
C1300	Hyperbaric oxygen	S	S	0707	0659
C9708	Preview Tx Planning Software	T	T	0975	0973
G0125	PET img WhBD sgl pulm ring	T	S	0976	0667
G0166	Extrnl counterpulse, per tx	T	T	0972	0678
G0168	Wound closure by adhesive	T	X	0970	0340
G0173	Stereo radoisurgery, complete	S	S	0721	0663
G0204	Diagnostic mammography digital	S	S	0707	0669
G0206	Diagnostic mammography digital	S	S	0707	0669
G0210	PET img whbd ring dxlung ca	S	S	0714	0667
G0211	PET img whbd ring init lung	S	S	0714	0667
G0212	PET img whbd ring restag lun	S	S	0714	0667
G0213	PET img whbd ring dx colorec	S	S	0714	0667
G0214	PET img whbd ring init colre	S	S	0714	0667
G0215	PET img whbd restag col	S	S	0714	0667
G0216	PET img whbd ring dx melanom	S	S	0714	0667
G0217	PET img whbd ring init melan	S	S	0714	0667
G0218	PET img whbd ring restag mel	S	S	0714	0667
G0220	PET img whbd ring dx lymphom	S	S	0714	0667
G0221	PET img whbd ring init lymph	S	S	0714	0667
G0222	PET img whbd ring resta lymp	S	S	0714	0667
G0223	PET img whbd reg ring dx hea	S	S	0714	0667
G0224	PET img whbd reg ring ini hea	S	S	0714	0667
G0225	PET img whbd ring restag hea	S	S	0714	0667
G0226	PET img whbd dx esophag	S	S	0714	0667
G0227	PET img whbd ring ini esopha	S	S	0714	0667
G0228	PET img whbd ring restg esop	S	S	0714	0667
G0229	PET img metabolic brain ring	S	S	0714	0667
G0230	PET myocard viability ring	S	S	0714	0667
G0231	PET WhBD colorec; gamma cam	S	S	0714	0667
G0232	PET WhBD lymphoma; gamma cam	S	S	0714	0667
G0233	PET WhBD melanoma; gamma cam	S	S	0714	0667
G0234	PET WhBD pulm nod, gamma cam	S	S	0714	0667

3. APC Assignment for New Codes Created During Calendar Year (CY) 2002 and Selected Codes and APC Assignments for 2003

During CY 2002, we created several HCPCS codes to describe services newly covered by Medicare and payable under the hospital OPPS. While we have assigned these services to APCs for CY 2002, we opened the assignments to public comment in the proposed rule. In addition, in the proposed rule, we proposed to create several new HCPCS codes and APC assignments with an effective date of January 1, 2003 and we solicited comments on these proposed codes and proposed APC assignments. Table 4 below includes new procedural HCPCS codes either created for implementation in July 2002, which we intend to implement in October 2002, or which we will implement in January 2003.

Table 4 does not include new codes for drugs and devices for which we established or intend to establish pass-through payment eligibility in July or October 2002.

TABLE 4.—NEW G CODES FOR 2002 AND 2003 FOR WHICH THERE ARE FINAL APC ASSIGNMENTS

Code	Long descriptor	Effective	Final APC	SI
G0245	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: 1. The diagnosis of LOPS, 2. A patient history, 3. A physical examination that consists of at least the following elements: (a) Visual inspection of the forefoot, hindfoot, and toe web spaces, (b) Evaluation of a protective sensation, (c) Evaluation of foot structure and biomechanics, (d) Evaluation of vascular status and skin integrity, and (e) Evaluation and recommendation of footwear. 4. Patient education.	7/1/2002	0600	V

TABLE 4.—NEW G CODES FOR 2002 AND 2003 FOR WHICH THERE ARE FINAL APC ASSIGNMENTS—Continued

Code	Long descriptor	Effective	Final APC	SI
G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS to include at least the following: 1. A patient history. 2. A physical examination that includes: (a) Visual inspection of the forefoot, hindfoot, and toe web spaces, (b) Evaluation of protective sensation, (c) Evaluation of foot structure and biomechanics, (d) Evaluation of vascular status and skin integrity, and (e) Evaluation and recommendation of footwear. 3. Patient education.	7/1/2002	0600	V
G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails.	7/1/2002	0009	T
G0248	Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing.	7/1/2002	0708	S
G0249	Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.	7/1/2002	0708	S
G0250	Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service).	7/1/2002	N/A	E
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes).	10/1/2002	0714	S
G0253	PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging of local regional recurrence or distant metastases (i.e., staging/restaging after or prior to course of treatment).	10/1/2002	0714	S
G0254	PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment.	10/1/2002	0714	S
G0255	Current perception threshold/sensory nerve conduction test, (sNCT) per limb, any nerve	10/1/2002	N/A	E
G0258	Intravenous infusion during separately payable observation stay, per observation stay (must be reported with G0244).	1/1/2003	0340 Deleted with 90-day grace period	X
G0257	Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility.	1/1/2003	0170	S
G0259	Injection procedure for sacroiliac joint; arthrography	1/1/2003	N/A	N
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent and arthrography.	1/1/2003	0204	T
G0256	Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source.	1/1/2003	0649	T
G0261	Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source.	1/1/2003	684	T
G0263	Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.	1/1/2003	N/A	N
G0264	Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.	1/1/2003	0600	S
G0290	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel.	1/1/2003	0656	E
G0291	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.	1/1/2003	0656	E

HCPCS Codes Created During CY 2002

The G codes G0245 through G0250 were created to implement payment for newly covered Medicare services due to national coverage determinations. The G codes G0252–G0255 were established October 1, 2002, as a result of national coverage policies that became effective October 1, 2002. These codes were created to accurately describe the services covered, to ensure that they were reported correctly, to track their utilization, and to establish payment. We solicited comments on the APC assignment of these services. The codes describing evaluation and management services were assigned to clinic visit APCs containing similar services, and the codes describing procedural services were assigned to new technology APCs or to APCs containing procedures requiring similar resource consumption. Because G0250 is a professional service furnished by a physician, it is not payable under OPPS.

We did not receive any comments on the codes or APC assignments for G0245, G0246, G0247, G0248, G0249, G0250, or G0255. Therefore, we are finalizing them as shown.

We are also finalizing APC assignments for G0252, G0253, and G0254. The comments and responses for these services are discussed elsewhere in this preamble.

We implemented HCPCS code G0258 (Intravenous Infusion(s) During Separately Payable Observation Stay)

effective October 1, 2002, to describe infusion therapy given during a separately payable observation stay. We assigned it to APC 0340 because we believed APC 0340 appropriately accounts for the resources used for infusion during observation. As discussed in section X.B, we received many comments opposing creation of this code. Therefore, we will delete it effective January 1, 2003.

New HCPCS Codes for January 1, 2003, for Which We Proposed APC Assignments in the August 9, 2002 Proposed Rule

In the August 9, 2002, proposed rule, we proposed to create several new HCPCS codes for 2003 to address issues that have come to our attention, to describe new technology procedures, to implement policy proposals discussed in the rule, and to allow more appropriate reporting of procedures currently described by (physician's) current procedural terminology (CPT) (HCPCS Level I) codes. The codes we proposed are as follows:

(1) G0FFF—Bone Marrow Aspiration and Biopsy Services—we proposed to create this code to describe bone marrow aspiration and biopsy performed through the same incision. We proposed to place this code in APC 0003. This code also appears in the proposed rule for the physician fee schedule, published in the June 28, 2002, issue of the **Federal Register** (67 FR 43846). This code would facilitate proper reporting of this procedure.

As discussed under general comments and responses below, we received many comments that objected to the proliferation of G codes for the services for which the CPT or HCPCS level II process could be used to create a code. After review of the comments, we agree that this code should go through the CPT process. Therefore, we have not implemented the G code we proposed. We will instead, submit a code for ''Bone Marrow Biopsy and Aspiration Performed in the Same Bone'' to CPT in time for the 2004 CPT code cycle.

(2) G0257—Unscheduled and Emergency Treatment for ESRD Patients—we proposed this code to facilitate payment for dialysis provided to ESRD patients in the outpatient department of a hospital that does not have a certified ESRD facility. The comments, responses, and final action regarding these services are discussed in section X.F of this rule.

(3) G0259 and G0260—Sacroiliac Joint Injections—we proposed to create these two codes to replace CPT code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid. CPT code 27096 describes two distinct procedures requiring different resource consumption. Moreover, our policy of packaging injection procedures for imaging required packaging of this procedure even when it was used to report injection of a steroid or anesthetic. In these cases, it was appropriately billed without another procedure and should have been payable. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096, we proposed to create G0259, Injection procedure for sacroiliac joint, arthrography, and G0260, Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid. We proposed to give G0259 status indicator N, and we proposed to assign G0260 to APC 0204.

Comment: Many commenters raised concern over nonpayment for sacroiliac joint injections. The commenter brings to our attention that when a sacroiliac joint injection, CPT code 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid), is performed for anesthetic/steroid purposes, the procedure is not being paid since the costs are only packaged into the arthrography imaging component.

Response: We appreciate this concern and agree with the commenter that payment should be made for sacroiliac joint injections when administered for anesthetic/steroid purposes. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid), we have created the following new G-codes to replace CPT code 27096: G0259 (Injection procedure for sacroiliac joint, arthrography) and G0260 (Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid). G0259 has been given status indicator N, and G0260 has been assigned to APC 0204.

(4) G0KKK—Prostate Brachytherapy—we proposed this code to implement our policy decision discussed in section III.C.3 of the proposed rule (section IV.E of this rule). As a result of comments we created two new codes G0256 and G0261. See section IV.E. for the discussion of prostate brachytherapy.

(5) G0263 and G0264—Observation Care—we proposed to create these codes to describe observation care provided to a patient who is directly admitted from a physician's office to a hospital for observation care. We discussed these codes in detail in section VIII.B of the proposed rule. Our discussion of the final action, comments, and responses is contained in section X.B of this rule.

(6) G0290, G0291; Drug Eluting Stents—We discuss these codes in the immediately following section.

Drug-Eluting Stents

In the August 9, 2002 proposed rule, we discussed the exceptional circumstances that led us to propose a departure from our standard OPPS payment methodology as we have done under the inpatient PPS for Federal fiscal year (FY) 2003 (67 FR 50003–50005). We made this unusual proposal to ensure consistent payment for drug-eluting stents in both the inpatient and outpatient settings; to ensure that hospital resources are not negatively affected by a sudden surge in demand for this new technology if FDA approval is received; and to ensure that Medicare payment does not impede beneficiary access to what appears to be a potentially landmark advance in the treatment of coronary disease. Consistent with the special approach we implemented in the inpatient PPS final rule, we proposed to create two new HCPCS codes and a new APC that may be used to pay for the insertion of coronary artery drug-eluting stents under the OPPS to be effective if these stents receive FDA approval for general use. Of course, as with other new procedures, FDA approval does not mean that Medicare will always cover the approved item. Medicare coverage depends upon whether an item or service is medically necessary to treat an illness or injury as determined by Medicare contractors based on the specifics of individual cases.

The new HCPCS codes that we proposed are as follows:

G0290—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

G0291—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel

We proposed to assign G0290 and G0291 to new APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, with a status indicator of T.

To establish a payment amount for the proposed new APC, we proposed to apply the same assumptions that we used in establishing the weights for diagnosis-related group (DRG) 526 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI) and DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI) as described in the final

rule implementing the FY 2003 inpatient PPS. That is, we assume a price differential of approximately $1,200 when drug-eluting stents are used. We assumed an average of 1.5 stents per procedure, and we proposed to add $1,200 to the median costs established for APC 0104 based on 2001 claims data to determine the payment rate for APC 656. We proposed to calculate a relative payment weight and payment rate for APC 0656 in accordance with the methodology that we discuss in section III.B. of this preamble.

We proposed to implement payment under APC 0656 effective April 1, 2003, consistent with the effective date for implementation of the drug-eluting DRGs under the OPPS and contingent upon FDA approval by that date. If the FDA grants approval prior to April 1, 2003, hospitals would be paid for insertion of coronary artery drug-eluting stents under APC 104. Such claims may qualify for outlier payments.

We proposed to establish the new HCPCS codes and APC group for coronary artery drug-eluting stents to allow close tracking of the utilization and costs associated with these services. In the proposed rule, we invited comments on this proposed methodology for recognizing the additional costs of drug-eluting stents under the OPPS.

Comment: All of the commenters who addressed our payment proposal for drug-eluting stents supported our taking proactive steps to create an APC for this new technology in anticipation of FDA approval by April 2003. However, most of the commenters expressed concern about the level of payment proposed for APC 656, stating that $1,200 significantly understates the added cost of the drug-eluting stents. One commenter suggested that indications from the market are projecting a cost of $2,000 per stent. Another commenter cited vendors who indicate that drug-eluting stents will cost 3 times the cost of the current stent for an approximate cost of $3,360 each. Several commenters stated that the incremental cost between a bare metal and a drug-eluting stent is expected to be $2,000. Two commenters urged us to set the rate for APC 656 based on the actual price difference between the current and drug-eluting stents, and one commenter recommended setting the initial payment amount at a level that is 60 percent above the probable hospital acquisition cost. One commenter asked why we added $1,200 to APC 656 rather than $1,800. The basis for this request was that the incremental payment for inpatient care was $1,800 for an average of 1.5 stents per procedure.

Response: To establish a payment rate for APC 656, we proposed to add $1,200 to the median cost of stent insertion procedures in APC 104, based on assumptions that we applied to establish the weights for DRGs involving drug-eluting stents under the inpatient PPS. Based on the median cost established for APC 104 using the 2001 claims data that were reflected in the August 9, 2002 proposed rates, we determined that an additional $1,200 would offset the incremental cost of an average of 1.5 drug-eluting stents per procedure.

We do not agree that the incremental payment should be $1,800. Although it is true that 1.5 stents are typically placed per procedure, it is rare for two stents to be placed in one coronary artery in an outpatient setting. Furthermore, hospitals can bill under the OPPS a separate code for each vessel in which a stent is placed, unlike the inpatient PPS. Because hospitals will in most cases be able to report each stent placement separately in the outpatient setting, making an incremental payment of $1800 would significantly overpay for each stent.

As we explain elsewhere in this preamble, the payment rates that this final rule implements are based on more current data than those that were available when we set the rates proposed in the August 9, 2002 rule. The rates in this final rule also reflect adjustments intended to level the transition from rates based on pre-OPPS data and estimated pass-through device and drug costs to rates based entirely on OPPS data that reflect actual device and drug costs reported by hospitals.

Comment: One commenter expressed concern about our expectation that a new technology must ''transform'' medical care and be the object of substantial demand in order to justify making an exception to our standard OPPS payment methodology. The commenter believes that our rationale for making an exception for drug-eluting stents establishes an almost unattainable threshold for other technologies to reach in order to receive similar treatment in the future. Conversely, another commenter expressed concern that by establishing codes and payment rates for drug-eluting stents, we are setting a precedent that will likely increase the pressure to create new temporary codes for non-breakthrough technologies. This commenter encouraged us to maintain highly selective criteria when creating new codes for new technologies in the future.

Response: As we explain at length in the August 9, 2002 proposed rule, we believe that drug-eluting stents are potentially a revolutionary approach to the treatment of coronary disease. Ordinarily, we would expect a new technology like the drug-eluting stent to qualify for a pass-through payment or for payment under a new technology APC.

However, because the drug-eluting stent does not meet the criteria established for these two methods of payment for new technology under the OPPS, we were compelled to seek an alternative approach in order to ensure beneficiary access to this extraordinary new treatment, once it receives FDA approval, without placing an extraordinary burden on hospital resources. We expect that either a pass-through payment or assignment to a new technology APC will, in the overwhelming preponderance of cases, provide adequate and timely payment under the OPPS for new technology. We agree with the commenter who supported maintaining highly selective standards when establishing codes for new technology. The threshold for such an approach must be exceptionally high and applicable only in the most extraordinary and unusual cases.

Comment: One commenter asked that we clarify how we will adjust the 2003 OPPS payment rates if FDA approval is not given for drug-eluting stents by April 1, 2003. The commenter is concerned about the adverse effect on the rates for other services that would result from our having recalibrated and scaled the relative payment weights for all services, taking into account additional payment for drug-eluting stents that turns out not to be an expenditure.

Response: We have reviewed the impact of the drug-eluting stents on the total recalibration exercise and determined that excluding the additional allowance for the drug-eluting stents would not result in a significant redistribution of funds for other services if FDA approval were not issued by April 1, 2003, triggering payment under the OPPS. We estimated that slightly fewer than one-third of the cases paid under APC 104 (approximately 5,400 procedures) would be performed using drug-eluting stents during the three quarters of 2003 when payment would be made for APC 656, assuming FDA approval is issued by April 1, 2003. Payment for the use of drug-eluting stents represents approximately 0.17 percent of the total APC weights. Restoration of these payments to the pool of weights for other services would not measurably

change the weights of the other APCs. Therefore, we would not revise the 2003 APC weights if payment for drug-eluting stents were not allowed beginning April 1, 2003.

Comment: One commenter expressed concern that the general use of data from other countries to set the national payment rate for a new device in the absence of hospital claims and cost data raises long term issues regarding the impact this approach would have on manufacturers' investment and pricing strategies, both abroad and in the United States. The commenter recommended that we consider these issues in more depth.

Response: We respond to this issue in our discussion of MedPAC comments in section XI.

Comment: One commenter recommended that we carefully monitor the use of APCs for which the national payment rate is established based on pricing in countries other than the United States and the costs reported by hospitals for those APCs. Another commenter stated that the new HCPCS codes for the drug-eluting stent procedures should be temporary and that we should ask the CPT Editorial Board to develop national CPT codes as soon as possible.

Response: As we indicated in the August 9, 2002 proposed rule, we intend to closely track the utilization and costs associated with the drug-eluting stents. We established the G-codes for the use of drug-eluting stents precisely in order to permit us to collect these data. However, the cost data taken from hospital claims associated with the use of the drug-eluting stents will ultimately be incorporated into the current CPT codes for coronary stent placement. We believe that the current CPT codes describe the procedure adequately and that separate permanent codes specific to the use of drug-eluting stents are not necessary based on the expectation that drug-eluting stents will eventually become the standard of care.

Effective for services furnished on or after April 1, 2003, contingent upon FDA approval of the drug-eluting stents, we are implementing payment under APC 656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two temporary HCPCS codes:

G0290 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel.

G0291 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.

Note that Table 6 and Addendum B show status indicator E for HCPCS codes G0290 and G0291 since payment under these codes will not be effective before April 1, 2001. However, we include the APC for drug eluting stent procedures (APC 0656) in Addendum A with the payment rate and status indicator of T to identify how these new codes will be paid once they are implemented.

If the FDA grants approval before April 1, 2003, hospitals will be paid for placement of drug-eluting stents under APC 104. If the FDA does not grant approval by April 1, 2003, we will announce a new effective date for APC 0656 and for HCPCS codes G0290 and G0291 by Program Memorandum.

G codes for Outpatient Services Under National Clinical Trials

We have created three new G codes for use in reporting services furnished in hospital outpatient departments under national clinical trials: G0292 Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day.

G0293 Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day.

G0294 Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.

On September 19, 2000, Medicare issued a national coverage decision stating that Medicare will pay for the routine costs of clinical trials. This policy is published as section 30–1 of Medicare's Coverage Issues Manual. Because the experimental intervention is not covered but items and services required solely because of the intervention are covered, we needed to identify ways to properly code for and pay for the routine costs when delivered in a hospital outpatient department.

We believe that to accurately pay for the covered services associated with the administration of drugs as part of a clinical trial, we need to create a new code to allow for correct billing and payment for routine costs, as defined by the national coverage determination. Therefore, the code G0292, ''Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day,'' should be billed when only experimental drugs are administered as part of a Medicare qualifying clinical trial. When an experimental drug is being administered in conjunction with payable drugs or on the same day as payable drugs, G0292 should not be used. Instead, the appropriate drug administration code should be billed.

There are also procedures that may be performed in the hospital outpatient department as part of a qualifying clinical trial. Because the intervention is not covered under Medicare's clinical trial policy, we need a mechanism to pay the hospital for its covered fixed costs associated with providing the service under the clinical trial. We have created two codes to allow for correct billing of procedures performed as the focus of qualifying clinical trials, G0293 and G0294. G0293 is defined as ''Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day,'' and G0294 is defined as ''Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.''

All three of these codes are for OPPS use only. Other provider types may not bill these codes.

The interim APC assignments for G0292, G0293, and G0294 are APC 0708, 0710, and 0707, respectively. The status indicator for these three codes is S. As discussed below, this APC assignment is subject to comment during the comment period discussed in section I of this rule.

General comments on creation and use of G codes

Comment: Several commenters were concerned about the creation of G codes with long descriptors that appear complex and specific to OPPS rules. In addition, we received comments indicating that the hospital coding community was less familiar with G codes and requesting that CMS consider other existing code sets.

Response: Prior to the creation of any G code, we examine alternative mechanisms for implementing coverage and payment policy in a timely fashion. In the event no other appropriate mechanism exists, we create a G code to allow accurate payment given applicable statutory and regulatory requirements. After the creation of a G code, we work with the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel whenever possible to create a replacement CPT code. We are deleting 25 G codes this year as a result of this process. However, there are instances

where G codes cannot be converted to CPT codes due to the unique nature of the statutory and regulatory requirements. In these situations, we work to educate the provider community as to the appropriate use of these codes. Part of this educational effort includes the development of comprehensive descriptors at the time the G code is created.

Comment: Two commenters indicated they would like to see a shorter timeframe between the FDA approval for a new drug and the development of a HCPCS code for that drug.

Response: The FDA approval process is one source of information we use in reviewing new drugs. However, the FDA process does not address the statutory and regulatory requirements of the Medicare program. We perform our review of new drugs as expeditiously as possible given these requirements. We are conscious of the need to streamline this process and we will continue to seek ways to do so.

Public Comments on Interim APC Assignments for Codes New for 2003

As discussed in section I, we are accepting public comment on the interim APC assignments for the new codes shown in Addendum A with the indicator NI. These codes are new for 2003 and the APC assignment was not subjected to public comment in the August 9, 2002 proposed rule. We are not accepting comment on APC assignments that were proposed in the August 9, 2002 proposed rule and are being shown as NF in Addendum B since they have already been subjected to public comment and are made final in this rule.

Comment: Several commenters expressed concern about the increasing frequency of G codes issued by CMS. Commenters asserted that, in the interest of coding standardization, clarity, and accuracy, G codes should be developed only as a last resort. Commenters also stated that G codes sometimes overlap or duplicate other code sets. One commenter recommended a single, standardized process for establishment of temporary HCPCS Level II codes, ensuring that a duplicate or overlapping code is not anticipated in another coding set (for example, CPT).

Response: We agree that, where appropriate, G codes should be temporary. Unfortunately, it is sometimes necessary to develop G codes to accommodate changes in legislation, regulation, coverage, and payment policy. Not only is the timetable for such changes inconsistent with the timetable for CPT publication, but frequently these changes must be made on a quarterly basis.

In 2002, CMS and CPT staff, working together, reviewed all existing G codes and agreed to transition over 20 of them to CPT codes. Therefore, for 2003 many G codes will be deleted in favor of newly created CPT codes. We believe that an annual review of G codes by CMS and CPT staff is the best way to determine which G codes should be transitioned to CPT codes and the process to use for such a transition. Therefore, we plan to continue working with CPT staff on an annual basis to continue transitioning existing G codes to CPT codes. We believe such an annual, comprehensive review will address the commenters' concerns. However, we do wish to emphasize that CMS, where appropriate, does consult with interested providers prior to the creation of G codes in order to facilitate coding clarity and minimize the coding burden on hospitals.

4. Other Public Comments on APC Assignments and Payment Rates

Comment: One commenter asked us to create three new tech APCs for cardiac resynchronization therapy, or, alternatively, to establish a new tech APC payment for placement of the left ventricular lead used in cardiac resynchronization therapy.

Response: We have placed the CPT codes for left ventricular lead placement in new tech APCs. We believe the APC placement accounts for the cost of the procedure and for the lead. The cost of the guidewires and catheters used in the procedure will be captured in the code used to report placement of the pacemaker or cardioverter defibrillator and other leads.

Comment: Several commenters were concerned about bundling payment of radiopharmaceuticals into procedures and about payment reductions for myocardial perfusion scanning.

Response: Payment for most myocardial perfusion scans will increase in 2003 and the payment reduction for scans in APC 666 is commensurate with the costs of performing those procedures. The issue of packaging radiopharmaceuticals is discussed elsewhere in this preamble.

Comment: A commenter expressed concern about CMS's decision to discontinue the pass-through category C1780 (New Technology Intraocular Lens (IOLs)). The commenter stated that the proposal to eliminate this code from pass through status and separate payment contradicts existing regulations.

Response: We do not agree that our proposal contradicts existing regulations. We believe the commenter is referring to § 141 (b) of the Social Security Act Amendments of 1994 (Public Law 103–432) that requires us to implement a process under which interested parties may request a review of the appropriateness of payment for IOLs furnished by ambulatory surgical centers (ASCs). In compliance with this statutory change, we published regulations concerning payment for IOLs in ASCs (42 CFR 416). Those regulations do not apply to the payment for such lenses furnished to patients of hospital outpatient departments. As described elsewhere in the final rule, the cost of IOLs, along with the costs of other sunsetting pass through devices, is reflected in the median cost and thus the payment for the procedures with which IOLs are used.

Comment: A commenter asserted that the current description of HCPCS code J2790 is flawed. According to the commenter, the description of ''1 dose package'' does not accurately describe the two sizes of dosage units available in the marketplace for different indications (50 mcg and 300 mcg). The commenter expressed hope that an application for new HCPCS codes would be approved, and the commenter also requested that we establish separate payment rates for this product based upon the distinction between the two dosages. The commenter noted that current ''Redbook'' average wholesale price (AWP) for the 50 mcg dose is $53.90; for the 300 mcg dose, it is $126.14.

Response: We reviewed the hospital charge data upon which the payment amount for this code must be based. In the absence of separate codes for two different product sizes, we are unable to determine a separate median cost per encounter for the two sizes. We can only base our determination about this product on existing data that represents the current descriptor of this code. We note that, in using the latest set of OPPS claims data available for the final rule, the median cost per encounter of this code was below the $150 threshold. Therefore, this code will be packaged in 2003.

Comment: A commenter requested that we create new HCPCS codes, one for digital-based computer-aided detection (CAD) with screening mammography and one for digital-based CAD with diagnostic mammography.

Response: When the computer-aided detection codes were originally assigned, there was minimal use of CAD in conjunction with direct digital mammography. The current descriptors of both HCPCS G0236 and CPT code 76085 do not explicitly state that these

services can be billed in conjunction with either direct digital images or standard film images converted to digital images for this reason. We agree with the commenter that use of CAD with direct digital images should be reportable. Therefore, we have revised the descriptor of HCPCS code G0236 to include conversion of both direct digital images and standard film images converted to digital images. Additionally, we will request that the CPT editorial panel review the current definition associated with the screening computer-aided detection code (CPT code 76085) for future revision. Until any such revision is made to CPT code 76085, hospitals should use CPT code 76085 for reporting application of CAD to both direct digital screening images and standard film images.

The descriptor for G0236 has been revised to read as follows: digitalization of film radiographic images with computer analysis for lesion detection, or computer analysis of digital mammogram for lesion detection, and further physician review for interpretation, diagnostic mammography (list separately in addition to code for primary procedure). We believe that we have sufficient claims data to use in assigning digital mammography to an APC.

Comment: Several commenters expressed concern over the payment rate reduction for CPT 52353 (Cystoureteroscopy with lithotripsy) in APC 0163 (Level IV Cystourethroscopy and other genitourinary procedures). Commenters also requested that we place CPT 52353 in APC 0169 (Lithotripsy).

Response: Movement of CPT 52353 to APC 0169 would result in APC 0169 no longer being clinically homogenous, therefore CPT 52353 (Cystoureteroscopy with lithotripsy) will remain in APC 0163 (Lithotripsy) with other similar procedures.

Comment: Several commenters brought to our attention that placing CPT 52234 (removal of small tumors) and CPT 52235 (removal of medium tumors) in APC 163 (Level IV Cystourethroscopy) instead of APC 0162 (Level III Cystourethroscopy) would adversely affect the payment rate for APC 0163, which contains several more costly procedures. Furthermore, commenters stated that it seemed illogical for CPT 52234 (removal of small tumors) and CPT 52235 (removal of medium tumors) to be placed in APC 0163 while CPT 52224 (removal of minor tumors) and CPT 52240 (removal of large tumors) were placed in APC 0162 (Level III Cystourethroscopy). These commenters requested that these four codes be placed together in APC 0162 (Level III Cystourethroscopy).

Response: We agree with commenters and have placed CPT codes 52234 and 52235 in APC 0162 (Level III Cystourethroscopy). This result is a significant increase in payment for APC 0163 while maintaining an appropriate payment rate for CPT codes 52234 and 52235.

Comment: A commenter stated that APC 0100 (Cardiac stress tests) carries a proposed payment rate of $69.69, which the commenter believes does not sufficiently cover the cost of CPT 93025 (Microvolt t-wave alternans). The commenter requested that CPT 93025 be assigned to an APC that pays in the $250 range.

Response: CPT 93025 (Microvolt t-wave assessment) is frequently performed simultaneously with CPT 93017 (Cardiovascular stress test) (that is, the patient is placed on a treadmill once and data for the stress test and Microvolt t-wave alternans are obtained simultaneously), achieving significant economies of scale. Therefore we will keep CPT 93025 (Microvolt t-wave assessment) in APC 0100 (Cardiac stress tests). However, we will review this request again next year when we have more claims data for 93025.

Comment: We received several comments urging that CPT 52647 (Laser surgery of prostate) be placed in a higher paying APC than APC 0163 (Level IV Cystourethroscopy and other genitourinary procedures) in order to cover the cost of a new laser source involved in this procedure.

Response: We have significant claims for this procedure. Any costs associated with new technology developed to perform this procedure should be reflected in future claims data, insofar as the new technology is used, and will be reflected in our updated payment rates. Because we have sufficient claims data indicating the appropriate placement of this service is in APC 0163, CPT 52647 (Laser surgery of prostate) will remain in APC 0163.

Comment: A commenter urged that we maintain a separate APC for items currently billed under C1784 (Ocular device, intraoperative, detached retina). The commenter stated that separate coding and payment would ensure that the procedure groupings maintain their clinical homogeneity and remain similar with respect to resource consumption.

Response: We do not agree that a separate APC for items currently billed under C1784 (Ocular device, intraoperative, detached retina) is necessary to maintain clinical homogeneity or to remain similar with respect to resource consumption. Therefore, items currently billed under C1784 will not remain in a separate APC. However, we will present this issue to the Advisory Panel on Ambulatory Payment Classification Groups (the APC Advisory Panel) next year for further review.

Comment: A commenter expressed concern over the movement of CPT 15000 (surgical debridement) from APC 0026 (Level III Skin repair) to APC 0025 (Level II Skin repair) due to the consolidation of these APCs. The commenter believed that if CPT 15000 and CPT 15342 (Cultured skin graft, 25 cm) were placed in the same APC that separate payment would not be made for both procedures.

Response: The commenter is incorrect. Separate payment will be made for both procedures even if they are in the same APC. Because this APC has a status indicator of ''T,'' payment of the full APC amount will be made for the first procedure and 50 percent of the APC amount will be paid for the second procedure. Furthermore, we believe that the codes within APC 0025 are clinically homogeneous and do not violate the 2 times rule. Therefore, we will not move either of these procedures into a different APC.

Comment: Several commenters stated that autonomic nervous system (ANS) services (HCPCS 95921 and 95922) are incongruent with the services grouped in APC 0218. The commenter asserted that ANS tests are more appropriately grouped in APC 0216 when evaluated on the basis of complexity and resources used.

Response: The APC Advisory Panel reviewed this issue and recommended that we move HCPCS 95921 and 95922 to APC 0216 only if our claims data supported such a move. Since our claims data did not support such a move, HCPCS 95921 and 95922 will remain in APC 0218. However, we will present this concern to the APC Advisory Panel again next year.

Comment: A commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341. The commenter asserted that the services within this group cannot be considered comparable with respect to the resources used. The commenter recommended the creation of a new APC titled, ''Miscellaneous Red Blood Cell Tests'' and suggested that the new APC contain the following HCPCS codes: 86880, 86885, 86886, 86900, and 86901.

Response: We do not agree with the commenter's assertion that the skin tests and miscellaneous red blood cell tests in APC 0341 are not comparable with respect to the resources used. However,

we will present this issue to the APC Advisory Panel.

Comment: A commenter asserts that HCPCS 86915 (Bone marrow/stem cell prep) does not fit within APC 346 (Level II Transfusion Laboratory Procedures) and should be moved to the highest paying Transfusion Laboratory Procedures APC 347(Level III Transfusion Laboratory Procedures). Similarly HCPCS 86932 (Frozen blood freeze/thaw) is more properly categorized with its sister codes (HCPCS 86930 and 86931) in APC 347.

Response: We thank the commenter and agree that CPT code 86915 (Bone marrow/stem cell prep) is not appropriately placed in APC 0346 (Level II Transfusion Laboratory Procedures). Therefore, we have moved HCPC 86915 to APC 0110 (Transfusion). This change maintains the clinical homogeneity of APC 110 and allows a more appropriate payment for CPT code 86915. We also agree with the commenter that CPT code 86932 is more appropriately assigned to APC 0347 based on resource consumption; therefore, we have assigned HCPC 86932 to APC 0347.

Comment: Several commenters asserted that the placement of all prosthetic urological procedures and devices in APC 0182 (Insertion of penile prosthesis) does not adequately reflect the difference in cost between inflatable and non-inflatable penile prostheses. These commenters suggested that CPTs 54401, 54405, and 54410 (codes for inflatable penile prosthesis) be separated from CPTs 54400, 54402, and 54416 (codes for insertion of penile prosthesis) and that the status indicator for APCs 0182 (Insertion of penile prosthesis) and 0179 (Insertion of artificial urinary sphincters) be changed from ''T'' to ''S.''

Response: To the extent that no facility specializes in implanting inflatable penile prostheses, the APC payment should, on average, be appropriate. Therefore, we will not make any changes in APC 182 at this time. However, we will present this issue to the APC Advisory Panel next year. In addition, the status indicator for APCs 0182 (Insertion of penile prosthesis) and 0179 (Insertion of artificial urinary sphincters) will remain a ''T.'' These APCs will rarely, if ever, be reported with a higher paying APC and thus rarely subject to reduction.

Comment: Several commenters were concerned about the large reduction in payment for APC 0222 (Implantation of Neurological Device) and APC 0225 (Implantation of Neurostimulator). They suggested that we continue the use of pass through codes or use manufacturer submitted device cost data, or hospital invoice data, to determine payment rates for these procedures. One commenter also suggested creating a new APC specifically to capture the costs of one brand of devices.

Response: We are also concerned about the payment reduction to these APCs (and other APCs) and have taken steps to address these reductions. Such steps are discussed elsewhere in this rule. For these APCs, we developed relative weights using only claims that contained C codes for devices and in addition we limited the absolute payment reduction. Furthermore, because APCs 0022 and 0225 may be billed together, we have changed the status indicator of APC 0225 to ''S.'' This means that APC 0225 will not be subject to a 50 percent reduction in payment when billed with APC 0222. We believe that the measures we have taken should address the concerns of the commenters.

Comment: Several commenters agreed with our proposal to make separate payment for radiological guidance procedures.

Response: We thank these commenters and are finalizing our proposal.

Comment: One commenter, who performs digital reconstruction of computed tomographic angiography images, stated that the claims data upon which we based our proposed payment rate for C9708 was flawed and that we should use other data sources in determining a payment rate for this code.

Response: In developing the final rule, we had access to a larger number of claims for C9708 and have concluded our proposed payment rate was inappropriate. Accordingly, we will not finalize our proposal, and C9708 will continue to be paid in APC 0975.

Comment: One commenter requested that guidance be provided on proper use of codes for strapping and casting (APCs 58 and 59).

Response: We agree with the commenter and will work with appropriate experts to provide such guidance. In view of the similar costs for all of these procedures in our current data, we will combine these two APCs (as we proposed), as this is administratively easier for hospitals.

Comment: One commenter disagreed with our proposal to combine APCs 0043 and 0044, as more work is involved in treating a fractured leg than a fractured toe.

Response: Our claims data indicates that the hospital resources involved in all of these procedures are very similar. Therefore, we are finalizing our proposal.

Comment: One commenter agreed with our moving all procedures in APCs 0144 and 0145 into APC 0147 but disagreed with our moving CPT code 46600 (diagnostic anoscopy) into APC 0340.

Response: We disagree. We had a substantial number of single procedure claims for CPT 46600, and the median cost for CPT 46600 makes it appropriate for placement in APC 0340. We are finalizing our proposal.

Comment: One commenter objected to our placement of impedence cardiography in APC 0099. The commenter stated that even though APC 0099 was clinically homogeneous, the resources required for impedence cardiography were greater than the resources required to perform other procedures in the APC.

Response: We disagree. The resources used for the procedures in this APC are similar, and it is clinically homogeneous. We are not making any changes in this APC at this time.

Comment: One commenter requested that we move CPT code 95955 (EEG during non intracranial surgery) to APC 213 and that we move CPT code 95904 (Sensory nerve conduction) to APC 0218.

Response: We are not making any changes at this time because our claims data indicates that these procedures are appropriately placed. However, we will present these concerns to the APC Advisory Panel.

Comment: One commenter requested that we move CPT code 0009T (Endometrial cryoablation) to APC 0984 because it should have a payment rate similar to prostate cryoablation (CPT code 55873).

Response: We have placed CPT code 0009T in APC 0980. Based on the information that we have reviewed, we believe that is an appropriate assignment. CPT 0009T is a significantly shorter procedure than CPT 55873 and requires the use of fewer resources. The main cost of CPT 0009T is a disposable probe, the cost of which is appropriately accounted for in APC 0980.

Comment: One commenter requested that we change the status indicator for CPT code 92974 (Coronary brachytherapy) to S.

Response: We are not making any changes at this time, but we will present this to the APC Advisory Panel next year to obtain its input.

Comment: A commenter requested that we move CPT code 57288 (Sling operation for stress incontinence) from APC 202 into its own APC. This is because it is the only procedure in the

APC that requires use of a device. The commenter also believed our claims data was flawed and did not reflect the true cost of the sling used for the procedure. The commenter also asked us to create a special APC payment for the sling.

Response: We are not making any changes at this time but will present this to the APC Advisory Panel. We note that we had many single procedure claims for 57288 and that 57288 was by far the most common procedure performed in APC 202. This means that 57288 determined the payment rate for the APC. Therefore, moving 57288 into its own APC would not change its payment rate. Furthermore, we do not create APCs for devices.

Comment: Two commenters were concerned about reduced payment for echocardiography.

Response: Review of payment rates for echocardiography does not show a significant decrease in payment from 2002 for the most commonly performed echocardiograms. The reduction in payment for echocardiograms in APC 671 appropriately reflects the costs of performing those procedures.

Comment: One commenter asked us to clarify the payment rate for Zevalin.

Response: As discussed elsewhere in this rule we have created G codes that describe the diagnostic and therapeutic administration of Zevalin. These two G codes are placed in APCs with payment rates that account for the procedure and the cost of Zevalin. We will use claims data to update the payment rates of these services when such data becomes available.

Comment: One manufacturer of medical devices submitted comments on a large number of APCs (76, 81, 83, 85, 86, 87, 93, 109, 141, 147, 151, 163, 229, 656, and 670). In general the commenter was concerned about seeming violations of the two times rule, use of improperly coded claims, lack of use of multiple procedure claims, and our use of medians to determine payment rates. The commenter also asked us to use outside cost data in setting payment rates and made some specific requests to move codes to differentAPCs.

Response: Many of this commenter's concerns have been addressed in other responses to APC issues. We did use properly coded claims where appropriate. Specifically, for procedures that required use of a device we only used claims that contained C codes. We also took other measures to mitigate steep reductions in payment for device related APCs and we increased the number of claims we used to set payment rates (as discussed in the proposed rule). We believe that many of the commenter's concerns have been addressed by these measures. However, we will review these comments and present several of the specific requests concerning APC changes to the APC Advisory Panel.

Comment: We received many comments from physicians, freestanding breast imaging centers, and others who believed that the proposed OPPS payment amounts for percutaneous breast biopsy (CPT codes 19102 and 19103) would affect the payments made for physician services and in freestanding breast imaging centers and who objected to reduced payments to physicians and to freestanding breast imaging centers.

Response: These commenters are mistaken. The proposed rates affect only hospital outpatient department payment. Payment to physicians and to freestanding facilities is addressed in the Physician Fee Schedule.

Comment: We received comments from hospitals and others who understood that the proposed payments would be limited to hospital outpatient department services. Some of these commenters indicated that the proposed payments for percutaneous breast biopsy (CPT codes 19102 and 19103) would be substantially below payments to hospitals for open breast biopsy (CPT code 19101) and that the proposed rule proposed reductions in payment for percutaneous breast biopsy while it proposed increases in payment for open breast biopsy. They believe that the proposed payment changes would create incentives for performing open breast biopsies instead of less invasive procedures such as percutaneous biopsies. This may result, they asserted, in an increased frequency of open breast biopsies and a decreased frequency of percutaneous breast biopsies, resulting in poorer quality of care and increased costs to Medicare and to beneficiaries. One commenter believed that our claims data do not appropriately account for the costs of CPT code 19103 because CPT code 19103 was a new CPT code in 2001 and hospitals were slow to transition from using CPT code 19101 for these procedures.

Response: We thank the commenters for their comments. We note that CPT codes 19102 and 19103 are never performed alone. They are always performed, at minimum, in conjunction with an imaging guidance procedure. Therefore, the true payment rate for CPT codes 19102 and 19103 is the sum of the APC payments for CPT codes 19102 or 19103 and of the APC payments for procedures billed with CPT codes 19102 and 19103. In order to determine the true payments for these procedures, we examined our claims data and determined the most common combination of CPT codes billed when CPT codes 19102 and 19103 were on the claim. Our claims data verified that CPT codes 19102 and 19103 are rarely performed alone.

Furthermore, we looked at the 10 most frequent combinations of codes billed with CPT codes 19102 and 19103 and summed the proposed APC payments that would be made for these combinations of codes. This represents the true Medicare payment for CPT codes 19102 and 19103. For CPT code 19102 (for which the proposed rule proposed payment under APC 0005 of $157.01), total payment by Medicare would range from $181.45 to $549.16 when the 10 most common combinations of services are provided. Similarly for CPT code 19103 (for which the proposed rule proposed payment under APC 0658 of $289.69), total payment by Medicare would range from $532.05 to $681.84. These combination totals are less than the proposed payment for open breast biopsy (APC 0028, CPT codes 19105, 19120 and 19125, for which we proposed to pay $908.04); however, as the commenters themselves asserted, the resources required for an open surgical procedure are greater than those used for a percutaneous procedure. We agree with the commenters that the costs to the Medicare program of an open breast biopsy are greater than the cost of a percutaneous biopsy. We also believe that the relative total payment rates, as discussed above, for open and percutaneous procedures are appropriate.

With regard to hospital miscoding, even if hospitals took time to transition from using CPT code 19101 to CPT codes 19102 and 19103, the cost data for CPT codes 19102 and 19103 should be accurate. While it is possible that the cost data for CPT code 19101 could be high as it may include some percutaneous procedures, this would not be true for cost data from CPT codes 19102 and 19103. Further, we would note that each of CPT codes 19102 and 19103 were reported over 20,000 times by hospital outpatient departments and that we had several thousand single claims for each code upon which to base relative weights.

We do not believe that the proposed payments will create incentives to perform inappropriate open breast biopsies. We believe that physicians will select the procedure that best meets the needs of the patient and that the hospital will provide the services

needed to support the procedure that the physician provides.

5. 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 the OPPS. In the April 7, 2000, final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. As we discussed in the April 7, 2000, and the November 30, 2001, final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes we have already moved off the inpatient list.

We last updated the inpatient list in the November 30, 2001 final rule. As we discuss in section II.A.2 above, the APC Panel at its January 2002 meeting reviewed certain procedures on the inpatient list for which we had received requests that they be made payable under the OPPS. As the Panel members recommended, we solicited comments and further information about all of these procedures except for CPT code 47001, which they recommended to be removed from the inpatient list.

In addition to considering the comments of the APC Panel, we compared procedures with status indicator ''C'' (status indicator ''C'' is assigned to inpatient procedures that are not payable under the OPPS) to the list of procedures that are currently on the ambulatory surgical center (ASC) list of approved procedures, to procedures that we proposed to add to the ASC list in a proposed rule published in the **Federal Register** on June 12, 1998 (63 FR 32291), and to procedures recommended for addition to the ASC list by commenters in response to the June 12, 1998, proposed rule. We concluded that it was appropriate to propose removal of procedures from the OPPS inpatient list that are being performed on an outpatient basis and/or that we had determined could be safely and appropriately performed on a Medicare beneficiary in an ASC under the applicable ASC rules, which are set forth in 42 CFR 416.22. Therefore, we proposed to add the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

In addition to the procedures considered by the APC Panel for removal from the inpatient list, Table 6 in the proposed rule includes other procedures that we proposed to remove from the inpatient list for payment under the OPPS for 2003. We applied the criteria discussed above in order to be consistent with the ASC list of approved procedures and with utilization data that indicate the procedures are being performed on an outpatient basis. We solicited comments on whether the procedures listed in Table 6 of the proposed rule should be paid under the OPPS. We also solicited comments on the APC assignment that we proposed for these procedures in the event we determine in the final rule, based on comments, that these procedures would be payable under the OPPS in 2003. We asked that commenters recommending reclassification of a procedure to an APC include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and appropriate manner.

Following our review of the comments, we either assigned a CPT code for a service formerly on the inpatient list to an APC for payment under the OPPS or, if the comments did not provide sufficient information and data to enable us to make a decision, we chose to keep the service on the inpatient list for 2003 and to present the comments to the APC Panel at its 2003 meeting. Table 6 identifies codes that were on the inpatient list in 2002 but are not on the inpatient list in 2003 and which, therefore, will be payable under the OPPS on and after January 1, 2003.

We received numerous comments on this proposal, which we summarize below.

Comment: In addition to the APC Advisory Panel, numerous hospital associations, hospitals, and other organizations recommended that we eliminate the inpatient list. They asserted that the inpatient list interferes with the practice of medicine and is unnecessarily intrusive. Most of these commenters argued that it is the physician, not the hospital, who determines what procedures should be performed and whether a patient's condition warrants an inpatient admission. Numerous commenters asserted that if CMS insists on retaining the inpatient list, then the same payment rules should apply to physicians as well as to hospitals. These commenters argued that if CMS believes Medicare beneficiaries are at risk for safety and quality issues, then Medicare should not pay for the professional services of the physician who performs a procedure on the inpatient list when payment for the hospital services is denied. In addition, several commenters noted that because the physician receives payment when a procedure on the inpatient list is performed on an outpatient basis, there is no incentive for the physician to heed whether Medicare will pay the hospital for the procedure. A few commenters noted that the inpatient list sometimes conflicts with the policy of private payers, creating confusion among physicians, patients, and hospitals. One commenter recommended that it should be left to medical review to monitor site of service. Several commenters viewed the inpatient list as an attempt to punish hospitals for a decision over which they have no real control. One commenter objected to the inpatient list because it places an unfair financial burden on beneficiaries, who are liable for payment if a procedure on the inpatient list is performed in the outpatient setting, and because the beneficiary normally relies on the physician to determine where a procedure is to be performed.

Response: Since implementation of the OPPS in August 2000, we have engaged in an ongoing review of the procedures on the inpatient list. In the August 9, 2002 proposed rule (67 FR 52092), we proposed APC assignments for 41 procedures that have a current status indicator designation of ''C''. We continue to move procedures from the inpatient list to an APC for payment under the OPPS in response to comments and recommendations from hospitals, surgeons, professional societies, and hospital associations which demonstrate that a procedure on the inpatient list meets our criteria for determining that a procedure can be performed on an outpatient basis in a

safe and effective manner. In spite of the assertions made by commenters, we have received very few requests since publication of the November 30, 2001 final rule.

Hospitals or associations representing hospitals submitted the overwhelming majority of comments recommending elimination of the inpatient list. Their comments expressed considerable frustration resulting from apparent conflicts with physicians over which procedures Medicare will pay for under the OPPS. Although we understand the frustration that exists in the hospital community about the inpatient list, we believe that appropriate education of physicians and other hospital staff by CMS, hospitals, and organizations representing hospitals is the best way to minimize any existing confusion. We are prepared to remove procedures from the inpatient list as part of the quarterly OPPS updates. If a physician believes that a procedure should be payable under the OPPS, we urge the hospital and physician to provide operative reports about specific procedures on the inpatient list are being performed on Medicare beneficiaries who are outpatients. In the meantime, we are reviewing with CMS provider education staff ways that we can support carrier and fiscal intermediary efforts to clarify the reasons for the OPPS inpatient list and its billing and payment implications. Also, in section X.C. of this preamble, we explain how hospitals can receive payment under certain conditions for procedures on the inpatient list that are performed on an emergency basis when the status of a patient is that of an outpatient.

Comment: We received a number of comments regarding the criteria that we use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS, including the two new criteria that we proposed in the August 2002 proposed rule to add to the current criteria. One commenter asked what we meant by ''numerous'' hospitals. Several commenters commended CMS for recognizing that surgical procedures payable in the ambulatory surgical center (ASC) setting should also be payable in an outpatient hospital setting and for removing a number of codes from the inpatient list that are currently payable in an ASC. Several commenters urged CMS to closely monitor and coordinate the OPPS inpatient list and the ASC list for consistency and to ensure that changes in medical practice are reflected within both lists as expeditiously as possible. Commenters expressed concern that more than 60 CPT codes remain on the inpatient list in Addendum E even though they are currently on the approved ASC list and urged CMS to reconcile the disparity between the two lists.

Response: The criterion that a procedure is being performed in ''numerous'' hospitals on outpatients means that the procedure is being performed nationally in hospitals other than a few large teaching hospitals that specialize in innovative surgery. We intend to continue monitoring for consistency the procedures that Medicare pays for in a hospital outpatient setting with those that are payable in an ASC as we prepare a final rule to update the ASC list based on the additions and deletions that we proposed in the June 12, 1998 **Federal Register** (63 FR 32290).

Comment: One commenter recommended that CMS remove from the inpatient list those procedures that routinely show a one-day inpatient stay.

Response: We believe this recommendation has merit and we will endeavor to conduct a study to explore the issue in preparation for the 2004 OPPS update.

Comment: One commenter stated that CMS should have a formal process to solicit and act on suggestions to remove procedures where community medical standards and practice can demonstrate the safety and efficacy of performing the procedure in an outpatient setting. Another commenter stated that physician comments, outcome data, post-procedure care data, and medical literature would be better criteria for determining which procedures are outpatient.

Response: As we stated above, anyone interested in having a particular code or group of codes on the inpatient list reviewed for payment under the OPPS need only submit a request to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. The request should include supporting information and data to demonstrate that the code meets the five criteria discussed above. We ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals. We agree with the commenters suggestions, and encourage, in addition to medical literature, the submission of community medical standards and practice as well physician comments, outcome data, and post-procedure care data to reinforce the point.

When this information is received, it is thoroughly reviewed by our medical advisors within the context of the criteria we have established. Further information or clarification may be requested. If, following this review, we determine that there is sufficient evidence to confirm that the code can be safely and appropriately performed on an outpatient basis, we will assign the procedure to an APC and include it as a payable procedure in the next OPPS quarterly update. The change in payment status will be subject to public comment as part of the subsequent annual OPPS update.

Interested parties may also submit a request to change the payment status of a code on the inpatient list for consideration as an agenda item at the next meeting of the APC Advisory Panel.

Comment: One commenter expressed concern about the inpatient list becoming a ''self-fulfilling prophecy'' because hospitals cannot be paid for procedures on the list, therefore no data become available to show that the procedure is safely done on an outpatient basis.

Response: Information may be available on non-Medicare patients receiving a procedure on the list. Further, this is not the sole criterion upon which a change is based, as we note above.

Comment: One commenter recommended that CMS establish a transitional methodology for estimating appropriate hospital costs for CPT codes on the inpatient list that are proposed for payment under the OPPS. The commenter expressed particular concern about payment for CPT codes 92986, 92987, and 92990.

Response: The APC assignments for the CPT codes in Table 6 of the August 2002 proposed rule (67 FR 52115) for which we propose to make payment under the OPPS take into account the expectation that the simplest procedure described by the codes, and therefore, relatively, the least resource intensive, would be performed on an outpatient basis. Also, we identify APCs that consist of procedures that are similar both in terms of clinical characteristics and in terms of resource consumption. Finally, we invited comments on the proposed APC assignment. Over time, claims data for the newly assigned codes will confirm either that the procedures belong in the designated APC or that they should be moved to different APC.

Comment: Two commenters supported our proposal to remove CPT

code 47001, Biopsy of liver, needle; when done for indicated purpose at time of other major procedure, from the inpatient list. Several commenters supported generally our proposal to pay under the OPPS for the procedures in Table 6 of the proposed rule, but did not comment on our proposed APC assignments. One commenter urged that CPT code 92986, Percutaneous balloon valvuloplasty; aortic valve, not be assigned to APC 0083, asserting that this procedure cannot be performed safely in an outpatient setting. We received no other comments opposing payment under the OPPS for the procedures listed in Table 6 of the August 9 proposed rule.

Response: We agree with the commenters and with the APC Panel's recommendations that CPT code 47001 be payable under the OPPS beginning in 2003. Because this is an add-on code, payment will be packaged with the payment for the surgical procedure with which it is billed.

We are making final our proposal to remove this code from the inpatient list, but we will consider presenting this concern to the APC Panel. In the absence of comments disagreeing with our proposal to pay under the OPPS for the 41 CPT codes listed in Table 6 of the August 2002 proposed rule (67 FR 52115), we are making these proposed changes final.

Comment: One commenter favored removing CPT 33967, insertion of intra-aortic balloon assist device, percutaneous, from the inpatient list, but did not submit any information to support this position.

Response: We discussed in the proposed rule our uncertainty, and that of the APC Advisory Panel, about whether or not this procedure should be removed from the inpatient list. We also indicated that we were having difficulty finding data to confirm that the procedure is being performed on Medicare beneficiaries in an outpatient setting. We asked for comments and clinical data and case reports that would support payment for CPT 33967 under the OPPS. No commenters submitted data in any form to support removing the procedure from the inpatient list. Therefore, we have decided not to remove CPT 33967 from the inpatient list in 2003.

Comment: One commenter recommended payment for CPT codes 22612, 22614, 33243, 49000, and 49062 under the OPPS.

Response: Our medical advisors reviewed these codes and have determined that CPT 22612, Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique), and CPT 22614, Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (list separately in addition to code for primary procedure), are safely and appropriately being performed on an outpatient basis. We are assigning these codes to APC 0208.

We did not propose to remove the other codes suggested by the commenter from the inpatient list, and the commenter submitted no evidence to support payment for these codes under the OPPS. Nor could we find any information to indicate that these codes meet the criteria for moving them off the inpatient list. Therefore, we will continue to designate these CPT codes with status indicator ''C'' in 2003.

- We are adopting two additional criteria to guide our determination of whether a procedure should be removed from the inpatient list:
- The procedure is being performed in numerous hospitals on an outpatient basis; or
- The procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.
- We are adding CPT codes 22612 and 22614 to APC 0208 effective for services furnished on or after January 1, 2003.
- We are making final our proposal in the August 2002 rule to pay under the OPPS for the CPT codes listed in Table 5, below.

TABLE 5.—PROCEDURES ON THE 2002 INPATIENT LIST WHICH ARE PAYABLE UNDER THE OPPS IN CY 2003

CPT Code	Status Indicator	APC	Description
21390	T	0256	OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE; PERIORBITAL APPROACH, WITH ALLOPLASTIC OR OTHER IMPLANT.
22100	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; CERVICAL.
22101	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; THORACIC.
22102	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; LUMBAR.
22103	T	0208	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE).
22612	T	0208	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH OR WITHOUT LATERAL) TRANSVERSE TECHNIQUE).
22614	T	0208	ARTHODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; EACH, ADDITIONAL VERTEBRAL SEGMENT (LIST, SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE).
23035	T	0049	INCISION, BONE CORTEX (EG, OSTEOMYELITIS OR BONE ABSCESS), SHOULDER AREA.
23125	T	0051	CLAVICULECTOMY; TOTAL.
23195	T	0050	RESECTION, HUMERAL HEAD.
23395	T	0051	MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; SINGLE.
23397	T	0052	MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; MULTIPLE.
23400	T	0050	SCAPULOPEXY (EG, SPRENGELS DEFORMITY OR FOR PARALYSIS).
24150	T	0052	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS;
24151	T	0052	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
24152	T	0052	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK;
24153	T	0052	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
25170	T	0052	RADICAL RESECTION FOR TUMOR, RADIUS OR ULNA.

TABLE 5.—PROCEDURES ON THE 2002 INPATIENT LIST WHICH ARE PAYABLE UNDER THE OPPS IN CY 2003—Continued

CPT Code	Status Indicator	APC	Description
25390	T	0050	OSTEOPLASTY, RADIUS OR ULNA; SHORTENING.
25391	T	0051	OSTEOPLASTY, RADIUS OR ULNA; LENGTHENING WITH AUTOGRAFT.
25392	T	0050	OSTEOPLASTY, RADIUS AND ULNA; SHORTENING (EXCLUDING 64876).
25393	T	0051	OSTEOPLASTY, RADIUS AND ULNA; LENGTHENING WITH AUTOGRAFT.
25420	T	0051	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT).
27035	T	0052	DENERVATION, HIP JOINT, INTRAPELVIC OR EXTRAPELVIC INTRA-ARTICULAR BRANCHES OF SCIATIC, FEMORAL, OR OBTURATOR NERVES.
27216	T	0050	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC RING FRACTURE AND/OR DISLOCATION (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM).
27235	T	0050	PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE, PROXIMAL END, NECK, UNDISPLACED, MILDLY DISPLACED, OR IMPACTED FRACTURE.
31582	T	0256	LARYNGOPLASTY; FOR LARYNGEAL STENOSIS, WITH GRAFT OR CORE MOLD, INCLUDING TRACHEOTOMY.
31785	T	0254	EXCISION OF TRACHEAL TUMOR OR CARCINOMA; CERVICAL.
32201	T	0070	PNEUMONOSTOMY; WITH PERCUTANEOUS DRAINAGE OF ABSCESS OR CYST.
38700	T	0113	SUPRAHYOID LYMPHADENECTOMY.
42842	T	0254	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; WITHOUT CLOSURE.
43030	T	0253	CRICOPHARYNGEAL MYOTOMY.
47490	T	0152	PERCUTANEOUS CHOLECYSTOSTOMY.
47001	N	.....	BIOPSY OF LIVER, NEEDLE; WHEN DONE FOR INDICATED PURPOSE AT TIME OF OTHER MAJOR PROCEDURE.
62351	T	0208	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG-TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITH LAMINECTOMY.
64820	T	0220	SYMPATHECTOMY; DIGITAL ARTERIES, EACH DIGIT.
69150	T	0252	RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITHOUT NECK DISSECTION.
69502	T	0254	MASTOIDECTOMY; COMPLETE.
92986	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; AORTIC VALVE.
92987	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; MITRAL VALVE.
92990	T	0083	PERCUTANEOUS BALLOON VALVULOPLASTY; PULMONARY VALVE.
92997	T	0081	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; SINGLE VESSEL.
92998	T	0081	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE).

C. Partial Hospitalization

Payment Methodology

As we discussed in the proposed rule, partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in the place of inpatient care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). In the August 1, 2000 final rule (65 FR 18452), we established a per diem payment methodology for the PHP APC based on hospital data. The current per diem payment amount is $212.27. This amount represents the hospital or CMHC overhead costs associated with the program.

In the August 9, 2002 OPPS proposed rule, we proposed to revise the PHP APC using 2001 claims data from hospitals and CMHCs and computed a median per diem using the same methodology as that used for all other APCs. As we explained in the August 9, 2002 proposed rule, we adjusted the CMHC costs to account for the difference between settled and as-filed cost reports. We proposed that the resulting per diem is $256.96, of which $51.39 is the beneficiary's coinsurance.

In addition, to facilitate proper billing and ensure comparable reporting of costs by hospitals and CMHCs, we proposed to revise § 410.43 (Partial hospitalization services: Conditions and exclusions) to add CSW services that meet the requirements of section 1861(hh)(2) of the Act to the list of professional services not considered to be PHP services. Such revision would mean that hospitals and CMHCs could bill the carrier for CSW services furnished to PHP patients.

Comment: One commenter indicated that the proposed methodology for ratesetting is appropriate.

Response: As we indicated in the April 7, 2000 OPPS final rule, payment to providers under OPPS represents the facility costs, that is, overhead, support staff, equipment, and supplies. The physician and nonphysician practitioner services excluded from the definition of PHP services are those professional services paid through the physician fee schedule. The facility continues to incur the overhead costs associated with provision of the professional service, for example, room, heat, lights, mental health technicians, and nurses. The OPPS is intended to pay providers for the resource costs associated with their outpatient programs, including outpatient psychiatric programs and PHPs.

As part of our analysis of current billing instructions for PHP, we discovered that Addendum B of the November 30, 2001, CY 2002 OPPS final rule does not clearly identify all the HCPCS codes that may be billed for PHP patients. We plan to revise this addendum in the 2004 update so that all PHP services are identified. However, in order to avoid billing errors, we are providing the following list of the current HCPCS codes for PHPs:

Revenue codes	Description	HCPCS codes
43X	Occupational Therapy	G0129.
904	Activity Therapy	G0176.
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899.
914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829.
915	Group Therapy	90849, 90853, 90857.
916	Family Psychotherapy	90846, 90847, 90849.
918	Psychiatric Testing	96100, 96115, 96117.
942	Education/Training	G0177.

Comment: Two national behavioral health care organizations commented that the proposed PHP rate for CY 2003 more adequately represents the resources needed to provide PHP; however, they expressed concern that providers continue to have difficulty in receiving reimbursement for PHP services as a result of intermediary medical review (MR) of claims.

Response: As noted in the comment, we have issued a program memorandum to intermediaries regarding medical review of PHP claims. While we recognize that MR can have a financial impact on PHP claims, there is no direct relationship between MR and the level of reimbursement for individual claims.

III. Recalibration of APC Weights for 2003

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 to 67827).)

To recalibrate the relative APC weights for services furnished on or after January 1, 2003, and before January 1, 2004, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule. 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 APC relative weights for CY 2003, the most recent available claims data are more than 90 million final action claims for hospital outpatient department services furnished on or after April 1, 2001, and before March 31, 2002, and processed through July 2002. In the proposed rule, we proposed to base the 2003 OPPS on claims for services furnished January 1, 2001 through December 31, 2001. However, after issuance of the proposed rule we determined that coding and charges for the period of April 1, 2001 thru March 31, 2002 would be a better base for recalculation of weights.

We believe that using claims data from this period is consistent with section 1833(t)(9)(A) of the Act, which directs us to take into account ''new cost data'' in our annual review and adjustment of components of the OPPS. This is also consistent with our proposal in the August 9, 2002 proposed rule (67 FR 52108) to use the most recent available claims data to set the weights. We had several reasons for using claims from this period: claims from this period provide the most recent charge data available to us. Since we did not implement the 2002 OPPS until April 1, 2002, we can use the claims for the period from January 1, 2002, through and including March 31, 2002, together with claims data from the period of April 1, 2001 to December 31, 2001 to set weights. Using claims data for services furnished during this period of time also provides the most reliable charge data for devices and services that use medical devices because the device category codes were in effect for the entire period. Hence, we believe that claims from this period are the most reliable basis for setting relative weights for CY 2003 OPPS.

Many of the claims from hospitals were for services that are not paid under OPPS (such as clinical laboratory tests). We matched the claims that are paid under OPPS 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.

A. Data Issues

1. Treatment of ''Multiple Procedure'' Claims

In the August 9, 2002 proposed rule, we discussed in detail the circumstances in which we had difficulty with using the data from claims that had multiple procedures (67 FR 52108). We solicited public comment on the methods we considered for apportioning the total charges to individual HCPCS codes as described above. These possible methods included: dividing the total charges in a revenue center, or for a packaged HCPCS code, by the number of payable HCPCS codes for the multiple procedures on the claim; apportioning the charges among the codes based on physician work relative value units (RVUs); apportioning the charges among the codes based on physician nonfacility practice expense RVUs; or requiring the hospital to apportion all charges currently shown in revenue centers to the HCPCS codes billed so that we could use all multiple services claims in the calculation of relative weights. We also invited suggestions of other alternative means of apportioning the total costs on multiple procedure claims to the HCPCS codes for the procedures so that we can use more data from multiple procedure claims in the 2004 update of the OPPS.

We also solicited information on existing studies that would provide comparative hospital outpatient resource inputs by HCPCS code. In addition, we welcomed suggestions for studies that we might undertake either to determine the relative value of OPD resources by HCPCS code or to provide a valid means of apportioning the charges among HCPCS codes when multiple surgical procedures are billed on the same claim with a single total charge for all services.

Finally, we solicited information regarding the extent to which efficiencies are realized when multiple services are furnished during the same visit or operative session.

The discussion of recalibration of relative weights in section III.B of this final rule summarizes the process that we used to determine the claims that could be used to set the weights.

Comments and our responses are summarized below:

Low Numbers of Services Used To Set Weights and Failure To Use Multiple Procedure Claims

Comment: Many commenters indicated that we used very few of the claims that were submitted for a particular service and that using so few claims resulted in lower weights than would have occurred if we had used all claims. Some commenters indicated that by using only single procedure claims and data from multiple procedure claims that met the criteria we set (see section III.A.I. of this final rule), we significantly reduced the validity of the cost data. Some commenters stated that by using median costs for procedures that can only be done as an add-on to other procedures, we had based the payment for the add-on procedure on data which, by definition, were faulty. Some commenters suggested that we needed to develop an allocation strategy that would enable us to use all multiple procedure claims, either based on a study of relative resource allocation or an arbitrary allocation that could be refined over the years. Some commenters asked that we reconsider our data trimming strategy to examine each claim that is eliminated by trimming for validity and to determine if it should be used. They asked that any claim that represents new technology be returned to the data set and used, notwithstanding its aberrancy.

Response: For 2003, we made great strides by increasing the number of claims used to set the OPPS weights from 39.9 million (66 FR 59885) for the 2002 OPPS to 62.2 million for the 2003 OPPS. We intend to review other means of using data from multiple claims for 2004. We recognize that it would be preferable to use data from all claims, including those with multiple procedures, in development of the weights, as long as we can ensure that the data recovered from those claims are valid. We were not able to develop and test a strategy for allocating undifferentiated charges to multiple HCPCS codes on a claim for the 2003 final rule. Therefore, in some cases, we continued to use data from small numbers of claims because many claims did not meet the tests for inclusion in the data set. As discussed in section II, the APC Panel recommended that we continue to rely on data from single procedure claims until we were able to validly allocate charges to multiple procedures, even in establishing payments for add-on codes. In addition, as requested by some commenters, we excluded claims for procedures that could not be performed without a device when the claim did not contain the device. This gave us a more valid base of claims on which to set the weight for that service but reduced the number of claims used for these APCs. It became clear from this activity that basing the weights on more claims does not necessarily result in more valid data because in the cases of these APCs, deleting claims from the set was necessary to arrive at a more valid relative weight.

With regard to the trimming methodology, it is a routine and accepted statistical practice that is well established in inpatient PPS data examination and has served well in the past to eliminate anomalies that could further skew the data. We will consider whether it is useful and to what extent it is practical to examine all trimmed claims to determine if they represent the first claims for a new technology and should remain in the body of claims.

Recommendations for Including More Multiple Procedure Claims

Comment: We received a number of comments that contained ideas for allocating charges to multiple procedures where they exist on the claim. Some commenters recommended that we allocate the charges to HCPCS codes in proportion to the relative weight of the HCPCS codes or the relative charges for the HCPCS codes. Some commenters suggested that we survey hospitals with regard to the most common combinations of procedures that appear on claims to determine which services and, therefore, which charges go with which HCPCS code. Some commenters suggested that we research the relative resources for each HCPCS code individually and then create an algorithm by which we would allocate charges to HCPCS codes on multiple procedure claims. One commenter provided a study that addressed the efficiency of resource usage when multiple procedures are performed on the same day that the commenter recommended could be useful in allocating charges for the second and subsequent procedures on a claim. One commenter also suggested that we ensure that the claim assesses services on the same date of service, since in many cases, the claim can have services that are spread over a period of time and, therefore, are not really multiple procedures provided at the same time. Several commenters submitted detailed descriptions of ways by which we could allocate charges to HCPCS codes. Many hospitals objected to any requirement that hospitals do the allocation of all charges to HCPCS codes to show the charges that go with each HCPCS code; they noted that doing so would require massive accounting and cost report changes and thus impose a burden and cost on hospitals, which would exist for no purpose other than to improve the Medicare OPPS claims data.

Response: We expect to explore a number of strategies for allocating charges to HCPCS codes on multiple procedure claims for the development of the 2004 OPPS and beyond.

Impact on Data of a Visit and Drug Administration the Same Day

Comment: Several commenters applauded our attempt to include some multiple procedure claims in the calculation of OPPS payment rates. They were, however, concerned whether some properly coded claims, which included both an administration code and a J code or claims that included an evaluation and management visit in addition to an administration code and a J code, were eliminated as multiple procedure claims.

Response: Where an evaluation and management visit and an administration code and J code were billed on the same claim, they would have been considered to be a multiple procedure claim and would not be used because there would be no way of knowing how to allocate the charges in revenue centers to the visit versus the administration code. As we explained in detail in the August 9, 2002 proposed rule, there would be no way to know to what extent charges in revenue centers, such as sterile supplies, were associated with the visit versus the administration code. We are concerned about this problem and are exploring ways to do an allocation of charges that would enable us to use all multiple procedure claims. However, we were not able to do it for this final rule.

2. Calendar Year 2002 Charge Data for Transitional Pass-Through Device Categories

In the August 9, 2002 proposed rule, we discussed our concerns with the claims data for the devices losing eligible for transitional pass-through status in CY 2003 (67 FR 52110). We had been advised that during the period in which the 2001 OPPS was in effect, hospitals may not have billed properly for devices eligible for transitional pass-through payments. We acknowledged in the 2002 proposed rule that changes in billing format and systems for implementation of the OPPS may have compounded the problems of billing using the device-specific codes during the first 9 months of the OPPS. We had been informed that these problems were

further compounded by the creation and requirement to use category codes on and after April 1, 2001. In general, we had been advised that hospitals may have been underpaid for transitional pass-through devices (because they did not bill separately for them and, therefore, did not get the pass-through payment) and that our data will not correctly show the charges associated with the devices (because the devices were not coded with device-category codes on the claim).

We proposed to package payment for devices into payment for the procedure in which they were furnished because doing so is consistent with the concept of a prospective payment system and because we believed that it would give us the best data on which to pay devices once they ceased to be paid at cost via the pass-through methodology. We thought that by packaging the cost of the devices into the cost of the procedure with which they were used, we would capture the charges for the devices whether billed in revenue centers or with the HCPCS code for the device.

Our subsequent review of the data for the period of April 1, 2001, through March 31, 2002, indicated that there was a notable absence of hospital billing for devices category codes, even when the procedure billed could not be done without a pass-through device. We calculated the median costs for the APCs containing procedures that we believed required use of devices (including both claims with and claims without device C codes on the claim) and compared them to the median costs for the procedures from only claims that were billed with devices. We found that the median costs on claims billed with devices were more consistent with the median costs that we would expect to see for these APCs. Hence, for these APCs, we used the median costs calculated from claims that reported a device C code in place of the median costs calculated from all claims (claims billed both with devices and without device C codes). We did not eliminate claims that did not contain a device C code where HCPCS codes within an APC indicated that the procedure did not require a pass-through device. In such cases, HCPCS codes were, appropriately, rarely reported with C codes. The APCs for which we used the medians from claims with device C codes billed are listed in Table 6. This methodology resulted in higher median costs and, therefore, higher weights for these APCs than would have occurred had we included claims that did not contain coding for a device. The medians we used for all APCs are contained in Addendum C, which is on our Web site at *http://www.cms.hhs.gov.*

TABLE 6.—APC RATES WHICH ARE SET BASED ONLY ON CLAIMS THAT CONTAINED CODES FOR DEVICES

APC	Description
0032	Insertion of Central Venous/Arterial Catheter.
0048	Arthroplasty with Prosthesis.
0080	Diagnostic Cardiac Catheterization.
0081	Non-Coronary Angioplasty or Atherectomy.
0082	Coronary Atherectomy.
0083	Coronary Angioplasty and Percutaneous Valvuloplasty.
0085	Level II Electrophysiologic Evaluation.
0086	Ablate Heart Dysrhythm Focus.
0087	Cardiac Electrophysiologic Recording/Mapping.
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.
0655	Insertion/Replacement of Permanent Dual Chamber Pacemaker.
0090	Insertion/Replacement of Pacemaker Pulse Generator.
0680	Insertion of Patient Activated Event Recorders.
0653	Vascular Reconstruction/Fistula Repair with Device.
0104	Transcatheter Placement of Intracoronary Stents.
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.
0107	Insertion of Cardioverter-Defibrillator.
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.
0115	Cannula/Access Device Procedures.
0119	Implantation of Devices.
0122	Level II Tube changes and Repositioning.
0652	Insertion of Intraperitoneal Catheters.
0167	Level III Urethral Procedures.
0179	Urinary Incontinence Procedures.
0182	Insertion of Penile Prosthesis.
0202	Level VIII Female Reproductive Proc.
0222	Implantation of Neurological Device.
0225	Implantation of Neurostimulator Electrodes.
0226	Implantation of Drug Infusion Reservoir.
0227	Implantation of Drug Infusion Device.
0229	Transcatherter Placement of Intravascular Shunts.
0259	Level VI ENT Procedures.
0670	Intravenous and Intracardiac Ultrasound.
0680	Insertion of Patient Activated Event Recorders.
0681	Knee Arthroplasty.
0693A	Breast Reconstruction with Prosthesis.

Application of Cost-to-Charge Ratio to Charges Not Resulting in Costs

Comment: Many commenters stated that the application of a departmental cost-to-charge ratio to the high cost of devices would not result in the true cost of the device because hospitals would have to mark up the cost by 300 percent or more for that to be the result.

Response: See the discussion of the comments on cost to charge ratios and charge compression in section III.B of this final rule.

Absence of Devices on Claims

Comment: Many commenters indicated that hospitals did not bill for the devices that were paid under the pass-through mechanism in 2001, and therefore the median costs for the APCs for which most of the cost is a device are grossly understated.

Response: As discussed previously, we believe the commenters have a point. For the APCs for which the service cannot be furnished without a pass-through device, we eliminated claims that were not billed with a device C code from the claims used to calculate the median cost for those APCs. By taking these steps as well as packaging the device cost billed with both revenue centers and device category codes, we believe our final rates for these procedures are more appropriate. The APCs for which we used only claims with devices are identified in Table 6 above.

B. Description of How Weights Were Calculated for CY 2003

As discussed previously in this section, we first selected claims for services provided from April 1, 2001 through March 31, 2002. The methodology we followed to calculate the final APC relative payment weights for CY 2003 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with ESRD).
- We eliminated 1.6 million claims from hospitals located in Maryland, Guam, and the U. S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 301 hospitals that we identified as having reported charges on their cost reports, which were not actual charges (for example, a uniform charge applied to 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 3.6 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of approximately 92.9 million claims to CCRs for remaining hospitals.
- We separated the 92.9 million claims that we had matched with a cost report into the following three distinct groups:

(1) Single-procedure claims.

(2) Multiple-procedure claims.

(3) Claims on which we could not identify at least one OPPS covered service.

Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture), which could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims in this manner yielded approximately 30.7 million single-procedure claims and 20.4 million multiple-procedure claims. Approximately 41.8 million claims without at least one covered OPPS service were set aside.

We converted 10.8 million multiple-procedure claims to single-procedure claims using the following criteria:

(1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim.

(2) For multiple procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for chest X-rays (HCPCS codes 71010 and/or 71020) and/or EKGs (HCPCS code 93005) on these claims. If only one procedure (other than HCPCS codes 71010, 71020, and 93005) existed on the claim, we treated it as a single-procedure claim.

(3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single claim if the line item was billed as a single unit.

(4) If the claim had no packaged HCPCS codes on the claim but had packaged revenue centers for the procedure, we ignored the line item for chest X-rays and/or EKG codes (as identified above) and if only one HCPCS code remained, we treated the claim as a single procedure claim. We created an additional 31.5 million single-procedure bills through this process, which enabled us to use these data from multiple-procedure claims in calculation of the APC relative payment weights.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.1 of this final rule, we did not use multiple-procedure claims that included more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using other multiple-procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges 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 departmental CCR. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or we used 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). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').
- To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing the service. We observed the packaging provisions set forth in the April 7, 2000 final rule with comment period that were in effect during 2001 (65 FR 18484). For instance, in calculating the cost of a surgical procedure, we included charges for the operating room; treatment rooms; recovery; observation; medical and surgical supplies; pharmacy; anesthesia; casts and splints; and donor tissue, bone, and organs. To determine medical visit costs, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances where they are still packaged. Table 7 lists packaged services by revenue center that we proposed to use to calculate per-service

costs for outpatient services furnished in CY 2003.

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
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.
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.
762	OBSERVATION ROOM.
810	ORGAN ACQUISITION.
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.

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
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.

• 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 FY 2003 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on August 1, 2002 (67 FR 49982). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (See the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including the proposed APC changes described in section II.A of this final rule.

• We calculated the median cost for each APC by using the claims for services included in the APC. In the case of APCs for which we eliminated the claims that did not contain device

C codes, we used only the claims that contained device codes to set the median cost for the APC. See section III.A.2 of this final rule for a complete discussion of why we used the device code medians for these codes (which are identified in Table 6).

• Using these median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. This approach is consistent with that used in developing RVUs 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. Using the 2001 through 2002 data, the median cost for APC 0601 is $57.56.

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 2003 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 2002 relative weights to aggregate payments using the CY 2003 final weights. Based on this comparison, in this final rule, we are making an adjustment of .969 to the weights. The final weights for CY 2003, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B of this final rule with comment period. The final weights are rounded to 4 decimals for greater precision.

We received many comments on the issues related to calculation of the OPPS payment weights, which we summarize and address below:

Changes in Payment Rates from 2002 to 2003

Comment: We received many comments expressing concern with the amount of decreases in payments for many services, in particular those that will include drugs and devices that will cease to be eligible for pass-through payment in 2003. Many commenters said that the costs for drugs and devices derived from claims data, on which we based weights for these APCs, were considerably below the acquisition price hospitals pay for the drugs and devices. Many commenters said that the proposed payments would result in hospitals ceasing to provide services that require expensive devices and drugs because they could no longer afford to furnish them under the proposed rates.

Response: We are concerned that our payments not compromise access of Medicare beneficiaries to high quality services involving new technologies. Accordingly, we have adopted a number of changes in our estimating procedures, as described in more detail below and elsewhere in this final rule, designed to better ensure that the payment rates we establish in this rule are as accurate and reasonable as possible.

Comment: Many commenters, in particular hospital organizations, supported the significant increases in payments for primary care and preventive services that were proposed. They strongly stated that we should rely only on Medicare claims data to ensure that these services would not be reduced in payment by increases to payments for device and drug related services, as happened in 2002 when external price data were used in the absence of Medicare claims data. They noted that the services that received increases in payments using 2001 claims data are furnished by all hospitals and that rural hospitals and small urban hospitals in particular are heavily dependent on adequate payment for these services to be able to continue to offer services to Medicare patients in their communities.

Response: We also are concerned that our payments not compromise access of Medicare beneficiaries to high quality services that may not involve new technologies; these services in fact represent the bulk of services in all hospitals. Accordingly, we have been mindful that increases in the payment on some services will result in decreases in others.

Comment: Many commenters shared with us data from various sources outside our claims data (for example, manufacturers' prices, prices reported by group purchasing organizations, and amounts from invoices as proof of acquisition price). Many of these commenters suggested we use these data as a substitute for or supplement to claims data for particular APCs or where particular drugs or devices are used.

Response: We appreciate the data that these commenters provided to us. We carefully reviewed all the data that were furnished to us and used the data to guide us in analysis of claims data and in making decisions regarding how to generate the final payment weights.

We note that the OPPS is not designed to pay hospitals their full accounting costs for delivery of particular services. The system was set up to be budget neutral to the prior system, which, under several provisions of the statute, paid approximately 82 percent of reported hospital outpatient department costs as shown on the cost reports. Payment rates for individual services are set, in essence, to reflect relative resource use within a payment system that pays at what was a discount of approximately 18 percent. Thus, for us to make changes to ensure that a particular service receives what observers believe is its ''full'' cost is difficult, partly because determination of ''full'' cost for a particular service is an uncertain exercise and partly because such a service could only be paid ''full'' cost at the expense of all other services, which in principle would be paid at an even greater discount than that already implied by the operation of the system. Accordingly, while we have used data from external sources to evaluate the reasonableness of our payment rates and to guide us in choice of methods that would achieve results as reasonable as possible, we have not directly substituted such data into our estimates.

Comment: Many commenters suggested that we use only claims on which pass-through devices had been coded to set medians for APCs containing procedures that required devices to be furnished.

Response: We agree that this suggestion presents a useful way to edit our data, and adopted it in calculating the rates presented in this rule. We calculated medians from our most current set of claims data using all claims, (that is, using claims with no device C code, and using claims with device C code) and compared the medians. We found that, in many APCs because the procedures require use of a pass-through device, the medians that resulted from using any claims on which device C codes were billed were more similar to the device and procedure costs provided by external data than were the medians calculated using all claims. For these APCs, shown in Table 6, we used the median calculated using only claims on which a device had been coded.

Comment: Many of the commenters asked that we adjust the weights so that no service, or at least no service for which a commenter had objected to a decrease, would receive a decrease in payment of more than 10 percent from 2002 to 2003.

Response: We agree that the substantial fall in payment rates for some APCs suggests the need for some approach to moderate the changes.

Many of these decreases appear to be linked to one or more of the following:

- Changes in the payment methodology for those drugs and devices that will no longer be eligible for pass-through payments,
- Miscoding,
- Restructuring of APCs (in which movement of a single code from one APC to another may change the median cost of both APCs), or
- Use of data from the period following implementation of the OPPS.

In the interest of using a method that could be employed simply and that could ensure that all APCs were treated similarly regardless of whether interested parties had identified them as sources of concern, we adopted a method that we applied to all APCs except new technology APCs, and APCs for drugs and devices that will receive pass-through payments in 2003.

We considered a number of different ways of moderating the reductions in payment that would have occurred under the August 9, 2002 proposed rule. We considered options that would have limited both significant increases and significant decreases in some fashion. However, we rejected these options because they would have reduced payments for those services that would otherwise have significant increases. Inspection of APCs that would have significant increases suggested that many of these increases were reasonable, and we did not want to reduce them more than necessary.

We considered options that would have created a fixed corridor that would have limited any reduction to some fixed value, such as 10 or 15 percent, as suggested by some commenters. However, we rejected this option, because it would have reduced the role of the claims data to a minimum, even though these data do reflect hospital charging behavior and are likely to have some degree of accuracy. In addition, setting an absolute floor on reductions would have shifted significant resources away from all other APCs.

We considered targeting those APCs that would experience a reduction in median costs beyond a threshold and limiting the reduction in median costs to half of the difference between the threshold level and the total reduction. Because of budget neutrality constraints, the costs of this approach must be met by reductions in other services. We concluded that setting a threshold at a 15 percent reduction and decreasing the reduction in median costs by half of the difference between the total proposed reduction and the threshold provided an appropriate balance, reflecting our assessment of the relative quality of claims data, other information from commenters, and the effects on services overall.

Thus, we adopt the following procedure. For any APC where the median cost would have fallen by 15 percent or more from between 2002 to 2003 from the values that would be otherwise applicable for 2003, after the data and method improvements noted above, we first decreased the reduction in median cost by one half of the difference between the value derived from the claims data and 15 percent. This methodology was applied to all APCs, not just those involving drugs or devices losing pass-through eligibility. We then assessed the results of this procedure with information from comments and concluded that several additional but more targeted steps were appropriate.

We examined further those APCs containing procedures involving devices where the device represented a very large portion of the overall costs. Noting that the overall reduction from cost discussed elsewhere in this section would mean that services where devices represented 80 percent or more of the total costs would leave virtually no margin to cover hospital costs in performing the procedure, we limited our attention to those APCs with device costs of 80 percent of more. We then calculated adjusted APC median costs for these APCs by determining the portion of the cost that was attributable to the procedure and summing it with a weighted average of the cost of the device. We determined the weighted average of the cost of the device by giving a weight of 3 to the median acquisition cost of the device as provided by external data and a weight of 1 to the median cost from our claims data. We then added the adjusted cost of the device to the unadjusted cost of the procedure to calculate the total cost of the procedure. Our dampening policy was then applied to the adjusted total cost of the procedure.

We believe that this process gave us credible adjusted medians for APCs 107, 108, 222 and 259. We gave external acquisition cost data a weight 3 times that of the adjusted claims median data because these APCs are disproportionately highly weighted with device costs and we recognize that our device data have weaknesses that would otherwise result in payments that are so low as to limit beneficiary access to these services.

We also examined further those APCs involving blood and blood products, and vaccines. Information from comments raised significant concerns about the payment reductions that would result, even after improvements in data and methods and the adjustments described above were applied, on blood and certain blood products (including antihemophilia factors). Considering the importance of these products to ongoing operation of hospitals, the short shelf life of many of them, other peculiarities of their distribution, and possible adverse effects on public health, we concluded that these products should be further protected from decreases. Accordingly, we limited the reduction in the median cost from 2002 to 2003 for these products to 11 percent, which resulted in limiting the reduction in payment from 2002 to 2003 to about 15 percent. We did this for the APCs listed in Table 8.

We also adopted specific changes relating to vaccines and certain orphan drugs, as described elsewhere in this final rule.

We created unscaled weights for all APCs by dividing the adjusted medians by the median cost for APC 601 (mid level visit). We then scaled the weights for budget neutrality. The budget neutrality scaler that we applied to the weights was .968969.

TABLE 8.—BLOOD AND BLOOD PRODUCTS WITH SPECIAL LIMITS

APC	Description
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T.
0950	Blood (Whole) For Transfusion.
0952	Cryoprecipitate.
0954	RBC leukocytes reduced.
0955	Plasma, Fresh Frozen.
0956	Plasma Protein Fraction.
0957	Platelet Concentrate.
0958	Platelet Rich Plasma.

TABLE 8.—BLOOD AND BLOOD PRODUCTS WITH SPECIAL LIMITS—Continued

APC	Description
0959	Red Blood Cells.
0960	Washed Red Blood Cells.
0966	Plasmaprotein fract,5%,250ml.
1009	Cryoprecip reduced plasma.
1010	Blood, L/R, CMV-neg.
1011	Platelets, HLA-m, L/R, unit.
1013	Platelet concentrate, L/R, unit.
1016	Blood, L/R, froz/deglycerol/washed.
1017	Platelets, aph/pher, L/R, CMV-neg, unit.
1018	Blood, L/R, irradiated.
1019	Platelets, aph/pher, L/R, irradiated, unit.
9500	Platelets, irradiated.
9501	Platelets, pheresis.
9502	Platelet pheresis irradiated.
9503	Fresh frozen plasma, ea unit.
9504	RBC deglycerolized.
9505	RBC irradiated.
9506	Granulocytes, pheresis.
0925	Factor viii per iu.
0926	Factor VIII (porcine) per iu.
0927	Factor viii recombinant per iu.
0928	Factor ix complex per iu.
0929	Anti-inhibitor per iu.
0931	Factor IX non-recombinant, per iu.
0932	Factor IX recombinant, per iu.
1409	Factor viia recombinant, per 1.2 mg.
1618	Vonwillebrandfactrcmplx, per iu

Comment: Many commenters, while indicating appreciation for our efforts to use data from multiple claims in determining relative weights as described in the August 9, 2002 proposed rule, believe that we have not done enough. Although we have significantly increased the number and proportion of claims that enter the calculation for relative weights, commenters asserted that, in particular, clinical areas, our mobility to draw on multiple claims distorts the relative weights assigned to services, because in normal circumstances certain services would always be performed with other particular services. If packaged services also appear on such claims, the claims would not be used in our current methodology, and relative weight calculations may not be as accurate as desired as a result. These commenters urged us to do more to include data from multiple claims.

Response: We appreciate the recognition of the methodological improvements that we have been able to accomplish this year. Although intend to continue the gains achieved for 2003, the development of appropriate methods is difficult. Further methodological development may be very detailed and involve clinical review of particular areas of services. We have been unable to develop any further methodological changes at present, so for 2003, we are adopting the same methods we proposed. We wish to develop further methods of allocation that will permit use of more multiple claims in the future, particularly in problem areas identified by commenters, and we hope to be able to make further progress in this area in time for the 2004 update.

Comment: Several commenters raised questions about our editing procedures relating to which claims were used in analysis. On one hand, some questioned whether our standard method of trimming claims with values over three standard deviations above the median was appropriate, or whether it might leave out reasonable claims involving newly disseminating, high cost technologies. Other commenters suggested that we edit the claims more restrictively, removing from analysis claims with values outside a clinically relevant range (of drug dosages, for instance).

Response: While we think the suggestions made by these commenters deserve further consideration, we have made no changes in developing the estimates for the final rule. Our procedure for trimming claims with values above three standard deviations, an exceedingly small proportion of claims, is a standard procedure we use in estimates for several payment systems. This procedure prevents undue influence on the estimates by claims that have a high probability of coding errors, and we have no particular indication that this procedure is inappropriately applied in this system. Establishing clinically relevant ranges would be difficult. The most obvious method would involve establishment of norms of particular services based on the judgment of clinicians, but these judgments might not be validated by actual experience in the field. We would have to develop this idea more thoroughly before adopting it. Accordingly, for 2003 we are using the trimming and editing procedures rules described in the August 9, 2002 proposed rule.

Comment: Several commenters noted that hospital coding appeared to improve over the course of 2001, based on quarter-by-quarter examination of claims data.

Response: We agree that hospital coding practices appear to have improved during the early months of the implementation of the OPPS. Because accurate coding now has definite implications for payment that it lacked in the past, this change was expected and comports with our experience in implementing other payment systems. To improve the quality of estimates for this final rule, we changed the reference period of the data used for the final rule by one quarter. The August 9, 2002 proposed rule was based on data from calendar year 2001; for the final rule, we dropped data from the first quarter of 2001 and added data from the first quarter of 2002. We were thus able to draw on data from a more recent period

while maintaining approximately the same number of claims for analysis. This change was possible in this instance because the implementation of the 2002 update on April 1, 2002 meant that the coding during the first quarter of calendar year 2002 was unchanged from the prior year. We believe that this change has improved the quality of our estimates.

Comment: Commenters asked a number of very detailed questions about our data and methods of calculation.

Response: Within a few weeks of the publication of this rule, we expect to invite interested parties to a meeting at our headquarters in Baltimore to discuss these and other questions regarding methods and estimates with our technical staff.

Use of Cost-to-Charge Ratios and Charge Compression

Comment: A number of commenters raised concerns about our use of cost-to-charge ratios in determining median costs of items and services. Of particular concern is the effect of our procedure on the costs we calculate for high-cost drugs and devices. These commenters asserted that hospitals markup their acquisition costs of drugs and devices by different percentages depending on the cost of the item. If so, application of cost-to-charge ratios that do not take this effect into account would result in a relative weight (and hence payment) for a high-cost item that was inappropriately low. Commenters asserted that differential mark-up behavior, sometimes referred to as ''charge compression,'' is common among hospitals, at least on purchased inputs such as implantable devices.

To illustrate, assume cost-to-charge ratios are about generally 50 percent. That would imply that an item that cost, for example, $100, would be marked up by 100 percent to $200. ($100/$200 = .5) If the hospital decided to mark up the cost of a high cost item by only 50 percent, the charge for an item that cost $1,000 would be $1,500, and the cost-to-charge ratio would be 67 percent. ($1,000/$1,500 = .67) On the other hand, the hospital might choose to mark up a low cost item by 150 percent: The charge for an item that cost $10 would be $25, and the cost-to-charge ratio would be 40 percent ($10/$25 = .4).

Commenters did not provide any useful empirical information on issues such as those above. One commenter presented results of a statistical analysis of the relation of average wholesale price (AWP) of some drugs to our proposed payments, but we do not know if average wholesale prices vary uniformly in proportion to the acquisition costs of hospitals and consequently do not find this analysis particularly informative.

Response: We calculate OPPS payment rates based on the charges made by the hospitals on OPD claims, reduced to costs by application of a cost-to-charge ratio that is either specific to each of the various departments of each hospital or, in cases where data are inadequate, to the individual hospital as a whole. Costs are not available on a service-specific basis, but are reported on each hospital's cost report by revenue center, which can in turn be grouped by department. Thus, the service-specific amount claimed is multiplied by the departmental cost-to-charge ratio to convert it into a measure of the cost on a service-specific basis. We then use these costs to adjust the relative weights for the various APCs as part of the annual update process.

In making this calculation, we are assuming that the ratio of cost to charges is constant across all services to which it is applied. This assumption has proved workable in the inpatient setting for almost 20 years. The calculations may not perfectly capture the costs identified for particular services, but as long as we use them in a set of relative calculations, any deviations should largely cancel out. However, if hospitals do not mark-up services in a uniform fashion within departments, the payment rates resulting from application of this assumption would be too low for some services (and too high for others), and the rates would create incentives for hospitals to avoid (or favor) particular services.

This postulated behavior of hospitals is not implausible, as they may attempt to avoid adverse reactions to high prices among consumers and to reduce coinsurance burden on high cost items used infrequently. However, the possibility of differential mark-up behavior is not well documented empirically. We do not know if differential mark-ups are common across many hospitals or across many services. Further, we do not know the size of any differential that may exist. Do hospitals apply differential mark-ups to all services or only to certain purchased inputs? Do they apply differential mark-ups only above some threshold (such as $1,000), or does the mark-up vary in some uniform fashion with the cost of the service?

In the face of the paucity of reliable empirical information on this issue, we find that we cannot move quickly to revise our current methodology. We are adopting our proposed methodology for calculating cost-to-charge ratios for 2003. We believe this issue merits further study, and we expect to address it further in the future.

Use of Means Rather Than Medians To Set Weights

Comment: Some commenters suggested that CMS use means rather than medians to set rates because means will result in higher values for device-related APCs than using medians. Some commenters noted that means are a better measure of central tendency because medians are so sensitive to the atypical distribution of new technology services within an APC. Some commenters recommended that if we use medians, we should revise the data set by deleting claims for services that require a device if the device was not billed.

Response: We will explore the possibility and potential impact of using means rather than medians for the 2004 OPPS. We lacked the resources and time to explore the impact of this change for the final rule with comment. However, since the purpose of these measures is to create relative payment weights, it does not necessarily follow that basing the relative weights of services on means will cause a change to the weights in a manner that would satisfy the commenter. We did, however, revise the data set by deleting claims for procedures that required a device if the device was not billed.

Collect at Least 3 Years' Data for Pass-Through Devices Before Setting Rates Based on Claims Data

Comment: Commenters recommended that we not use claims data to set weights for pass-through devices unless they have at least 3 years of claims data for the device. They argued that this was the minimum amount of time needed to allow stability in the hospitals' coding and charges for the items.

Response: We cannot ensure that we will wait for 3 years to pass before we will set payments based on data for new devices. The statute provides for no less than 2 years and no more than 3 years payment under pass-through for items that do not fit a previously existing device category. Hence, in most cases, items will not have received 3 years of transitional pass-through payment before they are priced based on costs. Moreover, many new devices do not receive pass-through status because they fit in a category that previously met the criteria and, once pass-through payment is no longer permitted for the category, these devices will be paid through payment for the procedure in which they are used from their first use.

In general, the statute requires us to use costs as the basis for the weights.

Claims data are the single national uniform basis of cost data for all OPD items and services. Other data sources are fragmented and are not national in scope, and may be biased in various ways. We believe that 2 years provides a sufficient time for hospitals to establish coding practices and to determine what charges to impose for items and services paid under the OPPS and that this will be even more true in the future as hospital coders and billers become more accustomed to HCPCS coding and the impact of charges on future payments.

Continue 2002 Weights for 2003 and Train Hospital Staff Coders and Billers Because Claims Data Are Flawed

Comment: Some commenters asserted that Medicare 2001 claims data are so badly flawed that the weights should be left untouched for 2003. They requested that we should initiate training of hospital staff billers and coders to ensure that future data accurately reflect the codes of the services furnished and that the charges accurately reflect the costs of drugs and devices.

Response: We have decided to revise the weights for 2003 based on the best available information. We believe that the adjustments and moderations we have made to the median costs for the services that would have been most adversely affected under the methodology used in the August 9, 2002 proposed rule have enabled us to establish a valid set of relative weights for the 2003 OPPS. This comports with the requirement of section 1833(t)(9)(A) of the Act that we review and revise the relative weights annually to take into account new cost data and other relevant information, and factors. Regarding training of hospital staff, we have greatly expanded our efforts to assist providers in complying with all Medicare rules, including creation of the Medlearn Web site, issuance of specialized articles and provider seminars. However, the fundamental responsibility for correct coding and billing for services lies with the hospitals who are paid under the OPPS system and who have every incentive to bill correctly to ensure that they are paid for all the services they furnish to Medicare beneficiaries.

Release of Crosswalk for Packaging Costs to Specific APCs

Comment: Some commenters asked that we release the crosswalk used to assign pass-through device costs to specific APCs. They indicated that without this crosswalk, they are unable to make specific comments and they urged the Congress to fund an additional activity to correct APCs they determine to be severely underfunded after they perform this analysis.

Response: There is no CMS-generated crosswalk that was used to assign pass-through device costs to APCs. We relied upon the coding of hospitals in their packaging of devices, drugs, and other items and services into the payment for the procedure in which they were used. We will make a public use file available that containing the claims data used to set the final payment weights. By examination of these data, interested parties can determine what was packaged into the medians for the APCs. While we recognize that the claims may contain errors, we believe that the probability of making errors in crosswalking services to procedures is reduced by accepting what providers bill as the items and services furnished with the procedure.

Impact of Medical Education on OPPS Payment Adequacy

Comment: Several commenters noted that payment under OPPS does not take into account the time and cost components associated with providing teaching services in teaching hospitals and thereby puts teaching hospitals at a disadvantage. Moreover, teaching hospitals are typically on the cutting edge of development and implementation of new innovations, technological and otherwise and would therefore be underpaid by the low payments proposed for APCs that use expensive devices. The commenters asked that Medicare provide an indirect medical education (IME) payment percentage add-on for all outpatient APCs similar to the IME factor used to adjust DRG payments for inpatient services.

Response: We have not developed an IME add-on for payments made under the OPPS because the statute does not provide for this adjustment, and we are not unconvinced that it would be appropriate in a budget-neutral system in which such changes would result in reduced payments to all other hospitals. Moreover, in the final rule, we have developed payment weights that we believe resolve many of the issues with payments for devices for which payment is packaged into the payment for the procedure in which the device is used. These and other payment changes should help ensure equitable payment for all hospitals as provided within the constraints of the statute.

Elimination of Payment for Cochlear Implants and Vagus Nerve Stimulators

Comments: A number of commenters objected to what they believed was a proposal to eliminate payment for cochlear implants and vagus nerve stimulators. Those who had the implant indicated that these devices had greatly improved their lives, or others who were expected to have the device implanted objected to what they believed was a proposal to no longer pay for them.

Response: We did not propose to cease payment for these devices under Medicare or to cease payment for services needed to implant them. We did propose payment amounts for 2003, and, in this final rule, we provide the payment rates that will determine payments under the OPPS in 2003. The establishment of payment amounts does not constitute a Medicare determination that these items and services are or are not covered in any particular case.

Underfunding of OPPS in General

Comment: Some commenters stated that OPPS was severely underfunded when it was established and it will never result in adequate payment of costs under its current budget neutrality requirements. They asked that we support their efforts to seek increased funding for outpatient services since hospital care is increasingly furnished in the outpatient setting and because continued absence of adequate funding will result in reduced access to services. Some commenters indicated that since the budget neutrality scaler is determined on the basis of estimates, we have considerable latitude to ensure that payments are as close to costs as possible, notwithstanding that the base was set at 82 percent of cost when the system was established.

Response: We do not believe that the OPPS system is severely underfunded, nor do we believe that the statute gives us flexibility in the determination of budget neutrality. Congress set the OPPS system to be budget neutral to the total payments under prior payment methods; those methods, as result of several statutory provisions dating back to FY 1990 and FY 1991, paid for hospital outpatient department services at approximately 82 percent of costs. We understand that observers at the time believed that hospitals had shifted accounting costs that might otherwise have been attributed to inpatient cost centers to the outpatient setting because the inpatient PPS limited hospital payment on the inpatient side while the outpatient side was not similarly constrained. Congress had thus reduced payments for outpatient department services below nominal costs, and the OPPS was set to be budget neutral relative to total payments under the prior system. Whether this situation

implies that hospital outpatient departments are underfunded under the OPPS is hard to judge.

With respect to budget neutrality, section 1833(t)(9)(B) of the Act makes clear that any adjustments to the OPPS made by the Secretary may not cause estimated expenditures to increase or decrease. We do not believe the statute provides us authority to depart from budget neutrality simply because it uses the word ''estimated.''

Data Issues Peculiar to Radiopharmaceuticals

Comment: Commenters stated various reasons why it would be inappropriate to use the 2001 claims data to calculate the median cost of radiopharmaceuticals. They claimed that additional costs unique to radiopharmaceuticals, such as overhead costs for nuclear pharmacies and safety/regulatory costs, were not reported in the 2001 claims. Also, they believe not all hospitals billed for their costs, particularly costs for overhead items, to the appropriate revenue codes. Therefore, they argue this misallocation of charges resulted in an underestimate of the cost-to-charge ratios that were used to set the payment rates. The low volume of claims for radiopharmaceuticals in the 2001 dataset may be attributed to the use of HCPCS A4641, which many hospitals used for radiopharmaceutical billing, instead of more specific coding. Also, they suggested that we did not receive reliable reporting data from the hospitals because of significant descriptor and payment rate changes in 2001. Thus, they recommended that we not implement the proposed changes until more accurate data on hospital costs could be collected.

Response: As discussed elsewhere in this section, we believe that we have satisfactorily resolved the data issues in the claims data for 2001 to enable us to create an appropriate set of relative weights for OPPS services for 2003. We find no justification for delaying the update of the 2003 OPPS. Moreover, we see nothing unique in the issues raised in the context of data for radiopharmaceuticals. As with other services, the costs in revenue centers and for A4641 were packaged into the procedure with which the items were billed. Similarly, we do not believe that the problem with multiple procedure claims is more of a problem for radiopharmaceuticals than for other services that are commonly provided in combinations. Lastly, there were significant descriptor and payment rate changes for all services paid under OPPS in 2001, and the extent of the changes for radiopharmaceuticals did not differ significantly from the extent of changes for other items and services.

Methodological Reasons That the Data for Drugs Are Flawed

Comment: Many commenters asserted that there are significant methodological problems in the 2001 claims data for drugs and biologicals, especially the high cost items. They said that the 2001 claims data do not reflect appropriate codes and charges for separately paid drugs and biologicals and that the proposed payment rate does not take into account additional pharmacy overhead costs. They indicated that when we process a claim, we reject the second and subsequent line if it is identical to a previously billed line as a duplicate claim and that, therefore, the subsequent lines are not included in the claims data. They maintained that the methodology of analyzing single line-items on drug claims is not consistent with how hospitals bill for particular drugs and biologicals. They stated that claims reported by hospitals for certain drugs and biologicals showed unit amounts that fell outside a therapeutic range and therefore should have been excluded from the body of claims used to set the rates. They said that many drugs and biologicals have a low HCPCS code dose that skews the computation of the relative weights, and thus the payment rates for these products.

Response: We recognize that not all hospitals billed properly for drugs and biologicals in 2001. However, since most payment for drugs and biologicals was made on a pass-through basis at 95 percent of AWP in 2001, hospitals had a significant incentive to bill properly and we believe that in most cases they billed properly for the services they furnished so as to receive payment for them. We recognize that if a claim was submitted in a manner that caused it to be rejected by duplicate claims edits, it would not appear in the data. However, we expect that in those cases, hospitals would submit an adjustment bill to secure payment for the full service and that the costs for the drugs or biologicals as shown in the adjustment bill would be reflected in the data. We also recognize that some claims reflect that the drugs were furnished in amounts that were outside of therapeutic ranges. However, we have no reason to believe that those claims do not represent what actually was furnished to the patient. Should a physician deviate from standard therapeutic ranges in particular a case, it is reasonable to expect the claim to reflect what was administered. With regard to the low dose of the HCPCS code, the payment is set based on the definition of the code and so to the extent that the drug or biological is correctly coded on the claim, the claims data would reflect the cost of the drug or biological.

Elimination of Data for Hospitals Without Actual Charges

Comment: Several commenters raised concerns regarding the elimination of about 3 million claims from 301 hospitals because their reported charges were not actual charges. The commenters requested the following information from us on the effect of eliminating these claims: Did the elimination of this information create more bias against higher cost drugs and biologicals? Were the claims from certain specialty hospitals?

Response: There is no way for us to determine what effect would have taken place if these hospitals had reported charges as other hospitals did. However, because we know that the reported charges for these hospitals are not actual charges, we know that the information provided by these hospitals is meaningless for the purpose of calculating payment rates under OPPS.

Impact of Rounding of Relative Weights for Drugs

Comment: Commenters stated that the rounding of relative weights down to only two decimal places causes a significant reduction in payment. For example, rounding a unit down to a relative weight of 0.01 from a greater amount (for example, 0.01433) can substantially decrease the payment amount of a therapeutic dose.

Response: We rounded relative weights to 4 decimal places in the final rule.

Comment: A commenter indicated that we included data from the 11 PPS-exempt cancer hospitals that should have been excluded from the rate-setting calculations.

Response: We disagree with the commenter's concern. According to 42 CFR 412.23(f), cancer hospitals that meet specific criteria are excluded from the inpatient PPS; however, these hospitals are not excluded from OPPS. Rather, under OPPS, cancer hospitals are held harmless. The hold harmless provision is set forth in our existing regulations at 42 CFR 419.70(d)(2). Therefore, we do not exclude claims for services furnished in these hospitals in our rate setting calculations.

Need for a Special Exceptions Process

Comment: Some commenters said that CMS should have a process by which hospitals should be able to submit special documentation to indicate that

unusual conditions exist and be paid an additional amount set by the contractor for the unusual conditions or costs that the hospital is incurring. They suggested this as a means of being assured of recouping costs where the APC payment would not otherwise reimbursement for full costs.

Response: We did not accept the comment because the OPPS already has an outlier system that provides for an additional payment when costs are incurred that meet the outlier criteria.

Claims Process

Comment: One commenter said that the implementation of OPPS was extremely daunting to providers because it was so different from prior billing and coding for these services and because CMS processes and rules changed so frequently. They indicated that software vendors often lagged behind CMS requirements and that errors in either provider billing or intermediary processing often required a hospital to detect a problem and resubmit claims. Moreover, the volume of claims can cause a small problem to become a large problem in very little time. They ask that CMS do whatever it can to simplify the processes they must undertake to achieve submission of a ''clean'' claim.

Response: We recognize that implementation of CMS was difficult for providers and we have tried to do all that we can to simplify billing and payment rules and to respond to problems as they arise. Most recently, the hospital open door forum calls have provided a means for hospitals to bring problems to the attention of the CMS staff as quickly as possible so that they can be resolved.

Reduced Quality of Care for Gamma Knife Services

Comment: A commenter said that reducing payment for hospital services for G0242 will force hospitals to reduce the hours of work for medical physicists in the hospital and will therefore decrease quality by increasing the opportunity for errors in the calculations that must be done before treatment.

Response: We believe that hospitals would not jeopardize themselves by decreasing the extent to which they ensure that errors are not made.

We are finalizing our rate methodology for PHP, including data from hospital outpatient and CMHC programs. The national unadjusted rate for CY 2003 will be $240.03, of which $48.17 is the beneficiary's national unadjusted coinsurance. Upon further review we have determined that we will not include the issue of separate billing for clinical social worker services provided to PHP patients in this final rule but will address it in future rulemaking.

IV. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biologicals.

For those drugs, biologicals, and devices referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), Public Law 106–554, enacted December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' medical devices, drugs, and biological agents that could not be described as current, 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 1833(t)(6)(B)(i) of the Act required that we establish, by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum. On March 22, 2001, we issued two Program Memoranda, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at *http://cms.hhs.gov.*

Transmittal A–01–41 includes a list of the initial device categories and a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments as of January 21, 2001 to the initial category code by which the device is to be billed beginning April 1, 2001. Items eligible for transitional pass-through payments are generally coded using a Level II HCPCS code with an alpha prefix of ''C.'' Pass-through device categories are identified by status indicator ''H'' and pass-through drugs and biologicals are identified by status indicator ''G.'' Subsequently, we added two additional categories and made clarifications to some of the categories' long descriptors found in transmittal A–01–73. A current list of device category codes in effect as of July 1, 2002 can be found in Transmittal A–02–050, which was issued on June 17, 2002. This Program Memorandum can be accessed on our Web site at *http://cms.hhs.gov.* The list is also included in this preamble in Table 7.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional device categories. The criteria for new categories are the subject of a separate interim final rule with comment period that we published in the **Federal Register** on November 2, 2001 (66 FR 55850). We respond to public comments on that interim final rule in this final rule with comment that implements the 2003 OPPS update.

Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations at § 419.64 governing transitional pass-through payments for eligible drugs and biologicals are unaffected by the creation of categories.

The processes to apply for transitional pass-through payment for eligible drugs and biological agents or for additional device categories can be found on respective pages on our Web site at *http://cms.hhs.gov*. If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes are generally posted on the OPPS Web site at *http://cms.hhs.gov/Medicare/hopps/default.asp.*

As we indicated in the NPRM (67FR52130), Determining that a drug or biological is eligible for a pass-through payment or making a decision to pay a drug or biological on a separate APC basis (rather than packaging payment into payment for a procedure) does not represent a determination that the drug or biological is covered by the Medicare program.

CMS and its contractors make coverage determinations and the FDA makes premarket approval decisions under different statutory standards. Whereas the FDA must determine that a product is safe and effective as a condition of approval, CMS must determine that the product is reasonable and necessary as a condition of coverage under section 1862(a)(1)(A) of the Social Security Act. Under a premarket approval review, the FDA determines whether or not the product is safe and effective for its intended use that is

stated in its proposed labeling. Medicare evidence-based NCD reviews consider the medical benefit and clinical utility of an item or service in determining whether the item or service and its expenses are reasonable and necessary under the Medicare program. Unlike the FDA safety and effectiveness evaluation, CMS determines whether or not the product is clinically effective, that is, does the item or service improve net health outcomes in the Medicare population as compared to other covered technologies or procedures. CMS and its contractors do require that a drug or biological first be approved by the FDA, although not necessarily for the indication for which coverage is sought. CMS and its contractors also strongly consider the FDA's evaluation when making a coverage determination for a product and do not substitute their judgment for that of the FDA's regarding safety and effectiveness. Instead, we focus our review on the issues that are unique to Medicare's reasonable and necessary determination. (We note that approval of a product by the FDA as a drug or biological does not automatically assure that Medicare payment for the product will be as a drug or biological. The product must still be placed into the most appropriate Medicare benefit category before Medicare can make appropriate payments.)

In the case of an FDA-approved indication for drugs and biologicals, CMS and its contractors have generally considered that use to be reasonable and necessary, without performing a separate review, although Medicare has always retained the right to perform a separate evaluation. (See, for example, 54 FR 4302, 4306, January 30, 1989) (Proposed Rule-Coverage Criteria) (''Questions regarding coverage of drugs and biologicals are rarely referred to PHS since we have determined as a matter of national policy that drugs or biologicals approved for marketing by FDA are safe and effective when used for indications specified in their labeling.'') (emphasis added); Medicare Carriers Manual section 2049.4 (''Use of the drug or biological must be safe and effective *and otherwise reasonable and necessary*. Drugs or biologicals approved for marketing by the Food and Drug Administration are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.'' (emphasis added). Under section 2049.4, our contractors ''*may* pay for the use of an FDA approved drug or biological, if: (1) It was injected on or after the date of the FDA's approval; (2) It is reasonable and necessary for the individual patient; and (3) All other applicable coverage requirements are met.'' (emphasis added).

CMS developed this approach, because, in the past, it was a more efficient mechanism for coverage and the impact of drugs and biologicals on the Medicare program was relatively small. Now, as a result of the increasing number of novel therapies on the market and the impact of new drugs and biologicals on the Medicare program, it is prudent for Medicare to perform its traditional coverage analysis for appropriate drugs and biologicals as it does for all other items and services to ensure that it only pays for those products that are clinically effective. For drugs and biologicals, Medicare will continue to use FDA approval as a default for a reasonable and necessary determination of an FDA-approved indication unless CMS decides otherwise. CMS may choose to perform a reasonable and necessary determination in several circumstances, including, but not limited to the following: the drug or biological in question represents a novel, complex or controversial treatment, may be costly to the Medicare program, may be subject to overutilization or misuse, or received marketing approval based on the use of surrogate outcomes.

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, we specify the applicable percentage up to 2.0 percent. If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a (prospective) uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether pass-through payments will exceed the applicable percentage but also to determine the appropriate reduction to the conversion factor.

In the August 9, 2002 proposed rule, we describe in detail the methodology we would use to make an estimate of pass-through spending in 2003 (67 FR 52117 through 52118). Very generally, after projecting 2003 pass-through spending for the groups of devices, drugs, biologicals, and radiopharmaceuticals as described in the proposed rule, we would calculate total projected 2003 pass-through spending as a percentage of the total (that is, Medicare and beneficiary payments) projected payments under OPPS to determine if the pro rata reduction would be required.

Below is a table showing our current estimate of 2003 pass-through spending based on information available at the time the table was developed. In the August 9, 2002 proposed rule we indicated that we were uncertain whether pass-through spending in 2003 will exceed $467 million or 2.5 percent of total estimated OPPS spending because we had not yet completed the estimate of pass-through spending for a number of drugs. We invited comments on the methodology we proposed to use to determine if a pro rata reduction would be necessary as well as the assumptions shown in Table X of the August 9, 2002 proposed rule that included anticipated utilization and utilization not yet determined.

We received several comments on this proposal, which are summarized below.

Estimates of Pass-Through Spending

Comment: A device manufacturer stated that it would be premature to impose pro rata reductions before we accurately account for an APC's device offset amount.

Response: Where applicable we have applied offset amounts to APCs with device categories for determining the final estimate of 2003 pass-through spending.

Comment: Many commenters said that there should be no pro rata reduction because we did not present the cost and utilization data that would be used to determine if the criteria for a reduction were met. Some commenters said that the pro rata reduction is discretionary and that we should not impose one because of the magnitude of the decreases for APCs that require expensive devices and the decreases in APCs for drugs (as compared to the pass-through payment). Some commenters said that our proposed projections overestimated the volumes that could be expected to occur in 2003.

Response: Section 1833(t)(6)(E)(i) of the Act requires that the Secretary estimate the total pass-through payments to be made for the forthcoming year (which allows us to determine the amount of the conversion factor for the forthcoming year) and to the extent the estimate exceeds the statutory limit, reduce the amount of each pass-through payment. For 2003,

the statutory limit is 2.5 percent of total estimated program payments. In the August 9, 2002 proposed rule, we provided our best estimate at that time of pass-through payments for the drugs and devices for which we expected to make pass-through payments in 2003, and we explained our methodology for determining the estimate for the final rule. We provided a list of the devices and drugs we either knew would be paid under pass-through next year or which we believed may be paid as pass-through items in 2003.

We have refined and finalized our estimate of pass-through spending in 2003 and, for the reasons discussed below, we have determined that no pro rata reduction will be required in 2003. Moreover, as discussed below the estimate falls under the statutory limit of 2.5 percent. Therefore, the conversion factor has been increased.

Comment: A commenter disagreed with the 2003 payment estimates in Table X of the August 9, 2002 proposed rule for the diagnostic and therapeutic radiopharmaceutical agents, IN–111 Zevalin and Y–90 Zevalin. The commenter estimated the number of patients receiving this therapy in the outpatient department setting in 2003 at approximately 2,500 for both the diagnostic and therapeutic portions, instead of the 9,000 that we projected in our August 9, 2002 proposed rule. The commenter further stated that the payment per patient for the Y–90 Zevalin therapy should be based on 40 mCi, the amount required in the preparation of the dose.

Response: Since publication of the August 9, 2002 proposed rule, we have determined that the appropriate payment mechanism for IN–111 Zevalin and Y–90 Zevalin is through the new technology APCs, rather than through the transitional pass-through payment methodology. Zevalin began receiving pass-through payment as a hospital outpatient service in 2002 as a radiopharmaceutical drug. After careful reexamination of Zevalin, we have determined that Zevalin is not a drug and therefore does not qualify for a pass-through payment.

Section 1861(t)(1) provides that the terms drugs and biologicals ''include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in [one of several pharmacopoeias] (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.'' A careful reading of this statutory language convinces us that inclusion of an item in, for example, the USPDI (as Zevalin is included, as a biological), does not necessarily mean that the item is a drug or biological. Inclusion in such reference (or approval by a hospital committee) is a necessary condition for us to call a product a drug or biological, but it is not enough. Rather, if we are to call a product a drug or a biological for our purposes, CMS must still make its own determination that the product is a drug or biological. In the case of Zevalin, we have determined that Zevalin is not a drug or a biological.

Zevalin consists of a radioactive isotope that is delivered to its target tissue by a monoclonal antibody. Because of the specific requirements associated with delivery of radioactive isotope therapy, any product containing a therapeutic radioisotope, including Y–90 Zevalin, will be considered to be in the category of benefits described under section 1861(s)(4) of the Act. Similarly, the appropriate benefit category for all diagnostic radiopharmaceuticals, including IN–111 Zevalin, is 1861(s)(3). We will consider neither diagnostic nor theraputic radiopharmaceuticals to be drugs as described in section 1861(t).

Thus, we have determined that the most appropriate Medicare benefit categories for IN–111 Zevalin and Y–90 Zevalin are as provided in sections 1861(s)(3) and (4) of the Act because they are a new diagnostic test and new radioactive isotope therapy, respectively. We will pay for IN–111 Zevalin under the New Technology APC 718 and for Y–90 Zevalin under the New Technology APC 725 until we have sufficient hospital charge data upon which to use in assigning these services to clinical APCs. Because we have decided that Zevalin does not qualify for transitional pass-through payments, we have not included the estimated payments for Zevalin in our revised estimates of total 2003 transitional pass-through payments.

We have based the determination of New Technology APCs for IN–111 Zevalin and Y–90 Zevalin on information received from the manufacturer and invoices made available to us, and we believe the resulting payment rates to hospitals should be adequate. We note that had we found it necessary to pay for these products as drugs, the average wholesale price alone could have exceeded $28,000 per treatment. We believe his pricing is excessive and that it would have placed an unnecessarily large burden on the Medicare Trust Funds. Had we found it necessary to treat these products as drugs, however, we could have invoked the authority of section 1833(t)(2)(E) to establish a more equitable payment rate.

A hospital may bill for the number of millicuries billed to them by a radiopharmacy or, if the hospital prepares Zevalin itself, the number of millicuries prepared for administration to the patient but, in either case, no more than 40 millicuries.

CMS has also undertaken a national coverage determination (NCD) for Zevalin, which has been approved by the Food and Drug Administration (FDA) to treat certain types of non-Hodgkin's lymphoma, to assure that the product is appropriately used in the Medicare program. A decision memorandum addressing the clinical uses of Zevalin to be covered by Medicare will appear on the CMS coverage Web site (*http://www.cms.hhs.gov/coverage*) soon after publication of this rule.

Comment: A drug company raised concerns about the relationship of epoetin alpha and darbepoetin alpha, two competing biologicals used for treatment of anemia. The commenter urged that CMS determine that the two products are substitutes with the same clinical effects and argued that the two should be paid, subject to an appropriate conversion ratio, at the same rate.

Response: Erythropoietin, a protein produced by the kidney, stimulates the bone marrow to produce red blood cells. In severe kidney disease, the kidney is not able to produce normal amounts of erythropoietin, and this leads to the anemia. Additionally, certain chemotherapeutic agents used in the treatment of some cancers suppress the bone marrow and cause anemia. Treatment with exogenous erythropoietin can increase red blood cell production in these patients and treat their anemia.

In the late 1980's, scientists used recombinant DNA technology to produce an erythropoietin-like protein called epoetin alpha. Epoetin alpha has exactly the same amino acid structure as the erythropoietin humans produce naturally, and, when given to patients with anemia, stimulates red blood cell production.

Two commercial epoetin-alpha products are currently marketed in the United States: Epogen™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech). These products are exactly the same but are marketed under two different trade names. Both Epogen™ and Procrit™ are approved by FDA for marketing for the following conditions: (1) Treatment of anemia of chronic renal failure (including patients

on and not on dialysis), (2) treatment of Zidovudine-related anemia in HIV patients, (3) treatment of anemia in cancer patients on chemotherapy, and (4) treatment of anemia related to allogenic blood transfusions in surgery patients. Both products are given either intravenously or subcutaneously up to three times a week.

Amgen has recently developed a new erythropoietin-like product, darbepoetin alpha, which it markets as Aranesp™. Also produced by recombinant DNA technology, darbepoetin alpha differs from epoetin alpha by the addition of two carbohydrate chains. The addition of these two carbohydrate chains affects the biologic half-life. This change, in turn, affects how often the biological can be administered, which yields a decreased dosing schedule for darbepoetin alpha by comparison to epoetin alpha. Amgen has received FDA approval to market Aranesp™ for treatment of anemia related to chronic renal failure (including patients on and not on dialysis) and for treatment of chemotherapy-related anemia in cancer patients.

Because darbepoetin alpha has two additional carbohydrate side-chains, it is not structurally identical to epoetin alpha. However, the two products are functionally equivalent: In this case, both products use the same biological mechanism to produce the same clinical result, stimulation of the bone marrow to produce red blood cells. Thus, Epogen™, Procrit™, and Aranesp™ are all functionally equivalent.

These biologicals are dosed in different units. Epoetin alpha is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alpha in micrograms per kilogram (mcg/kg). The difference in dosing metric is due to changes in the accepted convention at the time of each product's development. At the time epoetin alpha was developed, biologicals (such as those developed through recombinant DNA) were typically dosed in International Units (or Units for short), a measure of the product's biologic activity. They were not dosed by weight (for example, micrograms) because of a concern that weight might not accurately reflect their standard biologic activity. The biologic activity of such products can now be accurately predicted by weight, however, and manufacturers have begun specifying the doses of such biologicals by weight. No standard formula exists for converting amounts of a biologic dosed in Units to amounts of a drug dosed by weight.

In clinical practice, CMS recognizes that no strict method of converting an epoetin alpha dose to a darbepoetin alpha dose exists. There are general guidelines for conversion, and clinicians modify the dose based on the patient's hematopoietic response. For developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other.

As part of the process to define a conversion ratio between these biologicals, CMS held a series of meetings with both Amgen and Ortho Biotech. Both companies provided substantial written and published information. We reviewed the Food and Drug Administration labeling for each product (Epogen™, Procrit™, and Aranesp™). We also hired an independent contractor to review the available clinical evidence, and we performed an internal review of this evidence as well. The body of literature reviewed included 40 scientific articles culled from references submitted by the companies as well as a Medline literature search. CMS took into consideration both published and unpublished studies as well as abstracts, conference reports, and materials provided by the two companies.

In selecting articles for review, CMS sought studies that (1) provided a ''head-to-head'' comparison of epoetin alpha to darbepoetin alpha either in patients with chronic kidney disease (on or not on dialysis) or in cancer patients with chemotherapy-induced anemia, and (2) in which an appropriate outcome measure was used. In the absence of such data, we also considered clinical studies that either compared both products to each other or that linked the dose of a particular product with an appropriate health outcome measure.

CMS's identification of a conversion ratio between the dosages of these two products, darbepoetin alpha and epoetin alpha, is solely for the purpose of developing a Medicare payment policy. It is not meant to imply or suggest what should be done for individual patients in clinical practice. In addition, by using a conversion ratio CMS is not attempting to establish a lower or upper limit on the amount of either biological a physician can prescribe to a patient. CMS expects that physicians will continue to prescribe these biologicals based on the needs of individual patients. In terms of payment, however, CMS considers these biologicals to be functionally equivalent (even if structurally different), and, therefore, will establish an equitable payment policy that relates dosage of the agents to each other.

In our review, we placed the greatest emphasis on published, high quality clinical studies and looked for the best possible estimates based on an evaluation of the dosing of each product that, on average, produced the same clinical response. Based on our own review of the evidence, our consultation with the independent contactor who also reviewed the evidence, and our discussions with Amgen and Ortho Biotech, CMS concludes that an appropriate conversion ratio for the purposes of a payment policy is to 260 International Units of epoetin alpha to one microgram of darbepoetin alpha (260:1).

We think that improved information from clinical trials involving ''head-to-head'' comparisons of these two products could help us insure our policy is correct and if necessary update this policy in the future. In this vein, the National Cancer Institute has been directed to work with CMS to quickly develop and sponsor a trial or trials to evaluate the appropriate conversion ratio between these products for the purpose of Medicare pricing. We expect this project to be completed during the cycle for development of the 2004 OPPS update regulation. If we can estimate a more accurate conversion ratio based on this study or from our review of our own payment data, we will make a change to reflect this ratio so as soon as practicable.

We proposed that transitional pass-through payments for epoetin alpha end at the end of this calendar year, and that payment be made in calendar year 2003 in a separate, unpackaged APC. We are adopting these policies for the final rule.

We had proposed to continue transitional pass-through payments for darbepoetin alpha. We accept, however, the comment suggesting that these two biologicals should be paid at the same rate. As noted above, the products are almost identical; nevertheless there is a great disparity in their costs. In this situation, we believe it is appropriate for us to rely on our authority in section 1833(t)(2)(E) of the Social Security Act to make an adjustment we determine ''necessary to ensure equitable payments.'' We do not believe it would be equitable or an efficient use of Medicare funds to pay for these two functionally equivalent products at greatly different rates. We would package these two biologicals into the same APC, but the difference in dosage metrics makes this step technically impossible if we are to maintain the ability to pay on the basis of the actual dose used. Consequently, they will be in separate APCs but paid at equivalent rates. The 2003 payment rate for non-ESRD epoetin alpha is established as $9.10 per 1000 Units elsewhere in this

rule. We employ the conversion ratio of 260:1 to establish the 2003 payment rate for darbepoetin alpha as $2.37 per 1 microgram. Because this payment rate equals the payment rate for epoetin alpha (albeit expressed in different units), we reduce the transitional pass-through payment for darbepoetin alpha to zero.

An alternative line of reasoning would produce the same result. Section 1833(t)(6)(A) of the Social Security Act distinguishes between ''current'' and ''new'' biologicals. Epoetin alpha is a ''current'' biological. Since April 2002, we have treated darbepoetin alpha as a ''new'' biological. However, section 1833(t)(6)(A)(iv) sets forth the criteria that must be met for a biological to be considered ''new.'' One criterion is that the biological is not described by any item described in clauses (i), (ii) or (iii) of section 1833(t)(6)(A) of the Act, which define ''current'' drugs, biologicals, and devices. Given the determination stated above that these products are functionally equivalent, we believe that darbepoetin alpha is already described by epoetin alpha, a ''current'' biological. Because darbepoetin alpha is functionally equivalent to epoetin alpha, we believe we could conclude that it would be most appropriate to consider darbepoetin alpha a ''current'' biological. In that event, it would not qualify for a pass-through payment as a ''new'' biological. Accordingly, under this analysis, we would terminate the duration of transitional pass-through payment eligibility for darbepoetin alpha on December 31, 2002, and pay for it in a fashion comparable to other products that lose eligibility for transitional pass-through status on that date. More particularly, we would pay it equivalently to epoetin alpha.

Beneficiary copayments are unchanged as a result of the change in payment for darbepoetin alpha, because under this rule the copayment amount for both biologicals would have equaled that calculated for epoetin alpha in any case.

This change is budget neutral. As a result of this change, our estimate of total transitional pass-through payments is smaller than it would otherwise have been. The percentage we have reduced the conversion factor to compensate for transitional pass-through spending is accordingly smaller, and in a budget neutral fashion payment rates for other services are correspondingly higher.

We do not expect to make nationally-applicable determinations of similarity of drugs or biologicals, such as that discussed above, on a routine basis. We regard this situation as unusual, distinguished by the very strong similarity of the two products and by the size of the potential effects on the Medicare program. We thus believe that making this determination and insuring comparable payment is justified in this particular instance.

Comment: Commenters from pharmaceutical manufacturers, trade associations, and a provider of oncology services raised concern over the methods used to estimate 2003 pass-through payments for drugs. The primary concern was that we overestimated pass-through spending for 2003, and as a result would trigger pro rata reductions in pass-through payments for drugs appearing on Table X.

Some commenters suggested that we refine our estimation procedures by utilizing alternative modeling techniques and by using data from claims experience. Several of the comments included, in depth, data analysis along with models used to predict pass-through drug spending for calendar year 2003. Spending estimates ranged from $213 million to $441 million dollars.

Other commenters objected to the techniques used to estimate pass-through spending for future products, those items first eligible for pass-though payments in April 2003 or later. A manufacturer's association objected to the use of drugs eligible for pass-through payment beginning in January 1, 2003 as the basis of a forecast of drugs likely to acquire pass-through statusthroughout the remainder of the year. This objection stems from what the association views as the lack of similarities between drugs first eligible for pass-through payments on January 1, 2003 and those eligible later in the year. Further, they object to estimating any additional pass-through payments when it is not clear whether or not a product will be added to the list during 2003.

Another commenter proposed the use of a more sophisticated model based on drugs currently in the FDA pipeline to be used to project spending of drugs first eligible for pass-through payment between April and December 2003.

Other commenters objected to our estimates for specific drugs.

Response: We have made a number of changes in response to these comments and in the course of our efforts to complete and refine our preliminary estimates. We have removed several items from the list of 2003 pass-through items that appeared in our August 9, 2002 proposed rule and thus from our final estimates of 2003 pass-through payments. These include IN–111 Zevalin and Y–90 Zevalin, as noted above. FDG (HCPCS C1775; APC 1775) meets the statutory definition of a current radiopharmaceutical and has been receiving pass-through payments. Because we have decided that the pass-through status of current radiopharmaceuticals will not continue past December 31, 2002, pass-through payment status for FDG will end on January 1, 2003. Because a separate code for FDG did not exist until April 2002, we do not have discrete hospital charge data upon which to calculate a median cost for FDG. For transition purposes in 2003, we will pay separately for this supply based on an estimated acquisition cost of 71 percent applied to the 2002 payment rate.

We address below several other issues that arose during our refinement of Table X in the proposed rule. We proposed to continue pass-through payment status for TC 99M oxidronate under HCPCS C1058. However, following publication of the August 9, 2002 proposed rule, we determined that this drug was also represented by HCPCS code Q3009. Under HCPCS code Q3009, this radiopharmaceutical agent has received pass-through payment status for at least 2 years, and will no longer be eligible for pass-through payment under either HCPCS code Q3009 or C1058 beginning on January 1, 2003. As proposed, we are packaging the cost of Q3009 into the procedures with which the code was billed.

Two other HCPCS codes representing radiopharmaceutical agents were inadvertently included in the list of 2003 pass-through drugs in the proposed rule. HCPCS codes C1064 and C1065 were add-on codes used to bill for an additional mCi of I–131. These codes, along with the related HCPCS code C1188 and C1348, which are used to report an initial 1–5 or 1–6 mCi, respectively, will no longer be eligible for pass-through payment on January 1, 2003.

Table 9 contains the final list of items that are eligible for pass-through payments in 2002 and will remain eligible in 2003. Table 9 also contains items that have been approved for pass-through payments beginning in 2003.

It does not contain categories of devices or drugs for which pass-through applications are still pending at the time of issuance of this final rule or for which applications have yet to be received.

We used the following methodology to estimate the pass-through payments for 2003.

1. Devices eligible in 2002 [Device categories beginning July 1, 2002 (C1783, C1888, C1900)] that will continue in 2003: We used manufacturers' retail prices along with

claims utilization estimated for 2003 by our clinical staff, based on our claims data and coding and projected utilization information supplied in the applications. No device offsets were applicable.

2. Drugs eligible in 2002 that will continue in 2003: We used the July 2002 Redbook prices to determine the AWP, which we used in combination with our ratios for establishing estimated acquisition costs to derive pass-through payments for drugs in 2003. We determined the volume for pass-through drugs by soliciting manufacturer estimates of volume for the Medicare population where possible and relying upon a commenter's estimates for the volumes of other drugs.

3. Devices eligible in January 2003: We used manufacturers' retail prices along with claims utilization estimated for 2003 by our clinical staff, based on our claims data and coding and projected utilization information supplied in the applications. We applied offsets to procedures associated with devices that mapped to APCs with offsets.

4. Drugs eligible in January 2003: We used the July 2002 Redbook prices to determine the AWP which we used in combination with our ratios for establishing estimated acquisition costs to derive pass-through payments for drugs in 2003. We determined the volume for pass-through drugs by soliciting manufacturer estimates of volume for the Medicare population where possible and relying upon a commenter's estimates for the volumes of other drugs.

5. Devices eligible in 2001 and will continue in 2003: We used manufacturers' retail prices along with claims utilization for the 12 months that ended March 31, 2002, increased to 2003 by the growth rate provided by our actuary.

Our final estimate of transitional pass-through spending for 2003 also includes projected spending for items that have not yet been approved for 2003. We had proposed to base our estimate of spending for such items on items that have been newly approved for January 1, 2003. In response to comments, we have based our projection for items that will be approved later in 2003 on items that were newly approved for October 1, 2002 and January 1, 2003. We have based our estimate on the two most recent quarters of approval because we anticipate a higher volume of pass-through approvals compared to early 2002 for two reasons. First, we began paying for categories of devices on April 1, 2001. The vast majority of items in use at that time, as well as newly FDA approved items, could receive pass-through payments under a category code. We received, and subsequently approved, a relatively small number of pass-through applications in the first half of 2002. Consequently, we based our projection of spending for items that will be determined eligible for pass-through status in 2003 based on items determined eligible for October 1, 2002 and items determined eligible or expected to be determined eligible for January 1, 2003.

In summary, we estimate that pass-through spending in 2003 will approximate $427.4 million. We believe that pass-through spending in 2003 will break out into the following categories for 2003:

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2003

HCPC	APC	Drug Biological	2003 Pass-through payment portion	2003 Estimated utilization	2003 Anticipated pass-through payment
Existing Pass-through Drugs/biologicals					
A9700	9016	Echocardiography Contrast	$30.00	423,220	12,696,607
J9017	9012	Arsenic Trioxide	$7.92	4,047	32,054
J0587	9018	Botulinum toxin type B	$2.22	350,000	777,000
J0637	9019	Caspofugen acetate, 5 mg	$8.64	98,950	854,928
J9010	9110	Alemtuzumab, per 10mg/ml	$129.15	11249.19861	1,452,834
C9111	9111	Injectin Bivalrudin, 250 mg vial	$100.50	38,549	3,874,219
C9112	9112	Perflutren lipid micro, 2 ml	$1.25	12,676,293	15,845,366
C9113	9113	Inj Pantoprazole sodium, vial	$5.76	20,000	115,200
J2324	9114	Nesiritide, per 1.5 mg vial	$36.48	48,000	1,751,040
J3487	9115	Zoledronic acid, 2 mg	$102.77	228,000	23,431,560
C9200	9200	Orcel, per 36 cm2	$286.80	1,000	286,800
C9201	9201	Dermagraft, per 37.5 sq cm	$145.92	4,770	696,038
C9116	9116	Ertapenum sodium	$11.45	8,902	101,928
C9119	9119	Pegfilgrastim	$708.00	102,645	72,672,864
J9219	7051	Leuprolide acetate implant	$1,364.16	373	508,493
Pass-through Drugs/Biologicals Effective January 2003					
C9120	9120	Faslodex	$22.13	9,690	214,440
C9121	9121	Argatroban	$3.60	50,000	180,000
Existing Pass-through Devices					
C1765	1765	Adhesior barrier		224	110,880
C2618	2618	Probe, cryoablation		752	150,400
C1783	1783	Ocular implant, aqueous drainage dev		2,042	1,327,300
C1888	1888	Endovascular non-cardiac ablation catheter		208	150,800
C1900	1900	Lead, left ventricular coronary venous		2,042	4,084,000
Pass-through Devices Effective January 2003					
C2614	2614	Brachytherapy solution/liquid,I–125		100	840,000
C2632	2632	Percutaneous Lumbar Discectomy Probe		612	1,190,340

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2003—Continued

HCPC	APC	Drug Biological	2003 Pass-through payment portion	2003 Estimated utilization	2003 Anticipated pass-through payment
Other Items Expected to Be Determined Eligible for 2003					
		Spending for future approved drugs			234,581,267
		Spending for future approved devices			49,519,559
		Total Spending for Pass-through Drugs/biologicals, and devices 2003.			427,445,917

Our total 2003 estimate of $427.4 million is 2.3 percent of total estimated program payment. We proposed to reduce the conversion factor by 2.5 percent to account for pass-through spending. Since our estimate is now below 2.5 percent, we have adopted a reduction of 2.3 percent to the conversion factor in accord with our estimate of pass-through payments. Our final assumptions used to create the estimate are shown in Table 9 above.

C. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Devices

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We proposed that 95 device categories currently in effect will expire effective January 1, 2003. Our proposed payment methodology for devices that have been paid by means of pass-through categories, but for which pass-through status will expire effective January 1, 2003, is discussed in the section below.

Although the device category codes became effective on April 1, 2001, many of the item-specific C-codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000, or as of January 1, 2001. (The crosswalk for item-specific C-codes to category codes was issued in Transmittals A–01–41 and A–01–97,) To establish the expiration date for the category codes listed in Table 10, we determined when item-specific devices that are described by the categories were first made effective for pass-through payment before the implementation of device categories. These dates are listed in Table 7 in the column entitled ''Date First Populated.'' We proposed to base the expiration date for a device category on the earliest effective date of pass-through status for any device that populates that category. Thus, the 95 categories for devices that will have been eligible for pass-through payments for at least 2 years as of December 31, 2002 would not be eligible for pass-through payments effective January 1, 2003.

Below is Table 7, which includes a comprehensive list of all pass-through device categories effective on or before July 1, 2002 with the date that devices described by the category first became effective for payment under the pass-through provisions and their respective proposed expiration dates.

TABLE 10.—LIST OF PASS-THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES

	HCPCS codes	Category long descriptor	Date first populated	Expiration date
1	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable).	8/1/00	12/31/02
2	C1765	Adhesion barrier	10/01/00–3/31/01; 7/1/01	12/31/03
3	C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).	8/1/00	12/31/02
4	C1715	Brachytherapy needle	8/1/00	12/31/02
5	C1716	Brachytherapy seed, Gold 198	10/1/00	12/31/02
6	C1717	Brachytherapy seed, High Dose Rate Iridium 192	1/1/01	12/31/02
7	C1718	Brachytherapy seed, Iodine 125	8/1/00	12/31/02
8	C1719	Brachytherapy seed, Non-High Dose Rate Iridium 192	10/1/00	12/31/02
9	C1720	Brachytherapy seed, Palladium 103	8/1/00	12/31/02
10	C2616	Brachytherapy seed, Yttrium-90	1/1/01	12/31/02
11	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
12	C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable).	8/1/00	12/31/02
13	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
14	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
15	C1726	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02
16	C1727	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
17	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
18	C1729	Catheter, drainage	10/1/00	12/31/02
19	C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes).	8/1/00	12/31/02
20	C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes).	8/1/00	12/31/02
21	C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping.	8/1/00	12/31/02
22	C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip.	8/1/00	12/31/02

TABLE 10.—LIST OF PASS-THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES—Continued

	HCPCS codes	Category long descriptor	Date first populated	Expiration date
23	C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip.	10/1/00	12/31/02
24	C1887	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
25	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/00	12/31/02
26	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/00	12/31/02
27	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis).	8/1/00	12/31/02
28	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
29	C1754	Catheter, intradiscal	10/1/00	12/31/02
30	C1755	Catheter, intraspinal	8/1/00	12/31/02
31	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
32	C2628	Catheter, occlusion	10/1/00	12/31/02
33	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02
34	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
35	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
36	C1885	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
37	C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability).	8/1/00	12/31/02
38	C1714	Catheter, transluminal atherectomy, directional	8/1/00	12/31/02
39	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
40	C1758	Catheter, ureteral	10/1/00	12/31/02
41	C1760	Closure device, vascular (implantable/insertable)	8/1/00	12/31/02
42	L8614	Cochlear implant system	8/1/00	12/31/02
43	C1762	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02
44	C1763	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
45	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
46	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
47	C1767	Generator, neurostimulator (implantable)	8/1/00	12/31/02
48	C1768	Graft, vascular	1/1/01	12/31/02
49	C1769	Guide wire	8/1/00	12/31/02
50	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
51	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
52	C2626	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
53	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
54	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away.	10/1/00	12/31/02
55	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away.	1/1/01	12/31/02
56	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel- away.	1/1/01	12/31/02
57	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser.	8/1/00	12/31/02
58	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser.	1/1/01	12/31/02
59	C1776	Joint device (implantable)	10/1/00	12/31/02
60	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable).	8/1/00	12/31/02
61	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable).	8/1/00	12/31/02
62	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable).	8/1/00	12/31/02
63	C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
64	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
65	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
66	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
67	C1779	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
68	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable).	1/1/01	12/31/02
69	C1780	Lens, intraocular (new technology)	8/1/00	12/31/02
70	C1878	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
71	C1781	Mesh (implantable)	8/1/00	12/31/02
72	C1782	Morcellator	8/1/00	12/31/02
73	C1784	Ocular device, intraoperative, detached retina	1/1/01	12/31/02
74	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
75	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
76	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
77	C2621	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
78	C2620	Pacemaker, single chamber, non rate-responsive (implantable).	8/1/00	12/31/02
79	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
80	C1787	Patient programmer, neurostimulator	8/1/00	12/31/02
81	C1788	Port, indwelling (implantable)	8/1/00	12/31/02

TABLE 10.—LIST OF PASS-THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES—Continued

	HCPCS codes	Category long descriptor	Date first populated	Expiration date
82	C2618	Probe, cryoablation	4/1/01	12/31/03
83	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
84	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02
85	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
86	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
87	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
88	C1771	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
89	C2631	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
90	C1773	Retrieval device, insertable	1/1/01	12/31/02
91	C2615	Sealant, pulmonary, liquid (Implantable)	1/1/01	12/31/02
92	C1817	Septal defect implant system, intracardiac	8/1/00	12/31/02
93	C1874	Stent, coated/covered, with delivery system	8/1/00	12/31/02
94	C1875	Stent, coated/covered, without delivery system	8/1/00	12/31/02
95	C2625	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
96	C2617	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
97	C1876	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
98	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	12/31/02
99	C1879	Tissue marker (implantable)	8/1/00	12/31/02
100	C1880	Vena cava filter	1/1/01	12/31/02

We considered a number of options on how to pay for devices after their pass-through payment status expires effective January 1, 2003. We held a Town Hall Meeting on April 5, 2002, to solicit recommendations on how to pay for drugs, biologicals, and devices once their eligibility for transitional pass-through payments expires in accordance with the time limits set by the statute. Interested parties representing hospitals, physician specialty groups, device and drug manufacturers and trade associations, and other organizations presented their views on these issues.

After carefully considering all the comments, concerns, and recommendations submitted to us regarding payment for devices and drugs and biologicals that would no longer be eligible for pass-through payments in 2003, we proposed to package the costs of medical devices no longer eligible for pass-through payment in 2003 into the costs of the procedures with which the devices were billed in 2001. (Our proposal to pay for pass-through drugs and biologicals whose pass-through status expires in 2003 is discussed below, in section IV.D.)

The methodology that we proposed to use to package pass-through device costs is consistent with the methodology for packaging that we describe in section III.B of this preamble. That is, to calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator ''N.'' We also packaged the 2001 charges for devices that will cease to be eligible for pass-through payment in 2003 into the changes for the HCPCS codes with which the devices were billed. We relied on the hospitals to correctly code their bills for all costs, including pass-through devices, using HCPCS codes and revenue centers as appropriate to describe the services that they furnished.

To prevent the loss of the device costs billed by hospitals through revenue centers in developing our relative weights for APCs, we proposed to package the costs of both the device ''C'' codes and the billed revenue centers, whichever appeared on the claim. At the time, we believed that this method would allow us to capture all device related costs billed by hospitals. See our discussion of charges for devices in section III.A.2 of the preamble for this issue.

We customarily allow a grace period for HCPCS codes that are scheduled for deletion. When we allow a grace period for deleted codes, we permit deleted codes to continue to be billed and paid for 90 days after the effective date of the changes that require their deletion. However, we proposed to not allow a grace period for expiring pass-through codes because permitting a grace period would result in pass-through payment for the items for which we proposed to cease pass-through payment effective with services furnished on or after January 1, 2003. Effective for services furnished on or after January 1, 2003, hospitals would submit charges for all surgically inserted devices in the supply, implant, or device revenue center that most appropriately describes the implant. Device costs will thus be packaged into and reflected in the costs for the procedure with which they are associated. Therefore, effective for services furnished on or after January 1, 2003, we proposed to reject line items containing a ''C'' code for a device category scheduled to expire effective January 1, 2003.

We received several comments on this proposal, which are summarized below.

General

Comment: A number of hospital organizations indicated they were pleased with our handling of the transitional pass-through payment provisions. The commenters supported our proposal to package into procedural APCs the costs of devices that are no longer eligible for pass-through payment. The commenters asserted that packaging of device costs into base APC payments minimized the confusion and complication of identifying pass-through codes for certain devices and eliminates special payment incentives to use pass-through devices. Provider organizations emphasized the difficult and complicated task of appropriate coding of pass-through items, especially during the transition from a brand-specific to device category system. These commenters also supported our proposal to include device costs from revenue centers in packaging device costs into APCs, to include all device costs.

Response: We appreciate these comments. We are adopting our proposed policy in this area as final for 2003.

Comment: A hospital organization proposed that we release the crosswalk we used to assign pass-through device costs to specific APCs, so that it can study the assignments made, out of concern that some APCs may receive inadequate payment rates.

Response: Our methodology did not involve a cross-walk, so we do not have

one available. Claims files we have made publicly available may be used to analyze where device costs were allocated.

Comment: A device manufacturer stated it conceptually agreed that costs of devices should be packaged into ''base'' APC rates of related procedures. However, it viewed as critical that 2003 payment rates appropriately and adequately capture device costs.

Response: We agree. As described elsewhere, we are adopting a number of changes in our methodology to help insure appropriate payments for procedures whose payment rates would otherwise have fallen significantly from 2002.

Comment: A hospital provider organization urged us to remain committed to the averaging process inherent in a prospective payment system, rather than seek to pay actual cost for elements of total costs, such as new technology. It opposed the imposition of additional administrative costs, for example, any required reporting of acquisition costs on claims, in order to ''fine tune'' pass-through payments or relative weights. It preferred a sample survey to any reporting of acquisition costs. It also preferred that hospitals be permitted to establish their charge structures separately from our payment policies. It recommended that we avoid overriding the hospital-specific cost-to-charge ratio in order to alter the ratios for new technology devices and not distort the PPS to pay for selected items.

Response: We appreciate this comment. We have no plans to require reporting of acquisition costs on claims. Although we intend to consider further improvements in our methods for determining OPPS payment rates in the future, we recognize that the importance of maintaining a well developed and coherent methodology.

Comment: A hospital provider organization recommended that we furnish a regulatory impact analysis that reflects the total change in payments that are estimated to occur that include outlier, pass-through and corridor payments and each of these items should be separately identifiable.

Response: We regret that we are unable to provide the level of detail the commenter requests in the impact analysis. We discuss the extent of our knowledge of accuracy of the pro rata reduction and fold in impact in 2002 in section VIII.

Comment: A commenter requested that we disclose how much the ''fold-in'' of device costs into procedure APC payments for 2002 and the pro rata reduction imposed during 2002 over or under compensated hospitals for the new technology devices and drugs. This organization contended that we overestimated the amount of pass-through payments in 2002, when compared to actual payments, and thus arbitrarily removed some $400 million from an already underfunded OPPS.

Response: We do not have a revised estimate of transitional pass-through spending for 2002 available at this time. We note that the lack of a pro rata reduction in 2001 may have resulted in higher than expected spending in that year. In either case, the statute does not provide for any retrospective adjustments, either up or down, if the Secretary's estimate of transitional pass-through spending made in advance of the start of the relevant calendar year, and which is used to determine whether a pro rata reduction is necessary and if so how large it must be, later proves too high or too low.

Expiration of Device Categories

Comment: A large number of commenters questioned the adequacy of rates proposed for 2003 for APCs involving devices now paid transitional pass-through payments in instances where the device categories expire. Many of these commenters provided information about manufacturers' prices for these devices.

Response: We are also concerned about the adequacy of these payment rates. We have reviewed the information provided, and it has helped guide us in determining our final policies for 2003. As discussed elsewhere in this preamble, we have used more recent data, carefully selected appropriate claims for use in relative weight calculations, and adopted dampening provisions to mitigate the reduction in payment rates that might otherwise have occurred.

Comment: Some commenters recommended that we delay expiration of transitional pass-through device categories until we collect more accurate data. A device manufacturer suggested that we extend the pass-through payment period for another year to allow time to study ways of capturing hospital costs, to improve accuracy of APC rates.

Response: For devices that have been paid in 2000, we cannot extend the pass-through payment as suggested, because this would violate the statutory provision that limits pass-through payments for at least 2 but not more than 3 years. Section 1833(t)(6)(B)(iii)(II) states that a category of devices shall be in effect for a period of at least 2 but not more than 3 years, which begins in the case of the categories initially implemented on April 1, 2001, ''on the first date on which payment was made * * * for any device described by such category (including payments made during the period before April 1, 2001.'' We cannot extend the transitional pass-through payments in order to collect more data.

Comment: A number of organizations recommended that we continue transitional pass-through payment status for an additional year for one or more of several categories that were first populated with devices on January 1, 2001. One commenter recommended that we continue pass-through payments for all current device categories until July 31, 2003 and through December 31, 2003 for items in categories first populated as of January 1, 2001, stating that we make mid-year changes to billing requirements and HCPCS codes. The commenter acknowledged that this may be burdensome, but stated that the benefit of paying appropriately outweighs the cost of revising rates in mid-year.

Response: We have reviewed these categories and do not see a marked difference between these categories and the other categories the eligibility of which is expiring. As a result, we do not believe it would be appropriate to continue transitional pass-through payment status for them beyond December 31, 2002.

Revising rates in mid-year is not generally part of Medicare rate-making policy and is not appropriate in this instance either. It is not only burdensome for this agency, it also burdens the providers and fiscal intermediaries, and it would add confusion to an already complex system.

Comment: Organizations recommended that we continue pass-through payment status for cardiac resynchronization ICDs devices through category C1882. We indicated that this category contains devices that first received transitional pass-through payments as of August 1, 2000. The commenter is concerned that this category, which is described as ''cardioverter-defibrillator, other than single or dual chamber,'' also includes a cardiac resynchronization ICD that was first eligible for transitional pass-through payments on January 1, 2001. The commenter suggested that in order to avoid any unfair competitive advantage among categories with competing technologies, we should extend pass-through payments for both C1882 and C2621, ''pacemaker, other than single or dual chamber,'' which includes cardiac pacemakers.

Response: We cannot extend the pass-through payment status for C1882. We believe the most appropriate step is to end these categories in tandem. Therefore, we will terminate transitional pass-through payments for these 2 categories simultaneously as of January 1, 2003.

Comment: A hospital organization requested clarification regarding the expiration of transitional pass-through device categories effective January 1, 2003. This commenter was confused by our stated proposal to delete 95 pass-through category codes as of January 1, 2003, yet Addendum B of the proposed rule shows these 95 codes as active codes with an OPPS status indicator of ''N'' (packaged). A number of commenters recommended that hospitals retain the option to code them and have the ''N'' status drive the payment, or in order to continue to report and track those devices.

Response: We intend on deleting these codes, with the line item use of the codes rejected. We clarify the status indicator in this final rule.

Comment: A hospital provider organization requested clarification on our proposal that hospitals submit charges for all surgically inserted devices in the supply, implant, or device revenue center that most appropriately describes the implant and that the device costs will then be packaged into and reflected in the costs for the procedure with which they are associated. It noted that we published clear requirements on what revenue codes were appropriate for reporting medical devices that had been granted pass-through status in Program Memorandum A–01–50. The organization stated that that this would constitute the appropriate revenue center list to use for these devices even though they are now packaged.

Response: In the proposed rule we indicated that effective for services furnished on or after January 1, 2003, hospitals would not bill a ''C'' code for devices that no longer qualify for pass-through payment, but would submit charges for surgically inserted devices in the supply, implant or device revenue center that most appropriately describes the implant. We agree with the commenter that the revenue codes listed in Program Memorandum A–01–50 will continue to constitute the appropriate revenue codes under which such devices must be billed, even when the devices are no longer eligible for pass-through payments.

Use of Codes for Expiring Categories After January 1, 2003

Comment: A commenter asked us to clarify the use of device HCPCS codes after their expiration dates. Commenters expressed concern that our proposed deletion of the pass-through codes of drugs and devices as of January 1, 2003 without a grace period would place a burden on hospitals. One commenter recommends that we change the status indicator to ''N'', that is, packaged with other services. One commenter stated that we should keep all C-codes in effect permanently, even without reimbursement. The commenter argues that this step would provide better tracking for providers and payers and eliminates the coding burden caused by deletion of codes.

Response: We proposed to delete the pass-through category codes for devices when the eligibility of the category for pass-through payments expires. Therefore, any claims that use these codes will be returned to providers. We proposed to reject the line item in the proposed rule. However, on further consideration and discussion within CMS, we decided that we must return the claim to the provider so that the provider may correctly place the charges for the device in a revenue center. This is important to ensure that the hospital receives any hold harmless, corridor or outlier payments that it is due. If we were to line item reject the deleted code and process the rest of the claim, then the hospital could be underpaid by the absence of payments that would result if the charges for the device were correctly reported. Given the frequency with which our data shows that providers fail to bill for the device (even when they could receive pass-through payment for it as discussed in section III.A.2 of the preamble), we believe that it is important that the claim be returned to the provider so that it can be corrected and resubmitted for payment.

Comment: A hospital organization agreed with our proposal not to have a 90-day grace period for C-codes scheduled for deletion, to prevent additions to the pass-through payment pool, which could then contribute to a pro rata reduction to other services.

Response: We agree. We believe it is necessary in this instance to forgo a grace period to prevent incorrect payments.

New Device Categories

Comment: A number of commentersprovided both supportive and critical comments to the August 9, 2002 proposed rule on our criteria for establishing new device categories for transitional pass-through payment. One commenter indicated that we have been reviewing and evaluating applications for new device categories even though we have not issued a final rule on this subject.

Response: We have summarized comments that we received timely in response to the November 2, 2001 interim final rule on the criteria, and these are addressed in section V of this final rule. We will take note of all comments as we evaluate the new device category process and any modifications to the process we might propose in the future. Our review of applications for device categories has been done under authority of the November 2, 2001 interim final rule.

Stent Categories C1874 and C1875

Comment: A number of commenters took issue with our interpretation of existing category limitation in evaluating applications for new pass-through device categories. They cited our discussion on drug-eluting stents, that is, that this new technology was described by existing categories C1874, stent, coated/covered with delivery system, and C1875, stent, coated/covered without delivery system. These commenters asserted that neither of the existing categories appropriately describes the drug-eluting stent technology. While they indicated that creating a new APC for drug-eluting stents is appropriate, they expressed concern that many existing categories are described in broad terms, thus potentially excluding other new technologies from additional categories. Examples of applications for ICDs and total joint implants were provided.

Response: We are making final our proposal for separate, procedure APCs for procedures involving drug-eluting stents. These stents will not be in a transitional pass-through category nor receive transitional pass-through payments. In the case of breakthrough therapies that may quickly achieve widespread distribution and that are sufficiently expensive to have a significant effect on hospitals, we may propose to create appropriate APCs, as we have done in this instance. The existing transitional pass-through device categories were deliberately specified in fairly broad terms in order to provide an appropriate balance between specificity and the reporting burden on hospitals.

DME Payment for Implantable Devices

Comment: One commenter, concerned about reduced payments for implantable devices, suggested that we define certain implantable devices as durable

medical equipment and/or prosthetics, for payment under the durable medical equipment fee schedule instead of the OPPS.

Response: The BBRA of 1999 changed the OPPS and durable medical equipment fee schedule (see sections 1833(t)(1)(B)(iii) and 1834(h)(4)(B) of the Act) so that implantable prosthetic devices delivered in the hospital outpatient setting must be paid through the OPPS, rather than on the durable medical equipment fee schedule.

Category C1765, Adhesion Barrier

Comment: A commenter claimed that one of our categories that we propose to continue pass-through payment in 2003, Adhesion Barrier (C1765), contains a product that was manufactured by a single company. The FDA asked the company to recall the product, and it has been off the market for more than a year. This commenter suggested that C1765 be removed from the APC system for 2003, since neither this nor equivalent products are on the market. If and when this or another similar product is reintroduced to the market, it should be considered for pass-through payment at that time.

Response: We will not remove category C1765 from active pass-through payment, which is scheduled to continue through December 31, 2003. C1765 is open to any product that fits the category description of adhesion barrier in accordance with the definition in Program Memorandum A–02–050, not only the product of the stated manufacturer.

Cochlear Implants

Comment: Numerous providers, including hospitals, ENT clinics, physicians, clinical audiologists and other commenters, protested our proposed payment rates for cochlear implant services. They questioned our data for 2001, saying insufficient claims data appear to be reported for the procedure or that the charges appear inappropriately low. Some providers requested an average payment of $3,000 for the surgery, plus the invoice cost of the device, some offering to include the manufacturer's invoice with their claims. Comments also included recommendations that we continue to pay for cochlear implants as pass-through payments for another year or more to develop more accurate claims data . A group of manufacturers also recommended that we issue written guidance to hospitals regarding the correct billing procedures for cochlear implants.

Response: We have attempted to mitigate the proposed reductions in payment rates resulting from the expiration of transitional pass-through device categories, of which cochlear implant is one . Transitional pass-through payments were first made for cochlear implants on August 1, 2000, before pass-through category L8614 was established. Therefore, we cannot provide another year or more of pass-through payments, because the statute limits pass-through payments to a period of at least 2 years but not more than 3 years. We feel the recommendation that we issue guidance to hospitals regarding the correct billing procedures for device related procedures, such as cochlear implants, may have merit, and we will consider providing further guidance in this area.

IOLs

Comment: A number of commenters expressed concern that the expiration of the transitional pass-through device category for new technology intraocular lenses (IOLs) on January 1, 2003 would result in inadequate payment for new technology lenses. These commenters recommended that a new APC be created to pay for the provision of these lenses, even though the incremental cost is low. These commenters also recommended that we create new categories of new technology IOL ''for additional payment similar to the provision applicable in ambulatory surgical centers. One commenter was concerned that we not allow the broad description of the current category C1780, ''lens, intraocular (new technology)'' to interfere with future intraocular lenses being eligible for pass-through payment.

Response: Regarding the adequacy of payment after the new technology IOL category expires, no specific data were provided by any commenters. However, we believe that the incremental cost of such lenses is low. We do not believe a change the APC for implanting new technology IOLs is warranted at this time.

Implantation of Neurostimulator (APC 222) and Electrode (APC 225)

Comment: A manufacturer and a number of medical centers commented that the proposed payments for implantation of a neurostimulator generator (APC 222) and electrode (APC 225) are inadequate. One of these commenters recommended that we delay the expiration of these pass-through categories for another year or two.

Response: The implantations of a neurostimulator generator and electrode have been paid via pass-through payment for devices since August 2000, and we proposed to retire the pass-through categories as of January 1, 2003. For devices that have been paid since August 2000, we cannot extend the pass-through payment for another year or two, as suggested, because this would violate the statutory provision that limits pass-through payments for at least 2 but not more than 3 years. Therefore, we are moving to prospective payment for these devices from the charge-based pass-through payments.

Dialysis Access Systems

Comment: A manufacturer of a dialysis access system asserted that the 2003 proposed reduction in payment rates for dialysis access would curtail patient access.

The commenter provided two suggestions regarding the expiring category code for dialysis access systems, C1881. One option suggested is for us to assign a unique HCPCS code for placement of the manufacturer's brand specific dialysis system and place it in a new or existing APC that has appropriate payment. This commenter contended that bundling C1881 within APC 115 will result in inadequate payment, because the device will be bundled with standard hemodialysis catheters and chemotherapy ports. The second option suggested is to extend pass-through payment status for category C1881. This commenter stated its dialysis system was approved for pass-through payment in August 2000, and there were limited sales and therefore claims in 2000 and the first half of 2001. Thus, this commenter expressed the opinion that there is approximately 1 year of data for this category, not the 2 to 3 years required.

Response: Regarding the option proposed by this commenter for assignment of a unique product-specific HCPCS code, we do not assign unique HCPCS codes for brand-specific devices. Section 1833(t)(6)(B) of the Act indicates that transitional pass-through status of devices is to be determined based on categories. HCPCS codes are generally assigned for procedures that are not adequately described by existing HCPCS codes. This device has had a temporary category code for roughly two and one-half years, and we believe there are sufficient data to measure its utilization and cost. Regarding this commenter's proposal to extend pass-through payment status for category C1881, we cannot, by law, extend the pass-through payment period beyond the 2 to 3 year period. Although the commenter asserted that there were only limited claims for pass-through payment for the device in 2000 and the first half of 2001, section 1833(t)(6)(B)(iii) of the

Act explicitly indicates that the 2 to 3 year period for which categories of devices may be in effect applies from the first date on which payment was made under the OPPS for any device described by the category, which was August 2000.

Specific Category Applications

Comment: Several commenters commented on specific pass-through device category applications which we had open as of the time of the comment or applications which we had previously denied as eligible for pass-through payment.

Response: We evaluate all pass-through device category applications individually and respond to applicants directly.

D. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Drugs and Biologicals (Including Radiopharmaceutical Agents, Blood, and Blood Products)

Under the OPPS, we currently pay for drugs and biologicals, including radiopharmaceutical agents, blood, and blood products, in one of three ways: packaged payment, separate APCs and transitional pass-through payment.

Drugs as Packaged Supplies

As we explained in the April 7, 2000 final rule, we generally package the cost of drugs and biologicals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.) Hospitals bill for costs directly related and integral to performing a procedure or furnishing a service using a revenue center or packaged HCPCS code (status indicator ''N''). As discussed earlier in section III.A.2 of the preamble, we list the packaged services, by revenue center, that we use to calculate per-service costs.

As specified in the regulations at § 419.2(b), costs directly related and integral to performing a procedure or furnishing a service on an outpatient basis are included in the determination of OPPS payment rates for the procedure or service. In the August 9, 2002 proposed rule, we provided some illustrations of situations in which drugs are considered to be supplies. For example, sedatives administered to patients while they are in the preoperative area being prepared for a procedure are supplies that are integral to being able to perform the procedure. Similarly, mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to the patient immediately before, during, or immediately following an ophthalmic procedure are considered an integral part of the procedure without which the procedure could not be performed. The costs of these items are packaged into and reflected within the OPPS payment rate for the procedure. Likewise, barium or low osmolar contrast media are supplies that are integral to a diagnostic imaging procedure as is the topical solution used with photodynamic therapy furnished at the hospital to treat non-hyperkeratotic actinic keratosis lesions of the face or scalp. Local anesthetics such as marcaine, lidocaine (with or without epinephrine) and antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure, are other examples we cited in the proposed rule. The hospital furnishes these items while the patient is in the hospital and registered as an outpatient for the purpose of receiving a therapy, treatment, procedure, or service. These and other such supplies may be furnished pre-operatively, while the patient is being prepared for a procedure; intra-operatively, while the procedure is being performed; or post-operatively, while the patient is in the recovery area prior to discharge. Or, these items may be part of an E/M service furnished during a clinic visit or in the emergency department. All of these supplies are directly related and integral to the performance of a separately payable therapy, treatment, procedure, or service with which they are furnished. Therefore, we do not generally recognize them as separately payable services. We package their cost into the cost of the primary procedure, and we pay for them as part of the APC payment.

We received several comments concerning the treatment of drugs as supplies, which are summarized below, along with our responses.

Comment: Several commenters asked for clarification of CMS's policy with respect to self-administered drugs, claiming the discussion in the preamble which lists examples of drugs, including self-administered drugs, that are packaged and paid as integral to an outpatient service conflicts with section 1861(s)(2) of the Act and CMS manuals which consider self-administered drugs to be non-covered.

Response: Our policy is based on the premise that certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly a component part of the procedure or treatment, we believe that they are more appropriately considered as supplies and should be packaged as supplies into the APC payment for the procedure or treatment. Moreover, the payment for packaged supplies is included in the APC payment for the procedure or treatment, so beneficiaries should not be separately billed for them.

Comment: A commenter stated that virtually all drugs furnished in the outpatient setting are integral to an outpatient service and asked that CMS clarify those circumstances when usually self-administered drugs would not be considered integral to a service and therefore, non-covered.

Response: A drug would be treated as a packaged supply in cases where, although the drug is not separately payable, it is directly related and integral to a procedure or treatment and is required to be provided to a patient in order for a hospital to perform the procedure or treatment during a hospital outpatient encounter. A drug would not be treated as a packaged supply if it failed to meet these conditions. For example, we would not treat as packaged supplies any drugs that are given to a patient for their continued use at home after leaving the hospital. Another example would be a situation where a patient who is receiving an outpatient chemotherapy treatment develops a headache. Any medication given the patient for the headache would not meet the conditions necessary to be treated as a packaged supply. Similarly, if a patient who is undergoing surgery needs his or her daily insulin or hypertension medication, the medication would not be treated as a packaged supply.

Comment: A commenter from a teaching hospital indicated that revenue code 819, which is required for the acquisition of bone marrow or blood-derived peripheral stem cells, is bundled into the charge for the transplantation procedure, CPT 38240. The commenter noted that the transplant CPT code pays approximately $350–$400; however, charges for acquiring stem cells are generally $25,000–$35,000 each. Therefore, the commenter recommended that we create

a new biological pass-through code for the stem cells until we can build the cost of the acquisition into the procedure, and the code should be retroactive to January 1, 2002.

Comment: A commenter from a teaching hospital indicated that revenue code 819, which is required for the acquisition of bone marrow or blood-derived peripheral stem cells, is bundled into the charge for the transplantation procedure, CPT 38240. The commenter noted that the transplant CPT code pays approximately $350–$400; however, charges for acquiring stem cells are generally $25,000–$35,000 each. Therefore, the commenter recommended that we create a new biological pass-through code for the stem cells until we can build the cost of the acquisition into the procedure, and the code should be retroactive to January 1, 2002.

Response: We understand the commenter's concern. Pass-through payments, after December 31, 2002, will only be made for medical devices, drugs, or biologicals in accordance with section 1833(t)(6)(A)(iv) of the Act. Stems cells are not medical devices nor do they meet the statutory prerequisite for calling these items ''drugs and biologicals,'' as stated in sections 1861(t)(A) and (B) of the Act. For example, stems cells do not receive FDA approval and are not listed in the United States Pharmacopoeia.

The commenter indicates that the hospital is not being paid adequately for stem cell acquisition costs. However, the commenter should note that hospitals should be reporting all charges associated with the purchase of stem cells under Revenue Code 819. Therefore, to the extent that hospitals are billing a charge for the cost of acquiring stem cells under Revenue Code 819, those costs would be packaged into the median cost of CPT 38240 and be reflected in the APC payment rate. These services may also qualify for outlier payments.

Separate APCs for Drugs Not Eligible for Transitional Pass-Through Payment

There are certain new technology drugs and biologicals that are not eligible for transitional pass-through payments but for which we have made separate payment. Beginning with the April 7, 2000 rule (65 FR 18476), we created separate APCs for these drugs and biologicals as well as devices. We proposed to create temporary individual APC groups for the various drugs classified as tissue plasminogen activators and other thromobolytic agents that are used to treat patients with myocardial infarctions as well as certain vaccines to allow separate payment so as not to discourage their use where appropriate. In the case of blood and blood products, wide variations in patient requirements convinced us that we should pay for these items separately rather than packaging their costs into the procedural APCs. Moreover, the Secretary's Advisory Council on Blood Safety and Access recommended that blood and blood products be paid separately to ensure that to minimize incentives that would be inconsistent with the promotion of blood safety and access.

In the case of the other drugs and vaccines that we proposed not package into payment for visits or procedures, we paid separately for them because we wanted to avoid creating an incentive to cease providing these drugs when they were medically indicated.

We based the payment rate for the APCs for these drugs and biologicals on median hospital acquisition costs using 2001 claims data. We set beneficiary copayment amounts for these drug and biological APCs at 20 percent of the payment amount. In 2003 we will use status indicator ''K'' to denote the APCs for drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid separately from and in addition to the procedure or treatment with which they are associated but that are not eligible for transitional pass-through payment.

General

BBRA provided for special transitional pass-through payments for a period of 2 to 3 years for the following drugs and biologicals (pass-through payments for devices are addressed in section IV.C. of the preamble):

- 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.
- New drugs and biological agents.

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 is not paid under the OPPS as a ''current'' drug or biological, 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 with which it is associated.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs as the amount by which the amount determined under section 1842(o) of the Act, that is, 95 percent of the applicable average wholesale price (AWP), exceeds 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, in order to determine the 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 data on hospital acquisition costs for drugs from a survey that is described more fully in the April 7, 2000 and the November 30, 2001 final rules. The ratio of hospital acquisition cost, on average, to AWP that we used is as follows:

- For sole-source drugs, the ratio of acquisition cost to AWP equals 0.68.
- For multisource drugs, the ratio of acquisition cost to AWP equals 0.61.
- For multisource drugs with generic competitors, the ratio of acquisition cost to AWP equals 0.43.

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for current drugs and biologicals must be no less than 2 years nor any longer than 3 years beginning on the date that the OPPS is implemented. Therefore, the latest date for which current drugs that have been in transitional pass-through status since August 1, 2000 will be eligible for transitional pass-through payments is July 31, 2003. We proposed to remove these drugs from transitional pass-through status effective January 1, 2003 because the statute gives us the discretion to do so and because we generally implement annual OPPS updates on January 1 of each year. We would be in violation of the law if we were to not remove these drugs and biologicals from transitional pass-through status by August 1, 2003. The next update of the OPPS that will go into place will not be effective until January 1, 2004, at which time the statute's 3-year limit on pass-through payments for these drugs would have been exceeded. We further proposed to remove from transitional pass-through status, beginning January 1, 2003, those drugs for which transitional pass-through payments were made effective on or prior to January 1, 2001 because the law gives us the discretion to do so and we believe that, to the extent possible, payments should be made under the OPPS, without pass-through payment, when the law permits, as it does in this case.

As explained above, our policy has been to package payment for drugs and

biologicals into the payment for the procedure or service to which the drug is integral and directly related. In general, packaging the costs of items and services into the payment for the primary procedure or service with which it is associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Packaging costs into a single aggregate payment for a service procedure or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. Our proposal to package the costs of devices that we discuss in section IV.C of this preamble is based on this principle. As we refine the OPPS in the future, we intend to continue to package, to the maximum possible extent, the costs of any items and services that are furnished with an outpatient procedure or service into the APC payment for services with which it is billed.

In spite of our commitment to package as many costs as possible, we are aware of concerns that were presented at the April 5, 2002 Town Hall meeting and that have been brought to our attention by various interested parties, that packaging payments for certain drugs, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

The options that we considered included packaging the costs of all drugs and biologicals, both those with status indicator ''K'' in 2002 and those that would no longer receive pass-through payments in 2003, or continuing to make separate payment for both categories of drugs and biologicals through separate APCs. After careful consideration of the various options for 2003, we proposed to package the cost of many drugs for which separate payment is made currently. But we also proposed to continue making separate payment for certain orphan drugs (as discussed below), blood and blood products, vaccines that are paid under a benefit separate from the outpatient hospital benefit (that is, influenza, pneumococcal pneumonia, and hepatitis B), and certain higher cost drugs as explained below. The payment rates for those drugs for which we would make separate payment in 2003 would be an APC payment rate based on a relative weight calculated in the same way that relative weights for procedural APCs are calculated.

Comments on this proposal and our responses are summarized below:

Comment: We received many comments regarding the significant reduction in the payment rates for numerous drugs and biologicals that are sunsetting from their transitional pass-through status. The commenters asserted that proposed payment rates are significantly lower than the costs hospitals incur in acquiring and dispensing these products. As a result, inadequate payment may drive hospitals to discontinue stocking these products, and thus threaten beneficiary access to important drugs and biologicals. The commenters attributed the dramatic reduction in payment rates on the flaws in the 2001 claims data and deficiencies in the methodology that was used to derive the APC median costs. Commenters suggested numerous ways to correct the payment rates until reliable and sufficient claims data became available. Commenters proposed the following suggestions: maintain separate pass-through payments for APCs whose proposed payment rates decreased; pay a flat amount per item on a per patient basis; develop a rate setting methodology that does not depend upon the hospital's ability to record the proper number of units of a drug utilized; use information provided by commenters to set the 2003 payment rates; revise payment rates to include payment for the drug and related pharmacy overhead costs; pay 90 to 100 percent of AWP for non-pass-through drugs; use an appropriate ratio of acquisition cost to AWP as estimated in the proposed rule; conduct a new external survey of hospitals' drug acquisition costs to obtain more current data; or pay according to the median hospital cost for the item.

Response: As discussed elsewhere in this rule, in order to lessen the impact of the dramatic reduction in the proposed payment rates for many of the drugs and biologicals from 2002 to 2003, we decided that the most appropriate mechanism is to apply a dampening option to all of the APCs that decreased in median costs by more than 15 percent. For these APCs, we limited the reduction in median costs from 2002 median costs to half of the difference between the total proposed reduction and 15 percent. However, budget neutrality adjustments needed to compensate for the effects of this dampening subsequently reduced payment rates of all APCs by an additional percentage. Also, we applied a special dampening option to all blood and blood products and hemophilia clotting factors that limited the decrease in their payment rates to about 15 percent. These adjustments yielded significant moderation in the reduction of the final 2003 payment rates. These adjustments are described in detail in section III.B of the preamble.

After carefully reviewing all of the comments, a dampening option seemed most plausible and practical for us to undertake. Most of the recommendations proposed by the commenters were not feasible or not suitable for the purposes of OPPS.

Comment: Many commenters indicated that the median costs derived from the claims data was not reflective of the hospitals' true costs for acquiring and dispensing these drugs and biologicals.

Response: We agree with this point; however, the commenters should note that we intend to pay only for the cost of acquiring the drug under a drug APC and not for costs associated with the administration of the drug. Costs associated with administering the drug and with other pharmacy overhead are captured in pharmacy revenue cost centers and reflected in the median cost of APCs involving drug administration. Therefore, we believe that it is not appropriate for us to duplicate these costs in both the administration and drug APCs.

Comment: Several commenters noted that many drugs and biologicals were packaged into administration APCs; however, they were surprised to see decreases in the proposed payment rates for several of the administration APCs. The commenters stated that the addition of the costs of the packaged products should have caused the APC median cost levels to increase, thus their payment rates should have also increased compared to 2002. However, the commenters assert that the proposed payment rates for several administration APCs in which the drugs were packaged does not adequately cover the acquisition cost of the drugs themselves. Thus, they recommended that we reevaluate our data to ensure that costs of the packaged drug were included with the data for the applicable administration APCs, or otherwise explain how we plan to reimburse hospitals for the costs of the packaged drugs; retain the 2002 payment rates for administration services and pay for the drugs separately; or use our authority to limit any payment reductions for certain services. One commenter suggested that we conduct a survey of cancer centers to determine the true cost of infusion procedures and make an adjustment to the APC rates based on our finding.

Response: After reanalyzing our data, we were able to verify that the median costs of the drugs were indeed packaged into the median costs of the

administration APCs. We acknowledge that the median costs of several administration APCs before we packaged drug costs declined between those median costs used to set the 2002 rates and those median costs developed from the 2001 claims for the 2003 rates. This decline occurred because, in setting the 2002 rates, we packaged in 75 percent of the cost of pass through devices we projected would be billed with the administration codes, based on manufacturer prices. The 2001 claims data, however, did not reflect the charges that we predicted would be billed for such devices. An increase in the median cost of a service does not guarantee that the payment rate for the service will increase because payment rates under the OPPS are based on relative costs and the budget neutrality adjustment. If the relative cost of a service increases at a lower rate than other services, the payment rate may actually decline. In addition, all rates are affected by the budget neutrality adjustment that has lowered rates over the past several years. (We note that it is possible for the budget neutrality adjustment to increase rates as occurred in the proposed rates.) As noted elsewhere, for APCs whose median costs decreased by more than 15 percent from 2002 to 2003, the dampening option described elsewhere in this rule limits the decreases in their payment rates.

Comment: A commenter requested that we describe the methodology used to calculate the payment rates for sunsetting pass-through drugs that are being assigned to separate APCs.

Response: We have provided a detailed description of the methodology we used in the calculation of the APC payment rates for sunsetting drugs and biologicals in section III.B of the preamble.

Comment: A major hospital association supported our proposal to incorporate pass-through drugs into APC rates. However, the commenter was concerned that many of these same drugs would continue to receive 95 percent of AWP in other settings, and differential payments may result in patient care being directed out of the hospital outpatient setting and into physician offices for non-clinical reasons.

Response: We believe that the payment rates for sunsetting pass-through drugs and biologicals reflect hospital acquisition cost to a sufficient extent so that hospitals will not, in general, stop furnishing these products to beneficiaries. While Medicare payment in other settings will be higher, the extent of response that may be expected to these payment differentials is unclear. We note that the same differentials prevailed for years prior to the introduction of the outpatient prospective payment system. We believe that the appropriate policy response is to address the use of AWP as a basis for payment in non-hospital sites.

Comment: A state hospital association indicated that confusion exists among hospitals over which drugs can be self-administered and that instructions from fiscal intermediaries are inconsistent and/or confusing. The commenter requested that we publish a definitive list of drugs that are to be considered to be self-administrable, and thus is not part of covered services. Another commenter from a hospital urged us to clarify whether self-administrable drugs (both those that are integral and non-integral to the patient's procedure) in outpatient and observation settings are the patient's responsibility or should be packaged under procedure APCs. Another commenter from a hospital organization suggested that we exempt hospitals from determining which drugs should be classified as self-administered or allow hospitals to classify drugs based on the dosing form and pursue payment from the beneficiary.

Response: On May 15, 2002, we issued Transmittal AB–02–072 entitled ''Medicare Payment for Drugs and Biologicals Furnished Incident to a Physician's Service.'' The program memorandum gives instructions to the fiscal intermediaries for applying the exclusion to drugs that are usually self-administered by the patient. Each fiscal intermediary makes its determination on each drug based on whether the drug meets all of the program requirements for coverage. The payment rates that we are finalizing in this rule only indicate the Medicare payment amounts under OPPS when a drug is covered by Medicare; therefore, determination of a payment amount does not represent a determination that the Medicare program covers the drug. We discuss elsewhere in this preamble how Medicare makes payments for drugs that are considered to be supplies.

Comment: Several commenters suggested that we publish various sorts of additional information about the methodology we used to calculate the payment rates, including technical details of the methodology used in analysis of the 2001 claims.

Response: We do not believe the final rule is the appropriate vehicle for conveying the extensive background technical detail that may be of interest to the analytical community. However, we plan to hold a meeting in December 2002 or January 2003 to address the questions these commenters or other interested parties may have about our methodology.

Comment: Several commenters were concerned that fiscal intermediaries have addressed the issue of drug units of service with respect to billing and waste differently, and requested that we provide clear and consistent guidance to the fiscal intermediaries as well to providers on how to define ''waste.''

Response: In the fall of 1996, we issued a memorandum to our regional offices with guidance regarding our current policy on drug and biological product wastage. Although this memorandum focused on guidance for carriers, it overall reflects our current policy for drug and biological product wastage.

We recognize that some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered.

Example 1: Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2: An appropriate hospital staff must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

Comment: A few commenters urged us to provide a crosswalk identifying which drugs are being associated with which APCs and in what amounts, to help ensure that costs are being appropriately transferred to and allocated among APCs.

Response: Our methodology did not rely on a crosswalk, and we do not have one available. In our methodology, we

packaged drugs and biologicals that fell below the $150 median cost per line threshold into the procedure APCs they were billed from April 1, 2001 to March 31, 2002. Interested parties may analyze the claims data that is available to the public to determine the extent to which the costs of specific drugs and biologicals were included in payment rates of the procedure APCs.

Comment: A commenter expressed concern related to the adenosine products J0150 and J0151. The commenter stated that although these two codes reflect different uses and doses of the adenosine products, OPPS only recognizes billing only under the lowest dose of J0150 and J0151 is assigned a status indicator of E. Consequently, the hospitals have been billing for both products under code J0150. The commenter requested that we clear the confusion that exists among hospitals when billing for these products by reinstating J0151 under a separately paid APC with an adequate payment rate and revising J0150 so that the code is specific to its actual use.

Response: After reviewing the comment, we assigned a status indicator of N to J0150 to indicate that J0150 will be packaged in 2003; and changed the status indicator for J0151 from E to K and assigned it to APC 0917.

Comment: One commenter requested that we update the HCPCS description for all drugs to accurately report all medications in the way manufacturers currently package them. The commenter claimed that our current use of codes causes confusion and has the potential to create reimbursement problems for providers and the Medicare program.

Response: To the extent possible, when creating the ''C'' codes used to report drugs and biologicals eligible for transitional pass-through payment under OPPS, we employ the lowest common measurement of dosage for each drug so that hospitals can bill the number of units that are required to treat the patient by using multiple units of a single code. As drugs and biologicals retire from pass-through status, we expect to retire the ''C'' codes for these items. We expect these items will receive appropriate ''non-C'' HCPCS codes.

Comment: Several commenters claimed that our proposal to package many of the non-pass-through, lower cost drugs and biologicals with HCPCS codes for therapeutic administration is a violation of the ''two-times'' rule. Therefore, they recommended that we continue to pay for all drugs and biologicals separately or by revising the APCs in which the drugs are packaged.

Response: We do not agree with the commenters' assertion that packaging of drugs and biologicals results in violations of the two-times rule, stated in section 1833(t)(2) of the Act. We understand the commenters' confusion and attempt to provide a clarification on how we apply the ''two-times'' rule to determine APC structures. Most APC's consist of one or more services, which reported with CPT or HCPCS G codes, that are similar clinically and in terms of resource use. Many individual items (for example, sterile supplies or pharmaceuticals such as anesthetic agents) are integral to the procedure, and thus we have packaged them with the procedure. In some instances, such as APCs for transitional pass-through drugs and devices, the APC includes no procedure, and the APC is used only to pay for a specific item.

The ''two times'' rule requires that the highest median cost of a service or item within an APC cannot be more than two times greater than the lowest median cost of a service or item within that APC. We apply the ''two-times'' rule to the total cost of each procedure (which includes items that are packaged within that procedure). In the case of APCs containing only items, we apply the rule to the cost of each item that is grouped in the APC. We do not apply the two times rule to the variation in cost of individual items or ancillary services we attribute to a single HCPCS code.

If we were to attempt to apply the rule to all items within the various procedures, accounting for the variation in cost of supplies such as bandages, reusable instruments, and other medical supplies would be a practical impossibility. It would lead to a highly fragmented set of payment cells and a greatly more complex payment system that would reduce the incentives for effective management by hospitals. We do not believe the Congress would have intended such a result.

Consistent with the principles of prospective payment, we package the cost of as many items as possible into the median cost of a procedure. Therefore, our payment methodology for 2003 includes packaging the costs of drugs and biologicals with median costs below $150 per line into the costs of the procedures with which they were billed. We reviewed the median cost of the procedures used for administration of drugs and biologicals, before and after we packaged the costs of drugs and biologicals. Our review indicates that the final median cost appropriately accounts for the administration procedure and the cost of the administered drug and/or biologic.

Comment: Numerous commenters were concerned about the proposed reduction in payment rates for several radiopharmaceutical products. They asserted that hospitals would not be reimbursed adequately for these products, and thus, beneficiary access could be negatively impacted. They recommended that we should not base payments on the 2001 claims data and use a different methodology instead. They suggested that we estimate acquisitions costs using the proposed ratios for acquisition cost to AWP based on analysis conducted by the agency; maintain the 2002 payment levels; or create new APCs using cost ranges and assign radiopharmaceuticals to APCs based on their costs, as determined by AWP plus overhead fees, or another proxy for actual hospital costs.

Response: We are concerned about the possible effects of payment reductions on beneficiary access, and accordingly, we have included radiopharmaceuticals in the dampening policy described section III.B. of the Preamble.

Comment: Several commenters were concerned with our proposal to package numerous radiopharmaceutical products. They claimed that given the problems with the claims data and the great variation in the cost and use of radiopharmaceuticals for the same procedure, all radiopharmaceuticals should be paid under their own APCs, in addition to their associated nuclear medicine procedures. This would assure appropriate reimbursement for both the product and procedure, and would be the best way to capture hospital costs for radiopharmaceuticals in future claims data.

Response: While we acknowledge the commenters' concerns, we believe that the most appropriate payment structure is one that packages services together to the extent it is reasonable to do so, and thus presents hospitals with bundled payments that permit them to effectively manage resource allocation in the treatment of particular patients. Accordingly, we have not adopted this suggestion.

Comment: A manufacturer and a trade association suggested that we could improve the accuracy of the APC payment rates by establishing new revenue codes to accurately capture data and calculate costs for radiophamaceuticals in future years.

Response: While we do want to improve the accuracy of APC payment rates, we are reluctant to impose new requirements on hospital cost reports. In addition, the creation of new revenue centers must be made through a process that includes other payers as well as representatives of various providers.

Therefore, we will not adopt this suggestion for 2003. As discussed in section III. B of this final rule, we expect to address the issue of improving the accuracy of our data further in the future.

Comment: A hospital organization indicated that there is a competitive disadvantage between different types of providers (clinic, Independent Diagnostic Testing Facilities (IDTF), and outpatient hospital) and their payment policies for Low Osmolar Contrast Media (LOCM). The commenter stated that in a clinic or IDTF, LOMC receives separate payment when clinical conditions are met. However, when LOCM is administered in an outpatient hospital without an intrathecal procedure or if one of the Medicare coverage conditions is non-covered, hospitals are expected to issue an ABN to the patient. The commenter recommended that we allow hospitals to bill for LOCM even when the patient does not meet conditions, or instruct the clinics and IDTFs to seek ABNs for LOCM in non-covered circumstances. A state hospital association suggested that we eliminate the medical necessity requirement for LOCM since it is not applicable to hospital outpatient services.

Response: These suggestions involve several different Medicare payment systems, and appropriate resolution of this concern will require further analysis. We will consider this issue further in the future.

Comment: One commenter requested clarification on whether there will be any more changes to the payment calculation for HCPCS C1775 (FDG, per dose) other than what is proposed in Table X of the proposed rule.

Response: According to our new policy for radiopharmaceuticals, as described elsewhere in this final rule, FDG will no longer be granted pass-through status in 2003. It will instead be paid separately under its own APC and be assigned to a status indicator of K.

Comment: Another commenter requested that we describe our waste policy on whether a hospital may bill for a medication that is ordered and mixed, but not administered to the patient due to a change in patient status or a no-show by the patient for that day's visit. If the drug cannot be used later or on another patient, the hospital would still incur the costs.

Response: If the drug is not administered to a Medicare beneficiary, then payment may not be made by the Medicare Program.

Packaging Issue

Comment: Several commenters indicated that our methodology of analyzing single line-items on drug claims is not consistent with how hospitals bill for certain particular drugs and biologicals. This inconsistency particularly affects whether a drug or biological falls below the $150 median cost per line threshold or not. They claimed that we incorrectly assumed ''that a single administration of a drug was billed as a single line item on a claim and that the correct number of units was placed in the 'units' field of the claim form.'' Commenters noted that this was not always true because hospitals often bill for certain drugs using multiple lines in a claim that represents one patient encounter. They indicated that in our calculation of the median cost per line for a drug, we multiplied the median cost per unit of the drug by the average number of units billed per line. Thus, our methodology does not take into account all of the units of a drug administered during one encounter if the units were billed in multiple lines on the claim, and consequently, may not reflect the full cost of delivering the drug.

Response: For 2003, we chose to use the $150 median cost per line threshold level to determine whether to package a drug, as opposed to another packaging criterion, for the reasons of administrative simplicity, administrability, and responsiveness. However, in our analysis of the data, we observed that instances where a drug was billed on multiple lines in a claim were rare (less than 1 percent of total billings for drugs). We reiterate that our intent is to review and refine the packaging methodology in the future and will take the commenters' concern into account.

Orphan Drugs

We recognize that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believe that if the cost of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high cost of this special type of drug. Therefore, we proposed to establish separate APCs to pay for those orphan drugs that are used solely for orphan conditions.

To identify the orphan drugs for which we would continue to make separate payment, we applied the following criteria:

- The drug must be designated as an orphan drug by FDA and approved by FDA for the orphan condition.
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug had neither an approved use for other than an orphan condition nor an off label use for conditions other than the orphan condition. There are three orphan drugs that are used solely for orphan conditions for which we proposed to make separate payment: J0205 Alglucerase injection; J0256 Alpha 1 proteinase inhibitor; and J09300 Gemtuzumab ozogamicin.

Comment: Several commenters stated that the proposed payment rates for the orphan drugs would grossly underpay hospitals for providing these drugs to patients. They recommended that we pay for orphan drugs according to current year acquisition and actual total costs of providing the products; maintain the 2002 payment levels; or remove from them from the OPPS system and set payment according to the methodology used in the physician office and other non-inpatient settings.

Response: After reviewing the comments, we have decided to remove the three orphan drugs that do not have any other non-orphan indications from the OPPS system and will pay for them on a reasonable cost basis. Other drugs that have orphan status according to the FDA will be partly protected by the dampening options described in section III.B of this final rule.

Comment: Several commenters objected to what they characterized as our definition of ''orphan drug.'' These commenters believe we should treat comparably all drugs and biologicals that have been designated as under section 526 of the Federal Food, Drug, and Cosmetic Act.

Response: We emphasize that we are not creating a new definition of orphan drugs; instead, we continued to rely on the definition stated in the Federal Food, Drug, and Cosmetic Act. However, within the set of drugs that the FDA has identified as orphan drugs, we have identified a subset of three drugs that have only orphan indications and decided to remove them from the outpatient prospective payment system. We have distinguished these drugs from other orphan drugs because of their low volume of patient use and their lack of other indications, which means they can rely on no other source of payment. Many orphan drugs are approved for multiple indications, including non-orphan indications that have significant patient use that provide the drugs with financial support. For example, epoetin alfa was originally identified as an

orphan drug for use in ESRD patients; however, currently it is being used extensively in patients with chemotherapy-induced anemia. Once a drug is granted orphan status, no further effort is made to update this status, even though indications for use may change substantially with experience. After consulting with our clinical advisors, we have decided to remove from OPPS the three orphan drugs that have no other non-orphan indications. We recognize the importance of all orphan drugs, however, and accordingly we have applied the dampening policies described in section III.B of the preamble to the other orphan drugs.

Blood and Blood Products

From the onset of the OPPS, we have made separate payment for blood and blood products either in APCs with status indicator ''K'' or as pass-through drugs and biologicals with status indicator ''G'' rather than packaging them into payment for the procedures with which they were administered. As we explained in the April 7, 2000 final rule (65 FR 18449), the high degree of variability in blood use among patients could result in payment inequities if the costs of blood and blood products were packaged with their administration. We also want to ensure that costs associated with blood safety testing are fully recognized. The safety of the nation's blood supply continues to be among the highest priorities of the Secretary's council on Blood Safety and Access. Therefore, we proposed to continue to pay separately for blood and blood products.

Comment: Several major blood collection organizations, specialty physician groups, a large trade association, hospital associations, and individual hospitals supported our decision to maintain separate APCs for blood and blood products; however, the commenters were concerned with the reduction in payment rates for these products in the proposed rule.

The commenters provided several suggestions. They recommended that we base the payment rates for blood products on current year acquisition costs and actual total costs rather than on hospital claims from previous years, and use industry data on the current hospital costs of blood and blood products that have been submitted to us; consider costs related to additional costs that hospitals incur in storing and preparing units for transfusion when assigning APC relative weights to blood and blood products; continue the 2002 payment rates until more accurate information on the actual costs of blood and blood products are gathered; or reimburse hospitals on a reasonable cost basis for blood and blood products.

Response: After carefully reviewing the comments and comparing the industry data against our data, we were convinced that the proposed reduction in payment rates for many of the blood and blood products would result in payment that is significantly lower than hospital acquisition costs. Thus, inadequate reimbursement may compromise access to beneficiaries and the safety of these products. We continue to be aware of the variability in the use of blood and blood products in various procedures, and by our desire to recognize costs of new tests being performed on blood, we have decided to apply a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For these products, as described in section III.B of the preamble, we limited the decrease in their median costs by 11 percent, which limited the decrease in payment rates to approximately 15 percent. We note that the APCs for these products are intended to cover product costs; costs for storage, etc., are packaged into the APCs for the procedures with which the products are used.

Comment: A commenter from an individual hospital disagreed with our proposal to not change the current OPPS payment policy for transfusions. The commenter stated that their hospital has more than the average number of cases that require more than one unit of blood, and thus, averaging the payment would adversely affect specialty hospitals.

Response: For transfusion services that are paid under OPPS, hospitals can bill for the administration of the transfusion and the number of units of blood transfused. With the payment rates for transfusion and blood and blood products that are in the final rule, we believe that hospitals, including those that specialize in the transfusion of multiple units of blood, will receive adequate payment for transfusion services. The hospitals will receive separate payment for the blood in addition to the APC payment for the transfusion service. Even though we will not change our payment policy for transfusions for 2003, this is an issue that we will continue to monitor in the future.

Comment: Two commenters requested that we provide special comprehensive billing and coding guidelines in the area of blood, blood processing, and transfusion medicine, and the proper use or non-use of the transfusion medicine codes. They stated that Transmittal A–01–50 does not clarify all of the confusing issues that hospitals currently experience in billing and coding for blood-related services.

Response: We acknowledge that need for comprehensive billing and coding guidelines in the areas mentioned by the commenters and agree that the program memorandum that was issued previously may require further clarification. Therefore, this is an area that we expect to focus on during the upcoming year.

Comment: Several hospitals, advocacy organizations, manufacturers, and beneficiaries were concerned that the proposed decrease in reimbursement for certain clotting factors would not enable hospitals to recover the acquisition costs of the products. They indicated that inadequate reimbursement would create incentives for hospitals to not provide these products at all or to provide only those clotting factors that limit financial loss. Commenters also indicated that given the high cost of the clotting factors, the average cost to charge ratio methodology that might apply to other drugs does not apply to clotting factors, and the proposal would shift patients to the inpatient setting where costs of care are higher. Their recommendations were that we adjust the proposed payment with a rate consistent with the average acquisition cost of the drugs; maintain the 2002 payment rates; use current hospital inpatient payment rates in place of the proposed rates; or remove from the OPPS system and set payment according to the methodology used in the physician office and other non-inpatient settings.

Response: We recognize the importance of insuring adequate reimbursement and access to hemophilia clotting factors for our beneficiaries, as did the Congress when it created a separate benefit category for clotting factors in section 1861(s)(2)(I) of the Act. Accordingly, we have adopted a provision to insure that the payment rates for these products does not decrease by more than approximately 15 percent from 2002 to 2003.

Comment: Several commenters were very concerned with the proposed payment rates for plasma products and their recombinant analogs therapies. They argued that reduction in payments would create significant patient access problems since the hospitals will be unable to recoup costs incurred in acquiring and dispensing such therapies. They recommended that we pay for these products on a reasonable cost basis; revise the payment rates significantly to allow hospitals to recover their acquisition and dispensing costs; base payment on current acquisition costs and actual total costs

of the products in outpatient settings; maintain payment at the 2002 level; or establish an add-on payment to be based on a national formula derived outside of OPPS.

Response: We recognize the importance of these drugs, and consequently included them in the dampening procedure described section III.B of the preamble.

Comment: Several commenters urged us to clarify the category of ''blood and blood products'' to include drugs and biologicals that are derived from plasma fractionation and their biotechnology analogs. They stated that the rationale for creating separate APCs for blood and blood products also equally apply to plasma-based products and their recombinant therapies. These commenters recommended that we continue to pay for all plasma-derived and recombinant analog therapies in separate APCs and include them in the category of ''blood and blood products'' as it is done under the FDA's definition of ''blood and blood products.''

Response: We acknowledge that plasma-based products and their recombinant therapies are derived from blood however, these products are highly processed and not manufactured by local blood banks. Upon consultation with our clinical advisors, we have determined that these products do not have the same access and safety concerns as other blood and blood products. Thus, it is reasonable for us to distinguish these products from other blood and blood products. For the purposes of OPPS, we will not consider any plasma-derived products and their recombinant analogs, including albumin and immune globulins and except for hemophilia clotting factors, to fall under the category of ''blood and blood products''. Accordingly, we apply to these products the same packaging procedures applicable to other drugs and biologicals.

Vaccines Covered Under a Benefit Other Than OPPS

Outpatient hospital departments administer large numbers of the vaccines for influenza (flu), pneumococcal pneumonia (PPV), and hepatitis B, typically by participating in immunization programs encouraged by the Secretary because these vaccinations greatly reduce death and illness in vulnerable populations. In recent years, the availability and cost of the vaccines (particularly the flu vaccine) have varied considerably. We want to avoid creating any disincentives to provide these important preventative services that might result from packaging their costs into those of primary procedures, visits, or administration codes. Therefore, we proposed to pay for these vaccines under OPPS through the establishment of separate APCs.

We received no comments on our proposal to pay for these vaccines under separate APCs. However, we have had considerable discussion with providers in the past about the cost to hospitals of influenza and pneumococcal pneumonia vaccines in particular. In particular, we have had many discussions in which we were advised by providers that OPPS payment was insufficient for them to be able to guarantee that they would be able to offer these important vaccines to Medicare patients they treat. They cited the timing of updates to OPPS rates as well as volatility of costs as a result of irregular supplies of these vaccines as their major concern. Public health officials encourage high risk individuals, including Medicare beneficiaries, to receive flu immunitions beginning each September. Each flu season, a new vaccine is produced; the cost of the vaccine is also typically higher than the previous year's vaccine cost. Thus, from September through December, providers paid under the OPPS for administering flu vaccines do not receive the benefit of the update that occurs in January. In recent years, the cost of the vaccine has been volatile because of irregular supplies.

Therefore, we have decided to pay hospitals for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology. Section 1833(t)(2)(A)(i) of the Act gives the Secretary discretion to define outpatient hospital services for purposes of payment under the OPPS. Until now we have defined it to include influenza and pneumococcal pneumonia vaccines. However, in view of the importance of these vaccines to the public health and our strong desire to ensure that hospitals are paid appropriately for these vaccines, we have decided to exclude them from OPPS.

We are therefore revising regulations at § 419.21(d)(3) to remove the words ''influenza'' and ''pneumococcal pneumonia.'' As a result of this change, hospitals, HHAs and hospices which were paid for these vaccines under OPPS will be paid reasonable cost for these vaccines. We will issue further instructions regarding how CORFs will be paid for these vaccines in 2003 and will issue implementation instructions for hospitals, HHAs and hospices.

Higher Cost Drugs

While our preferred policy is to package the cost of drugs and other items into the cost of the procedures with which they are associated, we are concerned that beneficiary access to care may be affected by packaging certain higher cost drugs. For this reason, we proposed to allow payment under separate APCs for high cost drugs for an additional year while we further study various payment options. Specifically, we proposed to pay separately for drugs for which the median cost per line (cost per unit multiplied by the number of units billed on the claim) exceeded $150, as we briefly describe below. We provide more detail in the proposed rule regarding the methodology we used to determine this threshold (67 FR 52124–52125).

To establish a reasonable threshold for determining which drugs we would pay under separate APCs rather than through packaging, we calculated the median cost per unit using 2001 claims data for each of the drugs for which transitional pass-through payment ceases January 1, 2003 and for those additional drugs that we have paid separately (status indicator ''K'') since the outset of OPPS.

We excluded from these calculations the orphan drugs, vaccines, and blood and blood products discussed above. Because many drugs are used and billed in multiple unit doses, we then multiplied the median cost per unit for the drug by the average number of units that were billed per line. Once we calculated an approximate median cost per line for the drug, we then arrayed the median cost per line in ascending order and examined the distribution. A natural break occurs at $150 per line, the midpoint of a $10 span between the drug immediately above and below the $150 point. Within the array, approximately 61 percent of the drugs fall below the $150 point and 39 percent of the array are above the point. Among the drugs that we proposed to package are some radiopharmaceuticals, vaccines, anesthetics, and anticancer agents. After including the costs of packaged drugs in the services with which they were provided, we noted that the median costs of those services increased. We solicited comments that address specific alternative protocols we might use when several packaged drugs whose total cost significantly exceeds the applicable APC payment amount may be administered to a patient on the same day (for example, multiple agent cancer chemotherapy).

We requested comments on the factors we considered in determining which drugs to package in 2003. We were particularly interested in comments for the exclusion of high cost drugs from packaging. We added that we would continue to analyze the effect

of our drug-packaging proposal to assess whether the $150 threshold should be adjusted to avoid significant overpayments or underpayments for the base APCs relative to the median costs of the individual drugs packaged into the APCs. Depending on this analysis, we stated that we may revise our threshold or criteria for packaging in the final rule for 2003. We expect to further consider each of these exclusions for packaging when we develop our proposals for the 2004 OPPS.

Although we expect to expand packaging of drugs to package payment for more drugs into the APC for the services with which they are billed, we nonetheless, requested comments on alternatives to packaging. One example of an alternative approach is to use different criteria from those we propose in this proposed rule to identify the drugs to package into procedure APCs and the drugs to pay separately. Another alternative approach would be to create APCs for groups of drugs based on their costs. Still another approach would be to create separate APCs for each drug. We emphasized in the proposed rule that we welcomed a full discussion of the alternatives as we determine the best way to ensure that hospitals are paid appropriately for the drugs they administer to the Medicare beneficiaries whom they treat in their outpatient departments.

Drugs that we pay for separately in 2003 are designated in Addendum B by status indicator ''K'' or ''G.''

A summary of the comments we received on this proposal and our responses to them are summarized below.

Comment: Numerous national trade associations, drug manufacturers, consultants, and other commenters opposed our proposal to package sunsetting drugs and biologicals that fell below a threshold of $150 median cost per line into procedure APCs. These commenters urged us to continue to pay separately for drugs and biologicals that were paid separately in 2002, including those for which pass-through status has expired. Some recommended that we maintain the 2002 payment levels until more accurate data could be obtained.

In contrast, one national hospital organization recommended that we adopt a much higher threshold of $1,000 for a drug to warrant separate payment and package all other drugs that fall below the threshold. Furthermore, another national hospital association encouraged us to expeditiously incorporate into APCs both low and high cost drugs that will lose their eligibility for transitional pass-through payments, while limiting separate APC payment only to orphan drugs, blood and blood products, certain vaccines and extremely costly drugs. The commenter also stated that integrating payments for packaged services will be less burdensome for hospitals and will eliminate incentives for higher costs that might be created by special additional reimbursement. As noted in section XI, the Medicare Payment Advisory Committee also urged CMS to incorporate more drugs into the base APCs.

Response: We appreciate all of the comments regarding the various aspects we should consider in making our decision to package lower-cost drugs and biologicals into procedure APCs. After carefully considering all recommendations submitted by the commenters regarding how we should treat these drugs and biologicals, we concluded that the packaging methodology we proposed is appropriate. We believe that we have sufficient data on drugs and biologicals to allow us to make a reasonable decision on whether to package individual items. We further believe that our decision to package these costs is consistent with the concept of a prospective payment system and we expect to continue incorporating additional drugs into the base APCs in future years.

Comment: Several commenters stated that the $150 threshold established for separate APC payment is arbitrary and such a packaging rule would create confusion among hospitals. One national hospital association was concerned that the policy would create incentives for pharmaceutical companies to increase their prices so their drugs will receive separate payment, and, potentially, for physicians to choose one drug over a clinically appropriate substitute.

Response: We acknowledge the concerns for using a median cost per line threshold level when the cost of a particular drug may fluctuate over time. However, we must set the rates prospectively. We will consider these issues further as we determine our policy for the criteria for packaging as we develop our proposed rule for the 2004 update.

Comment: Several commenters supported our decision to pay separately for higher-cost drugs, clotting factors, and orphan drugs in 2003, but recommended that we delay packaging higher-cost drugs until more accurate data is available. Other commenters suggested that we collect at least 2 more years of data on all drugs and biologicals before contemplating bundling them with other APCs. They stated that once a drug or biological is bundled, hospitals will have no incentive to code for it, and there will be no means of collecting data on the product in the future. Thus, by not packaging, we would be able to determine appropriate payment rates that reflect variations in hospital expenses for these products and continue to collect product-specific information.

Response: We agree with the commenters who stated that we should not package higher cost drugs until we have more data on those products; however, we disagree with the other commenters who suggested that we should not consider packaging any drugs and biologicals until we have collected data for two more years. We believe that at this time we have sufficient data to determine which drugs and biologicals should be packaged and which products we will pay separately for in 2003. While some hospitals may fail to separately report codes that represent packaged items, we have repeatedly instructed hospitals to submit all charges related to covered outpatient services, including those for packaged items. The total charges submitted by hospitals for each service will be used to set future rates. For that reason, and because of the possible impact on their ability to receive outlier payments for which they might qualify, it is extremely important that hospitals report all appropriate charges for their covered outpatient services.

Comment: Several commenters suggested that, at minimum, we should continue to pay separately for drugs and biologicals that typically cost more than $150 per administration, regardless of whether the median cost per line exceeds $150 using the 2001 claims data. In addition, a trade association suggested that we reflect the common practice of combining radiopharmaceuticals and others drugs used in performing nuclear medicine procedures by qualifying for separate payment those drug combinations which exceed the agency's $150 threshold.

Response: We appreciate the commenters' suggestions regarding methodologies that would refine the $150 threshold level used in making packaging determinations for 2003. We believe our proposed policy strikes a reasonable balance of simplicity, administrability, and responsiveness. We intend to review and refine our methodology in the future, and the proposals submitted by commenters will be taken into consideration at that time.

Comment: Several commenters claimed that our proposal to package many of the non-pass-through, lower cost drugs and biologicals with HCPCS codes for therapeutic administration is a violation of the ''two-times'' rule. Therefore, they recommended that we continue to pay for all drugs and biologicals separately or by revising the APCs in which the drugs are packaged.

Response: We do not agree with the commenters' assertion that packaging of drugs and biologicals results in violations of the two-times rule, stated in section 1833(t)(2) of the Act. We understand the commenters' confusion and attempt to provide a clarification on how we apply the ''two-times'' rule to determine APC structures. Most APC's consist of one or more services, which we refer to as ''procedures'' and code with CPT or HCPCS G codes, that are similar clinically and in terms of resource use. Many individual items (for example, sterile supplies or pharmaceuticals such as anesthetic agents) or ancillary services (for example, nursing or recovery room services) are integral to the procedure, and thus we have packaged them with the procedure. In some instances, such as APCs for transitional pass-through drugs and devices, the APC includes no procedure, and the APC is used only to pay for a specific item.

The ''two times'' rule requires that the highest median cost of a within an APC cannot be more than two times greater than the lowest median cost of a procedure within that APC. We apply the ''two-times'' rule to the total cost of each procedure (which includes items and services that are packaged within that procedure). In the case of APCs containing only items, we apply the rule to the cost of each item that is grouped in the APC. We do not apply the two times rule to the variation in cost of individual items or ancillary services we attribute to a single HCPCS code.

If we were to attempt to apply the rule to all items and ancillary services within the various procedures, accounting for the variation in cost of supplies such as bandages, reusable instruments, and other medical supplies would be a practical impossibility. It would lead to a highly fragmented set of payment cells and a greatly more complex payment system that would reduce the incentives for effective management by hospitals. We do not believe Congress would have intended such a result.

Consistent with the principles of prospective payment, we package the cost of as many items and ancillary services as possible into the median cost of a procedure. Therefore, our payment methodology for 2003, includes packaging the costs of drugs and biologicals with median costs below $150 per line into the costs of the procedures with which they were billed. We reviewed the median cost of the procedures used for administration of drugs and biologicals, before and after we packaged the costs of drugs and biologicals. Our review indicates that the final median cost appropriately accounts for the administration procedure and the cost of the administered drug and/or biologic.

Comment: A commenter requested that we include a statement in the final rule that was included in the preamble of the September 8, 1998 proposed rule (63 FR 47563–47564) that stated ''We propose to allow hospitals to provide drugs to patients without requiring that the hospital bill the patient, and without Medicare paying the hospital. Normally, hospitals are not allowed to waive such billing, since not charging a patient could be seen as an inducement to the patient to use other services at the hospital, for which the hospital would be paid. However, if the benefit is not advertised, we believe that provision of the self-administered drugs at no charge to the beneficiary need not constitute an inducement in violation of the anti-kickback rules. The hospital may not advertise this to the public or in any other way induce patients to use the hospital's service in return for forgoing payment.''

Response: We are not making final the proposal in the September 8, 1998 rule (63 FR 47563–64) that the commenter quotes. Medicare policy affecting how payment is made under the OPPS has evolved considerably since that rule. In the intervening years, CMS, providers, contractors, and beneficiaries all have acquired considerable experience under the OPPS that has added perspective and substance to a broad range of policy issues, including what is and is not payable under the OPPS. The following points summarize our current policy related to the issue posed by the commenter:

- In accordance with the in section 1861(s)(2)(B) of the Act and related Medicare regulations and program issuances, drugs and biologicals that are not usually self-administered by the patient are payable under the OPPS. As we explain elsewhere in this final rule, Medicare makes separate payment for certain drugs and biologicals and packages payment for others into the procedure with which they are billed.
- The fact that a drug has a HCPCS code and a payment rate under the OPPS does not imply that the drug is covered by the Medicare program, but only indicates how the drug may be paid if it is covered by the program.
- A code and payment amount does not represent a determination that the Medicare program covers a drug. Contractors must determine whether the drug meets all program requirements for coverage; for example, that the drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment because it is usually self-administered.
- Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for the procedure or treatment. Consequently, payment for them is included in the APC payment for the procedure or treatment of which they are an integral part.
- Under the OPPS, hospitals may not separately bill beneficiaries for items whose costs are packaged into the APC payment for the procedure with which they are used (except for the copayment that applies to the APC).

In short, neither the OPPS nor other Medicare reimbursement rules regulate the provision or billing by hospitals of non-covered drugs to Medicare beneficiaries. Accordingly, it would be inappropriate to include the statement in the 1998 rule. However, in some circumstances, such practices potentially implicate other statutory and regulatory provisions, including the prohibition on inducements to beneficiaries, section 1128A(a)(5) of the Act, or the anti-kickback statute, section 1128B(b) of the Act.

E. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Brachytherapy

Section 1833(t)(6) of the Act requires us to establish transitional pass-through payments for devices of brachytherapy. As of August 1, 2000, we established item-specific device codes including codes for brachytherapy seeds, needles, and catheters. Effective April 1, 2001, we established category codes for brachytherapy seeds on a per seed basis (one for each isotope), brachytherapy needles on a per needle basis, and brachytherapy catheters on a per catheter basis. Because initial payment was made for a device in each of these categories in August 2000, we proposed that these categories (and the transitional pass-through payments) will be discontinued as of January 1, 2003. Furthermore, as discussed above, we

proposed that there will be no grace period for billing these category codes.

We received comments, both in writing and at the April 2002 Town Hall meeting, recommending that we continue to make separate payment for brachytherapy seeds. The basis for this recommendation is that the number of brachytherapy seeds implanted per procedure is variable. These commenters stated that the number and type of seeds implanted in a given patient depends on the type of tumor, its size, extent, and biology, and the amount of radioactivity contained in each seed. To further complicate the matter, the HCPCS codes used to report implantation of brachytherapy seeds are not tumor-specific. Instead, they are defined based on the number of sources, that is, the number of seeds or ribbons used in the procedure. This means that the treatment of many different tumors requiring implantation of widely varying numbers of seeds is described by a single HCPCS code. Therefore, it has been argued that given the costs of seeds and the variety of treatments described by a single HCPCS code, the cost of brachytherapy billed under a single HCPCS code could vary by as much as $3,000.

In determining whether to package seeds into their associated procedures, we considered all these factors as well as our claims data. Consistent with our proposed policy for other device costs and the cost of many drugs, as well as with the principles of a prospective payment system, our preferred policy is to package the cost of brachytherapy devices into their associated procedures. For 2003, in the case of remote afterloading high intensity brachytherapy and prostate brachytherapy, which we discuss below, weproposed to package the costs into payment for the procedures with which they are billed.

For other uses of brachytherapy, we proposed to defer packaging of brachytherapy seeds for at least 1 year. In those cases, when paying separately in 2003 for brachytherapy seeds, we proposed to continue payment on a per seed basis. The payment amount would be based on the median cost of brachytherapy seeds, per seed, as determined from our claims data.

We solicited comments on methodologies we might use to package all brachytherapy seeds beginning in CY 2004. For example, creation of tumor-specific brachytherapy HCPCS codes would reduce the variability in seed implantation costs associated with the current HCPCS codes used for seed implantation.

As stated above, beginning January 1, 2003, we proposed to package payment for brachytherapy seeds into the payment for the following two types of brachytherapy services:

Remote Afterloading High Intensity Brachytherapy

Participants in the April 5, 2002 Town Hall meeting expressed concern about packaging single use brachytherapy seeds into payment for procedures.

Remote afterloading high intensity brachytherapy treatment does not involve implantation of seeds. Instead, it utilizes a single radioactive ''source'' of high dose iridium with a 90-day life span. This single source is purchased and used multiple times in multiple patients over its life. One or more temporary catheters are inserted into the area requiring treatment, and the radioactive source is briefly inserted into each catheter and then removed. Because the source never comes in direct contact with the patient, it may be used for multiple patients. We note that the cost of the radioactive source, per procedure, is the same irrespective of how many catheters are inserted into the patient. We believe that the costs of this type of source should be amortized over the life of the source. Therefore, each hospital administering this type of therapy should include its own charge for the radiation source in the charge for the procedure. Therefore, we proposed to package the costs associated with high dose iridium into the HCPCS codes used to describe this procedure. Those codes are: 77781, 77782, 77783, and 77784.

Prostate Brachytherapy

The preponderance of brachytherapy claims under OPPS to date is for prostate brachytherapy. Brachytherapy is administered in several other organ systems, but the claims volume for non-prostate brachytherapy is very small, and hence our base of information on which to make payment decisions is slim. Furthermore, prostate brachytherapy uses only two isotopes, which are similar in cost, while brachytherapy on other organs involves a variety of isotopes with greater variation in cost. Consequently, we believe it would be prudent to wait for further experience to develop before proceeding to package non-prostate brachytherapy seeds.

A number of commenters at the April 5, 2002, Town Hall Meeting and elsewhere have stressed to us their views that brachytherapy seeds should remain unpackaged. The principle argument put forth in favor of this approach is that the number of seeds used is highly variable across patients. We do not find this argument compelling. Payments in the OPPS, as in other prospective payment systems, are based on averages. We believe the service volume at hospitals providing prostate brachytherapy is likely to be large enough for a payment reflecting average use of seeds to be appropriate.

Additionally, appropriate payment for prostate brachytherapy has been of concern to many commenters since implementation of the OPPS because facilities must use multiple HCPCS codes on a single claim to accurately describe the entire procedure. Because we determine APC relative weights using single procedure claims, commenters have argued that payments for prostate brachytherapy are, in part, based on error claims, resulting in underpayment for this important service. We agree that basing the relative weights for APCs reported for prostate brachytherapy services on only the small number of claims related to this service that are single procedure claims may be problematic. To increase the number of claims we could use to develop the proposed 2003 relative payment weights for prostate brachytherapy, we began by identifying all claims billed in 2001 for prostate brachytherapy. Unfortunately, closer analysis of these claims revealed that hospitals do not report prostate brachytherapy using a uniform combination of codes. Of the more than 12,000 claims for prostate brachytherapy that we identified in the 2001 claims data, no single combination of HCPCS codes occurred more than 25 times.

Therefore, in order to facilitate tracking of this service, we proposed to establish a G code for hospital use only that will specifically identify prostate brachytherapy. We proposed as the descriptor for this G code the following: ''Prostate brachytherapy, including transperineal placement of needles or catheters into the prostate, cystoscopy, and interstitial radiation source application.'' This G code would be used by hospitals instead of HCPCS codes 55859 and 77778 to bill for prostate brachytherapy. Hospitals would continue to use HCPCS codes 55859 and 77778 when reporting services other than prostate brachytherapy. We would also instruct hospitals to continue to report separately other services provided in conjunction with prostate brachytherapy, such as dosimetry and ultrasound guidance. These additional services would be paid according to the APC payment rate established by our usual methodology.

This G code will allow us to package brachytherapy seeds into the procedures for administering prostate brachytherapy while permitting us to pay separately for brachytherapy seeds which are administered for other procedures. Therefore, we proposed to package the costs of the brachytherapy seeds, catheters, and needles into the payment for the prostate brachytherapy G code. In order to develop a payment amount for this G code, we used all claims where both HCPCS codes 55859 and 77778 appeared. We packaged all revenue centers and appropriate HCPCS codes, that is, HCPCS with status indicator ''N.'' We then determined median costs of the line items for HCPCS codes 55859 and 77778 and added the two. Next, we packaged the costs of all C codes, whether an item-specific or a device category code, into the payment amount. We proposed to assign APC 0684 with status indicator ''T.'' We believe the payment rate proposed for this G code appropriately reflects the costs of the procedures, the brachytherapy seeds, and any other devices associated with these procedures. We solicited comments on this proposal.

Packaging of Other Device Costs Associated With Brachytherapy

We proposed to package the costs of brachytherapy needles and catheters with whichever procedures they are reported, similar to our proposal for packaging the costs of other devices that will no longer be eligible for a transitional pass-through payment in 2003. Because the HCPCS code descriptors for brachytherapy are based on the number of catheters or needles used, we believe the costs of these devices would be appropriately reflected within the costs of the associated procedure.

Brachytherapy

Comment: One commenter believed that assigning CPT Code 77799 to APC 313 was inappropriate because it was the highest paying brachytherapy APC and it violated the two times rule.

Response: We thank the commenter for bringing this to our attention. The CPT code 77799 should be assigned to APC 312, the lowest paying brachytherapy APC, which is consistent with our policy of assigning unspecified codes to the lowest paying similar APC because we do not know what procedures are being performed. However, we do not apply the two times rule to unspecified codes like 77799 for that same reason. We are assigning 77799 to APC 312.

Comment: Several commenters were concerned that the proposed payment rates for APCs 1718, for iodine seeds, and 1720, for palladium seeds were significantly lower than the 2002 payment rates for these brachytherapy sources. The commenters stated that the new rates do not reflect hospital acquisition costs and recommended that we continue pass-through status for these seeds in 2003 or refine the claims data used to set payment rates.

Response: Our payment rates for 1718 and 1720 are based on the median costs for these seeds in our 2001 claims data. We are confident that these data reflect actual hospital acquisition costs. By statutory mandate, the OPPS system, in aggregate, does not pay hospitals full costs for services. Therefore, it should not be expected that payment rates (which involve turning median costs into relative weights and applying scaling factors) will always reflect 100 percent of hospital acquisition cost.

Comment: Several commenters urged us to identify all sources currently used in brachytherapy and cover those sources on an interim basis. They suggested we retain a C code for ''unlisted'' brachytherapy sources to allow hospitals to bill for sources not on the current pass through list.

Response: We only create C codes for items based on formal applications for a specific device. We do not create C codes for unlisted devices. Interested parties may submit an application for a pass through device using the process described in the April 7, 2000 final rule (65 FR 18481–18482).

Comment: A commenter suggested continuing the pass-through categories for brachytherapy seeds, needles, and catheters for one year in order to collect more data.

Response: Statutory provisions preclude us from continuing these categories for an additional year.

Comment: One commenter asked us to refer to brachytherapy ''sources'' instead of brachytherapy ''seeds.''

Response: We agree and will do so.

Comment: One commenter responded to our solicitation of comments regarding the advisability of creating tumor specific brachytherapy HCPCS codes in the future. The commenter did not favor this idea because of the variability in number and type of brachytherapy devices used to treat a single disease. Additionally, it would create an overly complex coding system.

Response: We thank the commenter and are continuing to review this issue.

Comment: Several commenters were concerned about the proposed payment reduction for APC 313 (High Dose Afterloading Brachytherapy). The commenters stated that hospitals were coding incorrectly for these services because many claims did not use C codes for the sources or catheters. Therefore, our data did not reflect actual hospital costs. The commenters recommended that we increase the payment rate, use only claims that were correctly coded, or continue to pay separately for the sources.

Response: As described elsewhere in this rule, we have taken steps to mitigate the severe payment decreases that were proposed for several APCs including APC 313. Therefore the final payment rate for APC 313 will be higher than the proposed payment rate. We will continue to review the issues raised by the commenters. It is unclear how we should address the issue of coding for APC 313 because high dose brachytherapy sources are reusable whose costs must be amortized per use over a 90 day period. Furthermore, hospitals have been using these sources for many years; therefore, we would expect their charges would reflect this amortized cost even in the absence of using a C code. Additionally, it is likely we over estimated device costs for this APC because of the methodology we used for folding in device costs insetting 2002 payment rates. Lastly, we are unable to continue pass-through payments for devices used in APC 313 and do not think it is appropriate to pay separately for high dose brachytherapy sources for the reasons discussed.

Comment: Several commenters were concerned about the ''N'' status indicator assigned to Yttrium-90 brachytherapy sources. They stated that it is an implantable seed used in treating liver cancer. They also claimed that its median cost was much higher than the cost reflected in our claims data.

Response: We will place Yttrium-90 in an APC. Assigning status indicator ''N'' was an error. We will use our claims data to set the payment rate. We will continue to review our claims data and external data sources as we update the payment rate in 2004.

Comment: Several commenters suggested that we create HCPCS codes and APCs for high dose implantable brachytherapy sources. They explained that sources such as iodine-125 and palladium-103 may be ''high'' intensity or 'low'' intensity (that is, emit different amounts of radiation) and that our payment for these sources account for the cost variation associated with sources of different intensities. Another commenter requested that we create three levels of APCs for brachytherapy needles and catheters to account for cost variation of those devices. Lastly, another commenter suggested we create

three APCs to reflect levels of seed utilization (for example, simple for less than 85 seeds, intermediate for 85–99 seeds and complex for more than 100 seeds).

Response: We disagree. Our median cost data should reflect the cost variation among seeds of different intensity. For example if low intensity seeds cost $40 and are used 80 percent of the time, and high intensity seeds cost $50 and are used 20 percent of the time, then our cost data should reflect a cost of $42 per seed. Insofar as no hospital specializes in administering high intensity seeds, on average, hospitals should be paid appropriately for both types of seeds. Furthermore it would be administratively burdensome and make accurate coding very difficult, if we created APCs for every variation in seeds. We believe devices other than seeds should be packaged into procedure APCs, as we have done with all other devices. Because we pay for sources on a ''per seed'' basis there is no reason to create APCs for simple, intermediate, and complex seed utilization.

Comment: One commenter requested that we set up a system to account for the variability in use of brachytherapy devices. Another commenter said that brachytherapy codes were not well understood so all supplies and sources should be paid separately.

Response: We disagree and are finalizing our proposal to package all devices except for seeds in cases of non-prostate cancer brachytherapy. Doing what the commenters requested would create an extremely burdensome system with no discernable benefit.

Comment: Many commenters disagreed with our proposal to create a G code describing prostate brachytherapy with packaged implantable sources, needles, and catheters. They cited the following as reasons:

- The high variability in the number of sources used per treatment.
- The difference in cost between iodine and palladium seeds.
- Packaging of seeds violates the two times rule.
- Some hospitals specialize in complex cases requiring high numbers of seeds and would always be underpaid.
- A single payment rate would provide incentives to use cheaper (iodine) seeds when more expensive seeds (palladium) were clinically appropriate.
- A single payment rate would provide an incentive to use fewer, higher activity seeds even if use of more lower activity seeds was clinically appropriate.
- Underpayment for prostate brachytherapy will create an incentive to use more invasive, riskier, and costly treatments for prostate cancer.
- The proposed payment rate is too low as a result of using improperly coded claims.
- Creating a new G code is administratively burdensome.

Most commenters recommended that we continue to pay separately for brachytherapy sources used for prostate cancer, as we proposed to do for other forms of cancer. Some commenters requested that we withdraw our proposal for the G code describing brachytherapy and continue to recognize CPT codes 55859 and 77778 while other commenters agreed with our proposal to create the G code with packaged needles and catheters but asked that we not package brachytherapy sources into it. Some commenters requested that, if we finalize our G code, that it be paid as least as much as combined payment rate for the APCs containing CPT codes 55859 and 77778.

A few commenters agreed with our proposed G code approach but asked that we create 2 G codes, one for prostate brachytherapy using iodine seeds and another for prostate brachytherapy using palladium seeds. They also suggested that if CMS finalizes one or more G codes, coding edits should be developed to ensure proper coding of these procedures.

Response: We thank all the commenters. After review of all the comments we have decided to create 2 G codes describing prostate brachytherapy. G0256, Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source, and G0261, Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source. These codes package the costs of needles, catheters, and sources. In developing payment rates for these codes we used only correctly coded claims. For example, for G0256 we used only claims that included CPT codes 55859, 77778, and a C code for palladium sources. We did not use any claims where there was no C code for a brachytherapy source or a claim where there were C codes for more than one source (for example, palladium and iodine sources). Analysis of the claims we used in setting payment rates revealed that the median number of seeds packaged into both codes is 85. We believe that the median costs of these codes reflect the resources required to perform these procedures.

We believe that implementation of these G codes should address the clinical concerns of the commenters. We do not believe these codes will create an incentive to use one type of source rather than another. Additionally, because of the number of seeds packaged we do not believe there will be an incentive to use fewer seeds inappropriately. Furthermore, we believe the number of packaged seeds addresses the concerns about seed variability as we are not aware of facilities that specialize in using more palladium or iodine than are packaged in these codes. Finally, we do not have evidence that implementation of these G codes and their payment rates will create an incentive to treat prostate cancer with more invasive, more costly treatments.

For non-clinical concerns, we think that implementation of the G codes will actually decrease administrative burden as it will now be easier for hospitals to properly code for prostate brachytherapy procedures, and we believe that the methodology we used to develop median costs addresses the concerns about underpayment.

When performing prostate brachytherapy hospitals should use G0256 and G0261 and should not report CPT codes 55859 and 77778. Furthermore hospitals should not report the APCs for iodine and palladium brachytherapy sources. CMS will create edits to prevent billing of these items and services with prostate brachytherapy. However, other services provided during the provision of prostate brachytherapy such as intraoperative ultrasound, dosimetry, etc., are separately payable and should be reported on the claim if performed.

F. Payment for Transitional Pass-Through Drugs and Biologicals for Calendar Year 2003

As discussed in the November 13, 2000 interim final rule (65 FR 67809) and the November 30, 2001 final rule (66 FR 59895), we update the payment rates for pass-through drugs on an annual basis. Therefore, as we have done for prior updates, we proposed to update the APC rates for drugs that are eligible for pass-through payments in 2003 using the most recent version of the Red Book, the July 2002 version in this case. The updated rates effective January 1, 2003 would remain in effect until we implement the next annual

update in 2004, when we would again update the AWPs for any pass-through drugs based on the latest quarterly version of the Red Book. This retains the update of pass-through drug prices on the same calendar year schedule as the other annual OPPS updates.

As described in our final rule of November 30, 2001 (66 FR 59894), in order to establish the applicable beneficiary copayment amount and the pass-through payment amount, we must 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 from an external survey of hospital drug costs (see the April 7, 2000 final rule (65 FR 18481)). That survey concluded that—

- For drugs available through only one source drugs, the ratio of acquisition cost to AWP equals 0.68;
- For multisource drugs, the ratio of acquisition cost to AWP equals 0.61;
- For drugs with generic competitors, the ratio is 0.43.

As we stated in our final rule of November 30, 2001 (66 FR 59896), we considered the use of the study-derived ratios of drug costs to AWP to be an interim measure until we could obtain data on hospital costs from claims. We stated that we anticipated having this data to use in setting payment rates for 2003.

As described elsewhere in this preamble, we used 2001 claims data to calculate a median cost per unit of drug for each drug for which we are currently paying separately. We compared the median per unit cost of each drug to the AWP to determine a ratio of acquisition cost to AWP. Using the total units billed for each drug, we then calculated a weighted average for each of the above three categories of drugs. These calculations resulted in the following weighted average ratios:

- For sole-source drugs, the ratio of cost to AWP equals 71.0 percent.
- For multisource drugs, the ratio of cost to AWP equals 68.0 percent.
- For drugs with generic competitors, the ratio of cost to AWP equals 46.0 percent.

We proposed to use these percentages for determining the applicable beneficiary copayment amount and the pass-through payment amount for most drugs eligible for pass-through payment in 2003. However some drugs may fall into two other classes. The first class includes a drug that is new and for which no cost is yet included in an associated APC. For such a drug, because there is no cost for the drug yet included in an associated APC, the pass-through amount will be 95 percent of the AWP and there would be no copayment. The second class includes a drug that is new and is a substitute for only one drug that is recognized in the OPPS through an unpackaged APC. For drugs in this second class, the pass-through amount would be the difference between 95 percent of the AWP for the pass-through drug and the payment rate for the comparable dose of the associated drug's APC. The copayment would be based on the payment rate of its associated APC. We believe that using this methodology will yield a more accurate payment rate.

We have received questions for our definition of multisource drugs. In determining whether a drug is available from multiple sources, we consider repackagers to be among the sources. This is consistent with the findings of the survey cited above which indicated a lower ratio of acquisition cost to AWP from multiple sources including repackagers.

We note that determining that a drug is eligible for a pass-through payment or assigning a status indicator ''K'' to a drug or biological (indicating that the drugs or biologicals is paid based on a separate APC rate) indicates only the method by which the drug or biological is paid if it is covered by the Medicare program. It does not represent a determination that the drug is covered by the Medicare program. For example, Medicare contractors must determine whether the drug or biological is: (1) Reasonable and necessary to treat the beneficiary's conditions; and (2) excluded from payment because it is usually self-administered by the patient.

We received several comments on this proposal, which are summarized below.

Comment: A commenter stated that the payments for pass-through drugs were too generous compared to those for the devices.

Response: We calculated payments for pass-through drugs and devices in accordance with the statute in sections 1833(t)(6)(D)(i) and (ii) of the Act.

Comment: Numerous commenters were concerned with the time required to incorporate new drugs and biologicals into the APC system. Some commenters indicated that we frequently depart from our own timeframe of 4 to 7 months from the date of submission of an application to the potential effective data for pass-through status. Thus, they urged us to follow one of the following recommendations: Expedite the processing of pass-through applications and the creation of C codes; develop C codes for products pending FDA approval, or permit retroactive dates for new codes to allow for retroactive reimbursement for hospitals. Another commenter suggested that we create a centralized on-line listing of all current pass-through drugs, biologicals, and devices along with all of the new applications under review.

Response: We understand the commenters' concerns, and we would like to clarify the operation of our quarterly deadlines. We establish deadlines for submission of transitional pass-through applications that are 4 months in advance of the next quarterly update to the claims-payment system in order to accommodate time for review and decision and for revisions to the claims-payment systems. Thus an applicant submitting by the deadline can be assured we will consider the application for possible inclusion in the next quarterly update. However, we cannot guarantee that we will be able to make a decision regarding the application within that period of time. Incomplete applications or the need to answer technical questions that arise during review may extend the period of review.

We have instructed hospitals through our fiscal intermediaries that hospitals may bill for new drugs following FDA approval using an unspecified HCPCS code until a permanent HCPCS is established for the drug and/or we have approved pass-through payment for the drug. Payment for a new drug, if determined by the fiscal intermediary to be a covered drug, would be packaged. However inclusion of the drug charges for the procedure will be considered in determining outlier payments and will be used in future rate setting for the procedure and/or the drug once its pass-through status expires. Hospitals should note that we have lowered the threshold for outlier payments for 2003, and this new threshold requirement is described in section IX of the preamble.

We intend to minimize the delays in the review process as much as possible so that we can facilitate access to new products and services for our beneficiaries, which is why we review new pass-through applications on a quarterly basis. We disagree with the commenters who suggested that we allow retroactive reimbursement for hospitals to the date of FDA approval. Moving to such a policy would greatly increase the burden on our and hospitals' computer systems in programming, testing, and implementing updates to the payment system. We do not provide for retroactive changes in reimbursement because this is a prospectively

determined payment system and because retroactive payment rate changes are administratively burdensome and confusing for beneficiaries and providers.

We appreciate the suggestion to create an on-line listing of all transitional pass-through items and applications that are under review, and will consider it for the future.

Comment: Several national trade associations and drug companies were concerned with our proposal to consider drugs and biologicals that were subject to repackaging as multisource drugs. They indicated that repackagers do not manufacture the products; instead, they purchase the products from the manufacturers, package them differently, and then sell the products. The manufacturer of the product continues to be the sole source of the product; therefore, we should regard repackaged products as sole source drugs. Also, they recommended that we utilize the ''Orange Book'' to determine whether a drug should considered single source, multisource, or generic for OPPS purposes.

Response: We acknowledge that we treat certain drugs that have only one manufacturer as a multisource drug. Our rationale behind regarding a repackaged drug as a multisource product is that, even though there may be only one manufacturer of a repackaged drug, there is more than one party selling the repackaged drug in the market. Therefore, a repackager may charge a different price to hospitals for the same product sold by its manufacturer. Our intention in the payment system is to account for the economic relationship between market prices for repackagers, multisource drugs, and sole source drugs. From our analysis, we judged the drugs sold by repackagers to be similar to drugs available from more than one manufacturer in terms of price differentials and estimated hospital acquisition costs. We also note that if we were to recategorize these drugs as single source, we would have to recalculate the average values for acquisition costs for the three categories of drugs.

Comment: Several commenters suggested that we use the October 2002 Red Book information to set the final pass-through payment rates for 2003. Also, the commenters urged us to update the pass-through payment rates quarterly since there will be significantly fewer pass-through drugs in 2003.

Response: Upon considering the commenters' suggestions in using the October 2002 Red Book to set the pass-through payment rates for drugs and biologicals, we decided to continue using the July 2002 Red Book as we proposed since it is most consistent with our publication schedule. In the future, for all of our final rules that must be published by November, we will continue to use the July edition of the Red Book for that year.

We carefully considered the proposal to update the pass-through payments on a quarterly basis and decided to continue with only annual updates of the rates. From previous experience, we know that doing a quarterly update of the prices for all the pass-through drugs and biologicals would be burdensome on our contractors and disruptive to both our computer systems and pricing software. Although we make other updates on a quarterly basis, we do not include revision of rates in these updates unless an error was made in the calculation of the rate. We see no compelling reason to update the transitional pass-through drug prices under the OPPS more frequently than the other payment rates in the outpatient system.

Comment: Several commenters indicated that in the proposed rule we appeared intent on estimating pass-through expenditures that will exceed the statutory cap and trigger a pro-rata reduction of pass-through payments in 2003.

Response: Frankly, we find it puzzling that commenters would believe we would manipulate the estimates of pass-through spending with the intention of ensuring that a pro-rata reduction would be imposed. Our estimate of transitional pass-through spending indicates that no pro-rata reduction will be necessary in 2003.

Comment: A commenter urged us to develop a process for acknowledgement and payment adjustment when it is determined that the rates published in the Red Book are incorrect.

Response: As stated elsewhere in this final rule, we update payment rates for pass-through drugs and biologicals only on an annual basis using the information published in the July edition of the Red Book. We rely on information supplied by manufacturers to the Red Book to be accurate.

V. Criteria for New Device Categories As Implemented in the November 2, 2001 Interim Final Rule With Comment

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, amended section 1833(t) of the Act to make major changes that affected the new PPS for hospital outpatient services. Section 1833(t)(6) of the Act, which was added by section 201(b) of the BBRA, provided for temporary additional payments, referred to as ''transitional pass-through payments,'' for certain drugs, biologicals, and devices. Section 1833(t)(b) of the Act provided for payment of new medical devices, as well as 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. Section 402 of BIPA, which amends section 1833(t)(6) of the Act, requires us to use categories in determining the eligibility of devices for transitional pass-through payments effective April 1, 2001. Section 1833(t)(6)(B)(ii)(IV) of the Act, as added by section 402(a) of BIPA, requires us to establish a new category for a medical device when—

- The cost of the device is not insignificant in relation to the OPPS payment amount;
- No existing or previously existing device category is appropriate for the device; and
- Payment was not being made for the device as an outpatient hospital service as of December 31, 1996. However, section 1833(t)(6)(B)(iv) of the Act, also added by section 402(a) of BIPA, provides that a medical device shall be treated as meeting the first and third requirements if either—
- The device is described by one of the initial categories established and in effect or
- The device is described by one of the additional categories we established and in effect, and—

—An application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved; or
—The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or
—The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of that Act.

Thus, otherwise covered devices that are described by a currently existing category may be eligible for transitional pass-through payments even if they were paid as part of an outpatient service as of December 31, 1996. At the same time, no categories will be created on the basis of devices that were paid on or before December 31, 1996.

Section 1833(t)(6)(B)(i)(I) of the Act, as amended by BIPA, required us to establish, by April 1, 2001, an initial set of categories based on device by type in such a way that specific devices eligible

for transitional pass-through payments under sections 1833(t)(A)(ii) and (iv) of the Act as of January 1, 2001 would be included in a category. We developed this initial set of categories in consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties, as required by section 1833(t)(6)(B)(i)(II) of the Act. We issued the list of initial categories on March 22, 2001, in Program Memorandum (PM) No. A–01–41. Subsequently, an additional two categories and clarifications of some of the categories' long descriptors were made. The latest PM that lists all the existing device categories (including three additional categories that became effective July 1, 2002) is Transmittal No. A–02–050, issued June 17, 2002, which can be accessed on our Web site, *http://cms.hhs.gov.*

Section 1833(t)(6)(B)(ii)(III) of the Act, as amended by BIPA, requires us to establish criteria by July 1, 2001 that will be used to create additional categories. Section 1833(t)(6)(B)(ii)(II) of the Act requires that no medical device is described by more than one category. In addition, the criteria must include a test of whether the average cost of devices that would be included in a category is ''not insignificant'' in relation to the APC payment amount for the associated service.

On November 2, 2001, we set forth in an interim final rule (66 FR 55850) the criteria for establishing new (that is, additional) categories of medical devices eligible for transitional pass-through payments under the OPPS as required by section 1833(t)(6)(B)(ii) of the Act. We received five comments regarding our criteria published in the November 2, 2001 interim final rule with comment period. We summarize and respond to these comments below.

A. Criteria for Eligibility for Pass-Through Payment of a Medical Device

As noted above, in our April 7, 2000 final rule with comment period (65 FR 18480), we defined new or innovative devices using eight criteria, three of which were revised in our August 3, 2000 interim final rule with comment period (65 FR 47673 through 47674). These criteria were set forth in regulations at § 419.43(e)(4). For the most part, these criteria remained applicable when defining a new category for devices. That is, devices to be included in a category must meet all previously established applicable criteria for a device eligible for transitional pass-through payments. The definition of an eligible device, however, needed to change to conform to the requirements of the amended section 1833(t)(6)(B)(ii) of the Act, that is, the requirement to establish additional categories, which we accomplished in our November 2, 2001 interim final rule.

In addition, we clarified our criterion that states that a device must be approved or cleared by the FDA. The approval or clearance criterion applies only if FDA approval or clearance is required for the device as specified at new § 419.66(b)(1). For example, a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with § 405.203 through § 405.207 and § 405.211 through § 405.215 is exempt from this requirement. A device that has received an FDA IDE and is classified by the FDA as a Category B device is eligible for a transitional pass-through payment if all other requirements are met.

B. Criteria for Establishing Additional Device Categories

As described above, in determining the criteria for establishing additional categories, section 1833(t)(6)(B)(ii) of the Act mandates that new categories must be established for devices that were not being paid for as an outpatient hospital service as of December 31, 1996, and for which no category in effect (or previously in effect) is appropriate in such a way that no device is described by more than one category and the average cost of devices to be included in a category is not insignificant in relation to the APC payment amount for the associated service. Based on these requirements, we announced in the November 2, 2001 interim final rule that we will use the following criteria to establish a category of devices:

- *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established (that is, existing or previously existing) categories or other available treatments, as described in regulations at new § 419.66(c)(1).

We stated our belief that this criterion ensures that no existing or previously existing category contains devices that are substantially similar to the devices to be included in the new category. This criterion is consistent with the statutory mandate that no device is described by more than one category.

In addition, we said that this criterion limits the number of new categories, and consequently transitional pass-through payments, to those categories containing devices that offer the prospect of substantial clinical improvement in the care of Medicare beneficiaries. Section 1833(t)(6)(E)(iii) of the Act, requires that, if the Secretary estimates before the beginning of the year that the total estimated amount of pass-through payments would exceed a specified percentage of total program payments (2.5 percent before 2004 and no more than 2 percent thereafter), we must uniformly reduce (prospectively) each pass-through payment in that year by an amount adequate to ensure that the limit is not exceeded.

We established this criterion because it is important for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in the treatment of Medicare beneficiaries to facilitate access by beneficiaries to the advantages of the new technology. Conversely, the need for additional payments for devices that offer little or no clinical improvement over a previously existing device is less apparent. These devices can still be used by hospitals, and hospitals will be paid for them through the appropriate APC payment. To the extent these devices are used, the hospitals' charges for the associated procedures will reflect their use. We will use data on hospital charges to update the APC payment rates as part of the annual update cycle. Thus, the payment process will provide an avenue to reflect appropriate payments for devices that are not substantial improvements.

We are currently evaluating requests for a new category of devices against the following criteria in order to determine if it meets the substantial clinical improvement requirement:

- The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.
- The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.
- Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

—Reduced mortality rate with use of the device.
—Reduced rate of device-related complications.

—Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
—Decreased number of future hospitalizations or physician visits.
—More rapid beneficial resolution of the disease process treated because of the use of the device.
—Decreased pain, bleeding, or other quantifiable symptom.
—Reduced recovery time.

As part of the application process (described in section V.B.1 of this final rule), we require the requesting party to submit evidence that the category of devices meets one or more of these criteria. We noted that the requirements set forth above will be used only for determining whether a device is eligible for a new category under section 1833(t)(6)(B) of the Act, which authorizes transitional pass-through payments for categories of devices. These criteria are not intended for use in making coverage decisions under section 1862(a)(1)(A) of the Act. We noted that adoption of these criteria is consistent with the recommendation of the Medicare Payment Advisory Commission, in its March 2001 Report to Congress, that pass-through payments for specific technologies be made only when a technology is new or substantially improved.

We stated that we determine which devices represent a substantial clinical improvement over existing devices by using a panel of Federal clinical and other experts, supplemented if appropriate by individual consultation with outside experts. These decisions are, in general, based on information submitted by the requester about the clinical benefit of the devices as described in the above criteria, including, where available, evidence from clinical trials or other clinical investigations. A panel of clinical experts from CMS has thus far made all of our decisions on eligibility for an additional device category.

As indicated in the November 2, 2001 interim final rule, we believe that almost all substantial clinical improvements in technology that are appropriately paid for under the transitional pass-through provisions result in measurable improvements in care from the perspective of the beneficiary. Nevertheless, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment (as opposed to packaged payments) even though they do not directly result in substantial clinical improvements. For example, improvements in such factors as the strength of materials, increased battery life, miniaturization, might so improve convenience, durability, ease of operation, etc., that such an improvement in medical technology might be considered as a separate factor from ''substantial clinical improvement'' in beneficiary care.

We invited public comment on this issue and particularly asked for examples of medical technologies for which pass-through payments might be appropriate even though they would not also pass a test based on substantial improvement in beneficiary outcomes. Although we received a number of comments on this criterion, only one attempted to provide an example of new medical technology that might not also pass a test based on substantial improvement in beneficiary outcomes. This example is described in our summary of comments and responses below.

As we noted in the November 2, 2001 interim final rule, we will continue to evaluate these criteria as we gain experience in applying them, and we will consider revisions and refinements to them over time as appropriate.

Comment: Most commenters expressed concerns regarding our criterion that new device categories demonstrate substantial clinical improvement to be eligible for pass-through payment. Device manufacturers and representatives felt that evidence of clinical outcomes should not be part of the device category evaluation and eligibility process. Some maintained that we already have standards for determining clinical benefit as part of the Medicare coverage process and we should not have such requirements in payment determination. One commenter claimed that we would be unable to determine substantial clinical improvement for pass-through categories separately from national coverage decisions, since we will be reviewing the same types of evidence for both processes. This commenter held that a payment policy decision using clinical improvement criteria is a de facto coverage decision that our Coverage Analysis Group and carriers would feel compelled to go along with.

One device manufacturer was concerned that any employment of inappropriate evidentiary standards in evaluating improvement in diagnosis or treatment when applying this criterion could be a barrier to pass-through payment for some new technologies.

Yet, some manufacturers agree that pass-through payment should be limited to technologies that represent significant advancements in providing beneficial new therapy options. A number of commenters felt we should take into account improvements in devices' technology per se, for example, material, power source, size, etc., and not limit our criterion of improvement to clinical improvement. Some commenters held that only technological aspects of new medical devices should be analyzed to determine whether there are advancements over existing pass-through devices to determine whether a device should be considered for an additional category. A manufacturer stated that if we feel that a criterion based on clinical benefits is needed, we should employ a ''substantially different'' criterion to determine eligibility for a new category. Under this suggestion, any difference in therapeutic effect, indication, surgical approach, safety or side effects, mechanics or function that offers a ''new beneficial therapeutic alternative'' would be considered ''substantial.''

One manufacturer also stated that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses costs that are ''not insignificant.''

Response: Although the information required for pass-through category applications is similar for coverage determinations, the information is used differently. The purpose of the ''reasonable and necessary'' condition in evaluating coverage is different than the OPPS purpose of determining appropriate pass-through payment for new technology items. We are not attempting to determine coverage under the OPPS, only whether a payment under the pass-through mechanism is warranted. We adopted the ''substantial clinical improvement'' criterion to help us identify those devices that are not adequately described by any previously established device categories.

Those who argue that we should employ a ''substantially different'' or a ''clinical benefit'' criterion rather than the ''substantial clinical improvement'' do not answer the question as to how different a new technology should be to be considered eligible for a new device category. It seems to us that many of the differences listed in the suggestion to base a criterion on ''substantial differences'' noted above may not reflect qualitatively meaningful differences and such devices could be adequately described by the existing or previously existing categories. If a new device technology were adequately described by a category of devices in terms of its clinical application and benefits, then an additional category would not seem

warranted. Still, as we have stated in the November 2, 2001 interim final rule and again above, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even though they do not directly result in substantial clinical improvements. We will continue to allow the flexibility in our evaluation process to consider such items for new categories.

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.''

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass-through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.

The notion that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses ''not insignificant cost,'' is misplaced. The cost of the new technology may or may not directly address a nominated device's clinical benefits. Payment for a costly device may be related to a number of factors, such as Medicare payment policy for a technology or the cost of raw materials or manufacturing process, irrespective of substantial clinical improvement. We established the clinical improvement criterion in addition to the cost significance criterion mandated under statute because one cannot accurately infer that a high relative cost is indicative that a device cannot be described by an existing or previous category of devices. Nor can we automatically infer that a substantially clinically improved device necessarily bears significantly higher cost than what we are currently paying for pass-through devices and procedural payments through the APC payment rates. Therefore, both criteria are needed.

Comment: In the November 2, 2001 interim final rule, we invited public comment on the issue of substantial improvement, saying we would be interested in examples of medical technologies for which pass-through payments might be appropriate even though they would not pass a test based on substantial improvement in clinical outcomes. Several commenters pointed to differences in brachytherapy devices as examples. These commenters said that differences in devices should be reflected by establishing separate device categories by: different chemical substances/radioisotope, therapeutic radiation activity levels, implantation arrays of brachytherapy devices, and mechanisms of injecting brachytherapy devices that improve safety and function.

Response: We have reviewed many applications for brachytherapy devices and believe that there is a congruence between new technologies that might be eligible for transitional pass-through payments in the absence of producing substantial clinical benefit and new technologies that do produce substantial clinical benefit.

Comment: Commenters requested that we clarify the process that is employed by Federal and external experts to evaluate substantial clinical improvement on the part of nominated devices. One commenter expressed concern that a Federal panel of experts may slow down decision-making and suggested a flexible process in reviewing category applications. The commenter suggested that we rely on our internal clinical staff to make decisions not requiring outside assistance. The commenter also suggested that our review process should be open and allow the manufacturer the opportunity to present information to the panel. The list of panelists, agendas, proceedings and decisions should be made public.

Response: Our panel consists of CMS clinical experts. We consult with outside experts as appropriate. We believe that this process results in making appropriate, timely decisions while allowing for maximum flexibility. Public meetings would inevitably slow the process. We give ample opportunity for manufacturers to provide information, and we frequently meet with manufacturers to discuss their applications.

Comment: One commenter felt that the language of the statute does not support our criterion that devices show evidence of substantial clinical improvement in order to be considered for an additional category. The commenter stated that the statutory standard that no medical device be described by more than one category does not support the substantial clinical improvement criterion.

Response: The statute explicitly requires us to establish criteria that will be used for creation of additional categories. (Section 1833(t)(6)(B)(ii)(I) of the Act) This statutory requirement permits the criteria that we have established, including demonstration of substantial clinical improvement.

We are continuing to review the issue of technological change that is not associated with substantial clinical benefit to beneficiaries. We will continue to review applications for such devices on a case by case basis and work with applicants to understand exactly what technological changes were made to a device that would make the device eligible for transitional pass through payments. We solicit further examples of such devices so that, in the future, we may establish a more definite criterion for when such changes make a device eligible for transitional pass through payments.

Comment: Associations representing manufacturers stated that our assertion in the preamble of the November 2, 2001 interim final rule that says MedPAC's recommendation that pass-through payments for specific technologies be made only when a technology is new or substantially improved is a misinterpretation. The commenters asserted that MedPAC considers the concepts of improvements in devices themselves and substantial improvement to be separate, and that either of the two should be required for a criterion related to device improvement for pass-through eligibility.

Response: While we continue to believe that, in general, new technologies without a demonstrated substantial clinical benefit to beneficiaries should not receive transitional pass-through payments, we do review nominated devices for technological changes that are not associated with substantial clinical benefit to beneficiaries.

Comment: An association representing device manufacturers stated that our substantial clinical improvement criterion would significantly increase the time between FDA approval to market the device and recognition of the device for pass-through payment. The commenter claimed that this is counter to an objective of the pass-through payment mechanism as a means to promote rapid payment in the OPPS for new technology. This commenter, therefore, recommended replacing the criterion to demonstrate substantial clinical improvement with a requirement to demonstrate ''potential improvement.''

Similarly, another manufacturers' association asserted that clinical outcomes information should not be required for eligibility for a new pass-through category. This commenter suggested that our rules should request information that is appropriate and

relevant for the product and related procedures, which should include information other than published clinical trials.

Response: We are making every effort to minimize the time lag between FDA approval and establishment of a device category. We believe that we have succeeded in making timely decisions in this regard.

We will consider other information in addition to clinical outcomes that is available when clinical trial data are not yet available.

We do not know how one can demonstrate ''potential'' clinical improvement. ''Potential'' refers to the anticipated or possible capability, belief, or expectation for clinical improvement, without the evidentiary demonstration yet.

We do not believe potential improvement is an appropriate criterion. First, it would be difficult to prove; second, we would be in the position of potentially making extra payments for technologies that actually harmed beneficiaries. Thus using ''potential'' clinical improvement would assure that all new devices would meet such a criteria if the manufacturer asserted that the device in question offers a ''potential'' clinical improvement.''

Comment: Some commenters expressed concern with our rule that devices that are described by an existing category are not eligible for new categories. Some call for flexibility in applying this criterion, claiming that some of our category descriptors are too broad and confusing. One manufacturer was particularly concerned that newer technology pacemakers, internal cardioverter-defibrillators (ICDs), and pacemaker and ICD leads would be precluded from achieving new categories because they could be described by widely defined existing categories. The commenter stated that we should revise definitions of existing categories whenever necessary in order to accommodate the creation of new categories. Revising category descriptions to make them less broadly worded was one such example provided, including categories related to pacemakers, ICDs, and pacemaker and ICD leads.

Some commenters felt that new categories would need to be created in order to track cost of newer devices, even if they are described by existing categories. These commenters asserted that device costs eventually must be placed into APCs that appropriately reflect costs for future payment. Some commenters claimed that investigational devices that attained pass-through status have low procedural volumes and therefore they are underrepresented in the cost data.

Response: We believe that broadly defined categories are appropriate. Such categories are easier for coders to understand and allow devices to immediately receive transitional pass-through payments upon being marketed (instead of going through an application process). We have applied this criterion appropriately. There are devices that have been deemed eligible for a new category because the clinical applications are substantially different than devices of existing categories.

Some category descriptions have been modified when it has been brought to our attention that the descriptor is unclear. We first revised the descriptors of device categories in Program Memorandum A–01–73, effective July 1, 2001, in order to clarify the devices covered by categories. However, we do not intend to revise descriptors solely to allow the creation of new categories. If a device or class of devices is described by the categories we initially created, we will apply the criteria we implemented to determine whether an additional category is warranted. If we determine that an additional category is needed to adequately describe and pay for new devices, we will create a category. If in the course of that determination, we find that clarification of an existing or previously existing category is needed so that only one category describes the device, as required by statute, then we will modify the description of the existing or previously existing category or categories, in order to achieve that clarification.

We are maintaining our criteria to establish a new category of devices for pass-through payment.

Cost. We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures. The estimated cost of devices in a category is considered ''not insignificant'' if it meets the following criteria found in regulations at new § 419.66(d):

- The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service associated with the category of devices.
- The estimated average reasonable cost of devices in the category exceeds the cost of the device-related portion of the APC payment amount for the service associated with the category of devices by at least 25 percent.
- The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount determined to be associated with the device in the associated APC exceeds 10 percent of the total APC payment.

Of these three cost criteria, the latter two remain unchanged from the existing thresholds for individual devices (however, as discussed below, their effective date was revised). The first criterion, however, represents a change in the percentage threshold.

In the April 7, 2000 final rule, we provided that a device's expected reasonable cost must exceed 25 percent of the applicable APC payment for the associated service as the criterion for determining when the cost of a specific device is ''not insignificant'' in relation to the APC payment (65 FR 18480). In the August 3, 2000 interim final rule, we lowered the threshold to 10 percent because we believed the 25 percent limit was too restrictive based on the brand specific approach at the time (65 FR 47673; § 419.43(e)(1)(iv)(C)). However, given our payment experience in 2001 using the 10 percent threshold, including our information on the estimated amount of pass-through payments in CY 2002, we determined a higher threshold was warranted. We believed that setting a higher cost threshold ensures that new categories are created only in those instances where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. That is, pass-through payments will be targeted only to those devices where cost considerations might be most likely to interfere with patient access.

We found that once we lowered the threshold to 10 percent, a very small minority (less than 10 percent) of devices that met all other criteria for the pass-through payment was rejected on the basis of this criterion. Partly as a result, the list of devices qualified for pass-through payments increased to well over 1,000 devices by the end of 2000. Although the extensive number of qualified devices allowed hospitals to receive additional payment for many devices, we estimated that the overall pass-through payment amount for calendar year 2002 would exceed the 2.5 percent cap. Therefore, for that year, a substantial reduction in the amount of each pass-through payment, as required by section 1833(t)(6)(E)(iii) of the Act, was established. Thus, allowing a large number of marginally costly devices to qualify for the pass-through payment

would reduce the amount of additional payment a hospital would receive for any one device. We believe raising the threshold for this criterion benefits hospitals by focusing the pass-through payments on those devices that represent a substantial loss to the hospital. We believe this change also preserves beneficiary access to especially expensive devices.

In addition, once a category is established, devices included in the category are eligible for pass-through payments regardless of the cost of the devices. Therefore, we determined that it is reasonable to set a higher threshold than 10 percent to establish a new category. While the cost of most devices described by a category may equal or exceed the threshold we use in establishing a category, the cost of individual devices could easily fall below the threshold. Therefore, we believe that it is reasonable to use a higher threshold in establishing a category than in qualifying individual devices.

Concerning the latter two criteria for determining that the estimated cost of a category of devices is not insignificant, we intended to apply these criteria to devices for which a pass-through payment is first made on or after January 1, 2003, as we provided in the August 3, 2000 interim final rule (65 FR 47673). We stated that the delay would allow us sufficient time to gather and analyze data needed to determine the current portion of the APC payment associated with the devices.

Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use these criteria as of the November 2, 2001 interim final rule. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data have generally provided this level of detail. Therefore we applied the second and third cost criteria for the purpose of determining eligibility of proposed new categories, as described in regulations at § 419.66(d)(2) and § 419.66(d)(3), as soon after the implementation of the November 2, 2001 interim final rule as we had data to do so rather than on January 1, 2003. Although in some instances the lack of specific data prevented the application of these criteria, we believed that should not delay our use of these criteria in those situations in which the data have been available.

In order to implement these second and third criteria for the purpose of creating new device categories, it is necessary to obtain the cost of the device-related portion of the APC payment amount. For evaluations of device category applications in 2002, we used the device-offset amounts published in our March 1, 2002 final rule (67 FR 9557 through 9558), which are used to calculate the subtractions to device pass-through payments. For 2003, we will use the device-offset amounts found in Table 11 in this rule as the device-related portion of the APC payment needed for cost criteria 2 and 3. The device-offset amounts represent the device costs that have been folded into the respective APC payment rates. In those cases where an application is received in which the service-related HCPCS codes for the device is mapped to no APC that has a device offset amount, we apply only the first cost criterion.

Comment: Some commenters wrote that while we need to limit pass-through payments for new categories to those devices that are clearly underpaid relative to the APC rates, our ''not insignificant'' cost tests set the bar too high. Some held that this is particularly the case for APCs with high relative weights and consequent payments, in which our 25 percent minimum percentage of the APC as well as the device offset represent a significant cost to the hospital in absolute terms. Commenters proposed alternate percentage thresholds with specific dollar caps (for example, 20 percent of the APC payment or $1,000, whichever is less).

Response: In the cases of APCs with high relative weights and payment rates, such payments already encompass much of the costs of devices. The thresholds in dollar terms in those cases should be set higher to test for cost significance. We have heard from many commenters to our August 9, 2002 proposed rule that many device costs consist of a large percentage of the APC cost. The ratio method (for example, 25 percent) therefore equitably accounts for APC payment differences for devices.

We do not see any compelling reason to adopt the proposed alternate percentages of the APC amount as the threshold of using as an alternative to our current cost significance threshold of 25 percent for device portions related to any respective APC. Moreover, the initial pass-through categories were based on devices that achieved pass-through status with a lower 10 percent threshold.

Comment: Another commenter claimed that the statutory language demonstrates the congressional intent that only the cost of the devices in a category be compared to the applicable APC payment. Therefore, only the first of our three prongs to test cost significance of a new device should be used. This commenter claimed that section 1833(t)(6) of the Act states that we shall provide pass-through payments only for categories of devices when ''the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount * * * .'' The commenter further advocated that our criteria be amended to reflect that a proposed category of devices be required to meet any one of the three prongs, to give some weight to the potential benefits of the second and third prongs.

Response: The statute requires that the average cost of a new device category is not insignificant in relation to the OPD fee schedule amount payable for the service or group of services involved. The statute further requires the Secretary to establish criteria for creating additional categories, including criteria for cost significance. Beyond those requirements, the statute allows the Secretary the discretion to determine how to apply the cost significant criterion.

In developing the specific criteria for meeting the statutory cost significance requirement, we established thresholds which we believe ensure that new categories are created where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. Our goal is to target pass-through payments at those devices where cost considerations might be most likely to interfere with patient access.

To properly target the pass-through payments at devices that could represent a substantial loss to the hospital, it is important to both assess the incremental cost of performing the procedure using the new device as well as to compare the cost of the new device against the costs of existing devices already packaged into the APC payment for the procedure.

The first prong of our three prong criterion tests only the relationship of the new device to the cost of the entire procedure whereas the second and third prongs test for the relationship to device costs already incorporated into the payment rate for the procedure.

Comment: A hospital organization supported our two major criteria for establishing an additional device category for pass-through payment, that is, that a category of devices must demonstrate substantial clinical improvement and have costs that are ''not insignificant'' in relation to the APC payment. In particular, the

organization supported our decision to raise the threshold that device costs for a new category must exceed 25 percent of the related APC payment, as well as our re-institution of the two additional prongs of the not-insignificant cost test. However, the commenter noted that we had previously delayed the implementation of these latter two prongs of the ''not insignificant'' cost criterion until January 1, 2003, so that we could ensure reliable and accurate data to make the cost estimates. The organization would support the reinstitution of these cost prongs that establish that costs are not insignificant only when CMS has sufficiently accurate and reliable data to make such estimates. The commenter also believes that the data and methodology should be made available to the public for review.

This organization also felt that the (then) current number of initial categories is appropriate. It urged us to make application information regarding any proposed new categories public for comment before final creation of a new category.

Response: Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use the second and third cost criteria since the November 2, 2001 interim final rule became effective. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data we have used has generally provided this level of detail. Therefore, we applied the second and third cost criteria. As noted earlier, for 2002, we have used the device offsets we calculated for subtracting the cost of existing devices in APCs as the portion of the APC payment related to the device. We feel the offsets have been appropriate as this portion of the APC payment, and we will use them for 2003 as well. We therefore feel this commenter's concerns have been addressed.

We will continue to use the three prongs of the not insignificant cost test as published in the November 2, 2001 interim final rule.

1. Application Process for Creation of a New Device Category

Device manufacturers, hospitals, or other interested parties may apply for a new device category for transitional pass-through payments. Details regarding the informational requirements, deadlines for quarterly review, and other aspects of the application process are available on our Web site, *http://cms.hhs.gov.*

We will accept applications at any time. However, we will establish new categories only at the beginning of a calendar quarter, in deference to our computer systems needs and those of our contractors and hospitals. We must receive applications in sufficient time before the beginning of the calendar quarter in which a category would be established to allow for decision-making and programming. For now, we will require that applications be received at least 4 months before the beginning of the quarter. Moreover, we have found, that, due to the complexity of the information and review process for additional categories, we cannot always complete our review within that time frame. Review of applications involving devices with new technologies often involves requesting additional information from the applicants, as well as consultation with experts in certain clinical specialties (usually here at CMS) or with other clinical personnel at CMS with expertise in Medicare coverage issues, as needed (for example, the hearing aid issue).

We may change the details of this application process in the future to reflect experience in evaluating applications and programmatic needs. If we revise these instructions, we will submit the revisions to the Office of Management and Budget under the Paperwork Reduction Act. We will also post the revisions on our Web site.

Comment: One commenter recommended that we post draft new categories and any draft changes to existing categories to our Web site for public review and comment before final publication, as a collaborative, informal process to be accomplished within the 4-month quarterly application evaluation and update time frame.

Response: Such process could not be accomplished within the 4-month time frame. We note that the greater part of the four month period is consumed in systems changes, not review of the application, so little time is available for further information. Thus, further consultation would result in longer timeframes for action. We have listened and met with many parties concerning recommendations for additional categories and heard their concerns related to our existing and new categories and will continue to do so. However, we believe that the review, evaluation, and decision process and publication process for new category applications to meet the closest feasible quarterly updates is already compact. However, we will continue to consider informal comments or feedback from hospitals, manufacturers, and other parties regarding our decisions.

Comment: An association of manufacturers of brachytherapy sources and other brachytherapy devices recommended that we establish several specific new categories.

Response: We have established a uniform method for evaluating applications for new categories, based on the application information published on our Web site. We evaluate the necessity of new categories based on the specific information we receive, such as clinical differences between items nominated for the new categories and the existing or previously existing categories. We therefore are not able to react to the specific categories recommended through public comments by this commenter without complete applications on the subject brachytherapy sources.

We are making no change to our application process at this time.

2. Announcing a New Device Category

When we determine a new category is warranted, we issue a Program Memorandum specifying a new Healthcare Common Procedure Coding System (HCPCS, formerly known as HCFA Common Procedure Coding System) code and short and long descriptors for the category. We may also include additional clarifying or definitional information to help distinguish the new category from other existing or previously existing categories. It may be necessary to redefine, or make other changes to, existing or previously existing categories to accommodate a new category and ensure that no medical device is described by more than one category, though we attempt to keep these changes to a minimum. We will post these Program Memoranda on our Web site on a quarterly basis. We may find it necessary occasionally to correct or amend the list of (and clarifying information associated with) pass-through device categories. We do not expect this step will be needed often, but if it is necessary, we will issue any changes in a Program Memorandum.

VI. Wage-Index Changes for Calendar Year 2003

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget-neutral manner, the portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2003 hospital inpatient PPS

wage index to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2003 hospital inpatient wage index to calculate the final CY 2003 payment rates and coinsurance amounts for OPPS. We used the final Federal FY 2003 hospital inpatient PPS wage index to make wage adjustments in determining the final payment rates set forth in this final rule with comment. The final FY 2003 hospital inpatient wage index published in the August 1, 2002 **Federal Register** (67 FR 39858) is reprinted in this final rule with comment as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J— Wage Index for Hospitals That Are Reclassified. We use the final FY 2003 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule with comment to implement the OPPS for CY 2003. We note, however, that from time to time, there are mid-year corrections to these wage indices and that our contractors will adopt and implement the mid-year charges for OPPS in the same manner that they made mid-year changes for inpatient hospital prospective payment.

Comment: A commenter asked for an explanation of the rationale behind applying the area wage index to the device component of an APC. Also, another commenter urged us to clarify that APCs for drugs and biologicals would not be subject to geographic wage adjustment since the APC payment rates primarily reflect drug acquisition costs, not labor costs.

Response: Our rationale for applying the area wage index to the device component of an APC is that once a device cost is packaged into a procedure APC, we do not differentiate between which costs in the APC should or should not have the area wage index applied. We believe that it would be complicated and prone to error to segment out a device component of the APC and determine the appropriate portion of the APC payment amount that consists of device cost only. To address the second issue, we would like to clarify that we do not apply the area wage index to payment rates for drugs and biologicals that are assigned to the status indicator G or K.

VII. Copayment for Calendar Year 2003

Section 1833(t)(8)(C)(ii) of the Act accelerates 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 that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent of the APC payment rate in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

For 2003, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for 2002 (see the November 30, 2001 final at 66 FR 59888). See Addendum B for national unadjusted copayments for 2003. Our regulations at § 419.41 conform to this provision of the Act.

VIII. Conversion Factor Update for Calendar Year 2003

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis.

Section 1833(t)(3)(C)(iv) of the Act provides that for 2003, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The most recent forecast of the hospital market basket increase for FY 2003 is 3.5 percent. To set the proposed OPPS conversion factor for 2003, we increased the 2002 conversion factor of $50.904 (the figure from the March 1, 2002 final rule (67 FR 9556)) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for 2003 to ensure that the revisions we made to update the wage index are made on a budget-neutral basis. We calculated the proposed budget-neutrality factor of .98778 for wage-index changes by comparing total payments from our simulation model using the proposed FY 2003 hospital inpatient PPS wage-index values to those payments using the current (FY 2002) wage-index values.

The increase factor of 3.5 percent for 2003 and the required wage-index budget-neutrality adjustment of .98715 resulted in a proposed conversion factor for 2003 of 52.009.

In determining the proposed conversion factor of 52.009, we projected 2.5 percent pass-through payments based on our preliminary estimates of pass-through payments for CY 2003. As described in the section IV discussion of the pro-rata provisions, our final estimate of pass-through payments in CY 2003 is 2.3 percent of the total program payments for covered OPD services. Therefore, we have increased the final conversion factor to reflect the projected change in pass-through spending from 2.5 percent to 2.3 percent. After applying this adjustment, the 3.5 percent update factor and the final budget-neutrality adjustment of .98778 to account for changes due to the final FY 2003 hospital inpatient wage-index values, we establish the final conversion factor for 2003 at $52.151 (or 52.152).

We received several comments concerning the conversion factor update for 2003, which are summarized below along with our responses.

Comment: Several commenters contended that CMS imposed excessive pro-rata reductions in 2002, which exacerbated the inadequacy of Medicare payments and urged CMS to use its statutory authority under section 1833(t)(3)(C)(iii) to adjust the 2003 conversion factor for the unexpectedly low pass-through payments made in 2002.

Response: The commenters' estimates are based on 2001 claims. We do not know yet whether there will be excessive pro-rata reductions in 2002 because at the time of this rule, we do not have more than first-quarter 2002 claims data available. Therefore, it would not be appropriate to make such an adjustment. Furthermore, we do not believe that the statute permits us to make retroactive adjustments.

Comment: One commenter stated that the statute requires the conversion factor to be updated by the full increase in the hospital inpatient market basket of 3.5 percent, but the application of a budget-neutrality factor of .987156 results in an update factor of only 2.17 percent. Another commenter indicated the belief that the amount of reduction from the 3.5 percent market basket update is excessive and beyond what is required to achieve statutory goals. The commenter recommended that the 2003 conversion factor be increased.

Response: Statute requires us to ensure that a conversion factor for covered OPD services in subsequent years is an amount equal to the conversion factor applicable to the previous year before any increases due to the market-basket increase. In order to ensure that we maintain budget neutrality (except for the market-basket increase), we must make an adjustment to account for changes in the wage index. To do so, we calculate the total payments for 2002, using the 2002 wage index and weights, and compare that result to total payments calculated by applying the new 2003 wage index to

the 2002 APC weights. For 2003, that comparison resulted in the .969 adjustment.

IX. Outlier Policy for Calendar Year 2003

For OPPS services furnished between August 1, 2000, and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we will calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we proposed to set the target for outlier payments at 2.0 percent. The target was 2.0 percent for CY 2001 and 1.5 percent for 2002. For 2002, the outlier threshold is met when costs of furnishing a service or procedure exceed 3.5 times the APC payment amount, and the current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Based on our simulations for 2003, we proposed to set the threshold for 2003 at 2.75 times the APC payment amounts, and the proposed 2003 payment percentage applicable to costs over the threshold at 50 percent.

In this final rule we are setting the target amount for outlier payments at 2 percent of total payments. Based on revised simulations performed for the final rule, in order to pay outlier payments at the target amount, we are adopting the proposed outlier threshold of 2.75 but decreasing the outlier payment percentage to 45 percent. Simulations using the final APC rates and projecting outlier payments for 2003 using a different set of claims than we used for the proposed rule (claims for the period April 1, 2001 through March 31, 2002 instead of claims for calendar year 2001) resulted in outlier payments that were in excess of the 2 percent outlier payment target. In order to meet, but not exceed, the target we found it necessary to either increase the proposed outlier threshold of 2.75 or reduce the proposed outlier payment percentage of 50 percent. Because we wanted to make it easier for more for high cost services to qualify for outlier payments, we chose to adopt the proposed outlier threshold but reduce the outlier payment percentage to 45 percent. For 2003, the outlier threshold will be met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the outlier payment percent will be 45 percent of the amount of costs in excess of the threshold.

We received a number of comments concerning our proposed threshold and percentages for outlier payments, which are summarized below along with our responses. We also received comments concerning the changes that we proposed and finalized in 2002 with respect to the calculation of outliers on a service-by-service basis. Because we have not proposed any changes to the current policy, we do not summarize those comments in this preamble.

Comment: A number of commenters commended CMS on lowering the outlier threshold, but they urged CMS to reduce the threshold even further. The commenters also said that the outlier payment percentage of 50 percent of costs in excess of the outlier threshold was not sufficient to offset the losses hospitals incur in high-cost cases. Some of these commenters urged CMS to adopt the same marginal payment rate of 80 percent that is used for calculating outliers under the inpatient PPS.

Response: Under the OPPS, CMS must address two needs: the need to balance payment for high-cost cases with the need to ensure that appropriate payments are made for basic services for the average patient population. By setting our outlier target of 2 percent, we believe that we have struck the right balance to accomplish these goals.

Comment: According to one commenter, new technologies and drugs are expanding too rapidly for CMS to appropriately account for the costs in the APCs, which is a particular concern at larger hospitals that provide a wide scope of services and access to new technologies and drugs. The commenter said that outliers can help defray the costs of new technologies until adequately reflected in the APC payments and urged CMS to consider expanding the outlier target from 2 percent to 2.5 percent. Another commenter contended that the transition of expiring pass-through items into APCs will result in dramatic payment reductions and urged CMS to reduce the outlier threshold to 2.5 times the APC payment amount for 2003 and increase the outlier target as close as possible to the statutory maximum of 2.5 percent of total payments.

Response: As described elsewhere in this final rule, the recalibration of weights based on newer data and the additional steps that we have taken to limit the payment reductions should decrease the need for outliers. Also, the pass-through provisions for new drugs and devices and our payment mechanism for new technology procedures provide hospitals with an additional mechanism to defray costs for emerging technologies.

Comment: A number of commenters said that CMS does not provide sufficient data to support how outlier payments and thresholds are determined and to ensure that outlier payments are being made in the range of 2 percent to 2.5 percent. Additional outlier data that the commenters requested include information such as the actual outlays as compared to forecasted outlays 2001, estimated outlays for 2002, the historical outlier percentage of total OPPS payments, and information on the types of cases that are qualifying for outlier payments. The commenters wanted CMS to provide supporting information in the final rule, just as it does for the inpatient PPS.

Response: We agree with the commenters that we should provide this data. However, due to the time constraints in producing this final rule, we are unable to add this information to this preamble. Nonetheless, we will post this information to our Web site shortly after publication of the rule. We will notify the public through the CMS listserv when the information is available. To subscribe to this listserv, please go to the following Web site: *www.cms.hhs.gov/medlearn/listserv.* Follow the directions for subscribing to the OPPS listserv to get the most up-to-date information on OPPS directly from CMS.

Comment: One commenter expressed concern that CMS has made significant changes to the outlier target and eligibility thresholds in 2002 and 2003, in opposite directions, without sufficiently supporting the changes with experiential data. The commenter maintained that, in aggregate, outlier payments as a percentage of total payments should remain relatively predictable and, therefore, questions whether the experience in 2001 and 2002 would support the significant swings in funding and thresholds.

Response: It is too early for us to tell what the 2002 experience has been like in order to compare it to the 2001 experience. Nevertheless, as indicated in the previous response, we will also notify the public and share the 2001 data on our Web site.

Comment: One commenter urged CMS to provide clarification regarding the rationale to decrease the cost threshold that permits more items to qualify for outlier payments, rather than

to increase the payment percentage from its current level of 50 percent, which would provide more payments for high-cost cases.

Response: We apply an iterative process in which we try different combinations of thresholds and payment percentages until an appropriate combination results in outlier payments under our simulation that is equal to the target percentage of total OPPS payments. While some fluctuation is expected each year due to the use of newer and better data and policy changes, we attempt both to strike a balance and to prevent (to the extent possible) large changes in the outlier payments to hospitals. A significant increase in the threshold would limit the number of services and hospitals that qualify for outlier services.

Comment: One commenter expressed concern that without correcting for the significant reductions proposed for a number of high-cost APCs, those services may unnecessarily qualify for outlier payments because the costs that go into the outlier calculation are calculated using a hospital's overall cost-to-charge ratio (CCR), which may be higher than the departmental CCRs used to determine costs for payment-rate calculations. The commenter contends that, if this occurs, it will result in outlier payments that are higher than anticipated, which could unduly raise thresholds in the future and affect the integrity of the outlier policy.

Response: As described elsewhere in this rule, we believe that the adjustments we have made to many APC rates for this final rule will address the commenter's concerns about services unnecessarily qualifying for outlier payments.

X. Other Policy Decisions and Changes

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

Background

Currently, facilities code clinic and emergency department visits using the same current procedural terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are five levels of care. While there is only one set of codes for emergency visits, clinic visits are differentiated by new patient, established patient, and consultation visits. CPT codes 99201 through 99205 are used for new patients, CPT codes 99211 through 99215 are used for established patients, and CPT codes 99281 through 99285 for emergency patients.

Physicians determine the proper code for reporting their services by referring to CPT descriptors and our documentation guidelines. The descriptors and guidelines are helpful to physicians because they reference taking a history, performing an examination, and making medical decisions. The lower levels of service (for example, CPT codes 99201, 99211, and 99281) are used for shorter visits and for patients with uncomplicated problems, and the higher levels of service (for example, CPT codes 99205, 99215, and 99285) are used for longer visits and patients with complex problems.

These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services provided by facilities to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Before the implementation of the OPPS, facilities were paid on the basis of charges reduced to costs. In that system, because use of a correct HCPCS code did not influence payment, there was little incentive to correctly report the level of service. In fact, many facilities reported all clinic and emergency visits with the lowest level of service (for example, CPT codes 99211, 99201, and 99281) simply to minimize administrative burden (for example, charge-masters might include only one level of service).

This situation changed with the implementation of the OPPS. The OPPS requires correct reporting of services using HCPCS codes as a prerequisite to payment. For emergency and clinic visits, the OPPS distinguishes three levels of service for payment purposes. These are referred to as ''low-level,'' ''mid-level,'' and ''high-level'' emergency or clinic visits. Payment rates for low-level visits are less than for mid-level visits, which are less than rates for high-level visits.

In the April 7, 2000 final rule (65 FR 18434), we stated that to pay hospitals properly, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. We stated in the rule, that if hospitals set up these guidelines and follow them, they would be in compliance with OPPS coding requirements for the visits. Furthermore, we announced that we would be reviewing this issue and planned to set national guidelines for coding clinic and emergency visits in the future. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. We also announced that we would compile these comments and present them to our APC Panel at the January 2002 meeting. We also announced that we planned to propose uniform national facility coding guidelines in the proposed rule for the 2003 OPPS.

During its January 2002 meeting, the APC Panel reviewed written comments, heard oral testimony, discussed the issue, and made recommendations concerning establishment of facility coding guidelines for emergency and clinic visits. Among those who submitted oral and written comments to us and to the Panel were national hospital organizations, national physician organizations, hospital systems, individual hospitals, coding organizations, and consultants.

APC Panel Recommendations

The APC Panel reviewed the comments that we received, reviewed background material we prepared, and heard oral testimony. Most commenters recommended that we adopt the ACEP guidelines. However, one organization representing cancer centers stated that the most appropriate proxy for facility resource consumption in cancer care is staff time and asked that we consider basing our guidelines on staff time. Commenters agreed that we needed to address this problem in the proposed rule for CY 2003. They also agreed that to address potential HIPAA compliance issues, we should develop new HCPCS codes for facility visits; and that we should maintain five levels of service for emergency and clinic visits until data are available to show that only three levels of service are required to ensure accurate payments. Commenters also agreed that, for the same level of service, clinic resource consumption should be similar for new, established, and consultation patients. Therefore, we need only create a single set of five codes for clinic visits.

After a thorough discussion, the APC technical panel made the following recommendations:

1. Propose and make final facility coding guidelines for E/M services for calendar year 2003.
2. Create a series of G codes with appropriate descriptors for facility E/M services.
3. Maintain a single set of codes, with five levels of service, for emergency department visits.
4. Develop a single set of codes, with five levels of service, for clinic visits.

The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposed Rule

We reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations; we agreed that facility-coding guidelines should be implemented as soon as possible. We were particularly concerned that facilities be able to comply with HIPAA requirements. We announced that we have worked, and will continue to work, on this issue with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We noted that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we wanted to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we proposed the following (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services: GXXX1—Level 1 Facility Emergency Services, GXXX2—Level 2 Facility Emergency Services, GXXX3—Level 3 Facility Emergency Services, GXXX4—Level 4 Facility Emergency Services, and GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic visits: GXXX6—Level 1 Facility Clinic Services, GXXX7—Level 2 Facility Clinic Services, GXXX8—Level 3 Facility Clinic Services, GXXX9—Level 4 Facility Clinic Services, and GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

With regard to the documentation guidelines, our primary concerns were to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realized that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believed that the potential drawbacks of each of the recommended sets of guidelines outweighed the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as ''interventions'' or ''staff time'' in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC Panel recommendations, we also reviewed, for the proposed rule, the current distribution of paid emergency and clinic visit codes in the OPPS. With regard to emergency visits, we observed that well over 50 percent of the visits were considered ''multiple procedure claims'' because the claim includes services such as diagnostic tests (for example, EKGs and x-rays) or therapeutic interventions (for example, intravenous infusions). The distribution of all emergency services was in a bell-shaped curve with a slight left shift because there were more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also noted that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we observed that more than 50 percent of the services were considered ''single claims'' meaning that they were billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also noted that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution was consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, did not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believed that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits was appropriate. For example, as hospitals became more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we would continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We planned to begin the development of uniform guidelines over the next year. If we were ready, we would propose the guidelines for comments in our **Federal Register** document for the CY 2004 update. For CY 2003, we proposed the following new codes:

Emergency Visits

Because, our data indicated that, in general, hospitals under the OPPS were reporting emergency visits appropriately, we believed that insofar as hospitals have existing guidelines for determining the level of emergency service, those guidelines reflected facility resource consumption. Therefore, we proposed that GXXX1—Level 1 Facility Emergency Services be reported when facilities deliver, and document, basic emergency department services. These services included registration, triage, initial nursing assessment, minimal monitoring in the emergency department (for example,

one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. We expected that these services would be delivered to patients who present with minor problems of low acuity.

With regard to GXXX2 through GXXX5, we proposed to require that facilities develop internal documentation guidelines based on hospital resource consumption (for example, staff time). These guidelines would be appropriate for the type of services provided in the hospital and also clearly differentiate the relative resource consumption for each level of service so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided and validate the level of service reported. Because of the great variability in available facility resources, staff, and clinical protocols among facilities, we did not believe that it is advisable to require a single set of guidelines for all facilities. Instead, we believed it is appropriate for each facility to develop its own documentation guidelines that took into account the facility's clinical protocols, available facility resources, and staff types. As stated above, we did not propose any specific requirements with regard to the basis of these guidelines. However, the guidelines were to be tied to actual resource consumption in the emergency department such as number and type of staff interventions, staff time, clinical examples, or patient acuity. We also proposed to require that facilities have documentation guidelines available for review upon request. The guidelines had to emphasize relative resource consumption and not, to the extent possible, set minimal requirements as a basis for determining the level of service (for example, require 30 minutes of staff time or five staff interventions to bill a level three emergency visit).

We proposed that these requirements, if made final, would be interim. We proposed to work with interested parties to revise these requirements and to propose any revision to these requirements in a future proposed rule.

Clinic Visits

We believed that the current distribution of codes for clinic visits were due to a facility's continued use of pre-OPPS coding policies for clinic visits. We believed that over time facilities would become as experienced differentiating levels of clinic visits as they were at differentiating levels of emergency visits. Therefore, we proposed a set of guidelines for clinic visits that paralleled the requirements for emergency visits. We proposed that GXXX6—Level 1 Facility Clinic Services, be reported when facilities deliver, and document, basic clinic services. These services included registration, triage, initial nursing assessment, minimal monitoring in the clinic (for example, one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. Our proposal for GXXX7 through GXXX10 was the same as for GXXX2 through GXXX5 except that the facility-specific guidelines were tied to actual resource consumption in the clinic such as number and type of staff intervention, staff time, clinical examples, or patient acuity. The guidelines had to differentiate the relative resource consumption in the clinic for each level of service sufficiently so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided to validate the level of service provided.

We proposed that, if made final, these requirements would be interim. Any changes would be proposed in a future proposed rule.

We proposed to make final, in the 2003 OPPS final rule, changes in coding for clinic and emergency department visits and requirements related to the development of documentation guidelines for the new codes. However, we proposed to implement the new codes and documentation guidelines no earlier than January 1, 2004. This would have given hospitals time to develop documentation guidelines for the new codes and prepare their internal billing systems to accommodate the changes. We proposed to continue to work with hospitals throughout CY 2003 as they developed the documentation guidelines. In the proposed rule, we solicited comments on this proposal overall as well as the specific components of the proposal.

Comment: Many commenters recommended that CMS should keep the current E/M coding system until national coding guidelines with standard definitions can be established. Commenters also recommended that CMS convene a panel of experts to develop standard code definitions and guidelines that are simple to understand and implement and that allow for compliance with HIPAA requirements. Commenters generally recommended that code definitions and guidelines be established and implemented in 2003.

Response: We agree with many of the commenters concerns. While we agree that standard code definitions and guidelines should be implemented as soon as possible, we want to ensure that those definitions and guidelines are developed using an open process involving a variety of experts (for example, clinicians, coders, and compliance officers) in the field. Furthermore, the process should include adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines.

In view of the comments received we believe that the most appropriate forum for development of code definitions and guidelines is an independent expert panel that makes recommendations to CMS in time for CMS to propose specific code definitions in the next year's proposed rule. Organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) have such expertise and are particularly well equipped to provide the ongoing education of providers. We believe it is critically important to the development, acceptance, and implementation of code definitions and guidelines for the organizations that develop the guidelines to also maintain them, update them, and provide ongoing education to providers concerning them. We would be happy to work with such an expert panel as code definitions and guidelines are developed.

We encourage any independent expert panel sending recommendations to CMS concerning guidelines to carefully review the principles and requirements for codes and guidelines that we announced in the proposed rule. We still believe that any set of national guidelines must adhere to those principles and requirements (for example, guidelines must be resource-based). Moreover, we encourage any such panel to address our concerns about existing guidelines (for example, potential for upcoding) in its recommendations to CMS. For example, our Advisory Panel on APC Groups recommended that CMS adopt the facility coding guidelines developed by the American College of Emergency Physicians (ACEP). While we understand that those guidelines have widespread support in the hospital community and that an independent panel may review them while developing guidelines, we would encourage such a panel to review the

ACEP guidelines in light of the principles, requirements, and concerns we enunciated in the proposed rule.

CMS hopes to receive recommendations on code definitions in time to include them in the notice of proposed rulemaking for 2004. We agree with the commenters who were concerned about implementing code definitions without national guidelines, and we will not propose or finalize code definitions until national guidelines for them have been developed.

Comment: Several commenters believed that use of G codes to describe facility visits would cause problems with payment by non-Medicare payers for these services. They believed this problem would worsen if the G codes were not accompanied by guidelines.

Response: G codes are national codes and must be recognized by other payers, though other payers do not need to use these codes for payment. We are unsure if the commenters' assertions are true. However, as stated in the previous response, we do not plan to finalize new codes for these services until guidelines for their use have been developed. Moreover, we will work with CPT, as appropriate, to develop CPT codes for these services once we have finalized and implemented them.

Comment: One commenter asked that CMS provide protection for hospitals against fraud and abuse allegations stemming from the current ambiguous guidelines.

Response: We are unsure if the commenter is referring to the CPT guidelines as being ambiguous for facilities or if the concern is over allowing facilities to develop and implement facility-specific guidelines until national codes and guidelines are implemented. In any case, we believe that written facility guidelines-developed in accordance with the principles (which we enunciated in the proposed rule and reaffirmed in this final rule) and which are widely disseminated in the facility, accompanied by appropriate education of clinicians and coders, and made available to reviewers-should address the concerns of the commenters.

Comment: Several commenters voiced concerns about what activities should be described in possible guidelines (*e.g.*, use of time as a criterion for selecting a level of service), the burden on facilities of having to adapt to a new set of codes for visits, and any requirements for facilities to develop their own guidelines. One commenter listed several principles for the development of facility codes and descriptors (that is, codes and guidelines should: focus on resource use, be supported by medical record documentation, support code assignment by the chargemaster, and provide a means for benchmarking medical-visit data across the industry).

Response: We believe that having an independent panel develop guidelines and make recommendations to CMS will address the concerns of these commenters. With regard to requiring facilities to develop internal guidelines for visit services, we believe that development of internal guidelines is critical for ensuring appropriate medical review and for enabling facilities to prove that billing for services were actually rendered.

Comment: One commenter asked CMS to clarify the terms ''nursing assessment'' and ''nursing discharge'' when assigning a level of service to a visit.

Response: Because we expect to receive recommendations from an independent panel regarding coding guidelines, we will not finalize the proposal describing what constitutes a level one emergency or clinic visit. Instead, we will continue to allow hospitals to develop their own internal guidelines for such visits until we finalize codes and guidelines.

Comment: One commenter asked that we create five payment rates for emergency and clinic visits, one for each level of service—instead of the three payment rates that we currently use.

Response: We review the relative weights of each APC on a yearly basis, and we would consider such a change if our claims data indicated such a change is appropriate.

Comment: One commenter asked that we craft a surgical global package for facilities to provide guidance for facility billing of surgical procedures and visits.

Response: The current APC structure and coding edits already do this. Payment for surgical procedures includes payment for all services related to the procedure (for example, postoperative care, preoperative valuation). Facilities may bill for visits in addition to surgical procedures when the visit is a separately identifiable service unrelated to the procedure. In such cases, the facilities attest to this by appending the –25 modifier to the line item for the visit.

Comment: One commenter said that CMS should provide guidance as to when it is appropriate to add together levels of service from two visits, and bill one visit at a higher level. Another commenter requested that CMS stop using the GO condition code in favor of the –27 modifier.

Response: We disagree. Each clinic visit should be coded separately. It is important to track utilization and for each clinic visit to be reported separately. This is critical for determining proper payment rates in the OPPS. Clinic visits should never be added together and billed as a single service with a higher level of service. We plan to continue using the GO modifier as it specifically addresses coding issues arising in the OPPS.

Comment: One commenter asked us to reconsider our G code descriptors for clinic and emergency visits.

Response: We will propose and finalize G code descriptors after we receive recommendations from an independent expert panel.

Comment: Several commenters asked us to develop guidelines based on a point or acuity system.

Response: The divergence of opinion in the hospital community makes it imperative that an independent expert panel be convened and that such a panel should make recommendations to CMS on these issues.

Comment: Several commenters were concerned about disparities between physician and facility coding for the same service. One commenter asked that hospitals be allowed to code a different level of service than the physicians.

Response: We do not believe that facilities and physicians would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit. Facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all.

However, if a visit and another service is also billed (that is, chemotherapy, diagnostic test, surgical procedure) the visit must be separately identifiable from the other service because the resources used to provide non-visit services including staff time, equipment, supplies, and so forth, are captured in the line item for that service. Billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate.

Comment: One commenter asked CMS to clarify proper billing for E/M services when a visit and another service, such as chemotherapy, have been provided.

Response: If a visit and another service is also billed (that is, chemotherapy, diagnostic test, or surgical procedure) the visit must be separately identifiable from the other

service. This is because the resources used to provide non-visit services (including staff time, equipment, supplies and so forth) are captured in the line item for that particular service. However, billing a visit in addition to another service—merely because the patient interacted with hospital staff or spent time in a room for that service—is inappropriate.

B. Observation Services

Coding and Billing Instructions

On November 30, 2001, we published a final rule updating changes to the OPPS for 2002. We implemented provisions that allow separate payment for observation services under certain conditions. That is, a hospital may bill for a separate APC payment (APC 0339) for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure when certain criteria are met. The criteria discussed in the November 30, 2001 final rule and as corrected in the March 1, 2002 final rule are also explained in detail in section XI of a Program Memorandum to intermediaries issued on March 28, 2002 (Transmittal A–02–026). Payment for HCPCS code G0244, observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum eight hours, maximum 48 hours, was effective for services furnished on or after April 1, 2002.

Section XI of Transmittal A–02–026 that was issued on March 28, 2002, provides additional billing and coding instructions and requirements that flow from the basic criteria that we implemented in the November 30, 2001 and the March 1, 2002 final rules. Although we do not address them explicitly in the final rules, the additional instructions and requirements in Transmittal A–02–026 were developed to implement the basic observation criteria within the programming logic of the outpatient code editor (OCE), which is used to process claims submitted by hospitals for payment under the OPPS. For example, in the November 30, 2001 final rule, we state that an emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) must be billed in conjunction with each bill for observation services (66 FR 59879). In section XI of Transmittal A–02–026, we state that an E/M code (referred to, incorrectly, in Transmittal A–02–026 as an ''Emergency Management'' code), for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. That is, unless one of the CPT codes assigned to APCs 0600, 0601, 0602, 0610, 0611, 0612, or 0620 is billed on the day before or the day that the patient is admitted to observation, separate payment for G0244 is not allowed. The codes assigned to these APCs are categorized by CPT as E/M codes. Although we did not include APC 0620, Critical Care, among the APCs that must be billed in order to receive separate payment for observation services, we added it in the program memorandum because critical care is an E/M service that can be furnished in a clinic or an emergency department. Critical care may appropriately precede admission to observation for chest pain, asthma, or congestive heart failure. We clarify in Transmittal A–02–026 that both the associated E/M code and G0244 are paid separately if the observation criteria are met. We also specify that the E/M code associated with observation must be billed on the same claim as the observation service.

Similarly, in the November 30, 2001 and the March 1, 2002 final rules, we require that certain diagnostic tests be performed in order to bill for separate payment for observation services. In Transmittal A–02–026, in section XI.B.2, we list the diagnostic tests that the OCE looks for on a bill for G0244. This list, which amplifies what we published in the November 30, 2001 and March 1, 2002 final rules, is incomplete and should read as follows to reflect the current OCE logic that is applied to claims for G0244:

- For chest pain, at least two sets of cardiac enzymes [either two CPK (82550, 82552, or 82553), or two troponin (84484 or 84512)], and two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760, 94761, or 94762);
- For congestive heart failure, a chest x-ray (71010, 71020, or 71030) and an electrocardiogram (93005) and pulse oximetry (94760, 94761, or 94762).
- Note: Pulse oximetry codes 94760, 94761, and 94762 are treated as packaged services under the OPPS. Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

Transmittal A–02–026 also provides specific coding instructions that hospitals must use when billing for observation services that do not meet the criteria for separate payment under APC 0339. In addition, Transmittal A–02–026 addresses the use of modifier –25 with the E/M code billed with G0244.

Comment: A few commenters requested clarification of the requirement that CPT 94010 (peak flow) be billed to establish a diagnosis of asthma. The commenter noted that CPT 94010 is the code for spirometry with recording and that it would be erroneous to bill peak flow, which is all that is relevant for asthma, as a spirometry, which requires a record and should include such elements as vital capacity and flow-volume loops. The commenter is concerned that we are instructing hospitals to bill incorrectly if our intention is solely to require peak flow.

Response: We are reviewing this comment and if we determine that a modification of the current requirement for peak flow is appropriate, we will revise the requirement in the program memorandum that implements the 2003 OPPS update effective January 1, 2003.

Comment: One commenter asked whether bedside services other than infusion, such as CVP placement, arterial punctures, and IV injections, can be billed when furnished to observation patients or whether these services are considered to be packaged into the observation payment.

Response: We would not expect that placement of a CVP line would be billed for a patient in observation. However, in general, any service that is separately payable under the OPPS, that is, procedures with status indicators S, X, K, G, V, or H, can be billed with G0244 and paid separately, although services with status indicator ''T'' (with the exception of Q0081), as we explain below, are *not* separately payable with G0244.

Direct Admissions to Observation

Since implementation of the provision for separate payment for observation services under APC 0339, a number of hospitals, hospital associations, and other interested parties have asked if separate payment for observation services would be allowed for a patient with chest pain, asthma, or congestive heart failure who is admitted directly into observation by order of the patient's physician but without having received critical care or E/M services in a hospital clinic or the emergency department on the day before or the day of admission to observation. We have responded during monthly CMS hospital open forum calls that, consistent with the criteria in the November 30, 2001 final rule, effective for services furnished on or after April

1, 2002, separate payment for observation services requires that an admission to observation be made by order of a physician in a hospital clinic or in a hospital emergency department. If a patient is directly admitted to observation but without an associated E/M service (including critical care) shown on the same bill, the hospital should bill observation services using revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (CPT codes 99218, 99219, 99220, 99234, 99235, or 99236).

A related question has arisen in connection with a policy interpretation that was posted as a response to a ''Frequently Asked Question'' (FAQ) on our Web site on September 12, 2000. The FAQ follows:

''Q.97: If a patient is admitted from the physician's office to the observation room, will there be no reimbursement?

''A.97: Since observation is a packaged service, payment cannot be made if it is the only OPPS service on a claim. However, we believe that the ''admission'' of a patient to observation involves a low-level visit billed by the hospital, as well as whatever office visit the physician who arranged for the admission billed. Thus, when a patient arrives for observation arranged for by a physician in the community (that is, ''direct admit to observation''), and is not seen or assessed by a hospital-based physician, the hospital may bill a low-level visit code. This low-level visit code will capture the baseline nursing assessment, the creation of a medical record, the recording and initiation of telephone orders, and so forth. This visit may be coded only once during the period of observation. The observation charges should be shown in revenue code 762. The number of hours the patient was in observation status should be shown in the units field. Payment for those services is packaged into the APC for the visit. Other services performed in connection with observation, such as lab, radiology, and so forth, should be billed for as well. * * *''

We have been asked to clarify whether or not the low-level visit code suggested in the FAQ for patients directly admitted for observation services would satisfy the requirement that a line item for a hospital emergency visit, hospital clinic visit, or critical care appear on the same bill as HCPCS code G0244. Our response is that when we established the final criteria effective for services furnished on or after April 1, 2002, we did not contemplate that the low-level visit described in the FAQ would satisfy the requirement for the E/M code that a hospital must bill to show a hospital clinic visit or hospital emergency department visit was performed before observation services for asthma, congestive heart failure, or chest pain to bill and receive payment for G0244 under APC 0339.

In light of these questions, we have reviewed the criteria for separate payment for observation services under APC 0339, and we proposed to modify the criteria and coding for observation services furnished on or after January 1, 2003. Specifically, we proposed to create two new codes. These additional codes would allow us to collect data on the extent to which patients are directly admitted to hospital observation services without an associated hospital clinic visit or emergency department visit. The proposed codes were as follows:

G0LLL-Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma.

G0MMM-Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

If a hospital directly admits to observation from a physician's office a patient with a diagnosis of congestive heart failure, asthma, or chest pain, we proposed to require that G0LLL be billed with G0244. The current requirement that the hospital bill an emergency department visit (APC 0600, 0601, or 0602) or a clinic visit (APC 0610, 0611, or 0612) or a critical care service (APC 0620) in order to receive separate payment for observation services for patients not admitted directly from a physician's office would remain in effect. However, because the initial nursing assessment is part of any observation service, we proposed not to make separate payment for G0LLL. Rather, we proposed to assign status indicator ''N'' to G0LLL, to designate that charges submitted with G0LLL would be packaged into the costs associated with APC 0339. If G0LLL is billed, we would require that the medical record show that the patient was admitted directly from a physician's office for purposes of evaluating and treating chest pain, asthma, or congestive heart failure.

G0MMM describes the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. We proposed to assign G0MMM for payment under APC 0706, New Technology—Level I. We proposed to require hospitals to bill G0MMM instead of the low level clinic visit referred to in the FAQ above to describe the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. Separate payment would not be made for observation services billed with G0MMM. Rather, when billing G0MMM, hospitals would be required to use revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (99218, 99219, 99220, 99234, 992335, or 99236). We proposed to create G0MMM to establish a separately payable code into which costs for observation care for patients directly admitted for diagnoses other than asthma, chest pain, or congestive heart failure can be packaged and recognized.

We would use billing data for G0LLL and G0MMM in reviewing the provisions for payment of observation services in future updates of the OPPS. In the proposed rule, we invited comment on the extent to which these codes address the concerns that have been raised in connection with patients who are directly admitted to observation services.

Comment: Everyone who commented on our proposed refinements of the requirements to enable separate payment for observation services supported the proposal to allow separate payment for patients admitted to observation directly from physicians' offices. However, the majority of commenters opposed the coding and payment methodology that we proposed to implement this change.

Commenters stated that having to use G0LLL and G0MMM, combined with the other requirements that have to be met in order to receive separate payment for observation of patients with asthma, congestive heart failure, and chest pain, would be burdensome and confusing, and would create operational inconsistencies and problems for hospitals. Several commenters urged CMS to simplify, the observation rules in order to reduce their complexity and lessen the burden they currently impose on hospitals. Some commenters were concerned that other payors might not accept the proposed new codes and that the codes would not be HIPAA compliant.

A number of commenters recommended alternatives to the establishment of G0LLL and G0MMM that would utilize information already being reported by hospitals on the UB–92 within the existing coding system for revenue centers, diagnoses, and source and type of admission. One commenter suggested a single G code for ''Intake into observation after outside evaluation'' supported by appropriate diagnosis coding and claims edits. One

commenter recommended instituting a ''per visit'' payment logic in the OCE and PRICER similar to that used for mental health and PHP services. Several commenters suggested returning observation to a time-based charging and coding methodology based on hours. Several commenters supported using existing E/M codes instead of creating new codes.

Response: We agree with many of the commenters that our proposal for direct admissions to observation seems administratively burdensome. However, we believe that the importance of creating a payment mechanism for direct admissions to observation outweighs the administrative burden at this time. We also believe it is vital that we be able to track the utilization of these services so we will have data upon which to base policy decisions in the future.

A number of the alternatives suggested by commenters are promising and merit further analysis and review. However, our preliminary inquiries revealed that most of the suggested alternatives would require systems changes that could take six months or longer to develop and install, and that such changes could not be implemented effective January 1, 2003. Therefore, we have decided to implement the proposed G codes as follows:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

These codes would be HIPPA compliant. Other payers would make their own decisions about whether to use these codes for their own payment purposes.

Comment: One commenter asked that we instruct Fiscal Intermediaries to accept another revenue code in the 76X range for G0263 and G0264 because RC 762 may only be used to report observation charges.

Response: We are reviewing with our coding and claims processing experts to determine if there is a more appropriate revenue code to use when billing G0263 and G0264. We will provide specific instructions in the program memorandum issued to implement the January 2003 OPPS update.

Comment: Cancer centers urged CMS to expand the conditions for which we would make separate payment for observation to include febrile neutropenia, electrolyte disorders, chemotherapy hypersensitivity reaction, pulmonary embolisms, acute GI hemorrhage, and seizures presented by cancer patients under treatment at Cancer Centers. Other commenters suggested psychiatric conditions, acute abdominal pain, post-transplant threat of rejection, and pneumonia as appropriate for separate payment for observation.

Response: As we indicate in the November 30, 2001 final rule, we will review the indications for separately payable observation after we have acquired sufficient experience under the current system to make an informed decision as to whether an expansion is appropriate.

Comment: Most commenters asserted that our proposed payment for G0MMM for initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure (APC 706) is too low and does not recognize the substantial type, level, and quality of the initial nursing services being provided. Commenters urged CMS either to set a higher payment rate for G0MMM or to allow an E/M code to be billed with G0MMM. Another commenter suggested assigning G0MMM to APC 0600 to be consistent with what CMS says in the FAQ 97. One commenter noted that it is inappropriate to assign G0MMM to a new technology APC because the code describes an E/M service, not a new technology service.

Response: We agree. We have therefore assigned G0264 for payment in APC 600, Low Level Clinic Visits.

Comment: One commenter wanted to know if G0LLL and G0MMM could be used for patients admitted from their homes, either (1) based solely upon a telephone call from the patient to the community physician and that physician's call to the hospital to order a direct admission for observation management, or (2) when directly admitted by the physician after going home following a visit to the physician's office, the patient's condition having deteriorated after seeing the physician.

Response: As long as the physician notifies the hospital that he/she is ordering the direct admission of the patient for observation and supports that order with the appropriate suspected diagnosis, we believe this would constitute a direct admission. Either G0263 or G0264 would be billed, depending on the final diagnosis supporting the direct admission observation services.

C. Billing Intravenous Infusions With Observation

Based on questions and concerns raised by hospitals since implementation of payment for APC 0339 effective April 1, 2002, we have also reviewed the current status of billing intravenous infusions with observation. Several hospitals have noted that claims for G0244 when billed with intravenous infusion services reported with HCPCS code Q0081 are denied because of the ''T'' status indicator assigned to HCPCS code Q0081. Our current payment rules for G0244 require that G0244 be denied if a service with status indicator ''T'' is performed the day before, the day of, or the day after observation care. Because patients in observation may require intravenous infusions of fluid, we proposed to create code G0EEE, Intravenous infusion during separately payable observation stay, per observation, payable under APC 0340 with status indicator ''X.'' When observation services that otherwise meet the billing requirements for separate payment under APC 0339 include an intravenous infusion administered as part of the observation care, G0EEE would be used to report the infusion service. We included instructions on the use of G0258 in the program memorandum issued to implement OPPS coding changes for the October 1, 2002 OCE. In the proposed rule, we solicited comment on the use of this code.

Comment: While appreciative of our recognizing the need for a mechanism that permits hospitals to bill for infusion therapy during observation, most commenters did not support our proposal to introduce a new code for the service. One commenter recommended terminating G0258 effective 12/31/02 because it creates operational burdens for the hospital and does not accurately reflect the resources used. Several commenters urged CMS to change the SI for APC 120 to which Q0081 is assigned to S. This would solve the problem and permit payment of Q0081 with G0244 and would also align the status indicators for the infusion of non-chemotherapy drugs with the infusion of chemotherapy drugs.

Commenters asked if CMS intends hospital to use G0258 instead of Q0081 when the infusion therapy is provided to the patient in the emergency department or clinic prior to patient's placement in observation when the observation stay ultimately qualifies for separate payment. The commenters pointed out that the hospital may not know when the patient is in the emergency department or clinic and the infusion therapy is initiated that the patient will subsequently be placed in an observation stay that qualifies for payment under G0244. Commenters

asked CMS to clarify how G0258 is to be used.

One commenter recommended, that we install an OCE edit to ignore Q0081 when checking for the presence of a procedure with SI=T.

Many commenters stated that the payment for G0248 should be the same as the payment for Q0081 because the resources expended for infusion therapy performed during a packaged observation stay are the same as those required for Q0081 furnished. These commenters disagreed with CMS's assertion that payment for G0258 should be discounted to equal 50 percent of the payment for Q0081 because Q0081 is invariably billed with a higher-paying procedure and is, therefore, discounted. Another commenter advocated adjusting the payment for G0244 to include the cost of infusion and eliminating a separate new code. The same commenter supported payment at 50 percent of the rate set for Q0081 because Q0081 would always be discounted because it is always billed with another procedure.

Response: Having reviewed the numerous concerns raised by commenters in connection with the use of HCPCS code G0258, Intravenous infusion during separately payable observation stay, per observation stay (must be reported with G0244), and our proposed payment for G0258, we agree with commenters that requiring the use of this code is problematic. We have determined that the OCE logic can be modified to allow payment for G0244, even though Q0081 is assigned to an APC with status indicator T. Therefore, effective for services furnished on or after January 1, 2003, we are withdrawing G0258. Instead hospitals may submit claims for G0244 with Q0081 when infusion therapy is provided, and the claim will be paid if all other requirements and conditions are met. The status indicator for G0081 will not change.

Annual Update of ICD–9 Diagnosis Codes

To receive payment for G0244, we require hospitals to bill specified ICD–9–CM diagnosis code(s). Because ICD–9–CM codes are updated effective October 1 of each year, we proposed to issue by Program Memorandum any changes in the diagnosis codes required for payment of G0244 resulting from the ICD–9–CM annual update.

In the March 1, 2002 final rule (67 FR 9559) and in Transmittal A–02–026 issued on March 28, 2002, we listed the diagnosis codes required in order for separate payment of observation services under APC 0339 to be made for patients with congestive heart failure. We added by program memorandum the following new ICD–9–CM codes to the list of allowed diagnosis codes for separate payment for observation of patients with congestive heart failure, effective for services furnished on or after October 1, 2002:

428.20 Unspecified systolic heart failure
428.21 Acute systolic heart failure
428.22 Chronic systolic heart failure
428.23 Acute on chronic systolic heart failure
428.30 Unspecified diastolic heart failure
428.31 Acute diastolic heart failure
428.32 Chronic diastolic heart failure
428.33 Acute on chronic diastolic heart failure
428.40 Unspecified combined systolic and diastolic heart failure
428.41 Acute combined systolic and diastolic heart failure
428.42 Chronic combined systolic and diastolic heart failure
428.43 Acute on chronic combined systolic and diastolic heart failure

In the August 9, 2002 proposed rule, we invited comment on the addition of these diagnosis codes to the criteria for separate payment for observation services under APC 0339.

Comment: One commenter recommended adding the following codes to the list of diagnoses for asthma: 493.00, 493.10, 493.20, and 493.90

Response: We are not including these diagnoses because they would not be appropriate for use with patients requiring observation services because they are experiencing acute exacerbations of asthma.

• Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services using the following codes:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

• Payment for G0264 will be made under APC 600.

• Payment for G0263 will be packaged into the payment for APC 339

• Payment for G0244 will be allowed when billed with Q0081, Infusion therapy other than chemotherapy, when furnished to patients with asthma, congestive heart failure, or chest pain, subject to all other conditions for payment having been met.

C. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis

As we state in section II.B.5 of this preamble, the inpatient list specifies those services that are only paid when provided in an inpatient setting. The inpatient list proposed for 2003 is printed as Addendum E. In Addendum B, status indicator C designates a HCPCS code that is on the inpatient list.

Over the past year, some hospitals and hospital associations have asked how a hospital could receive Medicare payment for a procedure on the inpatient list that had to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition who was transferred or died before being admitted as an inpatient. We reviewed within the context of our current policy the cases brought to our attention for which payment under the OPPS was denied because a procedure with status indicator C was on the bill. Based on that review, we proposed to clarify our policy regarding Medicare payment when a procedure with status indicator C is performed under certain life-threatening, emergent conditions. In the proposed rule, we solicited comments on the extent to which the payment policy described below addresses hospitals' concerns. We stated it would be most helpful if commenters provided specific examples of cases when hospitals have, in these instances, submitted bills for a procedure with OPPS status indicator C that were not paid.

1. Current Policy

In the April 7, 2000 final rule (65 FR 18451), in response to comments about the appropriate level of payment for patients who die in the emergency department, we set forth the following guidelines for fiscal intermediaries to use in determining how to make payment when a patient dies in the emergency department or is sent directly to surgery and dies there.

• If the patient dies in the emergency department, make payment under the outpatient PPS for services furnished.

• If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient. If the patient had been admitted as an inpatient, pay under the hospital inpatient PPS (a DRG-based payment).

• If the patient was not admitted as an inpatient, pay under the outpatient PPS (an APC-based payment).

• If the patient was not admitted as an inpatient and the procedure is

designated as an inpatient-only procedure (payment status indicator C), no Medicare payment will be made for the procedure, but payment will be made for emergency department services.

The OPPS outpatient code editor (OCE) currently has an edit in place that generates a ''line item denial'' for a line on a claim that has a status indicator C. A line item denial means that the claim can be processed for payment but with some line items denied for payment. A line item denial can be appealed under the provisions of section 1869 of the Act. The OCE includes another edit that denies all other line items furnished on the same day as a line item with a status indicator C. The rationale for this edit is that all line items for services furnished on the same date as the procedure with status indicator C would be considered inpatient services and paid under the appropriate DRG.

As part of the definition of line item denial in the program memorandum that we issue quarterly to update the OCE specifications (for example, see Program Memorandum/Intermediaries, Transmittal A–02–052, June 18, 2002, which is available on our Web site at *http://cms.hhs.gov/manuals/pm_trans/A02052.pdf*), we state that a line item denial cannot be resubmitted except for an emergency room visit in which a patient dies during a procedure that is categorized as an inpatient procedure: ''Under such circumstances, the claim can be resubmitted as an inpatient claim.''

In Addendum D of the March 1, 2002 final rule, we designate payment status indicator ''C'' as follows: ''Admit patient; bill as inpatient.''

2. Hospital Concerns

Hospitals have requested clarification regarding billing and payment in certain situations that our current policy does not seem to explicitly address. The following scenarios synthesize cases described by hospitals for which they have encountered problems when billing for a procedure with status indicator C.

Scenario A: A procedure assigned status indicator C under the OPPS is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. The patient dies during surgery or postoperatively before being admitted.

Scenario B: An elective or emergent surgical procedure payable under the OPPS is being performed. Because of sudden, unexpected intra-operative complications, the physician must alter the surgical procedure and perform a procedure with OPPS status indicator C. The patient dies during the operation before he or she is admitted as an inpatient.

Scenario C: A procedure with status indicator C is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. After the procedure, the patient is transferred to another facility for postoperative care.

3. Clarification of Payment Policy

We proposed the following policy for fiscal intermediaries and providers to use in determining the appropriate Medicare payment in cases such as those described in the section above.

A procedure assigned status indicator C under the OPPS is never payable under the OPPS. Therefore, for a hospital to receive payment when a procedure with OPPS status indicator C is performed and: (1) The patient dies during or after the procedure, before being admitted, or (2) the patient survives the procedure and is transferred following the procedure, the patient's medical record must contain all of the following information:

- Either orders to admit written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient bed, or written orders to admit and transfer the patient to another hospital following the procedure.
- Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C (such as CPT code 61345) was actually performed.
- Documentation that the reported surgical procedure with status indicator C was medically necessary.
- If the patient is admitted and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

In the case of a patient who dies during performance of a procedure with OPPS status indicator C before being admitted, the hospital would submit a claim for all services provided, including a line item for the status indicator C procedure. The claim would be rejected for payment under the OPPS and returned to the hospital. The hospital would resubmit the claim for payment as an inpatient stay under the appropriate DRG.

In the case of a patient who is admitted and transferred, the transferring hospital would be paid a per diem DRG rate if all the above conditions are met. (We proposed to revise § 3610.5 of the Medicare Intermediary Manual accordingly.) Because these services would be paid according to the appropriate DRG or per diem (see below), all services that were furnished before admission that would otherwise be payable under the OPPS would be paid in accordance with the provisions of § 3610.3 of the Medicare Intermediary Manual (''3-day rule'') and § 415.6 of the Medicare Hospital Manual.

Note that a physician's order to admit a patient to an observation bed following a procedure designated with OPPS status indicator C would not constitute an inpatient admission and, therefore, would not qualify the procedure with status indicator C for payment. In this instance, the only allowable Medicare payment would be for a code payable under APC 0610, 0611, or 0612 if those services were provided. Payment would not be allowed for either the procedure with status indicator C or for any ancillary services furnished on the same date.

Comment: Commenters agreed that the current policy on billing and payment when procedures on the inpatient list are performed on an outpatient basis requires clarification and modification. However, commenters stated that our proposals, if implemented, would be burdensome and create extra work for hospitals. Commenters opposed our proposal that an outpatient claim be submitted for rejection and then resubmitted as an inpatient claim. Commenters asserted that this would be unwieldy and create an unacceptable delay in payment. Many commenters were concerned that it would be difficult to expect a physician to write an order to admit a patient who expired during emergency surgery, and that asking physicians to do so to satisfy a billing requirement would not be appropriate. Some commenters were concerned that submitting an inpatient claim that is inconsistent with medical records documentation could create problems with medical review. However, commenters did not provide illustrations of actual cases when hospitals have submitted outpatient bills for a procedure with status indicator C that was performed in an emergency situation and not paid which would have added specificity to the general comments.

Commenters offered several alternatives to our proposal. Several commenters suggested that these cases be initially billed as inpatient stays,

supported by documentation that the procedure was performed and was medically necessary, and that a presumption of admission be made for payment purposes. Several commenters suggested that a reduced DRG-related amount be established as payment in these special cases. Several commenters suggested the use of a condition code that would allow submission of an outpatient claim when procedures on the inpatient list are performed in emergency situations.

Response: We appreciate commenters' reactions and suggestions of ways to make payment under the OPPS in emergency situations when procedures on the inpatient list are performed on a beneficiary who is not admitted as an inpatient. After careful review and consideration of the comments and recommendations, we have decided to modify certain aspects of our proposed policy, while retaining certain others. We are also taking steps to ensure that OCE edits are consistent with our policy.

The underlying principle is our policy that procedures on the inpatient list performed on patients whose status is that of outpatient are not payable as outpatient services.

However, we recognize that there are occasions when a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. To receive payment in those cases, hospitals admit the patient and submit an inpatient claim.

In cases where a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, the patient may be admitted and transferred to another hospital. In these cases, the transferring hospital is paid a per diem DRG rate. We shall revise section 3610.5 of the Medicare Intermediary Manual to reflect this policy.

On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient. For those rare and unusual cases, we are instructing hospitals to submit an outpatient claim for all services furnished, including the procedure code with status indicator C to which a new modifier is attached. The exact modifier that is to be used in these cases had not been issued by the HCPCS alpha-numeric workgroup in time for publication in this final rule. The modifier and instructions for its use will be included in the program memorandum for the January 2003 update. We believe that such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth), and administration of intravenous fluids and medication prior to the surgical procedure. Because these combined services constitute an episode of care, we will pay claims with a procedure code on the inpatient list that are billed with the new modifier under new technology APC 977. Separate payment will not be allowed for other services furnished on the same date. This approach allows hospitals to submit an outpatient claim and receive payment without additional paperwork, it results in consistency between the medical record and patient status, and it allows us to collect data on the costs associated with these very unusual and infrequent cases for future use in updating the OPPS.

Procedures with status indicator C but without the new modifier that are submitted on an outpatient bill will receive a line item denial, and no other services furnished on the same date are payable.

If an outpatient has a procedure that is on the inpatient list performed, and is subsequently admitted to an observation bed, the procedure with status indicator C submitted on an outpatient bill will receive a line item denial. Further, we have decided not to make final our proposal to make payment for APC 610, 611 or 612 under such circumstances. Rather, in such cases no other services furnished on the same date are payable.

We did not receive any comments on the documentation that we proposed to require in the patient's medical record when a procedure with status indicator C is performed and: (1) The patient dies before being admitted as an inpatient, or (2) the patient survives the procedure and is admitted and transferred. Therefore, we are making those requirements final.

4. Orders To Admit

Some hospitals have raised questions about the timing of a physician's order to admit a patient. The requirements for authenticating physician orders and the standards for medical record keeping fall outside the scope of this rule and OPPS payment policy. The payment provisions that we are making final in this rule are to assist hospitals and contractors in determining how to bill and pay for services appropriately under Medicare. The patient's admission status, as documented by the medical records, determines what Medicare payment is appropriate. Medical record keeping and documentation requirements are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State law and State licensing rules and hospital accreditation standards.

Comment: A few commenters requested clarification on what is meant by ''admit'' and the documentation that CMS would expect to see in order to substantiate that a patient was admitted as an inpatient. One commenter expressed concern about the variability in fiscal intermediaries' policies regarding the changing of an admission status after the service has been provided.

Response: As we have indicated, these issues are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State licensing rules and hospital accreditation standards. Questions and concerns related to these issues should be addressed to the parties who are responsible for these rules, regulations, and standards.

When a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient, the hospital should submit an outpatient claim for all services furnished, including the procedure with status indicator C to which a new modifier, which will be announced by program memorandum is attached. Claims with a procedure code on the inpatient list that are billed with the new modifier will be paid under APC 977.

We are making final the requirement that information specified in the proposed rule be included in the medical record to support payment when a procedure with status indicator C is performed on an outpatient and the patient dies or is admitted and transferred.

D. Status Indicators

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate if a service represented by a HCPCS code is payable under the OPPS or another payment system and also if particular OPPS policies apply to the code. We are providing our status indicator assignments for APCs in Addendum A, HCPCS codes in

Addendum B, and definitions of the status indicators in Addendum D.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we need a way to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D defines the meaning of each status indicator for purposes of the OPPS.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

Specifically, in 2003, we proposed to use the status indicators in the following manner:

- ''A'' to indicate services that are paid under some payment method other than OPPS, such as the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the physician fee schedule. Some but not all—of these other payment systems are identified in Addendum D.
- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that was deleted effective with the beginning of the calendar year.
- ''E'' to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- ''F'' to indicate acquisition of corneal tissue, which is paid at reasonable cost.
- ''G'' to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- ''H'' to indicate devices that are paid under OPPS transitional pass-through rules.
- ''K'' to indicate drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid in separate APCs under the OPPS, but that are not paid under OPPS transitional pass-through rules.
- ''N'' to indicate services that are paid under the OPPS for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- ''S'' to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
- ''V'' to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services. We sometimes change these indicators in the course of a year through program memoranda. Moreover, indicators are established for new codes that we establish in the middle of the year, either as a result of a national coverage decision or otherwise. A status indicator, as well as an APC, must be assigned so that payment can be made for the service identified by the new code.

Our proposed status indicators identified for each HCPCS code and each APC appear in Addenda A and B of the proposed rule. We requested comments on the appropriateness of the indicators we have assigned.

We received several comments on this proposal, which are summarized below:

Comment: Some commenters said that our proposed payment for influenza and pneumococcal pneumonia vaccines and orphan drugs were inadequate to ensure the provision of these drugs and biologicals.

Response: As discussed in section III.B, we will pay reasonable cost for these drugs and biologicals in 2003. Therefore, we have assigned orphan drugs a status indicator of F and have redefined the status indicator F to mean that the item or service is paid on a reasonable cost basis. Until now, only corneal tissue acquisition has been paid as reasonable cost under OPPS and, therefore, the status indicator was specific to corneal tissue. However, beginning January 1, 2003, the ''F'' status indicator will apply to any item or service paid at reasonable cost.

With regard to influenza and pneumococcal pneumonia vaccine, which we will also pay on a reasonable cost basis, effective January 1, 2003, we have created a new status indicator ''L'' ''Influenza vaccine; pneumococcal pneumonia vaccine'' to indicate that these vaccines are paid on a reasonable cost basis but deductible and coinsurance do not apply to the payment. We show the new status indicator in Addendum D and we show it for these services in Addendum B. We are doing the following:

- Redefining status F to indicate an item or service that is paid on a reasonable-cost basis.
- Changing the status indicator for influenza and pneumococcal pneumonia vaccines to status indicator L and change orphan drugs to status indicator F.
- Changing the status indicator for APC 225 to S.

E. Other Policy Issues Relating to Pass-Through Device Categories

1. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Effective with implementation of the 2002 OPPS update on April 1, 2002, we deduct from the pass-through payments for those devices an amount that offsets the portion of the otherwise applicable APC payment amount that we determined is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the March 1, 2002 final rule, we published the applicable offset amounts for 2002, which we had recalculated to reflect certain device cost assignments that were corrected in the same final rule (67 FR 9557).

For the 2003 OPPS update, we proposed to estimate the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data for services furnished between July 1, 2001, through December 31, 2001. We proposed to use only the last 6 months of 2001 claims data because bills for pass-through devices submitted during this time period would use only device category codes, allowing a more consistent analysis than would result were we to include pre-July 1 claims that might still show item-specific codes for pass-through devices. Using these claims, we would calculate a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We would then calculate a median cost for every APC with the

costs of associated C-codes for device categories that were billed with the APC packaged into the median. Dividing the median APC cost minus device packaging by the median APC cost including device packaging would allow us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to the APC payment amount, we would determine the applicable offset amount. Table 11 shows the offsets that we applied in 2003 to each APC that contains device costs. APCs were included for offsets if their device costs comprised at least 1 percent of the APC's costs. (However, if any APC's calculated offset had been less than 1 dollar, that APC and offset would not have been included.)

For this final rule, we used the device data for the 12 months ended March 31, 2002 to calculate the device and non-device portions of APCs median costs. We began with the same APCs that were listed on Table 9 of our proposed rule, with two additions. We added APCs 0648 and 0651, because they showed appreciable device percentages using our methodology. We again applied these percentages to the APC payment amounts and excluded any APC's percentage of device costs less than one percent and calculated offset amounts less than one dollar.

We received some comments on this proposal, which are summarized below:

Comment. A commenting party contended that our list of device offsets in our proposed rule is incorrect since it includes many computed offsets to APC payments for devices that will no longer receive pass-through payments. The commenter recommended that we exclude the offsets of all devices in categories that are bundled, since there is no separate pass-through payment to be offset.

Response. The offset list is a list of potential offsets. We, of course, do not know in advance which procedures and APCs will be mapped into new categories as the new categories are created and become effective. Yet, we are required to subtract the amount of similar devices in pass-through payment under section 1833(t)(6)(D)(ii) of the Act. Therefore, for the proposed rule, we calculate the device costs in each APC and include APCs on the offset list if their device costs were at least 1 percent of the APC's cost. We use a similar list for this final rule.

Comment. One commenter expressed concern about the difference in offset amounts proposed for APC 0107, Insertion of Cardioverter-Defibrilator, and APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrilator Leads. The commenter wondered why, when the cost of the cardioverter-defibrilator is 2 to 3 times the cost of the leads, the offset amount for APC 0107 is less than the offset amount for APC 0108.

Response. The commenter is incorrect that we proposed an offset amount for 0107 (83.18 percent) that is less than for 0108 (82.18 percent). Moreover, the commenter mistakenly believes that APC 0107 is for insertion/replacement/repair of cardioverter-defibrilator leads when, in fact, the definition of CPT code 33249 (the only CPT code in APC 0108) is ''Insertion or repositioning of electroleads for single or dual chamber pacing cardioverter-defibrilator and insertion of pulse generator.'' Hence, CPT code 33249 is for the insertion of a pulse generator and insertion or repositioning of leads. It is not, as the commenter indicates, for insertion or repositioning of leads alone. As shown in Table 11, the offset percent for APC 0107 is 93.29 and the offset percent for APC 0108 is 92.99.

Comment. A commenting party contended that the offsets appear to be computed using departmental cost-to-charge ratios (CCRs), yet pass-through payments for devices were computed using an overall hospital CCR. The party contended that in cases in which the hospital CCR is higher than the departmental CCR, there is effectively a zero pass-through payment for devices. Therefore, the party recommended that the offsets should be calculated using the same CCRs used to compute pass-through payments.

Response: Although the commenter states that calculating a device pass-through payment using a hospital CCR that is higher than the departmental CCR used to determine the applicable offset amount results in effectively no payment for a device, it appears to us that the opposite result would occur. That is, in the situation described, a lower offset amount would be applied to a higher calculated device cost, resulting in a higher net device payment. Offset amounts represent device costs that are included in the median costs of a procedure. The median cost of the procedure is determined, as we determine median costs for all services, by totaling all the procedure's component costs calculated using department-specific CCRs. We use department-specific CCRs to calculate the cost of the procedure, which includes devices, and because offsets are intended to represent the cost of devices that are included in the cost of the procedure, we believe the same departmental-CCR method must be applied in calculating offsets.

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	APC percent attributed to devices	Device related costs to be subtracted from pass-through payment
0032	Insertion of Central Venous/Arterial Catheter	31.96	$191.22
0048	Arthroplasty with Prosthesis	29.92	633.96
0051	Level III Musculoskeletal Procedures Except Hand and Foot	1.31	22.48
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	3.08	65.48
0080	Diagnostic Cardiac Catheterization	10.63	195.69
0081	Non-Coronary Angioplasty or Atherectomy	31.45	713.58
0082	Coronary Atherectomy	48.25	2,174.88
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	29.59	802.06
0085	Level II Electrophysiologic Evaluation	37.00	805.10
0086	Ablate Heart Dysrhythm Focus	41.96	1,156.01
0087	Cardiac Electrophysiologic Recording/Mapping	51.40	1,056.10
0088	Thrombectomy	3.80	64.56
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.40	4,543.29
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	77.14	4,942.78
0090	Insertion/Replacement of Pacemaker Pulse Generator	79.61	3,782.34
0654	Insertion/Replacement of a permanent dual chamber pacemaker	78.27	3,749.52

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS—Continued

APC	Description	APC percent attributed to devices	Device related costs to be subtracted from pass-through payment
0091	Level II Vascular Ligation	1.08	15.04
0653	Vascular Reconstruction/Fistula Repair with Device	10.83	169.60
0104	Transcatheter Placement of Intracoronary Stents	46.65	1,862.31
0105	Revision/Removal of Pacemakers, AICD, or Vascular	4.60	44.61
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	50.46	1,442.72
0107	Insertion of Cardioverter-Defibrillator	93.29	15,871.30
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	92.99	21,509.86
0109	Removal of Implanted Devices	1.61	6.27
0115	Cannula/Access Device Procedures	25.85	327.87
0119	Implantation of Devices	74.37	3,463.86
0122	Level II Tube Changes and Repositioning	40.26	225.62
0124	Revision of Implanted Infusion Pump	52.73	1,377.33
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	2.87	26.21
0152	Percutaneous Abdominal and Biliary Procedures	31.57	165.11
0652	Insertion of Intraperitoneal Catheters	10.91	160.05
0154	Hernia/Hydrocele Procedures	2.73	36.63
0167	Level III Urethral Procedures	43.96	649.32
0168	Level II Urethral Procedures	1.15	14.67
0179	Urinary Incontinence Procedures	56.34	3,066.24
0182	Insertion of Penile Prosthesis	58.45	2,908.45
0202	Level VIII Female Reproductive Proc	38.35	911.22
0222	Implantation of Neurological Device	88.08	10,461.01
0223	Implantation of Pain Management Device	52.96	1,133.11
0225	Implantation of Neurostimulator Electrodes	81.03	5,888.13
0226	Implantation of Drug Infusion Reservoir	82.74	6,228.55
0227	Implantation of Drug Infusion Device	81.57	6,147.49
0229	Transcatheter Placement of Intravascular Shunts	63.65	1,907.33
0246	Cataract Procedures with IOL Insert	1.38	16.00
0259	Level VI ENT Procedures	84.07	16,118.86
0279	Level II Angiography and Venography except Extremity	2.18	9.83
0280	Level III Angiography and Venography except Extremity	4.89	38.80
0297	Level II Therapeutic Radiologic Procedures	1.35	5.41
0651	Complex Interstitial Radiation Source Application	85.13	2,429.25
0670	Intravenous and Intracardiac Ultrasound	53.75	847.71
0680	Insertion of Patient Activated Event Recorders	77.72	2,275.14
0681	Knee Arthroplasty	64.16	4,945.63
0686	Level III Skin Repair	37.79	280.72
0687	Revision/Removal of Neurostimulator Electrodes	35.06	472.51
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	69.42	2,699.74
0648	Breast Reconstruction with Prosthesis	31.69	740.32

2. Devices Paid With Multiple Procedures

As explained above, under section 1833(t)(6)(D)(ii) of the Act, the amount of additional payment for a device eligible for pass-through payment 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, for devices eligible for pass-through payment, we reduce the pass-through payment amount by the cost attributable to the device that is already packaged into the APC payment for an associated procedure. For 2002, we developed offset amounts for 59 APCs (March 1, 2002 final rule, 67 FR 9556 through 9557, Table 1).

In our November 30, 2001 final rule (66 FR 59856), we articulated a policy regarding the calculation of the offsets for device costs already reflected in APCs in cases where the payment for the associated APC is reduced due to the multiple procedure discount. The policy was in response to several commenting parties that recommended that we apply the multiple procedure discount only to the non-device-related portion of the APC payment amount (66 FR 59906).

We agreed with the commenters that the full pass-through offset should not be applied when the APC payment is subject to the multiple procedure discount of 50 percent.

The purpose of the offset is to ensure that the OPPS is not making double payments for any portion of the cost associated with the use of the pass-through item. We stated in the November 30, 2001 rule that the offset should reflect that portion of the cost for the pass-through device actually reflected in the payment that is received for the associated APC. We consequently ruled that the most straightforward methodology for applying this principle is to reduce the amount of the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC. This discounting of the offset is applied in 2002 to bills subject to multiple procedure discounting that also include devices eligible for pass-through payment.

The significant number of device categories that are expiring in 2003 combined with our proposal to package 100 percent of device costs into their associated APCs has prompted us to revisit the current policy of reducing offsets for pass-through devices in instances when multiple procedure discounts are applied to procedures

associated with pass-through device categories. In order to determine the impact of multiple procedure discounting on APCs with full packaging of device costs, we reviewed the median costs of all APCs after incorporation of device costs and arrayed them in order of descending median cost. We also determined the contribution (in absolute dollars and as a percentage) of device costs to the median costs of each APC.

We then determined which APCs containing devices would be billed together. We next determined, based on median cost data, which device containing APCs would be subject to the 50 percent multiple procedure reduction. After identifying these APCs, we applied a 50 percent reduction to arrive at a discounted payment amount. We then reviewed the contribution of device costs to the discounted APC both as a percentage and in absolute dollars to determine if applying the 50 percent reduction would result in underpayment for the service. We determined that the reduced payment was adequate to pay both for the devices incorporated into the APC and for the procedure cost in the context of performing multiple procedures. We obtained the same results even when we overstated device costs in our model by 5 or 10 percent to offset concerns expressed by some manufacturers and physicians that hospital charges for transitional pass-through devices may be understated.

We noted that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps and neurostimulator electrodes) would never be subject to a multiple procedure discount. They have the highest relative weights in the OPPS, and we would not expect these procedures to be performed during the same operative session with a higher paying procedure with status indicator ''T.'' Therefore, we proposed to continue our current policy of multiple procedure discounting. That is, when two or more APCS with status indicator ''T'' are billed together we proposed to pay 100 percent for the highest cost APC and 50 percent for all other APCs with status indicator ''T.'' We proposed not to adjust these payments to account for device costs in the APCs.

We received a large number of comments on this proposal, which are summarized below:

Comment: Many commenters asked that the status indicator be changed from ''T'' to ''S'' for APCs for which a large amount of the cost of the APC is cost for a device that is packaged into the APC. They said that it is not appropriate to apply the multiple procedure discount that is applied to services with status indicator ''T'' to APCs for which the cost of a device is the majority of the cost of the APC because there is no efficiency in the provision of multiple devices. They said that the multiple procedure discount should only apply to the nondevice portion of the APC payment.

Response: We reviewed the data for combinations of APCs billed on the same claim and determined that it would not be typical for an APC, which is predominantly device cost, to be the second or subsequent APC on the same claim. Hence, it would not be typical that the predominantly device APC would be reduced (because a predominantly device APC would generally be the highest cost APC on the claim).

In the case of APC 225, however, we did change the status indicator to ''S'' because we were convinced that it must be performed when APC 222 also performed and that, therefore, a status indicator of ''T'' would not result in appropriate payment for 225.

Comment: A number of commenters took issue with our claim that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps, and neurostimulator electrodes) would never be subject to a multiple procedure discount. They asserted that some high cost APCs do incur multiple procedure discounting. The example most provided is the implantation of a neurostimulator (APC 0222) with neurostimulator electrodes or leads (APC 0225). They said that the multiple procedure discount along with proposed payment cuts to these APCs even more significantly impact the payment of these services and warrant extensive review, analysis, and consideration of outside data. They also recommended that we change the status indicators for these procedures to ''S'' (significant procedure), which are not reduced when performed as a multiple procedure in the same session. Other examples cited were: bilateral neurostimulator implants for patients with Parkinson's disease (APC 0222) and implantation of a spinal infusion pump, which involves implantation of a catheter (APC 0223) and infusion pump (APC 0227) and dual implantation of an artificial urinary sphincter and a penile prosthesis in prostate cancer survivors. One commenter recommended that all device-related APCs have a status indicator of ''S'' to reflect significant resources.

Response: We continue to believe that most procedures with significant device costs packaged in will, if provided on the same day and billed in conjunction with another procedure, be the most expensive procedure on the claim and thus not subject to discounting. We are concerned that, if we were to discontinue our policy of reducing payment for multiple procedures, we would overpay some lower valued procedures. We received many thoughtful comments on the multiple procedure discounting of certain APCs and we intend to take these comments under advisement and study this issue further.

Comment: One commenter objected to our proposal to stop applying the 50 percent discount to offsets to pass-through payments when there are multiple procedures involving a claim of a pass-through device also.

Response: As discussed above, the discount to offsets to pass-through payments will become a much less significant aspect beginning January 1, 2003, when we will retire 95 of 97 existing categories and add a limited number of new categories.

F. Outpatient Billing for Dialysis

Currently, Medicare does not pay for dialysis treatments furnished to End-Stage Renal Disease (ESRD) patients on an outpatient basis, unless the hospital also has a certified hospital-based ESRD facility. As a result of this policy, ESRD patients in need of emergency dialysis have been admitted to the hospital. These admissions have been found to be inappropriate by the Quality Improvement Organizations, and payment has been denied.

When ESRD patients come to the hospital for a medical emergency or for problems with their access sites, they typically miss their regularly scheduled dialysis appointments. If the ESRD patient's usual facility is unable to reschedule the dialysis treatment, the ESRD patient has to wait until the next scheduled dialysis appointment. We are concerned that by maintaining this policy, ESRD patients may be receiving interrupted care because there will be unnecessary lapses in treatment. The ESRD patient should not be prevented from receiving her or his normal dialysis because he or she experienced another unrelated medical situation. Therefore, we proposed to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital in specific situations. Payment would be limited to unscheduled dialysis for ESRD patients in exceptional circumstances. Outpatient dialysis for acute patients

would not be included in this payment mechanism.

In certain instances, it is appropriate to dialyze ESRD patients on an outpatient basis. We proposed to allow payment for these nonroutine dialysis treatments in medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility. The circumstances in which we proposed to allow payment are limited to:

- Dialysis performed following or in connection with a vascular access procedure;
- Dialysis performed following treatment for an unrelated medical emergency; for example, if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we would allow the hospital to provide and bill Medicare for the dialysis treatment; and
- Emergency dialysis—Currently, the only mechanism available for payment in this situation is through an inpatient admission. We will maintain our policy that routine treatments in non-ESRD certified hospitals would not be payable under OPPS.

We believe it is important to make this change in the policy for two reasons:

- To ensure that hospital outpatient departments are paid for providing this much needed service; and
- To prevent dialysis patients from receiving interrupted care. Non-ESRD certified hospital outpatient facilities would bill Medicare using a new G code, G0GGG, ''Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.'' We proposed that this new code will have status indicator ''S'' and be assigned to APC 0170. Payment would be roughly equivalent to the reimbursement rate for acute dialysis. We proposed to implement this change effective January 1, 2003. Effective January 1, 2003, this would be the only way for non-ESRD certified hospital outpatient facilities to bill Medicare and be paid for providing nonroutine outpatient dialysis to ESRD patients.

We will be monitoring the use of this new code to ensure the following:

- Certified dialysis facilities are not incorrectly using this code.
- The same dialysis patient is not repeatedly using this code, which would indicate routine dialysis treatment.

When ESRD patients receive outpatient dialysis in non-ESRD certified hospital outpatient facilities, the patient's home facility would be responsible for obtaining and reviewing the patient's medical records to ensure that appropriate care was provided in the hospital and that modifications are made, if necessary, to the patient's plan of care upon her or his return to the facility. This ensures continuity of care for the patient.

We received eight comments on our proposal to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital. Although all of the comments support our proposed changes, some commenters asked for clarification on issues pertaining to this provision.

Comment: One commenter requested that we provide clarification on how the payment rate would be determined for this service.

Response: In the August 9, 2002 proposed rule, we provided the payment rate for providing dialysis treatments for ESRD patients in the outpatient department of a hospital. The proposed rule stated that this service would be assigned Ambulatory Payment Classification (APC) 0170, and Addendum A provides the payment rate for this APC. Effective January 1, 2003, the payment national unadjusted rate for this service will be $252.16.

Comment: One commenter wanted clarification on how services typically associated with outpatient dialysis such as covered pharmaceuticals and laboratory testing will be accounted for under the proposed policy.

Response: We would pay separately for laboratory tests based on the laboratory fee schedule. Drugs may or may not be paid separately from the payment for the dialysis treatment. The drugs that would be paid separately would have a separate APC. If there is not a separate APC, then the drugs would be packaged into the APC paid for the dialysis treatment.

Comment: One commenter expressed concern that the proposal to require the ESRD patient's home facility to obtain and review the patient's medical records from the hospital would create an additional information collection burden for dialysis facilities. The commenter requested that we include language in the final rule that specifically outlines the hospital's responsibilities in providing the patient's medical records to the home facility.

Response: There should be a regular exchange of information between a patient's home facility and any treating facilities to verify the care that has been provided and to ensure that patients are not receiving inappropriate or incorrect treatment. The dialysis facility is, however, ultimately responsible for effectively coordinating the care of its patients, including the inclusion of all information in the patient's medical record, and we believe obtaining and reviewing information from other treating facilities is part of this responsibility. The medical record indicates what care has actually been provided, and it also provides the data for evaluation and documentation of the quality and appropriateness of the care delivered. We believe subsequent dialysis treatment at the patient's home facility should not be provided without information from another treatment facility because the home facility may need to make adjustments to the plan of care when the patient returns to the facility, so the facility should obtain this information from the hospital to implement any new strategies, etc. Furthermore, since dialysis facilities should already be collecting medical records for home dialysis patients and for traveling patients, we do not view this as an additional information collection burden. We view this as a responsibility within the facilities scope of practice.

Comment: One commenter cautioned us about the potential for abuse with this proposal and recommended that we develop clear guidelines governing the use of this new code.

Response: We agree with the commenter, and we plan to issue instructions for the use of the code as well as develop code edits to monitor the use of this code to prevent potential fraud and abuse. The instructions will be issued at a later date.

Comment: Another commenter requested clarification of the word ''routine,'' and what criteria that we will apply to establish whether a patient is receiving ''routine'' dialysis treatment. The commenter also requested documentation requirements (for example, diagnoses, other procedures, etc.) for meeting these ''exceptional circumstances'' defined in the August 9, 2002 proposed rule.

Response: We define ''routine'' dialysis as the three times per week maintenance treatment the same patient would normally receive at his or her home facility. We would consider a patient to be receiving routine dialysis if the claims received from the outpatient department indicated that the same patient received dialysis treatment more than once a week in this setting.

The August 9, 2002 proposed rule states that we would allow payment for this unscheduled dialysis under exceptional circumstances, and these circumstances would be (1) dialysis

performed following or in connection with a vascular access procedure; (2) dialysis performed following treatment for an unrelated medical emergency; and (3) emergency dialysis. These are the only situations in which payment would be made for dialysis provided in the outpatient department of a hospital without a certified dialysis facility. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

Comment: The commenter requested clarification as to whether an emergency department that is part of a larger hospital that contains a certified dialysis unit is already considered an ESRD certified location. Specifically, is this proposed payment change only for those providers that do not have a certified dialysis unit on their premises, making them a non-ESRD certified outpatient facility? If the answer is yes, then would the emergency department that is part of the hospital that has an ESRD-certified location bill the new dialysis G code if dialysis is given on an emergency basis while the ESRD certified location is closed?

Response: The proposed G code is specifically designated for an outpatient department of a hospital that does not have a certified ESRD facility. Therefore, a hospital's emergency department cannot use the code just because the certified dialysis facility is closed. The basis for this decision is to prevent potential fraud and abuse. We do not want dialysis facilities to use this as a means of circumventing the current requirements to receive a higher reimbursement rate for providing dialysis treatment. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

XI. Summary and Responses of Public Comments to CMS's Response to MedPAC Recommendations

In the August 9, 2002 proposed rule, we responded to the Medicare Payment Advisory Commission (MedPAC) March 2002 Report to the Congress: ''Medicare Payment Policy,'' recommendations relating to the OPPS (67 FR 52141 through 52143). We received no comments on our responses to MedPAC's recommendations. Therefore, we will not discuss that response further here. We did receive comments from MedPAC on other issues in the proposed rule. For convenience we group those comments and our responses here:

Comment: MedPAC endorsed our proposal to create APCs for procedures involving drug-eluting stents and noted, ''This step illustrates that CMS can respond rapidly to ensure adequate payment for technologies that are thought to be of a breakthrough nature.'' The Commission noted that our reliance on data from other countries to set the payment rate for this new technology appeared adequate in this instance. However, it expressed some reservation about the long-term issues that might attend more general use of such data. MedPAC has begun to consider these issues in more depth and urges us to do so as well.

Response: We appreciate the Commission's views. We have adopted our proposal for drug-eluting stents, including our method of setting the payment rate. We will give further consideration to the issues involved in use of foreign data.

Comment: MedPAC discussed the possibility that a pro rata reduction to payments for transitional pass-through drugs and devices would be needed this year, though we had not reached a conclusion on this question in the August 9, 2002 proposed rule. The Commission commented that even if a modest pro rata reduction is needed, it does not anticipate serious consequences for access to new technology services for several reasons. First, the methods for calculating transitional pass-through payments may overcompensate for these services. Second, hospitals are still likely to use these items to improve care and maintain reputations for excellence. Third, little evidence is available that indicates access problems resulting from the large pro rata reduction in 2002. Fourth, asking hospitals to share in the costs of new technologies gives them incentives to assess their value before adopting them.

Response: We have concluded that no pro rata reduction will be necessary for 2003. We appreciate and agree with the Commission's analysis of the possible effects of a pro rata reduction.

Comment: Regarding payment for medical devices no longer eligible for transitional pass-through payments, MedPAC urged us to work with stakeholders in instances where creditable evidence is available that coding issues may have led to inaccurate payment rates. The Commission does not believe that an extension of transitional pass-through eligibility is warranted or that data other than hospital cost data should be used where reliable hospital cost data are available. It also urged us to monitor beneficiary access to procedures that include such devices if payments are cut significantly.

Response: We agree that extension of transitional pass-through eligibility is not warranted, and we do not believe that the statute contemplates that it could be continued. We also agree that stakeholders may have valuable input, and as we describe elsewhere in this final rule, we have received a great deal of helpful information that has informed the policies adopted in this rule designed to moderate payment reductions that may be associated with use of devices (and of drugs) previously in transitional pass-through status. We also agree that monitoring access by beneficiaries to these procedures is important, and we expect to do so to the extent feasible.

Comment: MedPAC expressed concern that our proposal to pay separately for high-cost drugs but not for other drugs has the potential to distort the payment system. Where drugs may substitute for one another, hospitals may face incentives to use those paid separately. The Commission urged us to limit the amount of time this policy is followed and to work to move more drugs into the procedure APCs.

Response: We agree that this policy may have distorting effects on incentives, and we do not intend to use it longer than necessary. In future years, we hope to propose additional changes to this policy, and in particular to package drugs into procedure APCs where this approach appears reasonable. We hope further improvements in our data and further attention to the structure of APCs involving the use of drugs, such as those for infusion and injection, will provide the foundation for future policy development in this area.

Comment: MedPAC commented that hospital cost data are preferable to AWPs set by manufacturers. The Commission indicated the need to give careful consideration to stakeholder comments on payment for drugs and the importance of monitoring beneficiary access.

Response: We agree.

Comment: MedPAC commented that the reductions in payments for drugs that may no longer be eligible for transitional pass-through payments based on 95 percent of average wholesale price (AWP) will result in lower payments for these drugs than in other settings, such as physicians' offices. These differences may lead to shifts in the site of care based on financial considerations. MedPAC commented that this effect is not sufficient reason to change payments for these drugs in the hospital outpatient setting, but that it indicates the need for a new approach to paying for Part B drugs.

Response: The possibility of inappropriate shifts in site of service is a source of concern. We note, however, that payment rates for these drugs only shifted to 95 percent of AWP at the inception of the OPPS; before that time, Medicare paid for drugs in outpatient departments at reasonable cost, subject to statutory reductions. Medicare payment for drugs in physicians' offices has been set at 95 percent of AWP throughout this period. It is not clear that the increase in drug payments in outpatient departments from August 2000 to the present has led to substantial shifts in site of service, and the response to the forthcoming reductions may be muted as well. Nonetheless, we believe that Medicare should attempt to align payments across settings to the greatest extent possible in order to avoid inappropriate incentives to shift the site of service. In particular, we agree that a new approach to paying for Part B drugs would be desirable.

Comment: MedPAC noted that we have the statutory authority to modify updates to correct for unnecessary increases in the volume of services or for ''upcoding'' by hospitals. The Commission urged us to carefully track the volume of services and increases in coding intensity.

Response: We have not proposed any adjustment to the update for either of these reasons, and we will not adopt any such adjustment for 2003. We continue to monitor the progress of the OPPS system to discern whether we should make any such adjustment in the future.

Comment: MedPAC noted that small rural hospitals will continue to be held harmless for losses under the OPPS in 2003. The Commission urged us to study the performance of small rural hospitals and evaluate the impact of the end of their hold-harmless status.

Response: We agree that small rural hospitals warrant special attention. We expect to study the effect of the transitional corridor provision, including the protection it affords these hospitals, in the period since the implementation of the OPPS so that we can help evaluate what provision would be appropriate for 2004 and beyond.

XII. Provisions of the Final Rule With Comment for 2003

A. OPPS

The provisions of this final rule with comment restate changes to the Medicare hospital OPPS and CY 2003 payment rates including changes used to determine these payment rates set forth in the August 9, 2002 proposed rule, except as noted elsewhere in the preamble. The following is a highlight of provisions implemented in this final rule, which are discussed in detail above.

1. Statutory and Discretionary Changes

- We revised the methodology for calculating relative weights to dampen the difference in the median costs for all APCs for which the median costs fell more than 15 percent from 2002 to 2003; used only claims on which devices were reported to set the median for APCs for which the device was either essential or frequently used in the procedures in the APC; split some APCs for which devices were an issue to achieve more accurate pricing; limited the reduction in median costs for blood and certain blood products to 11 percent, which limited the reduction in payment from 2002 to 2003 to about 15 percent; used acquisition costs from external sources as a factor together with claims data in setting adjusted medians for four APCs.
- We reviewed and revised the composition of APCs to comply with the limitation on variation in procedure medians and to achieve more accurate reflections of the costs.
- We removed from pass-through status those drugs and devices that will have been on pass-through status for at least 2 years on January 1, 2003. We packaged the costs of the expiring devices into the payments for the APCs with which the devices were billed. We packaged the costs of the expiring drugs into the APCs with which the drugs were billed if the per encounter drug cost was less than $150; we established APCs for those drugs for which the per encounter drug cost was more than $150 and for blood and certain blood products. We paid for influenza and pneumococcal pneumonia vaccines and orphan drugs on a reasonable cost basis.
- We estimated the amount of payment that would be made under the pass through provisions and compared it to 2.5 percent of the projected program expenditures; we determined that no pro rata reduction would be needed for 2003, and we adjusted the conversion factor accordingly.
- We established the percentages by which pass-through devices would be reduced to remove the part of the payment that is packaged into the APC when it is billed with the device.
- We finalized the regulations that describe the criteria that must be met for a device to get a pass-through code.
- We issued the 2003 wage index and conversion factor that would be applied to the relative weights to determine the amount of payment for a particular hospital.

2. Changes to the Regulations Text

- We amended § 419.21(d)(3) to delete influenza and pneumococcal pneumonia vaccines from the list of items that are paid to CORFs, HHAs, and hospices under OPPS.
- We amended § 419.66(c)(1) to specify that we must establish a new category for a medical device if it is not described by any category previously in effect as well as an existing category. We received no comments concerning this technical correction to our regulations text. We are making this proposal final in this final rule.

B. Payment Suspension for Unfiled Cost Reports

We are adopting the provisions set forth in the proposed rule without change.

C. Partial Hospitalization Services

In the August 9, 2002 proposed rule, we indicated we would be addressing comments received on our proposal to establish a new payment amount for partial hospitalization services and remove clinical social worker services from the partial hospitalization benefit. Upon further review we have determined that we will not include this issue in this final rule, but will address it in future rulemaking.

D. Pneumococcal and Influenza Vaccines

Section 419.21(d)(3) states that ''Pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine'' are paid under the OPPS for comprehensive outpatient rehabilitation facilities, home health agencies, and hospices. There is no specific inclusion of hospitals, but we have paid hospitals for them under the OPPS since the OPPS began. We are removing the pneumococcal vaccine and influenza vaccine from this paragraph and want to pay for it under reasonable cost. We are requesting public comment on this change.

XIII. Response to Public Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to comments in the preamble to that document.

XIV. Collection of Information Requirements

This rule does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XV. Regulatory Impact Analysis

The regulatory impact analysis for this final rule consists of an impact analysis for the OPPS provisions and a regulatory impact statement for the provision for payment suspension for unfiled cost reports.

A. OPPS

1. General

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the final rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2003 compared to CY 2002 to be approximately $1.372 billion. Therefore, this final rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (see 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals will be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

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. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule has a significant impact on a substantial number of small entities. However, the statute provides for small rural hospitals (of fewer than 100 beds) to be held harmless by the law and to continue to be paid at cost; therefore this final rule has no impact on them.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments. This final rule imposes no unfunded mandates on the private sector.

Federalism

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 an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see Table 10) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 5 percent under the final rule.

2. Changes in this Final Rule

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2003 as we discuss in sections VIII and VI, respectively, of this preamble. We are also revising the relative APC payment weights based on claims data from January 1, 2001 through December 31, 2001. Finally, we are removing 95 devices and more than 200 drugs and biologicals from pass-through payment status.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 3.7 percent in 2003. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) do not increase OPPS payments because the OPPS is budget neutral. However, the

wage index and APC weight changes do change the distribution of payments within the budget neutral system as shown in Table 10 and described in more detail in this section.

Alternatives Considered

Alternatives to the changes we are making and the reasons that we are choosing not to make them are discussed throughout this final rule. Below we discuss options we considered when analyzing methodologies to appropriately recognize the costs of former pass-through items. For a more detailed discussion, see section IV.C regarding the expiration of pass-through payment for devices and section IV.D regarding the expiration of pass-through payment for drugs and biologicals.

Payment for Categories of Devices

We considered establishing separate APCs for categories of devices and paying for them separately. We are not choosing this option because we believe that to the extent possible, hospital payment for procedures and visits should include all of the costs required to provide the procedures and visits.

A second option we considered involved (1) packaging some categories of devices into the procedures with which they were billed in 2001 and (2) paying the rest through separate APCs (as discussed in section IV of this final rule.). We are not choosing this option because we believe that devices are routinely used in the services for which they are needed and therefore are consistently paid at the cost of providing the service. Furthermore, criteria that will provide a basis for some devices to be packaged and for others to be paid separately must be developed and approved, thereby further complicating an already complex payment system.

Payment for Drugs and Biologicals

We considered continuing to make separate payment for all drugs and biologicals through separate APCs. We are not choosing to pay separately for all drugs through separate APCs because we believe that, to the extent possible, hospital payment for services should include all of the costs of the services. We believe that drugs should be packaged with the services in which they are furnished except when we determine that there is a valid reason to do otherwise. However, we recognize that (unlike the stability that exists with device usage with the applicable procedures) the use of drugs may vary widely depending upon patient and disease characteristics. Therefore, packaging payment for all drugs may, in some cases, provide inadequate payment for the services furnished. Where a hospital has a disproportionate share of patients who need greater amounts of expensive drugs, underpayment for the drugs needed by these patients could result in cessation of needed services. For the first year that we are ceasing transitional pass-through payment for drugs, we decided to proceed cautiously by paying separately for drugs when the cost per encounter was more than $150 or when special characteristics existed (for example, orphan drugs, blood products).

We also considered packaging the costs of all drugs into the cost of the associated procedures with which they were billed in 2001. We did not package all payment for drugs into the payment for the procedures because, while this packaging is ultimately our goal, we believe, for the reasons indicated above, that we need to proceed cautiously to ensure that we do not inadvertently threaten access to needed care.

Conclusion

It is clear that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a regulatory impact analysis.

The OPPS rates for CY 2003 will have, overall, a positive effect for every category of hospital with the exception of children's hospitals, which are held harmless under the OPPS. These changes in the OPPS for 2003 will result in an overall 3.7 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments and transitional corridor payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 10.

The overall projected increase in payments for urban hospitals is slightly lower (3.1 percent) than the average increase for all hospitals (3.7 percent) while the increase for rural hospitals is significantly greater (6.2 percent) than the average increase. Rural hospitals gain 2.2 percent from the wage index change, and also gain 0.1 percent from APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.A.4 below. Table 11 presents the outlier distribution that we expect to see under this final rule.

3. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2003, 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.

4. Estimated Impacts of This Final Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistributive effects of the wage index and APC changes. In some cases, under this final rule, hospitals will receive more total payment than in 2002 while in other cases they will receive less total payment than they received in 2002. The impact of this final rule will depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 12 represents the full impact on each hospital group of all the changes for 2003. Columns 2 and 3 in the table reflect the independent effects of the change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the 2003 OPPS rates that is summarized in Table 12. For that reason, the total number of hospitals included in Table 10 (4,551) is lower than in previous years. CAHs are excluded from the OPPS.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that will experience a negative impact due to wage index changes are those in Puerto Rico, a decrease of 3.2 percent. Conversely, the urban hospitals are generally negatively

affected by wage index changes, with the largest decreases occurring in those with 300 to 499 beds (−0.7 percent) and those in the Middle Atlantic (−1.0 percent), Pacific (−1.2 percent), and Puerto Rico Regions (−1.6 percent). However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals and have a negative effect on urban hospitals in excess of 200 beds. Specifically, urban hospitals with 300 to 499 beds (−0.6 percent decrease) and urban hospitals in excess of 500 beds (a −0.8 percent decrease) all show a decrease attributed to APC recalibration. However, this decrease is much less than what would have occurred under the proposed rule.

In urban areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with higher volumes are expected to receive higher increases in payments. In rural areas, hospitals with volumes greater than 42,999 services are projected to experience a significant increase in payments (7.7 percent). The less favorable impact for the high volume urban hospitals is attributable to both wage index and APC changes. For example, urban hospitals providing more than 42,999 services are projected to gain a combined 2.8 percent due to these changes.

Major teaching hospitals are projected to experience a smaller increase in payments (2.7 percent) than the aggregate for all hospitals (3.7 percent) due to negative impacts of the wage index (−0.3 percent) and recalibration (−0.8 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.2 percent) that is smaller than the average for all hospitals.

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of Hospitals[1] (1)	New Wage Index[2] (2)	APC Changes[3] (3)	All CY 2003 Changes[4] (4)
ALL HOSPITALS	4,519	0	0	3.7
NON-TEFRA HOSPITALS	3,989	0	−0.1	3.6
URBAN HOSPS	2,420	−0.5	−0.1	3.1
LARGE URBAN (GT 1 MILL.)	1,397	−0.6	−0.1	3.1
OTHER URBAN (LE 1 MILL.)	1,023	−0.5	−0.1	3.1
RURAL HOSPS	1,569	2.2	0.1	6.2
BEDS (URBAN):				
0–99 BEDS	550	−0.4	0.7	4.0
100–199 BEDS	877	−0.6	0.6	3.7
200–299 BEDS	488	−0.6	0.1	3.3
300–499 BEDS	364	−0.7	−0.6	2.4
500+ BEDS	141	−0.1	−0.8	2.8
BEDS (RURAL):				
0–49 BEDS	752	0.2	0	4.0
50–99 BEDS	478	1.4	−0.3	4.9
100–149 BEDS	200	2.4	0.3	6.6
150–199 BEDS	73	5.4	−0.5	8.9
200+ BEDS	66	3.1	0.8	8.0
VOLUME (URBAN):				
LT 5,000	182	0.9	3.4	8.0
5,000–10,999	293	−0.8	2.2	5.2
11,000–20,999	476	−0.7	1.1	4.2
21,000–42,999	667	−0.7	0.2	3.2
GT 42,999	802	−0.5	−0.4	2.8
VOLUME (RURAL):				
LT 5,000	334	0	1.1	4.9
5,000–10,999	419	0.3	1.2	5.4
11,000–20,999	387	1.2	0	5.0
21,000–42,999	295	1.9	0	5.8
GT 42,999	134	4.1	−0.3	7.7
REGION (URBAN):				
NEW ENGLAND	127	−0.6	0.4	3.4
MIDDLE ATLANTIC	372	−1	0.1	2.7
SOUTH ATLANTIC	367	−0.3	0.5	3.9
EAST NORTH CENT.	411	−0.7	−0.9	2.1
EAST SOUTH CENT.	153	−0.8	−0.1	2.8
WEST NORTH CENT.	170	−0.6	−1.1	2.0
WEST SOUTH CENT.	292	1	0	4.8
MOUNTAIN	122	0.2	−0.8	3.0
PACIFIC	367	−1.2	0.8	3.3
PUERTO RICO	39	−1.6	2.1	4.1
REGION (RURAL):				
NEW ENGLAND	40	1.7	−0.2	5.3
MIDDLE ATLANTIC	63	1.9	−0.5	5.3
SOUTH ATLANTIC	224	2.4	0.9	7.2
EAST NORTH CENT.	212	1.1	−1.7	3.2
EAST SOUTH CENT.	232	2.2	1.2	7.3
WEST NORTH CENT.	271	1.8	−0.6	5.0

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of Hospitals[1] (1)	New Wage Index[2] (2)	APC Changes[3] (3)	All CY 2003 Changes[4] (4)
WEST SOUTH CENT.	278	1.9	1.4	7.2
MOUNTAIN	141	4.6	−0.6	7.9
PACIFIC	103	4.9	1	10.0
PUERTO RICO	5	−3.2	7.2	7.6
TEACHING STATUS:				
NON-TEACHING	2,922	0.3	0.3	4.4
MINOR	782	−0.3	−0.2	3.2
MAJOR	284	−0.3	−0.8	2.7
DSH PATIENT PERCENT:				
0	11	5.3	5.5	15.3
GT 0–0.10	975	−0.2	−0.6	2.9
0.10–0.16	872	0.6	−0.6	3.7
0.16–0.23	766	−0.6	0	3.1
0.23–0.35	755	−0.1	0.4	4.1
GE 0.35	610	0.1	1.6	5.5
URBAN IME/DSH:				
IME & DSH	982	−0.6	−0.4	2.7
IME/NO DSH	0	0	0	0.0
NO IME/DSH	1,432	−0.5	0.4	3.6
NO IME/NO DSH	6	6.1	5.1	15.7
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	607	0.5	0.3	4.6
RRC	167	4.2	0.2	8.4
SCH/EACH	507	1.4	−0.1	5.1
MDH	199	0.5	−0.7	3.6
SCH AND RRC	75	3.8	0.1	7.9
TYPE OF OWNERSHIP:				
VOLUNTARY	2,434	−0.1	−0.2	3.5
PROPRIETARY	703	−0.5	0.5	3.7
GOVERNMENT	852	0.6	0	4.4
SPECIALTY HOSPITALS:				
EYE AND EAR	13	−1.3	9.1	11.7
TRAUMA	153	−0.3	−0.6	2.9
CANCER	10	1	−4.5	0.4
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	163	10.1	0.8	14.7
PSYCH	191	0	7.4	11.4
LTC	135	4.3	15.1	23.0
CHILDREN	41	−1.4	−1	1.3

[1] Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.

[2] This column shows the impact of updating the wage index used to calculate payment by applying the FY 2003 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2003 was published in the **Federal Register** on May 9, 2002.

[3] This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2001 hospital claims data.

[4] This column shows changes in total payment from CY 2002 to CY 2003, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2003 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

Note: For CY 2003, under the OPPS transitional corridor policy, the following categories of hospitals are held harmless compared to their 1996 payment margin for these services: cancer and children's hospitals and rural hospitals with 100 or fewer beds.

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2003 expenditures to outlier payments. In Table 13 below, we provide a distribution by percentage of the total projected outlier payments for the categories of hospitals that we show in the impact table (Table 10).

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2003, that most hospitals will receive outlier payments.

The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals	Percent of Total Hospitals	Number of Hospitals with Outliers	Percent of Total Outlier Payments
ALL HOSPITALS	4,519	100.00	4,298	100.00
NON-TEFRA HOSPITALS	3,989	88.20	3,977	99.40
URBAN HOSPS	2,420	53.60	2,413	83.20
LARGE URBAN (GT 1 MILL.)	1,397	31.00	1,394	56.00
OTHER URBAN (LE 1 MILL.)	1,023	22.60	1,019	27.20
RURAL HOSPS	1,569	34.80	1,564	16.20
BEDS (URBAN):				
0–99 BEDS	550	12.20	545	7.20
100–199 BEDS	877	19.40	875	18.20
200–299 BEDS	488	10.80	488	16.80
300–499 BEDS	364	8.00	364	21.00
500 + BEDS	141	3.20	141	19.80
BEDS (RURAL):				
0–49 BEDS	752	16.60	749	4.40
50–99 BEDS	478	10.60	477	5.00
100–149 BEDS	200	4.40	199	2.40
150–199 BEDS	73	1.60	73	2.00
200 + BEDS	66	1.40	66	2.20
VOLUME (URBAN):				
LT 5,000	182	4.00	176	1.00
5,000–10,999	293	6.40	292	2.80
11,000–20,999	476	10.60	476	6.80
21,000–42,999	667	14.80	667	17.60
GT 42,999	802	17.80	802	55.00
VOLUME (RURAL):				
LT 5,000	334	7.40	330	1.00
5,000–10,999	419	9.20	418	2.40
11,000–20,999	387	8.60	387	4.00
21,000–42,999	295	6.60	295	4.20
GT 42,999	134	3.00	134	4.40
REGION (URBAN):				
NEW ENGLAND	127	2.80	126	5.60
MIDDLE ATLANTIC	372	8.20	371	24.20
SOUTH ATLANTIC	367	8.20	366	11.40
EAST NORTH CENT	411	9.00	408	14.80
EAST SOUTH CENT	153	3.40	153	3.20
WEST NORTH CENT	170	3.80	170	4.20
WEST SOUTH CENT	292	6.40	292	8.00
MOUNTAIN	122	2.60	122	3.00
PACIFIC	367	8.20	366	8.80
PUERTO RICO	39	0.80	39	0.00
REGION (RURAL):				
NEW ENGLAND	40	0.80	40	1.00
MIDDLE ATLANTIC	63	1.40	63	1.00
SOUTH ATLANTIC	224	5.00	222	3.00
EAST NORTH CENT	212	4.60	211	3.00
EAST SOUTH CENT	232	5.20	232	1.60
WEST NORTH CENT	271	6.00	270	2.40
WEST SOUTH CENT	278	6.20	278	1.60
MOUNTAIN	141	3.20	141	1.40
PACIFIC	103	2.20	102	1.20
PUERTO RICO	5	0.20	5	0.00
TEACHING STATUS:				
NON-TEACHING	2,922	64.60	2,910	40.40
MINOR	782	17.40	782	27.00
MAJOR	284	6.20	284	31.80
DSH PATIENT PERCENT:				
0	11	0.20	11	0.00
GT 0–0.10	975	21.60	973	24.60
0.10–0.16	872	19.20	872	19.20
0.16–0.23	766	17.00	764	17.60
0.23–0.35	755	16.80	752	19.40
GE 0.35	610	13.40	605	18.40
URBAN IME/DSH:				
IME & DSH	982	21.80	982	56.60
IME/NO DSH	0	0.00	0	0.00
NO IME/DSH	1,432	31.60	1,425	26.40
NO IME/NO DSH	6	0.20	6	0.00
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	607	13.40	605	5.00

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of Hospitals	Percent of Total Hospitals	Number of Hospitals with Outliers	Percent of Total Outlier Payments
RRC	167	3.60	166	4.00
SCH/EACH	507	11.20	507	4.40
MDH	199	4.40	198	1.20
SCH AND RRC	75	1.60	75	1.60
TYPE OF OWNERSHIP:				
VOLUNTARY	2,434	53.80	2,431	73.60
PROPRIETARY	703	15.60	699	10.60
GOVERNMENT	852	18.80	847	15.20
SPECIALTY HOSPITALS:				
EYE AND EAR	13	0.20	13	0.20
TRAUMA	153	3.40	153	15.00
CANCER	10	0.20	10	3.60
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	163	3.60	115	0.20
PSYCH	191	4.20	67	0.00
LTC	135	3.00	99	0.20
CHILDREN	41	1.00	40	0.20

5. Estimated Impacts of This Final Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example for a mid level office visit (APC 0601), the minimum unadjusted copayment in 2002 was $9.67; under this final rule, the minimum unadjusted copayment for APC 601 is $10.11 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted copayment amount is shown in Addendum B), however, the beneficiary copayment is frozen based on historic data and will not change, therefore not presenting any potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. This amount was $812 for 2002, and is $840 for 2003. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the copayment for the service is one that is frozen under the OPPS.

B. Payment Suspension for Unfiled Cost Reports

Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Public Law 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. (A description of each of these requirements is stated above in section XV.A.1.)

We have determined that the payment suspension provision does not have an economic impact on Medicare payments or other payments to providers. We are allowing the Secretary flexibility in payment suspensions, but we are not altering the final payment determination in any way. With the implementation of the various prospective payment systems, the majority of the payment to providers is based on the PPS methodology and not on the cost report. Suspending all payments because the cost report is not timely filed negatively affects providers. Providing the Secretary with flexibility in payment suspension can lessen the financial impact on providers. For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Under the requirement for Unfunded Mandates, this final rule will not have an economic effect on State, local, or tribal governments, in the aggregate, or on the private sector.

Anticipated Effects

1. Effects on Providers That File Cost Reports

The majority of providers that file cost reports comply with the timeliness provisions and will be unaffected by this regulation. In FY 2000, collectively 16 percent of hospitals, skilled nursing facilities, and home health agencies filed late cost reports. Of this 16 percent, 65 percent of those were only 1 day late. Currently, when a provider fails to file an acceptable cost report, the provider is placed on a complete payment suspension. Under this provision, for those providers who do not file timely, an immediate payment suspension less than the total suspension currently required might be imposed if the Secretary deemed it appropriate, which will allow the provider to more easily continue operations while completing and submitting the acceptable cost report.

2. Effects on Other Providers

The payment suspension provision does not affect other providers.

3. Effects on the Medicare Program

The provision will allow the Secretary to more effectively manage the Medicare program by imposing other than complete payment suspension when it is appropriate to do so. The Medicare program benefits because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients. There are no costs to the Medicare program to doing so, because when the cost report is submitted, the suspended payments are returned to the provider.

4. Effects on Beneficiaries

We have determined that this provision has a potentially positive impact on beneficiaries. Under this provision, the Secretary will have the

discretion to impose less than 100 percent payment suspension when a provider fails to timely file an acceptable cost report. Doing so will lessen the financial burden on the provider and thereby allow it to provide adequate services to its patient population as it works to complete and file an acceptable cost report.

Alternatives Considered

We considered not revising existing § 405.371(c) to provide that payment suspension could be ''in whole or in part.'' However, we did not choose this option because we believe the Secretary should have the discretion to impose partial payment suspensions when circumstances warrant in order to more effectively manage the Medicare program.

Conclusion

In conclusion, we have determined that the payment suspension provision does not have an economic impact on Medicare payments.

C. Federalism

Since this regulation does not impose any costs on State or local governments, it will not have an effect on State or local governments. State or local governments will have no roles or responsibilities associated with this provision.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 419

Hospitals, 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 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

1. The authority citation for subpart C of part 405 continues to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

2. Section 405.371(c) is revised to read as follows:

§ 405.371 Suspension, offset and recoupment of Medicare payments to providers and suppliers of services.

* * * * *

(c) Suspension of payment in the case of unfiled cost reports. If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the intermediary to be acceptable. In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

1. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

2. In § 419.21, paragraph (d)(3) is revised to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(d) * * *

(3) Hepatitis B vaccine.

§ 419.66 [Amended]

3. In § 419.66, paragraph (c)(1) is amended by adding the phrase ''or by any category previously in effect'' after ''categories'' and before ''and''.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary (Medical Insurance Program).

Dated: October 23, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare and Medicaid Services.

Approved: October 23, 2002.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.3779	$19.71	$7.09	$3.94
0002	Fine needle Biopsy/Aspiration	T	0.5911	$30.83		$6.17
0003	Bone Marrow Biopsy/Aspiration	T	1.2306	$64.18		$12.84
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7441	$90.96	$23.47	$18.19
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	3.1201	$162.72	$71.59	$32.54
0006	Level I Incision & Drainage	T	1.7926	$93.49	$24.12	$18.70
0007	Level II Incision & Drainage	T	10.0191	$522.51	$108.89	$104.50
0008	Level III Incision and Drainage	T	16.1430	$841.87		$168.37
0009	Nail Procedures	T	0.6298	$32.84	$8.34	$6.57
0010	Level I Destruction of Lesion	T	0.6589	$34.36	$10.08	$6.87
0011	Level II Destruction of Lesion	T	1.8507	$96.52	$27.88	$19.30
0012	Level I Debridement & Destruction	T	0.7849	$40.93	$11.18	$8.19
0013	Level II Debridement & Destruction	T	1.0756	$56.09	$14.20	$11.22
0015	Level III Debridement & Destruction	T	1.5407	$80.35	$20.35	$16.07
0016	Level IV Debridement & Destruction	T	2.6162	$136.44	$57.31	$27.29
0017	Level VI Debridement & Destruction	T	15.8233	$825.20	$227.84	$165.04
0018	Biopsy of Skin/Puncture of Lesion	T	0.9399	$49.02	$16.04	$9.80
0019	Level I Excision/ Biopsy	T	3.7693	$196.57	$71.87	$39.31
0020	Level II Excision/ Biopsy	T	7.1898	$374.96	$113.25	$74.99
0021	Level III Excision/ Biopsy	T	13.9338	$726.66	$219.48	$145.33
0022	Level IV Excision/ Biopsy	T	17.3930	$907.06	$354.45	$181.41
0023	Exploration Penetrating Wound	T	2.5193	$131.38	$40.37	$26.28
0024	Level I Skin Repair	T	1.8507	$96.52	$34.75	$19.30
0025	Level II Skin Repair	T	5.8623	$305.72	$115.49	$61.14
0027	Level IV Skin Repair	T	15.2225	$793.87	$329.72	$158.77
0028	Level I Breast Surgery	T	16.8698	$879.78	$303.74	$175.96
0029	Level II Breast Surgery	T	28.7881	$1,501.33	$632.64	$300.27
0030	Level III Breast Surgery	T	37.5185	$1,956.63	$763.55	$391.33
0032	Insertion of Central Venous/Arterial Catheter	T	11.4726	$598.31		$119.66
0033	Partial Hospitalization	P	4.6026	$240.03	$48.17	$48.01
0035	Placement of Arterial or Central Venous Catheter	T	0.2229	$11.62	$3.51	$2.32
0041	Level I Arthroscopy	T	26.1234	$1,362.36		$272.47
0042	Level II Arthroscopy	T	40.9680	$2,136.52	$804.74	$427.30
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	2.4999	$130.37		$26.07
0045	Bone/Joint Manipulation Under Anesthesia	T	12.9357	$674.61	$268.47	$134.92
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	29.2920	$1,527.61	$535.76	$305.52
0047	Arthroplasty without Prosthesis	T	28.2842	$1,475.05	$537.03	$295.01
0048	Arthroplasty with Prosthesis	T	40.6289	$2,118.84	$695.60	$423.77
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	18.6042	$970.23	$197.14	$194.05
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	23.3037	$1,215.31		$243.06
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	32.9062	$1,716.09		$343.22
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	40.7646	$2,125.91		$425.18
0053	Level I Hand Musculoskeletal Procedures	T	14.1760	$739.29	$253.49	$147.86
0054	Level II Hand Musculoskeletal Procedures	T	22.7223	$1,184.99		$237.00
0055	Level I Foot Musculoskeletal Procedures	T	17.6740	$921.72	$355.34	$184.34
0056	Level II Foot Musculoskeletal Procedures	T	22.1700	$1,156.19	$405.81	$231.24
0057	Bunion Procedures	T	22.9064	$1,194.59	$475.91	$238.92
0058	Level I Strapping and Cast Application	S	1.0368	$54.07		$10.81
0060	Manipulation Therapy	S	0.3294	$17.18		$3.44
0068	CPAP Initiation	S	2.0736	$108.14	$59.48	$21.63
0069	Thoracoscopy	T	27.5575	$1,437.15	$591.64	$287.43
0070	Thoracentesis/Lavage Procedures	T	3.3623	$175.35		$35.07
0071	Level I Endoscopy Upper Airway	T	0.9205	$48.00	$12.89	$9.60
0072	Level II Endoscopy Upper Airway	T	1.1628	$60.64	$26.68	$12.13
0073	Level III Endoscopy Upper Airway	T	3.1976	$166.76	$73.38	$33.35
0074	Level IV Endoscopy Upper Airway	T	12.8582	$670.57	$295.70	$134.11
0075	Level V Endoscopy Upper Airway	T	19.6604	$1,025.31	$445.92	$205.06
0076	Endoscopy Lower Airway	T	8.9533	$466.92	$189.82	$93.38
0077	Level I Pulmonary Treatment	S	0.2907	$15.16	$8.34	$3.03
0078	Level II Pulmonary Treatment	S	0.6492	$33.86	$14.55	$6.77
0079	Ventilation Initiation and Management	S	1.6376	$85.40		$17.08
0080	Diagnostic Cardiac Catheterization	T	35.2996	$1,840.91	$838.92	$368.18
0081	Non-Coronary Angioplasty or Atherectomy	T	43.5067	$2,268.92		$453.78
0082	Coronary Atherectomy	T	86.4321	$4,507.52	$1,293.59	$901.50
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	51.9755	$2,710.57		$542.11
0084	Level I Electrophysiologic Evaluation	S	9.3312	$486.63		$97.33
0085	Level II Electrophysiologic Evaluation	T	41.7238	$2,175.94	$480.03	$435.19
0086	Ablate Heart Dysrhythm Focus	T	52.8282	$2,755.04	$936.35	$551.01

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0087	Cardiac Electrophysiologic Recording/Mapping	T	39.3983	$2,054.66		$410.93
0088	Thrombectomy	T	32.5768	$1,698.91	$655.22	$339.78
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	112.5555	$5,869.88	$1,722.59	$1,173.98
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	87.9631	$4,587.36	$1,651.45	$917.47
0091	Level II Vascular Ligation	T	26.7048	$1,392.68	$348.23	$278.54
0092	Level I Vascular Ligation	T	23.7882	$1,240.58	$505.37	$248.12
0093	Vascular Reconstruction/Fistula Repair without Device	T	20.6294	$1,075.84	$277.34	$215.17
0094	Level I Resuscitation and Cardioversion	S	3.8371	$200.11	$67.63	$40.02
0095	Cardiac Rehabilitation	S	0.6105	$31.84	$16.73	$6.37
0096	Non-Invasive Vascular Studies	S	1.7054	$88.94	$48.15	$17.79
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0077	$52.55	$23.80	$10.51
0098	Injection of Sclerosing Solution	T	1.6666	$86.91	$20.88	$17.38
0099	Electrocardiograms	S	0.3682	$19.20		$3.84
0100	Cardiac Stress Tests	X	1.6085	$83.88	$41.44	$16.78
0101	Tilt Table Evaluation	S	4.2247	$220.32	$105.27	$44.06
0103	Miscellaneous Vascular Procedures	T	11.8408	$617.51	$223.63	$123.50
0104	Transcatheter Placement of Intracoronary Stents	T	76.5486	$3,992.09		$798.42
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	18.5945	$969.72	$370.40	$193.94
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	54.8243	$2,859.14		$571.83
0107	Insertion of Cardioverter-Defibrillator	T	326.2231	$17,012.86	$3,699.14	$3,402.57
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	443.5460	$23,131.37		$4,626.27
0109	Removal of Implanted Devices	T	7.4708	$389.61	$131.49	$77.92
0110	Transfusion	S	4.0309	$210.22		$42.04
0111	Blood Product Exchange	S	14.9803	$781.24	$217.61	$156.25
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.4236	$1,899.53	$612.47	$379.91
0113	Excision Lymphatic System	T	18.7496	$977.81		$195.56
0114	Thyroid/Lymphadenectomy Procedures	T	36.1135	$1,883.36	$485.91	$376.67
0115	Cannula/Access Device Procedures	T	24.3211	$1,268.37	$459.35	$253.67
0116	Chemotherapy Administration by Other Technique Except Infusion	S	0.7752	$40.43		$8.09
0117	Chemotherapy Administration by Infusion Only	S	3.6046	$187.98	$48.28	$37.60
0118	Chemotherapy Administration by Both Infusion and Other Technique.	S	5.4844	$286.02	$72.03	$57.20
0119	Implantation of Devices	T	89.3100	$4,657.61		$931.52
0120	Infusion Therapy Except Chemotherapy	T	2.1802	$113.70	$30.75	$22.74
0121	Level I Tube changes and Repositioning	T	2.0833	$108.65	$43.80	$21.73
0122	Level II Tube changes and Repositioning	T	10.7459	$560.41	$114.93	$112.08
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	6.4049	$334.02		$66.80
0124	Revision of Implanted Infusion Pump	T	50.0861	$2,612.04		$522.41
0125	Refilling of Infusion Pump	T	2.0639	$107.63		$21.53
0130	Level I Laparoscopy	T	30.4644	$1,588.75	$659.53	$317.75
0131	Level II Laparoscopy	T	40.2026	$2,096.61	$1,001.89	$419.32
0132	Level III Laparoscopy	T	56.9948	$2,972.34	$1,239.22	$594.47
0140	Esophageal Dilation without Endoscopy	T	6.0948	$317.85	$107.24	$63.57
0141	Upper GI Procedures	T	7.4126	$386.57	$143.38	$77.31
0142	Small Intestine Endoscopy	T	8.1393	$424.47	$152.78	$84.89
0143	Lower GI Endoscopy	T	7.9165	$412.85	$186.06	$82.57
0146	Level I Sigmoidoscopy	T	3.4302	$178.89	$64.40	$35.78
0147	Level II Sigmoidoscopy	T	7.0153	$365.85	$79.46	$73.17
0148	Level I Anal/Rectal Procedure	T	3.4205	$178.38	$63.38	$35.68
0149	Level III Anal/Rectal Procedure	T	16.3756	$854.00	$293.06	$170.80
0150	Level IV Anal/Rectal Procedure	T	21.2398	$1,107.68	$437.12	$221.54
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	17.5093	$913.13	$245.46	$182.63
0152	Percutaneous Abdominal and Biliary Procedures	T	10.0288	$523.01	$131.28	$104.60
0153	Peritoneal and Abdominal Procedures	T	19.5441	$1,019.24	$410.87	$203.85
0154	Hernia/Hydrocele Procedures	T	25.7262	$1,341.65	$464.85	$268.33
0155	Level II Anal/Rectal Procedure	T	10.1936	$531.61	$188.89	$106.32
0156	Level II Urinary and Anal Procedures	T	2.9747	$155.13	$46.55	$31.03
0157	Colorectal Cancer Screening: Barium Enema	S	2.5387	$132.40		$26.48
0158	Colorectal Cancer Screening: Colonoscopy	T	7.0638	$368.38		$92.10
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.3255	$121.28		$30.32
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.3080	$328.97	$105.06	$65.79
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	15.7070	$819.14	$249.36	$163.83
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	20.5906	$1,073.82		$214.76
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.3714	$1,479.60		$295.92
0164	Level I Urinary and Anal Procedures	T	1.1240	$58.62	$17.59	$11.72
0165	Level III Urinary and Anal Procedures	T	12.2672	$639.75		$127.95
0166	Level I Urethral Procedures	T	15.4163	$803.98	$218.73	$160.80
0167	Level III Urethral Procedures	T	28.3230	$1,477.07	$555.84	$295.41

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0168	Level II Urethral Procedures	T	24.4665	$1,275.95	$405.60	$255.19
0169	Lithotripsy	T	44.0978	$2,299.74	$1,115.69	$459.95
0170	Dialysis	S	4.8352	$252.16		$50.43
0179	Urinary Incontinence Procedures	T	104.3581	$5,442.38	$2,340.22	$1,088.48
0180	Circumcision	T	18.1004	$943.95	$304.87	$188.79
0181	Penile Procedures	T	29.2435	$1,525.08	$621.82	$305.02
0182	Insertion of Penile Prosthesis	T	95.4145	$4,975.96		$995.19
0183	Testes/Epididymis Procedures	T	21.2592	$1,108.69		$221.74
0184	Prostate Biopsy	T	3.6918	$192.53	$96.27	$38.51
0187	Miscellaneous Placement/Repositioning	X	3.9534	$206.17	$90.71	$41.23
0188	Level II Female Reproductive Proc	T	1.0465	$54.58	$11.95	$10.92
0189	Level III Female Reproductive Proc	T	1.5310	$79.84	$18.60	$15.97
0190	Surgical Hysteroscopy	T	19.0596	$993.98	$424.28	$198.80
0191	Level I Female Reproductive Proc	T	0.2035	$10.61	$3.08	$2.12
0192	Level IV Female Reproductive Proc	T	2.7228	$142.00	$39.11	$28.40
0193	Level V Female Reproductive Proc	T	14.4764	$754.96	$171.13	$150.99
0194	Level VI Female Reproductive Proc	T	18.0228	$939.91	$397.84	$187.98
0195	Level VII Female Reproductive Proc	T	23.7301	$1,237.55	$483.80	$247.51
0196	Dilation and Curettage	T	15.5035	$808.52	$338.23	$161.70
0197	Infertility Procedures	T	1.5697	$81.86	$33.06	$16.37
0198	Pregnancy and Neonatal Care Procedures	T	1.2597	$65.69	$32.19	$13.14
0199	Obstetrical Care Service	T	3.9146	$204.15	$57.16	$40.83
0200	Therapeutic Abortion	T	15.1838	$791.85	$307.83	$158.37
0201	Spontaneous Abortion	T	15.3097	$798.42	$329.65	$159.68
0202	Level VIII Female Reproductive Proc	T	45.5610	$2,376.05	$1,164.26	$475.21
0203	Level IV Nerve Injections	T	11.7924	$614.99	$276.76	$123.00
0204	Level I Nerve Injections	T	2.0251	$105.61	$40.13	$21.12
0206	Level II Nerve Injections	T	4.7867	$249.63	$75.55	$49.93
0207	Level III Nerve Injections	T	5.7654	$300.67	$123.69	$60.13
0208	Laminotomies and Laminectomies	T	38.4487	$2,005.14		$401.03
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.3369	$591.23	$280.58	$118.25
0212	Nervous System Injections	T	3.3139	$172.82	$79.53	$34.56
0213	Extended EEG Studies and Sleep Studies, Level I	S	3.2557	$169.79	$70.41	$33.96
0214	Electroencephalogram	S	2.2286	$116.22	$58.12	$23.24
0215	Level I Nerve and Muscle Tests	S	0.5814	$30.32	$15.76	$6.06
0216	Level III Nerve and Muscle Tests	S	2.8972	$151.09	$67.98	$30.22
0218	Level II Nerve and Muscle Tests	S	1.0077	$52.55		$10.51
0220	Level I Nerve Procedures	T	15.8136	$824.70		$164.94
0221	Level II Nerve Procedures	T	21.5208	$1,122.33	$463.62	$224.47
0222	Implantation of Neurological Device	T	227.7370	$11,876.71		$2,375.34
0223	Implantation of Pain Management Device	T	41.0262	$2,139.56		$427.91
0224	Implantation of Reservoir/Pump/Shunt	T	34.0302	$1,774.71	$453.41	$354.94
0225	Implantation of Neurostimulator Electrodes	S	139.3379	$7,266.61		$1,453.32
0226	Implantation of Drug Infusion Reservoir	T	144.3474	$7,527.86		$1,505.57
0227	Implantation of Drug Infusion Device	T	144.5122	$7,536.46		$1,507.29
0228	Creation of Lumbar Subarachnoid Shunt	T	59.6207	$3,109.28	$696.46	$621.86
0229	Transcatherter Placement of Intravascular Shunts	T	57.4599	$2,996.59	$771.23	$599.32
0230	Level I Eye Tests & Treatments	S	0.7364	$38.40	$14.97	$7.68
0231	Level III Eye Tests & Treatments	S	2.1705	$113.19	$50.94	$22.64
0232	Level I Anterior Segment Eye Procedures	T	4.4960	$234.47	$103.17	$46.89
0233	Level II Anterior Segment Eye Procedures	T	13.4202	$699.88	$266.33	$139.98
0234	Level III Anterior Segment Eye Procedures	T	20.4259	$1,065.23	$511.31	$213.05
0235	Level I Posterior Segment Eye Procedures	T	5.0871	$265.30	$73.44	$53.06
0236	Level II Posterior Segment Eye Procedures	T	19.4278	$1,013.18		$202.64
0237	Level III Posterior Segment Eye Procedures	T	33.2647	$1,734.79	$818.54	$346.96
0238	Level I Repair and Plastic Eye Procedures	T	2.9747	$155.13	$58.96	$31.03
0239	Level II Repair and Plastic Eye Procedures	T	6.8119	$355.25	$115.94	$71.05
0240	Level III Repair and Plastic Eye Procedures	T	16.3078	$850.47	$315.31	$170.09
0241	Level IV Repair and Plastic Eye Procedures	T	20.6294	$1,075.84	$384.47	$215.17
0242	Level V Repair and Plastic Eye Procedures	T	28.0517	$1,462.92	$597.36	$292.58
0243	Strabismus/Muscle Procedures	T	19.9705	$1,041.48	$431.39	$208.30
0244	Corneal Transplant	T	35.6290	$1,858.09	$803.26	$371.62
0245	Level I Cataract Procedures without IOL Insert	T	14.5442	$758.49	$251.21	$151.70
0246	Cataract Procedures with IOL Insert	T	22.2379	$1,159.73	$495.96	$231.95
0247	Laser Eye Procedures Except Retinal	T	4.7092	$245.59	$104.31	$49.12
0248	Laser Retinal Procedures	T	4.2925	$223.86	$95.08	$44.77
0249	Level II Cataract Procedures without IOL Insert	T	26.7242	$1,393.69	$524.67	$278.74
0250	Nasal Cauterization/Packing	T	1.6376	$85.40	$29.89	$17.08

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
0251	Level I ENT Procedures	T	1.9089	$99.55		$19.91
0252	Level II ENT Procedures	T	5.8041	$302.69	$113.41	$60.54
0253	Level III ENT Procedures	T	14.4473	$753.44	$282.29	$150.69
0254	Level IV ENT Procedures	T	20.1158	$1,049.06	$321.35	$209.81
0256	Level V ENT Procedures	T	34.0302	$1,774.71		$354.94
0258	Tonsil and Adenoid Procedures	T	19.8736	$1,036.43	$437.25	$207.29
0259	Level VI ENT Procedures	T	367.6466	$19,173.14	$9,394.83	$3,834.63
0260	Level I Plain Film Except Teeth	X	0.7655	$39.92	$21.95	$7.98
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.2887	$67.21		$13.44
0262	Plain Film of Teeth	X	0.5717	$29.81	$9.82	$5.96
0263	Level I Miscellaneous Radiology Procedures	X	1.8992	$99.05	$43.58	$19.81
0264	Level II Miscellaneous Radiology Procedures	X	2.8197	$147.05	$79.41	$29.41
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.9787	$51.04	$28.07	$10.21
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.5988	$83.38	$45.86	$16.68
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4418	$127.34	$65.52	$25.47
0268	Ultrasound Guidance Procedures	S	1.3856	$72.26		$14.45
0269	Level III Echocardiogram Except Transesophageal	S	3.2170	$167.77	$87.24	$33.55
0270	Transesophageal Echocardiogram	S	5.3003	$276.42	$146.79	$55.28
0271	Mammography	S	0.6492	$33.86	$16.80	$6.77
0272	Level I Fluoroscopy	X	1.3372	$69.74	$38.36	$13.95
0274	Myelography	S	3.8759	$202.13	$96.54	$40.43
0275	Arthrography	S	2.9747	$155.13	$69.09	$31.03
0276	Level I Digestive Radiology	S	1.5891	$82.87	$41.72	$16.57
0277	Level II Digestive Radiology	S	2.3546	$122.79	$60.47	$24.56
0278	Diagnostic Urography	S	2.5290	$131.89	$66.07	$26.38
0279	Level II Angiography and Venography except Extremity	S	8.6432	$450.75	$174.57	$90.15
0280	Level III Angiography and Venography except Extremity	S	15.2128	$793.36	$353.85	$158.67
0281	Venography of Extremity	S	5.2227	$272.37	$115.16	$54.47
0282	Miscellaneous Computerized Axial Tomography	S	1.6763	$87.42	$44.51	$17.48
0283	Computerized Axial Tomography with Contrast Material	S	4.5057	$234.98	$126.27	$47.00
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.2382	$377.48	$201.02	$75.50
0285	Myocardial Positron Emission Tomography (PET)	S	18.1294	$945.47	$409.56	$189.09
0286	Myocardial Scans	S	6.5309	$340.59	$187.32	$68.12
0287	Complex Venography	S	6.9863	$364.34	$114.51	$72.87
0288	Bone Density:Axial Skeleton	S	1.2984	$67.71		$13.54
0289	Needle Localization for Breast Biopsy	X	1.8992	$99.05	$44.80	$19.81
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	2.0251	$105.61	$53.17	$21.12
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.9825	$207.69	$104.55	$41.54
0292	Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.2925	$223.86	$112.69	$44.77
0294	Level II Therapeutic Nuclear Medicine	S	4.0794	$212.74	$117.01	$42.55
0296	Level I Therapeutic Radiologic Procedures	S	2.4127	$125.82	$69.20	$25.16
0297	Level II Therapeutic Radiologic Procedures	S	7.6839	$400.72	$172.51	$80.14
0299	Miscellaneous Radiation Treatment	S	5.9785	$311.78		$62.36
0300	Level I Radiation Therapy	S	1.5794	$82.37		$16.47
0301	Level II Radiation Therapy	S	3.1588	$164.73		$32.95
0302	Level III Radiation Therapy	S	9.2343	$481.58	$182.43	$96.32
0303	Treatment Device Construction	X	2.8391	$148.06	$66.95	$29.61
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6182	$84.39	$41.52	$16.88
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6530	$190.51	$91.38	$38.10
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.6625	$712.51	$325.27	$142.50
0312	Radioelement Applications	S	52.8864	$2,758.08		$551.62
0313	Brachytherapy	S	21.0363	$1,097.06		$219.41
0314	Hyperthermic Therapies	S	4.1763	$217.80	$101.77	$43.56
0320	Electroconvulsive Therapy	S	4.2635	$222.35	$80.06	$44.47
0321	Biofeedback and Other Training	S	1.2112	$63.17	$21.78	$12.63
0322	Brief Individual Psychotherapy	S	1.3275	$69.23	$12.40	$13.85
0323	Extended Individual Psychotherapy	S	1.8410	$96.01	$21.26	$19.20
0324	Family Psychotherapy	S	2.4612	$128.35		$25.67
0325	Group Psychotherapy	S	1.4244	$74.28	$18.27	$14.86
0330	Dental Procedures	S	4.7770	$249.13		$49.83
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.4398	$179.39	$91.27	$35.88
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.3681	$279.95	$146.98	$55.99
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.2983	$328.46	$151.46	$65.69

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
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.5987	$344.13	$176.94	$68.83
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	9.2440	$482.08	$240.77	$96.42
0339	Observation	S	7.2188	$376.47		$75.29
0340	Minor Ancillary Procedures	X	0.6492	$33.86		$6.77
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.1453	$7.58	$3.08	$1.52
0342	Level I Pathology	X	0.2132	$11.12	$5.88	$2.22
0343	Level II Pathology	X	0.4457	$23.24	$12.55	$4.65
0344	Level III Pathology	X	0.6201	$32.34	$17.46	$6.47
0345	Level I Transfusion Laboratory Procedures	X	0.1938	$10.11	$3.10	$2.02
0346	Level II Transfusion Laboratory Procedures	X	0.5136	$26.78	$6.75	$5.36
0347	Level III Transfusion Laboratory Procedures	X	1.1240	$58.62	$14.76	$11.72
0348	Fertility Laboratory Procedures	X	0.5523	$28.80		$5.76
0352	Level I Injections	X	0.2229	$11.62		$2.32
0353	Level II Allergy Injections	X	0.3973	$20.72		$4.14
0355	Level III Immunizations	K	0.2132	$11.12		$2.22
0356	Level IV Immunizations	K	0.7655	$39.92		$7.98
0359	Level II Injections	X	1.1337	$59.12		$11.82
0360	Level I Alimentary Tests	X	1.6279	$84.90	$42.45	$16.98
0361	Level II Alimentary Tests	X	3.3914	$176.86	$83.23	$35.37
0362	Level III Otorhinolaryngologic Function Tests	X	2.8391	$148.06		$29.61
0363	Level I Otorhinolaryngologic Function Tests	X	1.0852	$56.59	$20.94	$11.32
0364	Level I Audiometry	X	0.4457	$23.24	$9.06	$4.65
0365	Level II Audiometry	X	1.2112	$63.17	$18.95	$12.63
0367	Level I Pulmonary Test	X	0.5814	$30.32	$15.16	$6.06
0368	Level II Pulmonary Tests	X	1.0562	$55.08	$27.55	$11.02
0369	Level III Pulmonary Tests	X	2.5871	$134.92	$44.18	$26.98
0370	Allergy Tests	X	0.7752	$40.43	$11.58	$8.09
0371	Level I Allergy Injections	X	0.5039	$26.28		$5.26
0372	Therapeutic Phlebotomy	X	0.5329	$27.79	$10.09	$5.56
0373	Neuropsychological Testing	X	2.2577	$117.74		$23.55
0374	Monitoring Psychiatric Drugs	X	1.1434	$59.63	$9.97	$11.93
0600	Low Level Clinic Visits	V	0.8430	$43.96		$8.79
0601	Mid Level Clinic Visits	V	0.9690	$50.53		$10.11
0602	High Level Clinic Visits	V	1.4631	$76.30		$15.26
0610	Low Level Emergency Visits	V	1.4147	$73.78	$19.57	$14.76
0611	Mid Level Emergency Visits	V	2.5290	$131.89	$36.47	$26.38
0612	High Level Emergency Visits	V	4.3410	$226.39	$54.14	$45.28
0620	Critical Care	S	9.9610	$519.48	$150.55	$103.90
0648	Breast Reconstruction with Prosthesis	T	44.7955	$2,336.13		$467.23
0649	Prostate Brachytherapy Palladium Seeds	T	115.0167	$5,998.24		$1,199.65
0650	Intermediate/Complex Proton Beam Radiation Therapy	S	12.0152	$626.60		$125.32
0651	Complex Interstitial Radiation Source Application	S	54.7177	$2,853.58		$570.72
0652	Insertion of Intraperitoneal Catheters	T	28.1292	$1,466.97		$293.39
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.0284	$1,566.01		$313.20
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	91.8583	$4,790.50		$958.10
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	122.8654	$6,407.55		$1,281.51
0656	Transcatheter Placement of Intracoronary of Drug-Eluting Stents	T	96.7516	$5,045.69		$1,009.14
0657	Placement of Tissue Clips	S	1.4438	$75.30		$15.06
0658	Percutaneous Breast Biopsies	T	5.2712	$274.90		$54.98
0659	Hyperbaric Oxygen	S	3.2364	$168.78		$33.76
0660	Level II Otorhinolaryngologic Function Tests	X	1.5891	$82.87	$30.66	$16.57
0661	Level IV Pathology	X	3.5077	$182.93	$100.61	$36.59
0662	CT Angiography	S	5.4553	$284.50	$156.47	$56.90
0664	Proton Beam Radiation Therapy	S	10.0482	$524.02		$104.80
0665	Bone Density:AppendicularSkeleton	S	0.8236	$42.95		$8.59
0666	Myocardial Add-on Scans	S	2.9650	$154.63	$85.05	$30.93
0668	Level I Angiography and Venography except Extremity	S	10.3292	$538.68	$237.76	$107.74
0669	Digital Mammography	S	0.8915	$46.49		$9.30
0670	Intravenous and Intracardiac Ultrasound	S	30.2416	$1,577.13	$571.17	$315.43
0671	Level II Echocardiogram Except Transesophageal	S	2.3643	$123.30	$64.12	$24.66
0672	Level IV Posterior Segment Procedures	T	37.9061	$1,976.84	$988.43	$395.37
0673	Level IV Anterior Segment Eye Procedures	T	25.9490	$1,353.27	$649.56	$270.65
0674	Prostate Cryoablation	T	62.9152	$3,281.09		$656.22
0675	Prostatic Thermotherapy	T	48.5648	$2,532.70		$506.54
0676	Level II Transcatheter Thrombolysis	T	4.1278	$215.27	$58.21	$43.05

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
0677	Level I Transcatheter Thrombolysis	T	2.6453	$137.96		$27.59
0678	External Counterpulsation	T	2.2189	$115.72		$23.14
0679	Level II Resuscitation and Cardioversion	S	5.4069	$281.98	$95.30	$56.40
0680	Insertion of Patient Activated Event Recorders	S	56.1324	$2,927.36		$585.47
0681	Knee Arthroplasty	T	147.8067	$7,708.27	$3,067.55	$1,541.65
0682	Level V Debridement & Destruction	T	7.2770	$379.50	$174.57	$75.90
0683	Level II Photochemotherapy	S	1.8992	$99.05	$35.65	$19.81
0684	Prostate Brachytherapy Iodine Seeds	T	98.8349	$5,154.34		$1,030.87
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.9882	$312.29	$137.40	$62.46
0686	Level III Skin Repair	T	14.2439	$742.83	$341.70	$148.57
0687	Revision/Removal of Neurostimulator Electrodes	T	25.8424	$1,347.71	$619.95	$269.54
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	74.5719	$3,889.00	$1,905.61	$777.80
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5814	$30.32		$6.06
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.4263	$22.23	$10.63	$4.45
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.9166	$152.10	$83.65	$30.42
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	6.2595	$326.44	$179.54	$65.29
0693	Level II Breast Reconstruction	T	37.5863	$1,960.16	$798.17	$392.03
0694	Mohs Surgery	T	3.4689	$180.91	$72.36	$36.18
0695	Level VII Debridement & Destruction	T	18.6817	$974.27	$266.59	$194.85
0697	Level I Echocardiogram Except Transesophageal	S	1.5697	$81.86	$42.57	$16.37
0698	Level II Eye Tests & Treatments	S	0.9205	$48.00	$18.72	$9.60
0699	Level IV Eye Tests & Treatments	T	3.7596	$196.07	$88.23	$39.21
0701	SR 89 chloride, per mCi	K	8.9920	$468.94		$93.79
0702	SM 153 lexidronam, 50 mCi	K	14.6218	$762.54		$152.51
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	New Technology - Level XX ($19500 - $20500)	S		$20,000.00		$4,000.00
0726	Dexrazoxane hcl injection, 250 mg	K	2.2577	$117.74		$23.55
0728	Filgrastim 300 mcg injection	K	2.1027	$109.66		$21.93
0730	Pamidronate disodium , 30 mg	K	3.2654	$170.29		$34.06
0732	Mesna injection 200 mg	K	0.5039	$26.28		$5.26
0733	Non esrd epoetin alpha inj, 1000 u	K	0.1744	$9.10		$1.82
0734	Injection, darbepoetin alfa (for non-ESRD use), pre 1 mcg	K	0.0454	$2.37		$.47
0800	Leuprolide acetate, 3.75 mg	K	3.7984	$198.09		$39.62
0802	Etoposide oral 50 mg	K	0.5523	$28.80		$5.76
0807	Aldesleukin/single use vial	K	7.2867	$380.01		$76.00
0810	Goserelin acetate implant 3.6 mg	K	5.5619	$290.06		$58.01
0811	Carboplatin injection 50 mg	K	1.4922	$77.82		$15.56
0812	Carmustine, 100 mg	K	1.5310	$79.84		$15.97
0813	Cisplatin 10 mg injection	K	0.4263	$22.23		$4.45
0820	Daunorubicin 10 mg	K	1.9379	$101.06		$20.21
0821	Daunorubicin citrate liposom 10 mg	K	2.9069	$151.60		$30.32
0822	Diethylstilbestrol injection 250 mg	K	2.0251	$105.61		$21.12
0823	Docetaxel, 20 mg	K	3.8953	$203.14		$40.63
0827	Floxuridine injection 500 mg	K	2.2189	$115.72		$23.14
0828	Gemcitabine HCL 200 mg	K	1.2984	$67.71		$13.54
0830	Irinotecan injection 20 mg	K	1.7538	$91.46		$18.29
0831	Ifosfomide injection 1 gm	K	1.9186	$100.06		$20.01
0832	Idarubicin hcl injection 5 mg	K	4.8642	$253.67		$50.73
0838	Interferon gamma 1-b inj, 3 million u	K	3.0426	$158.67		$31.73
0840	Melphalan hydrochl 50 mg	K	4.5348	$236.49		$47.30
0842	Fludarabine phosphate inj 50 mg	K	3.2848	$171.31		$34.26
0843	Pegaspargase, singl dose vial	K	8.8079	$459.34		$91.87
0844	Pentostatin injection, 10 mg	K	19.8833	$1,036.93		$207.39

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
0849	Rituximab, 100 mg	K	5.4941	$286.52		$57.30
0852	Topotecan, 4 mg	K	7.7130	$402.24		$80.45
0855	Vinorelbine tartrate, 10 mg	K	1.0756	$56.09		$11.22
0856	Porfimer sodium, 75 mg	K	29.6117	$1,544.28		$308.86
0857	Bleomycin sulfate injection 15 u	K	3.1879	$166.25		$33.25
0858	Cladribine, 1mg	K	0.7946	$41.44		$8.29
0861	Leuprolide acetate injection 1 mg	K	0.7752	$40.43		$8.09
0862	Mitomycin 5 mg inj	K	1.1337	$59.12		$11.82
0863	Paclitaxel injection, 30 mg	K	2.3158	$120.77		$24.15
0864	Mitoxantrone hcl, 5 mg	K	2.9263	$152.61		$30.52
0888	Cyclosporine oral 100 mg	K	0.0484	$2.52		$.50
0890	Lymphocyte immune globulin 250 mg	K	3.3429	$174.34		$34.87
0891	Tacrolimus oral per 1 mg	K	0.0291	$1.52		$.30
0902	Botulinum toxin a, per unit	K	0.0484	$2.52		$.50
0903	Cytomegalovirus imm IV/vial	K	4.7383	$247.11		$49.42
0905	Immune globulin 500 mg	K	0.8333	$43.46		$8.69
0906	RSV-ivig, 50 mg	K	0.5911	$30.83		$6.17
0909	Interferon beta-1a, 33 mcg	K	2.7906	$145.53		$29.11
0910	Interferon beta-1b /0.25 mg	K	1.9864	$103.59		$20.72
0916	Injection imiglucerase /unit	K	0.0484	$2.52		$.50
0917	Inj, Adenosine, 90 mg	K	3.1986	$166.81		$33.36
0925	Factor viii per iu	K	0.0097	$.51		$.10
0926	Factor VIII (porcine) per iu	K	0.0291	$1.52		$.30
0927	Factor viii recombinant per iu	K	0.0194	$1.01		$.20
0928	Factor ix complex per iu	K	0.0097	$.51		$.10
0929	Anti-inhibitor per iu	K	0.0194	$1.01		$.20
0930	Antithrombin iii injection per iu	K	0.0194	$1.01		$.20
0931	Factor IX non-recombinant, per iu	K	0.0097	$.51		$.10
0932	Factor IX recombinant, per iu	K	0.0194	$1.01		$.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.3837	$124.31		$24.86
0950	Blood (Whole) For Transfusion	K	1.6860	$87.93		$17.59
0952	Cryoprecipitate	K	0.5620	$29.31		$5.86
0954	RBC leukocytes reduced	K	2.2868	$119.26		$23.85
0955	Plasma, Fresh Frozen	K	1.8217	$95.00		$19.00
0956	Plasma Protein Fraction	K	1.7829	$92.98		$18.60
0957	Platelet Concentrate	K	0.7946	$41.44		$8.29
0958	Platelet Rich Plasma	K	1.0271	$53.56		$10.71
0959	Red Blood Cells	K	1.6569	$86.41		$17.28
0960	Washed Red Blood Cells	K	3.0813	$160.69		$32.14
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.9980	$52.05		$10.41
0963	Albumin (human), 5%, 250 ml	K	4.9708	$259.23		$51.85
0964	Albumin (human), 25%, 20 ml	K	1.0756	$56.09		$11.22
0965	Albumin (human), 25%, 50ml	K	2.6840	$139.97		$27.99
0966	Plasmaprotein fract,5%,250ml	K	8.9145	$464.90		$92.98
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
0989	New Technology - Level XX ($19500-$20500)	T		$20,000.00		$4,000.00
1009	Cryoprecip reduced plasma	K	0.7170	$37.39		$7.48
1010	Blood, L/R, CMV-neg	K	2.3352	$121.78		$24.36
1011	Platelets, HLA-m, L/R, unit	K	9.5831	$499.77		$99.95
1013	Platelet concentrate, L/R, unit	K	0.9496	$49.52		$9.90
1016	Blood, L/R, froz/deglycerol/washed	K	5.7848	$301.68		$60.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	7.5386	$393.15		$78.63
1018	Blood, L/R, irradiated	K	2.5387	$132.40		$26.48

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1019	Platelets, aph/pher, L/R, irradiated, unit	K	7.7905	$406.28		$81.26
1020	Pit, pher,L/R,CMV,irrad	K	9.4959	$495.22		$99.04
1021	RBC, frz/deg/wsh, L/R, irrad	K	6.4436	$336.04		$67.21
1022	RBC, L/R, CMV neg, irrad	K	3.8565	$201.12		$40.22
1045	Iobenguane sulfate I-31per 0.5 mCi	K	1.5697	$81.86		$16.37
1059	Cultured chondrocytes implnt	K	114.2706	$5,959.33		$1,191.87
1084	Denileukin diftitox, 300 MCG	K	12.1315	$632.67		$126.53
1086	Temozolomide,oral 5 mg	K	0.0581	$3.03		$.61
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.7092	$245.59		$49.12
1092	IN 111 Pentetate, per 0.5 mCi	K	4.4379	$231.44		$46.29
1095	Technetium TC 99M Depreotide	K	5.6006	$292.08		$58.42
1096	TC 99M Exametazime, per dose	K	4.4379	$231.44		$46.29
1122	TC 99M arcitumomab, per vial	K	11.4726	$598.31		$119.66
1167	Epirubicin hcl, 2 mg	K	0.3294	$17.18		$3.44
1178	Busulfan IV, 6 mg	K	0.4845	$25.27		$5.05
1203	Verteporfin for injection	K	16.5209	$861.58		$172.32
1207	Octreotide acetate depot 1mg	K	1.4244	$74.28		$14.86
1305	Apligraf	K	13.0520	$680.67		$136.13
1348	I-131 sol, per 1-6 mCi	K	0.9399	$49.02		$9.80
1409	Factor viia recombinant, per 1.2 mg	K	20.7844	$1,083.93		$216.79
1604	IN 111 capromab pendetide, per dose	K	16.4434	$857.54		$171.51
1605	Abciximab injection, 10 mg	K	5.8526	$305.22		$61.04
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.2229	$11.62		$2.32
1611	Hylan G-F 20 injection, 16 mg	K	2.3643	$123.30		$24.66
1612	Daclizumab, parenteral, 25 mg	K	4.3991	$229.42		$45.88
1613	Trastuzumab, 10 mg	K	0.6298	$32.84		$6.57
1614	Valrubicin, 200 mg	K	3.5658	$185.96		$37.19
1615	Basiliximab, 20 mg	K	13.3621	$696.85		$139.37
1618	Vonwillebrandfactrcmplx, per iu	K	0.0194	$1.01		$.20
1620	Technetium tc99m bicisate	K	3.8759	$202.13		$40.43
1625	Indium 111-in pentetreotide	K	8.2169	$428.52		$85.70
1628	Chromic phosphate p32	K	1.5891	$82.87		$16.57
1716	Brachytx seed, Gold 198	K	0.4360	$22.74		$4.55
1718	Brachytx seed, Iodine 125	K	0.6008	$31.33		$6.27
1719	Brachytxseed, Non-HDR Ir-192	K	0.5232	$27.29		$5.46
1720	Brachytx seed, Palladium 103	K	0.8430	$43.96		$8.79
1765	Adhesion barrier	H				
1775	FDG, per dose (4-40 mCi/ml)	K	7.5289	$392.64		$78.53
1783	Ocular implant, aqueous drain device	H				
1888	Endovascular non-cardiac ablation catheter	H				
1900	Lead coronary venous	H				
2614	Probe, percutaneous lumbar disc	H				
2616	Brachytx seed, Yttrium-90	K	8.8370	$460.86		$92.17
2618	Probe, cryoablation	H				
2632	Brachytx sol, I-125, per mCi	H				
7000	Amifostine, 500 mg	K	4.5057	$234.98		$47.00
7001	Amphotericin B lipid complex, 50 mg	K	2.3449	$122.29		$24.46
7011	Oprelvekin injection, 5 mg	K	2.7325	$142.50		$28.50
7024	Corticorelin ovine triflutat	K	2.2965	$119.76		$23.95
7025	Digoxin immune FAB (ovine)	K	4.9805	$259.74		$51.95
7030	Hemin, per 1 mg	K	0.0097	$.51		$.10
7031	Octreotide acetate injection	K	1.2694	$66.20		$13.24
7034	Somatropin injection	K	0.7170	$37.39		$7.48
7035	Teniposide, 50 mg	K	1.9573	$102.08		$20.42
7038	Muromonab-CD3, 5 mg	K	6.9572	$362.82		$72.56
7041	Tirofiban hydrochloride 12.5 mg	K	4.9417	$257.71		$51.54
7042	Capecitabine, oral, 150 mg	K	0.0291	$1.52		$.30
7043	Infliximab injection 10 mg	K	0.7364	$38.40		$7.68
7045	Trimetrexate glucoronate	K	1.3081	$68.22		$13.64
7046	Doxorubicin hcl liposome inj 10 mg	K	4.3894	$228.91		$45.78
7049	Filgrastim 480 mcg injection	K	3.2267	$168.28		$33.66
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$807.13
9000	Na chromate Cr51, per 0.25mCi	K	1.8798	$98.03		$19.61
9002	Tenecteplase, 50mg/vial	K	27.5963	$1,439.17		$287.83
9003	Palivizumab, per 50mg	K	8.5657	$446.71		$89.34
9005	Reteplase injection	K	12.6547	$659.96		$131.99
9009	Baclofen refill kit - per 2000 mcg	K	0.7267	$37.90		$7.58
9010	Baclofen refill kit - per 4000 mcg	K	0.9205	$48.00		$9.60

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9012	Arsenic Trioxide	G		$31.35		$4.69
9015	Mycophenolate mofetil oral 250 mg	K	0.0291	$1.52		$.30
9016	Echocardiography contrast	G		$118.75		$17.75
9018	Botulinum toxin B, per 100 u	G		$8.79		$1.31
9019	Caspofungin acetate, 5 mg	G		$34.20		$5.11
9020	Sirolimus tablet, 1 mg	K	0.0581	$3.03		$.61
9021	Immune globulin 10 mg	K	0.0097	$.51		$.10
9022	IM inj interferon beta 1-a	K	0.9302	$48.51		$9.70
9023	Rho d immune globulin 50 mcg	K	0.0484	$2.52		$.50
9024	Amphotericin b lipid complex	K	0.4167	$21.73		$4.35
9104	Anti-thymocycte globulin rabbit	K	2.6356	$137.45		$27.49
9105	Hep B imm glob, per 1 ml	K	1.5116	$78.83		$15.77
9108	Thyrotropin alfa, per 1.1 mg	K	7.5870	$395.67		$79.13
9109	Tirofliban hcl, per 6.25 mg	K	2.1996	$114.71		$22.94
9110	Alemtuzumab, per ml	G		$511.22		$76.41
9111	Inj, bivalirudin, per 250 mg vial	G		$397.81		$56.46
9112	Perflutren lipid micro, per 2ml	G		$4.94		$.74
9113	Inj, pantoprazole sodium, vial	G		$22.80		$3.41
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$64.75
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$60.80
9116	Inj, Ertapenem sodium, per 1 gm vial	G		$45.31		$6.77
9119	Inj, Pegfilgrastim, per 6 mg single dose vial	G		$2,802.50		$418.90
9120	Inj, Fulvestrant, per 50 mg	G		$87.58		$13.09
9121	Inj, Argatroban, per 5 mg	G		$14.25		$2.13
9200	Orcel, per 36 cm2	G		$1,135.25		$169.69
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$86.34
9217	Leuprolide acetate suspnsion, 7.5 mg	K	6.5696	$342.61		$68.52
9500	Platelets, irradiated	K	1.4341	$74.79		$14.96
9501	Platelets, pheresis	K	7.8390	$408.81		$81.76
9502	Platelet pheresis irradiated	K	8.5076	$443.68		$88.74
9503	Fresh frozen plasma, ea unit	K	1.3372	$69.74		$13.95
9504	RBC deglycerolized	K	3.5174	$183.44		$36.69
9505	RBC irradiated	K	2.0833	$108.65		$21.73
9506	Granulocytes, pheresis	K	23.9432	$1,248.66		$249.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	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	S		Cervicography	0706		$25.00		$5.00
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	0980		$1,875.00		$375.00
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	26.1234	$1,362.36		$272.47
0013T	T		Osteochondral knee allograft	0041	26.1234	$1,362.36		$272.47
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	26.1234	$1,362.36		$272.47
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	0.5814	$30.32	$15.76	$6.06
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, intrcrn nerve					
00222	N		Anesth, head nerve surgery					
0023T	A		Phenotype drug test, hiv 1					
0024T	C		Transcath cardiac reduction					
0025T	S		Ultrasonic pachymetry	0230	0.7364	$38.40	$14.97	$7.68
0026T	A		Measure remnant lipoproteins					
0027T	T	NI	Endoscopic epidural lysis	0976		$875.00		$175.00
0028T	N	NI	Dexa body composition study					
0029T	N	NI	Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A	NI	Antiprothrombin antibody					
0031T	N	NI	Speculoscopy					
00320	N		Anesth, neck organ surgery					
00322	N		Anesth, biopsy of thyroid					
00326	N	NI	Anesth, larynx/trach, < 1 yr					
0032T	N	NI	Speculoscopy w/direct sample					
0033T	C	NI	Endovasc taa repr incl subcl					
0034T	C	NI	Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C	NI	Insert endovasc prosth, taa					
0036T	C	NI	Endovasc prosth, taa, add-on					
0037T	C	NI	Artery transpose/endovas taa					
0038T	C	NI	Rad endovasc taa rpr w/cover					
0039T	C	NI	Rad s/i, endovasc taa repair					
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					
0040T	C	NI	Rad s/i, endovasc taa prosth					
00410	N		Anesth, correct heart rhythm					
0041T	A	NI	Detect ur infect agnt w/cpas					
0042T	N	NI	Ct perfusion w/contrast, cbf					
0043T	A	NI	Co expired gas analysis					
0044T	N	NI	Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
00470	N		Anesth, removal of rib					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
00539	N	NI	Anesth, trach-bronch reconst					
00540	C		Anesth, chest surgery					
00541	N	NI	Anesth, one lung ventilation					
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					
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 transplnt					
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					
00640	N	NI	Anesth, spine manipulation					
00670	C		Anesth, spine, cord surgery					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
00730	N		Anesth, abdominal wall surg					
00740	N		Anesth, upper gi visualize					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
00770	N		Anesth, blood vessel repair					
00790	N		Anesth, surg upper abdomen					
00792	C		Anesth, hemorr/excise liver					
00794	C		Anesth, pancreas removal					
00796	C		Anesth, for liver transplant					
00797	N		Anesth, surgery for obesity					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
00810	N		Anesth, low intestine scope					
00820	N		Anesth, abdominal wall surg					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N	NI	Anesth, hernia repair< 1 yr					
00836	N	NI	Anesth hernia repair preemie					
00840	N		Anesth, surg lower abdomen					
00842	N		Anesth, amniocentesis					
00844	C		Anesth, pelvis surgery					
00846	C		Anesth, hysterectomy					
00848	C		Anesth, pelvic organ surg					
00851	N		Anesth, tubal ligation					
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
00869	N	DG	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					
00902	N		Anesth, anorectal surgery					
00904	C		Anesth, perineal surgery					
00906	N		Anesth, removal of vulva					
00908	C		Anesth, removal of prostate					
00910	N		Anesth, bladder surgery					
00912	N		Anesth, bladder tumor surg					
00914	N		Anesth, removal of prostate					
00916	N		Anesth, bleeding control					
00918	N		Anesth, stone removal					
00920	N		Anesth, genitalia surgery					
00921	N	NI	Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	C		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					
00950	N		Anesth, vaginal endoscopy					
00952	N		Anesth, hysteroscope/graph					
01112	N		Anesth, bone aspirate/bx					
01120	N		Anesth, pelvis surgery					
01130	N		Anesth, body cast procedure					
01140	C		Anesth, amputation at pelvis					
01150	C		Anesth, pelvic tumor surgery					
01160	N		Anesth, pelvis procedure					
01170	N		Anesth, pelvis surgery					
01180	N		Anesth, pelvis nerve removal					
01190	C		Anesth, pelvis nerve removal					
01200	N		Anesth, hip joint procedure					
01202	N		Anesth, arthroscopy of hip					
01210	N		Anesth, hip joint surgery					
01212	C		Anesth, hip disarticulation					
01214	C		Anesth, hip arthroplasty					
01215	N		Anesth, revise hip repair					
01220	N		Anesth, procedure on femur					
01230	N		Anesth, surgery of femur					
01232	C		Anesth, amputation of femur					
01234	C		Anesth, radical femur surg					
01250	N		Anesth, upper leg surgery					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
01404	C		Anesth, amputation at knee					
01420	N		Anesth, knee joint casting					
01430	N		Anesth, knee veins surgery					
01432	N		Anesth, knee vessel surg					
01440	N		Anesth, knee arteries surg					
01442	C		Anesth, knee artery surg					
01444	C		Anesth, knee artery repair					
01462	N		Anesth, lower leg procedure					
01464	N		Anesth, ankle 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					
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					
01829	N	NI	Anesth, dx wrist arthroscopy					
01830	N		Anesth, lower arm surgery					
01832	N		Anesth, wrist replacement					
01840	N		Anesth, lwr arm artery surg					
01842	N		Anesth, lwr arm embolectomy					
01844	N		Anesth, vascular shunt surg					
01850	N		Anesth, lower arm vein surg					
01852	N		Anesth, lwr arm vein repair					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
01922	N		Anesth, cat or MRI scan					
01924	N		Anes, ther interven rad, art					
01925	N		Anes, ther interven rad, car					
01926	N		Anes, tx interv rad hrt/cran					
01930	N		Anes, ther interven rad, vei					
01931	N		Anes, ther interven rad, tip					
01932	N		Anes, tx interv rad, th vein					
01933	N		Anes, tx interv rad, cran v					
01951	N		Anesth, burn, less 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01960	N		Anesth, vaginal delivery					
01961	N		Anesth, cs delivery					
01962	N		Anesth, emer hysterectomy					
01963	N		Anesth, cs hysterectomy					
01964	N		Anesth, abortion procedures					
01967	N		Anesth/analg, vag delivery					
01968	N		Anes/analg cs deliver add-on					
01969	N		Anesth/analg cs hyst add-on					
01990	C		Support for organ donor					
01991	N	NI	Anesth, nerve block/inj					
01992	N	NI	Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Manage daily drug therapy					
01999	N		Unlisted anesth procedure					
10021	T		Fna w/o image	0002	0.5911	$30.83		$6.17
10022	T		Fna w/image	0002	0.5911	$30.83		$6.17
10040	T		Acne surgery	0010	0.6589	$34.36	$10.08	$6.87
10060	T		Drainage of skin abscess	0006	1.7926	$93.49	$24.12	$18.70
10061	T		Drainage of skin abscess	0006	1.7926	$93.49	$24.12	$18.70
10080	T		Drainage of pilonidal cyst	0006	1.7926	$93.49	$24.12	$18.70
10081	T		Drainage of pilonidal cyst	0007	10.0191	$522.51	$108.89	$104.50
10120	T		Remove foreign body	0006	1.7926	$93.49	$24.12	$18.70
10121	T		Remove foreign body	0021	13.9338	$726.66	$219.48	$145.33
10140	T		Drainage of hematoma/fluid	0007	10.0191	$522.51	$108.89	$104.50
10160	T		Puncture drainage of lesion	0018	0.9399	$49.02	$16.04	$9.80
10180	T		Complex drainage, wound	0007	10.0191	$522.51	$108.89	$104.50
11000	T		Debride infected skin	0015	1.5407	$80.35	$20.35	$16.07
11001	T		Debride infected skin add-on	0013	1.0756	$56.09	$14.20	$11.22
11010	T		Debride skin, fx	0022	17.3930	$907.06	$354.45	$181.41
11011	T		Debride skin/muscle, fx	0022	17.3930	$907.06	$354.45	$181.41
11012	T		Debride skin/muscle/bone, fx	0022	17.3930	$907.06	$354.45	$181.41
11040	T		Debride skin, partial	0015	1.5407	$80.35	$20.35	$16.07
11041	T		Debride skin, full	0015	1.5407	$80.35	$20.35	$16.07
11042	T		Debride skin/tissue	0016	2.6162	$136.44	$57.31	$27.29
11043	T		Debride tissue/muscle	0016	2.6162	$136.44	$57.31	$27.29
11044	T		Debride tissue/muscle/bone	0682	7.2770	$379.50	$174.57	$75.90
11055	T		Trim skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11056	T		Trim skin lesions, 2 to 4	0012	0.7849	$40.93	$11.18	$8.19
11057	T		Trim skin lesions, over 4	0012	0.7849	$40.93	$11.18	$8.19
11100	T		Biopsy of skin lesion	0018	0.9399	$49.02	$16.04	$9.80
11101	T		Biopsy, skin add-on	0018	0.9399	$49.02	$16.04	$9.80
11200	T		Removal of skin tags	0013	1.0756	$56.09	$14.20	$11.22
11201	T		Remove skin tags add-on	0015	1.5407	$80.35	$20.35	$16.07
11300	T		Shave skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11301	T		Shave skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11302	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11303	T		Shave skin lesion	0015	1.5407	$80.35	$20.35	$16.07
11305	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11306	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11307	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11308	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11310	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11311	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11312	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11313	T		Shave skin lesion	0016	2.6162	$136.44	$57.31	$27.29
11400	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11401	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11402	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11403	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11404	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11406	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11420	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11421	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11422	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11423	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11424	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11426	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11440	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11441	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11442	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11443	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11444	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11446	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11450	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11451	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11462	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11463	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11470	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11471	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11600	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11601	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11602	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11603	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11604	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11606	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11620	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11621	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11622	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11623	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11624	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11626	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11640	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11641	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11642	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11643	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11644	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11646	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11719	T		Trim nail(s)	0009	0.6298	$32.84	$8.34	$6.57
11720	T		Debride nail, 1-5	0009	0.6298	$32.84	$8.34	$6.57
11721	T		Debride nail, 6 or more	0009	0.6298	$32.84	$8.34	$6.57
11730	T		Removal of nail plate	0013	1.0756	$56.09	$14.20	$11.22
11732	T		Remove nail plate, add-on	0012	0.7849	$40.93	$11.18	$8.19
11740	T		Drain blood from under nail	0009	0.6298	$32.84	$8.34	$6.57
11750	T		Removal of nail bed	0019	3.7693	$196.57	$71.87	$39.31
11752	T		Remove nail bed/finger tip	0022	17.3930	$907.06	$354.45	$181.41
11755	T		Biopsy, nail unit	0019	3.7693	$196.57	$71.87	$39.31
11760	T		Repair of nail bed	0024	1.8507	$96.52	$34.75	$19.30
11762	T		Reconstruction of nail bed	0024	1.8507	$96.52	$34.75	$19.30
11765	T		Excision of nail fold, toe	0015	1.5407	$80.35	$20.35	$16.07
11770	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11771	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11772	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11900	T		Injection into skin lesions	0012	0.7849	$40.93	$11.18	$8.19
11901	T		Added skin lesions injection	0012	0.7849	$40.93	$11.18	$8.19
11920	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11921	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30
11922	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30
11950	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11951	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11952	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11954	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11960	T		Insert tissue expander(s)	0027	15.2225	$793.87	$329.72	$158.77
11970	T		Replace tissue expander	0027	15.2225	$793.87	$329.72	$158.77
11971	T		Remove tissue expander(s)	0022	17.3930	$907.06	$354.45	$181.41
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	3.7693	$196.57	$71.87	$39.31
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6492	$33.86		$6.77
11981	X		Insert drug implant device	0340	0.6492	$33.86		$6.77
11982	X		Remove drug implant device	0340	0.6492	$33.86		$6.77
11983	X		Remove/insert drug implant	0340	0.6492	$33.86		$6.77
12001	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12002	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12004	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12005	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12006	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12007	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12011	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12013	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12014	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12015	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12016	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12017	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12018	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12020	T		Closure of split wound	0024	1.8507	$96.52	$34.75	$19.30
12021	T		Closure of split wound	0024	1.8507	$96.52	$34.75	$19.30
12031	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12032	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12034	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12035	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12036	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12037	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
12041	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12042	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12044	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12045	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12046	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12047	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
12051	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12052	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12053	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12054	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12055	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12056	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12057	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
13100	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13101	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13102	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13120	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13121	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13122	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13131	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13132	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13133	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13150	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13151	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13152	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13153	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13160	T		Late closure of wound	0027	15.2225	$793.87	$329.72	$158.77
14000	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
14001	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14020	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14021	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14040	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14041	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14060	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14061	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14300	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14350	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
15000	T		Skin graft	0025	5.8623	$305.72	$115.49	$61.14
15001	T		Skin graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15050	T		Skin pinch graft	0025	5.8623	$305.72	$115.49	$61.14
15100	T		Skin split graft	0027	15.2225	$793.87	$329.72	$158.77
15101	T		Skin split graft add-on	0027	15.2225	$793.87	$329.72	$158.77
15120	T		Skin split graft	0027	15.2225	$793.87	$329.72	$158.77
15121	T		Skin split graft add-on	0027	15.2225	$793.87	$329.72	$158.77
15200	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15201	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15220	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15221	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15240	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15241	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15260	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15261	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15342	T		Cultured skin graft, 25 cm	0025	5.8623	$305.72	$115.49	$61.14
15343	T		Culture skn graft addl 25 cm	0024	1.8507	$96.52	$34.75	$19.30
15350	T		Skin homograft	0686	14.2439	$742.83	$341.70	$148.57
15351	T		Skin homograft add-on	0027	15.2225	$793.87	$329.72	$158.77
15400	T		Skin heterograft	0025	5.8623	$305.72	$115.49	$61.14
15401	T		Skin heterograft add-on	0025	5.8623	$305.72	$115.49	$61.14
15570	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15572	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15574	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15576	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15600	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15610	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15620	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15630	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15650	T		Transfer skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15732	T		Muscle-skin graft, head/neck	0027	15.2225	$793.87	$329.72	$158.77
15734	T		Muscle-skin graft, trunk	0027	15.2225	$793.87	$329.72	$158.77
15736	T		Muscle-skin graft, arm	0027	15.2225	$793.87	$329.72	$158.77
15738	T		Muscle-skin graft, leg	0027	15.2225	$793.87	$329.72	$158.77
15740	T		Island pedicle flap graft	0027	15.2225	$793.87	$329.72	$158.77
15750	T		Neurovascular pedicle graft	0027	15.2225	$793.87	$329.72	$158.77
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	15.2225	$793.87	$329.72	$158.77
15770	T		Derma-fat-fascia graft	0027	15.2225	$793.87	$329.72	$158.77
15775	T		Hair transplant punch grafts	0025	5.8623	$305.72	$115.49	$61.14
15776	T		Hair transplant punch grafts	0025	5.8623	$305.72	$115.49	$61.14
15780	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15781	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15782	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15783	T		Abrasion treatment of skin	0016	2.6162	$136.44	$57.31	$27.29
15786	T		Abrasion, lesion, single	0013	1.0756	$56.09	$14.20	$11.22
15787	T		Abrasion, lesions, add-on	0013	1.0756	$56.09	$14.20	$11.22
15788	T		Chemical peel, face, epiderm	0012	0.7849	$40.93	$11.18	$8.19
15789	T		Chemical peel, face, dermal	0015	1.5407	$80.35	$20.35	$16.07
15792	T		Chemical peel, nonfacial	0012	0.7849	$40.93	$11.18	$8.19
15793	T		Chemical peel, nonfacial	0013	1.0756	$56.09	$14.20	$11.22
15810	T		Salabrasion	0016	2.6162	$136.44	$57.31	$27.29
15811	T		Salabrasion	0016	2.6162	$136.44	$57.31	$27.29
15819	T		Plastic surgery, neck	0025	5.8623	$305.72	$115.49	$61.14

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15820	T		Revision of lower eyelid	0027	15.2225	$793.87	$329.72	$158.77
15821	T		Revision of lower eyelid	0027	15.2225	$793.87	$329.72	$158.77
15822	T		Revision of upper eyelid	0027	15.2225	$793.87	$329.72	$158.77
15823	T		Revision of upper eyelid	0027	15.2225	$793.87	$329.72	$158.77
15824	T		Removal of forehead wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15825	T		Removal of neck wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15826	T		Removal of brow wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15828	T		Removal of face wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15829	T		Removal of skin wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15831	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15832	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15833	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15834	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15835	T		Excise excessive skin tissue	0025	5.8623	$305.72	$115.49	$61.14
15836	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15837	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15838	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15839	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15840	T		Graft for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15841	T		Graft for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15842	T		Flap for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15845	T		Skin and muscle repair, face	0027	15.2225	$793.87	$329.72	$158.77
15850	T		Removal of sutures	0016	2.6162	$136.44	$57.31	$27.29
15851	T		Removal of sutures	0013	1.0756	$56.09	$14.20	$11.22
15852	X		Dressing change,not for burn	0340	0.6492	$33.86		$6.77
15860	S		Test for blood flow in graft	0706		$25.00		$5.00
15876	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15877	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15878	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15879	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15920	T		Removal of tail bone ulcer	0022	17.3930	$907.06	$354.45	$181.41
15922	T		Removal of tail bone ulcer	0027	15.2225	$793.87	$329.72	$158.77
15931	T		Remove sacrum pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15933	T		Remove sacrum pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15934	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15935	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15936	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15937	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15940	T		Remove hip pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15941	T		Remove hip pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15944	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15945	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15946	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15950	T		Remove thigh pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15951	T		Remove thigh pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15952	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15953	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15956	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15958	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15999	T		Removal of pressure sore	0022	17.3930	$907.06	$354.45	$181.41
16000	T		Initial treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16010	T		Treatment of burn(s)	0016	2.6162	$136.44	$57.31	$27.29
16015	T		Treatment of burn(s)	0017	15.8233	$825.20	$227.84	$165.04
16020	T		Treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16025	T		Treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16030	T		Treatment of burn(s)	0015	1.5407	$80.35	$20.35	$16.07
16035	C		Incision of burn scab, initi					
16036	C		Incise burn scab, addl incis					
17000	T		Destroy benign/premlg lesion	0010	0.6589	$34.36	$10.08	$6.87
17003	T		Destroy lesions, 2-14	0010	0.6589	$34.36	$10.08	$6.87
17004	T		Destroy lesions, 15 or more	0011	1.8507	$96.52	$27.88	$19.30
17106	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17107	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17108	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17110	T		Destruct lesion, 1-14	0010	0.6589	$34.36	$10.08	$6.87

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17111	T		Destruct lesion, 15 or more	0011	1.8507	$96.52	$27.88	$19.30
17250	T		Chemical cautery, tissue	0013	1.0756	$56.09	$14.20	$11.22
17260	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17261	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17262	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17263	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17264	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17266	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17270	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17271	T		Destruction of skin lesions	0013	1.0756	$56.09	$14.20	$11.22
17272	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17273	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17274	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17276	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17280	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17281	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17282	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17283	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17284	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17286	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17304	T		Chemosurgery of skin lesion	0694	3.4689	$180.91	$72.36	$36.18
17305	T		2 stage mohs, up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17306	T		3 stage mohs, up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17307	T		Mohs addl stage up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17310	T		Extensive skin chemosurgery	0694	3.4689	$180.91	$72.36	$36.18
17340	T		Cryotherapy of skin	0012	0.7849	$40.93	$11.18	$8.19
17360	T		Skin peel therapy	0012	0.7849	$40.93	$11.18	$8.19
17380	T		Hair removal by electrolysis	0012	0.7849	$40.93	$11.18	$8.19
17999	T		Skin tissue procedure	0006	1.7926	$93.49	$24.12	$18.70
19000	T		Drainage of breast lesion	0004	1.7441	$90.96	$23.47	$18.19
19001	T		Drain breast lesion add-on	0004	1.7441	$90.96	$23.47	$18.19
19020	T		Incision of breast lesion	0008	16.1430	$841.87		$168.37
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.1201	$162.72	$71.59	$32.54
19101	T		Biopsy of breast, open	0028	16.8698	$879.78	$303.74	$175.96
19102	T		Bx breast percut w/image	0005	3.1201	$162.72	$71.59	$32.54
19103	T		Bx breast percut w/device	0658	5.2712	$274.90		$54.98
19110	T		Nipple exploration	0028	16.8698	$879.78	$303.74	$175.96
19112	T		Excise breast duct fistula	0028	16.8698	$879.78	$303.74	$175.96
19120	T		Removal of breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19125	T		Excision, breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19126	T		Excision, addl breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19140	T		Removal of breast tissue	0028	16.8698	$879.78	$303.74	$175.96
19160	T		Removal of breast tissue	0028	16.8698	$879.78	$303.74	$175.96
19162	T		Remove breast tissue, nodes	0693	37.5863	$1,960.16	$798.17	$392.03
19180	T		Removal of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19182	T		Removal of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19200	C		Removal of breast					
19220	C		Removal of breast					
19240	T		Removal of breast	0030	37.5185	$1,956.63	$763.55	$391.33
19260	T		Removal of chest wall lesion	0021	13.9338	$726.66	$219.48	$145.33
19271	C		Revision of chest wall					
19272	C		Extensive chest wall surgery					
19290	N		Place needle wire, breast					
19291	N		Place needle wire, breast					
19295	S		Place breast clip, percut	0657	1.4438	$75.30		$15.06
19316	T		Suspension of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19318	T		Reduction of large breast	0693	37.5863	$1,960.16	$798.17	$392.03
19324	T		Enlarge breast	0693	37.5863	$1,960.16	$798.17	$392.03
19325	T		Enlarge breast with implant	0648	44.7955	$2,336.13		$467.23
19328	T		Removal of breast implant	0029	28.7881	$1,501.33	$632.64	$300.27
19330	T		Removal of implant material	0029	28.7881	$1,501.33	$632.64	$300.27
19340	T		Immediate breast prosthesis	0030	37.5185	$1,956.63	$763.55	$391.33
19342	T		Delayed breast prosthesis	0648	44.7955	$2,336.13		$467.23
19350	T		Breast reconstruction	0029	28.7881	$1,501.33	$632.64	$300.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19355	T		Correct inverted nipple(s)	0029	28.7881	$1,501.33	$632.64	$300.27
19357	T		Breast reconstruction	0648	44.7955	$2,336.13		$467.23
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	28.7881	$1,501.33	$632.64	$300.27
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	28.7881	$1,501.33	$632.64	$300.27
19371	T		Removal of breast capsule	0029	28.7881	$1,501.33	$632.64	$300.27
19380	T		Revise breast reconstruction	0030	37.5185	$1,956.63	$763.55	$391.33
19396	T		Design custom breast implant	0029	28.7881	$1,501.33	$632.64	$300.27
19499	T		Breast surgery procedure	0028	16.8698	$879.78	$303.74	$175.96
20000	T		Incision of abscess	0006	1.7926	$93.49	$24.12	$18.70
20005	T		Incision of deep abscess	0049	18.6042	$970.23	$197.14	$194.05
20100	T		Explore wound, neck	0023	2.5193	$131.38	$40.37	$26.28
20101	T		Explore wound, chest	0027	15.2225	$793.87	$329.72	$158.77
20102	T		Explore wound, abdomen	0027	15.2225	$793.87	$329.72	$158.77
20103	T		Explore wound, extremity	0023	2.5193	$131.38	$40.37	$26.28
20150	T		Excise epiphyseal bar	0051	32.9062	$1,716.09		$343.22
20200	T		Muscle biopsy	0021	13.9338	$726.66	$219.48	$145.33
20205	T		Deep muscle biopsy	0021	13.9338	$726.66	$219.48	$145.33
20206	T		Needle biopsy, muscle	0005	3.1201	$162.72	$71.59	$32.54
20220	T		Bone biopsy, trocar/needle	0019	3.7693	$196.57	$71.87	$39.31
20225	T		Bone biopsy, trocar/needle	0019	3.7693	$196.57	$71.87	$39.31
20240	T		Bone biopsy, excisional	0022	17.3930	$907.06	$354.45	$181.41
20245	T		Bone biopsy, excisional	0022	17.3930	$907.06	$354.45	$181.41
20250	T		Open bone biopsy	0049	18.6042	$970.23	$197.14	$194.05
20251	T		Open bone biopsy	0049	18.6042	$970.23	$197.14	$194.05
20500	T		Injection of sinus tract	0251	1.9089	$99.55		$19.91
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	3.7693	$196.57	$71.87	$39.31
20525	T		Removal of foreign body	0022	17.3930	$907.06	$354.45	$181.41
20526	T		Ther injection, carp tunnel	0204	2.0251	$105.61	$40.13	$21.12
20550	T		Inject tendon/ligament/cyst	0204	2.0251	$105.61	$40.13	$21.12
20551	T		Inject tendon origin/insert	0204	2.0251	$105.61	$40.13	$21.12
20552	T		Inject trigger point, 1 or 2	0204	2.0251	$105.61	$40.13	$21.12
20553	T		Inject trigger points, > 3	0204	2.0251	$105.61	$40.13	$21.12
20600	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20605	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20610	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20612	T	NI	Aspirate/inj ganglion cyst	0204	2.0251	$105.61	$40.13	$21.12
20615	T		Treatment of bone cyst	0004	1.7441	$90.96	$23.47	$18.19
20650	T		Insert and remove bone pin	0049	18.6042	$970.23	$197.14	$194.05
20660	C		Apply, rem fixation device					
20661	C		Application of head brace					
20662	C		Application of pelvis brace					
20663	C		Application of thigh brace					
20664	C		Halo brace application					
20665	X		Removal of fixation device	0340	0.6492	$33.86		$6.77
20670	T		Removal of support implant	0021	13.9338	$726.66	$219.48	$145.33
20680	T		Removal of support implant	0022	17.3930	$907.06	$354.45	$181.41
20690	T		Apply bone fixation device	0050	23.3037	$1,215.31		$243.06
20692	T		Apply bone fixation device	0050	23.3037	$1,215.31		$243.06
20693	T		Adjust bone fixation device	0049	18.6042	$970.23	$197.14	$194.05
20694	T		Remove bone fixation device	0049	18.6042	$970.23	$197.14	$194.05
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	23.3037	$1,215.31		$243.06

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20902	T		Removal of bone for graft	0050	23.3037	$1,215.31		$243.06
20910	T		Remove cartilage for graft	0027	15.2225	$793.87	$329.72	$158.77
20912	T		Remove cartilage for graft	0027	15.2225	$793.87	$329.72	$158.77
20920	T		Removal of fascia for graft	0027	15.2225	$793.87	$329.72	$158.77
20922	T		Removal of fascia for graft	0027	15.2225	$793.87	$329.72	$158.77
20924	T		Removal of tendon for graft	0050	23.3037	$1,215.31		$243.06
20926	T		Removal of tissue for graft	0027	15.2225	$793.87	$329.72	$158.77
20930	C		Spinal bone allograft					
20931	C		Spinal bone allograft					
20936	C		Spinal bone autograft					
20937	C		Spinal bone autograft					
20938	C		Spinal bone autograft					
20950	T		Fluid pressure, muscle	0006	1.7926	$93.49	$24.12	$18.70
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	18.6042	$970.23	$197.14	$194.05
20979	A		Us bone stimulation					
20999	T		Musculoskeletal surgery	0049	18.6042	$970.23	$197.14	$194.05
21010	T		Incision of jaw joint	0254	20.1158	$1,049.06	$321.35	$209.81
21015	T		Resection of facial tumor	0253	14.4473	$753.44	$282.29	$150.69
21025	T		Excision of bone, lower jaw	0256	34.0302	$1,774.71		$354.94
21026	T		Excision of facial bone(s)	0256	34.0302	$1,774.71		$354.94
21029	T		Contour of face bone lesion	0256	34.0302	$1,774.71		$354.94
21030	T		Removal of face bone lesion	0254	20.1158	$1,049.06	$321.35	$209.81
21031	T		Remove exostosis, mandible	0254	20.1158	$1,049.06	$321.35	$209.81
21032	T		Remove exostosis, maxilla	0254	20.1158	$1,049.06	$321.35	$209.81
21034	T		Removal of face bone lesion	0256	34.0302	$1,774.71		$354.94
21040	T		Removal of jaw bone lesion	0254	20.1158	$1,049.06	$321.35	$209.81
21041	T	DG	Removal of jaw bone lesion	0256	34.0302	$1,774.71		$354.94
21044	T		Removal of jaw bone lesion	0256	34.0302	$1,774.71		$354.94
21045	C		Extensive jaw surgery					
21046	T	NI	Remove mandible cyst complex	0256	34.0302	$1,774.71		$354.94
21047	T	NI	Excise lwr jaw cyst w/repair	0256	34.0302	$1,774.71		$354.94
21048	T	NI	Remove maxilla cyst complex	0256	34.0302	$1,774.71		$354.94
21049	T	NI	Excis uppr jaw cyst w/repair	0256	34.0302	$1,774.71		$354.94
21050	T		Removal of jaw joint	0256	34.0302	$1,774.71		$354.94
21060	T		Remove jaw joint cartilage	0256	34.0302	$1,774.71		$354.94
21070	T		Remove coronoid process	0256	34.0302	$1,774.71		$354.94
21076	T		Prepare face/oral prosthesis	0254	20.1158	$1,049.06	$321.35	$209.81
21077	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21079	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21080	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21081	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21082	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21083	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21084	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21085	T		Prepare face/oral prosthesis	0253	14.4473	$753.44	$282.29	$150.69
21086	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21087	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21088	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21089	T		Prepare face/oral prosthesis	0253	14.4473	$753.44	$282.29	$150.69
21100	T		Maxillofacial fixation	0256	34.0302	$1,774.71		$354.94
21110	T		Interdental fixation	0252	5.8041	$302.69	$113.41	$60.54
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21121	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21122	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21123	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21125	T		Augmentation, lower jaw bone	0254	20.1158	$1,049.06	$321.35	$209.81
21127	T		Augmentation, lower jaw bone	0256	34.0302	$1,774.71		$354.94
21137	T		Reduction of forehead	0254	20.1158	$1,049.06	$321.35	$209.81
21138	T		Reduction of forehead	0256	34.0302	$1,774.71		$354.94
21139	T		Reduction of forehead	0256	34.0302	$1,774.71		$354.94
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	20.1158	$1,049.06	$321.35	$209.81
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	34.0302	$1,774.71		$354.94
21199	T		Reconstr lwr jaw w/advance	0256	34.0302	$1,774.71		$354.94
21206	T		Reconstruct upper jaw bone	0256	34.0302	$1,774.71		$354.94
21208	T		Augmentation of facial bones	0256	34.0302	$1,774.71		$354.94
21209	T		Reduction of facial bones	0256	34.0302	$1,774.71		$354.94
21210	T		Face bone graft	0256	34.0302	$1,774.71		$354.94
21215	T		Lower jaw bone graft	0256	34.0302	$1,774.71		$354.94
21230	T		Rib cartilage graft	0256	34.0302	$1,774.71		$354.94
21235	T		Ear cartilage graft	0254	20.1158	$1,049.06	$321.35	$209.81
21240	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21242	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21243	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21244	T		Reconstruction of lower jaw	0256	34.0302	$1,774.71		$354.94
21245	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21246	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21249	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21261	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21263	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21267	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	34.0302	$1,774.71		$354.94
21275	T		Revision, orbitofacial bones	0256	34.0302	$1,774.71		$354.94
21280	T		Revision of eyelid	0256	34.0302	$1,774.71		$354.94
21282	T		Revision of eyelid	0253	14.4473	$753.44	$282.29	$150.69
21295	T		Revision of jaw muscle/bone	0252	5.8041	$302.69	$113.41	$60.54
21296	T		Revision of jaw muscle/bone	0254	20.1158	$1,049.06	$321.35	$209.81
21299	T		Cranio/maxillofacial surgery	0253	14.4473	$753.44	$282.29	$150.69
21300	T		Treatment of skull fracture	0253	14.4473	$753.44	$282.29	$150.69
21310	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77
21315	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21320	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77
21325	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21330	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21335	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21336	T		Treat nasal septal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
21337	T		Treat nasal septal fracture	0253	14.4473	$753.44	$282.29	$150.69
21338	T		Treat nasoethmoid fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21339	T		Treat nasoethmoid fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21340	T		Treatment of nose fracture	0256	34.0302	$1,774.71		$354.94
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	20.1158	$1,049.06	$321.35	$209.81
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	34.0302	$1,774.71		$354.94
21356	C		Treat cheek bone fracture					
21360	C		Treat cheek bone fracture					
21365	C		Treat cheek bone fracture					
21366	C		Treat cheek bone fracture					
21385	C		Treat eye socket fracture					
21386	C		Treat eye socket fracture					
21387	C		Treat eye socket fracture					
21390	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	5.8041	$302.69	$113.41	$60.54
21401	T		Treat eye socket fracture	0253	14.4473	$753.44	$282.29	$150.69
21406	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21407	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	20.1158	$1,049.06	$321.35	$209.81
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	20.1158	$1,049.06	$321.35	$209.81
21445	T		Treat dental ridge fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21450	T		Treat lower jaw fracture	0251	1.9089	$99.55		$19.91
21451	T		Treat lower jaw fracture	0252	5.8041	$302.69	$113.41	$60.54
21452	T		Treat lower jaw fracture	0253	14.4473	$753.44	$282.29	$150.69
21453	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21454	T		Treat lower jaw fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21461	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21462	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21465	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21470	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21480	T		Reset dislocated jaw	0251	1.9089	$99.55		$19.91
21485	T		Reset dislocated jaw	0253	14.4473	$753.44	$282.29	$150.69
21490	T		Repair dislocated jaw	0256	34.0302	$1,774.71		$354.94
21493	T		Treat hyoid bone fracture	0252	5.8041	$302.69	$113.41	$60.54
21494	T		Treat hyoid bone fracture	0252	5.8041	$302.69	$113.41	$60.54
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	14.4473	$753.44	$282.29	$150.69
21499	T		Head surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
21501	T		Drain neck/chest lesion	0008	16.1430	$841.87		$168.37
21502	T		Drain chest lesion	0049	18.6042	$970.23	$197.14	$194.05
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	13.9338	$726.66	$219.48	$145.33
21555	T		Remove lesion, neck/chest	0022	17.3930	$907.06	$354.45	$181.41
21556	T		Remove lesion, neck/chest	0022	17.3930	$907.06	$354.45	$181.41
21557	C		Remove tumor, neck/chest					
21600	T		Partial removal of rib	0050	23.3037	$1,215.31		$243.06

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21610	T		Partial removal of rib	0050	23.3037	$1,215.31		$243.06
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	0049	18.6042	$970.23	$197.14	$194.05
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	18.6042	$970.23	$197.14	$194.05
21725	T		Revision of neck muscle	0006	1.7926	$93.49	$24.12	$18.70
21740	C		Reconstruction of sternum					
21742	T	NI	Repair stern/nuss w/o scope	0051	32.9062	$1,716.09		$343.22
21743	T	NI	Repair sternum/nuss w/scope	0051	32.9062	$1,716.09		$343.22
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	2.4999	$130.37		$26.07
21805	T		Treatment of rib fracture	0046	29.2920	$1,527.61	$535.76	$305.52
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	2.4999	$130.37		$26.07
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
21920	T		Biopsy soft tissue of back	0020	7.1898	$374.96	$113.25	$74.99
21925	T		Biopsy soft tissue of back	0022	17.3930	$907.06	$354.45	$181.41
21930	T		Remove lesion, back or flank	0022	17.3930	$907.06	$354.45	$181.41
21935	T		Remove tumor, back	0022	17.3930	$907.06	$354.45	$181.41
22100	T		Remove part of neck vertebra	0208	38.4487	$2,005.14		$401.03
22101	T		Remove part, thorax vertebra	0208	38.4487	$2,005.14		$401.03
22102	T		Remove part, lumbar vertebra	0208	38.4487	$2,005.14		$401.03
22103	T		Remove extra spine segment	0208	38.4487	$2,005.14		$401.03
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	2.4999	$130.37		$26.07
22310	T		Treat spine fracture	0043	2.4999	$130.37		$26.07
22315	T		Treat spine fracture	0043	2.4999	$130.37		$26.07
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	12.9357	$674.61	$268.47	$134.92
22520	T		Percut vertebroplasty thor	0050	23.3037	$1,215.31		$243.06
22521	T		Percut vertebroplasty lumb	0050	23.3037	$1,215.31		$243.06
22522	T		Percut vertebroplasty addl	0050	23.3037	$1,215.31		$243.06
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	38.4487	$2,005.14		$401.03
22614	T		Spine fusion, extra segment	0208	38.4487	$2,005.14		$401.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22630	C		Lumbar spine fusion					
22632	C		Spine fusion, extra segment					
22800	C		Fusion of spine					
22802	C		Fusion of spine					
22804	C		Fusion of spine					
22808	C		Fusion of spine					
22810	C		Fusion of spine					
22812	C		Fusion of spine					
22818	C		Kyphectomy, 1-2 segments					
22819	C		Kyphectomy, 3 or more					
22830	C		Exploration of spinal fusion					
22840	C		Insert spine fixation device					
22841	C		Insert spine fixation device					
22842	C		Insert spine fixation device					
22843	C		Insert spine fixation device					
22844	C		Insert spine fixation device					
22845	C		Insert spine fixation device					
22846	C		Insert spine fixation device					
22847	C		Insert spine fixation device					
22848	C		Insert pelv fixation device					
22849	C		Reinsert spinal fixation					
22850	C		Remove spine fixation device					
22851	C		Apply spine prosth device					
22852	C		Remove spine fixation device					
22855	C		Remove spine fixation device					
22899	T		Spine surgery procedure	0043	2.4999	$130.37		$26.07
22900	T		Remove abdominal wall lesion	0022	17.3930	$907.06	$354.45	$181.41
22999	T		Abdomen surgery procedure	0022	17.3930	$907.06	$354.45	$181.41
23000	T		Removal of calcium deposits	0021	13.9338	$726.66	$219.48	$145.33
23020	T		Release shoulder joint	0051	32.9062	$1,716.09		$343.22
23030	T		Drain shoulder lesion	0008	16.1430	$841.87		$168.37
23031	T		Drain shoulder bursa	0008	16.1430	$841.87		$168.37
23035	T		Drain shoulder bone lesion	0049	18.6042	$970.23	$197.14	$194.05
23040	T		Exploratory shoulder surgery	0050	23.3037	$1,215.31		$243.06
23044	T		Exploratory shoulder surgery	0050	23.3037	$1,215.31		$243.06
23065	T		Biopsy shoulder tissues	0021	13.9338	$726.66	$219.48	$145.33
23066	T		Biopsy shoulder tissues	0022	17.3930	$907.06	$354.45	$181.41
23075	T		Removal of shoulder lesion	0021	13.9338	$726.66	$219.48	$145.33
23076	T		Removal of shoulder lesion	0022	17.3930	$907.06	$354.45	$181.41
23077	T		Remove tumor of shoulder	0022	17.3930	$907.06	$354.45	$181.41
23100	T		Biopsy of shoulder joint	0049	18.6042	$970.23	$197.14	$194.05
23101	T		Shoulder joint surgery	0050	23.3037	$1,215.31		$243.06
23105	T		Remove shoulder joint lining	0050	23.3037	$1,215.31		$243.06
23106	T		Incision of collarbone joint	0050	23.3037	$1,215.31		$243.06
23107	T		Explore treat shoulder joint	0050	23.3037	$1,215.31		$243.06
23120	T		Partial removal, collar bone	0051	32.9062	$1,716.09		$343.22
23125	T		Removal of collar bone	0051	32.9062	$1,716.09		$343.22
23130	T		Remove shoulder bone, part	0051	32.9062	$1,716.09		$343.22
23140	T		Removal of bone lesion	0049	18.6042	$970.23	$197.14	$194.05
23145	T		Removal of bone lesion	0050	23.3037	$1,215.31		$243.06
23146	T		Removal of bone lesion	0050	23.3037	$1,215.31		$243.06
23150	T		Removal of humerus lesion	0050	23.3037	$1,215.31		$243.06
23155	T		Removal of humerus lesion	0050	23.3037	$1,215.31		$243.06
23156	T		Removal of humerus lesion	0050	23.3037	$1,215.31		$243.06
23170	T		Remove collar bone lesion	0050	23.3037	$1,215.31		$243.06
23172	T		Remove shoulder blade lesion	0050	23.3037	$1,215.31		$243.06
23174	T		Remove humerus lesion	0050	23.3037	$1,215.31		$243.06
23180	T		Remove collar bone lesion	0050	23.3037	$1,215.31		$243.06
23182	T		Remove shoulder blade lesion	0050	23.3037	$1,215.31		$243.06
23184	T		Remove humerus lesion	0050	23.3037	$1,215.31		$243.06
23190	T		Partial removal of scapula	0050	23.3037	$1,215.31		$243.06
23195	T		Removal of head of humerus	0050	23.3037	$1,215.31		$243.06
23200	C		Removal of collar bone					
23210	C		Removal of shoulder blade					
23220	C		Partial removal of humerus					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23221	C		Partial removal of humerus					
23222	C		Partial removal of humerus					
23330	T		Remove shoulder foreign body	0020	7.1898	$374.96	$113.25	$74.99
23331	T		Remove shoulder foreign body	0022	17.3930	$907.06	$354.45	$181.41
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	32.9062	$1,716.09		$343.22
23397	T		Muscle transfers	0052	40.7646	$2,125.91		$425.18
23400	T		Fixation of shoulder blade	0050	23.3037	$1,215.31		$243.06
23405	T		Incision of tendon & muscle	0050	23.3037	$1,215.31		$243.06
23406	T		Incise tendon(s) & muscle(s)	0050	23.3037	$1,215.31		$243.06
23410	T		Repair of tendon(s)	0052	40.7646	$2,125.91		$425.18
23412	T		Repair rotator cuff, chronic	0052	40.7646	$2,125.91		$425.18
23415	T		Release of shoulder ligament	0051	32.9062	$1,716.09		$343.22
23420	T		Repair of shoulder	0052	40.7646	$2,125.91		$425.18
23430	T		Repair biceps tendon	0052	40.7646	$2,125.91		$425.18
23440	T		Remove/transplant tendon	0052	40.7646	$2,125.91		$425.18
23450	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23455	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23460	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23462	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23465	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23466	T		Repair shoulder capsule	0052	40.7646	$2,125.91		$425.18
23470	T		Reconstruct shoulder joint	0048	40.6289	$2,118.84	$695.60	$423.77
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	32.9062	$1,716.09		$343.22
23485	T		Revision of collar bone	0051	32.9062	$1,716.09		$343.22
23490	T		Reinforce clavicle	0051	32.9062	$1,716.09		$343.22
23491	T		Reinforce shoulder bones	0051	32.9062	$1,716.09		$343.22
23500	T		Treat clavicle fracture	0043	2.4999	$130.37		$26.07
23505	T		Treat clavicle fracture	0043	2.4999	$130.37		$26.07
23515	T		Treat clavicle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23520	T		Treat clavicle dislocation	0043	2.4999	$130.37		$26.07
23525	T		Treat clavicle dislocation	0043	2.4999	$130.37		$26.07
23530	T		Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23532	T		Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23540	T		Treat clavicle dislocation	0043	2.4999	$130.37		$26.07
23545	T		Treat clavicle dislocation	0043	2.4999	$130.37		$26.07
23550	T		Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23552	T		Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23570	T		Treat shoulder blade fx	0043	2.4999	$130.37		$26.07
23575	T		Treat shoulder blade fx	0043	2.4999	$130.37		$26.07
23585	T		Treat scapula fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23600	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
23605	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
23615	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23616	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23620	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
23625	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
23630	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23650	T		Treat shoulder dislocation	0043	2.4999	$130.37		$26.07
23655	T		Treat shoulder dislocation	0045	12.9357	$674.61	$268.47	$134.92
23660	T		Treat shoulder dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23665	T		Treat dislocation/fracture	0043	2.4999	$130.37		$26.07
23670	T		Treat dislocation/fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23675	T		Treat dislocation/fracture	0043	2.4999	$130.37		$26.07
23680	T		Treat dislocation/fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23700	T		Fixation of shoulder	0045	12.9357	$674.61	$268.47	$134.92
23800	T		Fusion of shoulder joint	0051	32.9062	$1,716.09		$343.22
23802	T		Fusion of shoulder joint	0051	32.9062	$1,716.09		$343.22
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	5.8623	$305.72	$115.49	$61.14
23929	T		Shoulder surgery procedure	0043	2.4999	$130.37		$26.07
23930	T		Drainage of arm lesion	0008	16.1430	$841.87		$168.37

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23931	T		Drainage of arm bursa	0006	1.7926	$93.49	$24.12	$18.70
23935	T		Drain arm/elbow bone lesion	0049	18.6042	$970.23	$197.14	$194.05
24000	T		Exploratory elbow surgery	0050	23.3037	$1,215.31		$243.06
24006	T		Release elbow joint	0050	23.3037	$1,215.31		$243.06
24065	T		Biopsy arm/elbow soft tissue	0021	13.9338	$726.66	$219.48	$145.33
24066	T		Biopsy arm/elbow soft tissue	0021	13.9338	$726.66	$219.48	$145.33
24075	T		Remove arm/elbow lesion	0021	13.9338	$726.66	$219.48	$145.33
24076	T		Remove arm/elbow lesion	0022	17.3930	$907.06	$354.45	$181.41
24077	T		Remove tumor of arm/elbow	0022	17.3930	$907.06	$354.45	$181.41
24100	T		Biopsy elbow joint lining	0049	18.6042	$970.23	$197.14	$194.05
24101	T		Explore/treat elbow joint	0050	23.3037	$1,215.31		$243.06
24102	T		Remove elbow joint lining	0050	23.3037	$1,215.31		$243.06
24105	T		Removal of elbow bursa	0049	18.6042	$970.23	$197.14	$194.05
24110	T		Remove humerus lesion	0049	18.6042	$970.23	$197.14	$194.05
24115	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24116	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24120	T		Remove elbow lesion	0049	18.6042	$970.23	$197.14	$194.05
24125	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24126	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24130	T		Removal of head of radius	0050	23.3037	$1,215.31		$243.06
24134	T		Removal of arm bone lesion	0050	23.3037	$1,215.31		$243.06
24136	T		Remove radius bone lesion	0050	23.3037	$1,215.31		$243.06
24138	T		Remove elbow bone lesion	0050	23.3037	$1,215.31		$243.06
24140	T		Partial removal of arm bone	0050	23.3037	$1,215.31		$243.06
24145	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
24147	T		Partial removal of elbow	0050	23.3037	$1,215.31		$243.06
24149	C		Radical resection of elbow					
24150	T		Extensive humerus surgery	0052	40.7646	$2,125.91		$425.18
24151	T		Extensive humerus surgery	0052	40.7646	$2,125.91		$425.18
24152	T		Extensive radius surgery	0052	40.7646	$2,125.91		$425.18
24153	T		Extensive radius surgery	0052	40.7646	$2,125.91		$425.18
24155	T		Removal of elbow joint	0051	32.9062	$1,716.09		$343.22
24160	T		Remove elbow joint implant	0050	23.3037	$1,215.31		$243.06
24164	T		Remove radius head implant	0050	23.3037	$1,215.31		$243.06
24200	T		Removal of arm foreign body	0019	3.7693	$196.57	$71.87	$39.31
24201	T		Removal of arm foreign body	0021	13.9338	$726.66	$219.48	$145.33
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	12.9357	$674.61	$268.47	$134.92
24301	T		Muscle/tendon transfer	0050	23.3037	$1,215.31		$243.06
24305	T		Arm tendon lengthening	0050	23.3037	$1,215.31		$243.06
24310	T		Revision of arm tendon	0049	18.6042	$970.23	$197.14	$194.05
24320	T		Repair of arm tendon	0051	32.9062	$1,716.09		$343.22
24330	T		Revision of arm muscles	0051	32.9062	$1,716.09		$343.22
24331	T		Revision of arm muscles	0051	32.9062	$1,716.09		$343.22
24332	T		Tenolysis, triceps	0049	18.6042	$970.23	$197.14	$194.05
24340	T		Repair of biceps tendon	0051	32.9062	$1,716.09		$343.22
24341	T		Repair arm tendon/muscle	0051	32.9062	$1,716.09		$343.22
24342	T		Repair of ruptured tendon	0051	32.9062	$1,716.09		$343.22
24343	T		Repr elbow lat ligmnt w/tiss	0050	23.3037	$1,215.31		$243.06
24344	T		Reconstruct elbow lat ligmnt	0051	32.9062	$1,716.09		$343.22
24345	T		Repr elbw med ligmnt w/tissu	0050	23.3037	$1,215.31		$243.06
24346	T		Reconstruct elbow med ligmnt	0051	32.9062	$1,716.09		$343.22
24350	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24351	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24352	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24354	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24356	T		Revision of tennis elbow	0050	23.3037	$1,215.31		$243.06
24360	T		Reconstruct elbow joint	0047	28.2842	$1,475.05	$537.03	$295.01
24361	T		Reconstruct elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24362	T		Reconstruct elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24363	T		Replace elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24365	T		Reconstruct head of radius	0047	28.2842	$1,475.05	$537.03	$295.01
24366	T		Reconstruct head of radius	0048	40.6289	$2,118.84	$695.60	$423.77
24400	T		Revision of humerus	0050	23.3037	$1,215.31		$243.06
24410	T		Revision of humerus	0050	23.3037	$1,215.31		$243.06

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24420	T		Revision of humerus	0051	32.9062	$1,716.09		$343.22
24430	T		Repair of humerus	0051	32.9062	$1,716.09		$343.22
24435	T		Repair humerus with graft	0051	32.9062	$1,716.09		$343.22
24470	T		Revision of elbow joint	0051	32.9062	$1,716.09		$343.22
24495	T		Decompression of forearm	0050	23.3037	$1,215.31		$243.06
24498	T		Reinforce humerus	0051	32.9062	$1,716.09		$343.22
24500	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24505	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24515	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24516	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24530	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24535	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24538	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24545	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24546	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24560	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24565	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24566	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24575	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24576	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24577	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24579	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24582	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24586	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24587	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24600	T		Treat elbow dislocation	0043	2.4999	$130.37		$26.07
24605	T		Treat elbow dislocation	0045	12.9357	$674.61	$268.47	$134.92
24615	T		Treat elbow dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
24620	T		Treat elbow fracture	0043	2.4999	$130.37		$26.07
24635	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24640	T		Treat elbow dislocation	0043	2.4999	$130.37		$26.07
24650	T		Treat radius fracture	0043	2.4999	$130.37		$26.07
24655	T		Treat radius fracture	0043	2.4999	$130.37		$26.07
24665	T		Treat radius fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24666	T		Treat radius fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24670	T		Treat ulnar fracture	0043	2.4999	$130.37		$26.07
24675	T		Treat ulnar fracture	0043	2.4999	$130.37		$26.07
24685	T		Treat ulnar fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24800	T		Fusion of elbow joint	0051	32.9062	$1,716.09		$343.22
24802	T		Fusion/graft of elbow joint	0051	32.9062	$1,716.09		$343.22
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	40.7646	$2,125.91		$425.18
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	2.4999	$130.37		$26.07
25000	T		Incision of tendon sheath	0049	18.6042	$970.23	$197.14	$194.05
25001	T		Incise flexor carpi radialis	0049	18.6042	$970.23	$197.14	$194.05
25020	T		Decompress forearm 1 space	0049	18.6042	$970.23	$197.14	$194.05
25023	T		Decompress forearm 1 space	0050	23.3037	$1,215.31		$243.06
25024	T		Decompress forearm 2 spaces	0050	23.3037	$1,215.31		$243.06
25025	T		Decompress forarm 2 spaces	0050	23.3037	$1,215.31		$243.06
25028	T		Drainage of forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25031	T		Drainage of forearm bursa	0049	18.6042	$970.23	$197.14	$194.05
25035	T		Treat forearm bone lesion	0049	18.6042	$970.23	$197.14	$194.05
25040	T		Explore/treat wrist joint	0050	23.3037	$1,215.31		$243.06
25065	T		Biopsy forearm soft tissues	0021	13.9338	$726.66	$219.48	$145.33
25066	T		Biopsy forearm soft tissues	0022	17.3930	$907.06	$354.45	$181.41
25075	T		Removel forearm lesion subcu	0021	13.9338	$726.66	$219.48	$145.33
25076	T		Removel forearm lesion deep	0022	17.3930	$907.06	$354.45	$181.41
25077	T		Remove tumor, forearm/wrist	0022	17.3930	$907.06	$354.45	$181.41
25085	T		Incision of wrist capsule	0049	18.6042	$970.23	$197.14	$194.05
25100	T		Biopsy of wrist joint	0049	18.6042	$970.23	$197.14	$194.05

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25101	T		Explore/treat wrist joint	0050	23.3037	$1,215.31		$243.06
25105	T		Remove wrist joint lining	0050	23.3037	$1,215.31		$243.06
25107	T		Remove wrist joint cartilage	0050	23.3037	$1,215.31		$243.06
25110	T		Remove wrist tendon lesion	0049	18.6042	$970.23	$197.14	$194.05
25111	T		Remove wrist tendon lesion	0053	14.1760	$739.29	$253.49	$147.86
25112	T		Reremove wrist tendon lesion	0053	14.1760	$739.29	$253.49	$147.86
25115	T		Remove wrist/forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25116	T		Remove wrist/forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25118	T		Excise wrist tendon sheath	0050	23.3037	$1,215.31		$243.06
25119	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25120	T		Removal of forearm lesion	0050	23.3037	$1,215.31		$243.06
25125	T		Remove/graft forearm lesion	0050	23.3037	$1,215.31		$243.06
25126	T		Remove/graft forearm lesion	0050	23.3037	$1,215.31		$243.06
25130	T		Removal of wrist lesion	0050	23.3037	$1,215.31		$243.06
25135	T		Remove & graft wrist lesion	0050	23.3037	$1,215.31		$243.06
25136	T		Remove & graft wrist lesion	0050	23.3037	$1,215.31		$243.06
25145	T		Remove forearm bone lesion	0050	23.3037	$1,215.31		$243.06
25150	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25151	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
25170	T		Extensive forearm surgery	0052	40.7646	$2,125.91		$425.18
25210	T		Removal of wrist bone	0054	22.7223	$1,184.99		$237.00
25215	T		Removal of wrist bones	0054	22.7223	$1,184.99		$237.00
25230	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
25240	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	18.6042	$970.23	$197.14	$194.05
25250	T		Removal of wrist prosthesis	0050	23.3037	$1,215.31		$243.06
25251	T		Removal of wrist prosthesis	0050	23.3037	$1,215.31		$243.06
25259	T		Manipulate wrist w/anesthes	0043	2.4999	$130.37		$26.07
25260	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25263	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25265	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25270	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25272	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25274	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25275	T		Repair forearm tendon sheath	0050	23.3037	$1,215.31		$243.06
25280	T		Revise wrist/forearm tendon	0050	23.3037	$1,215.31		$243.06
25290	T		Incise wrist/forearm tendon	0050	23.3037	$1,215.31		$243.06
25295	T		Release wrist/forearm tendon	0049	18.6042	$970.23	$197.14	$194.05
25300	T		Fusion of tendons at wrist	0050	23.3037	$1,215.31		$243.06
25301	T		Fusion of tendons at wrist	0050	23.3037	$1,215.31		$243.06
25310	T		Transplant forearm tendon	0051	32.9062	$1,716.09		$343.22
25312	T		Transplant forearm tendon	0051	32.9062	$1,716.09		$343.22
25315	T		Revise palsy hand tendon(s)	0051	32.9062	$1,716.09		$343.22
25316	T		Revise palsy hand tendon(s)	0051	32.9062	$1,716.09		$343.22
25320	T		Repair/revise wrist joint	0051	32.9062	$1,716.09		$343.22
25332	T		Revise wrist joint	0047	28.2842	$1,475.05	$537.03	$295.01
25335	T		Realignment of hand	0051	32.9062	$1,716.09		$343.22
25337	T		Reconstruct ulna/radioulnar	0051	32.9062	$1,716.09		$343.22
25350	T		Revision of radius	0051	32.9062	$1,716.09		$343.22
25355	T		Revision of radius	0051	32.9062	$1,716.09		$343.22
25360	T		Revision of ulna	0050	23.3037	$1,215.31		$243.06
25365	T		Revise radius & ulna	0050	23.3037	$1,215.31		$243.06
25370	T		Revise radius or ulna	0051	32.9062	$1,716.09		$343.22
25375	T		Revise radius & ulna	0051	32.9062	$1,716.09		$343.22
25390	T		Shorten radius or ulna	0050	23.3037	$1,215.31		$243.06
25391	T		Lengthen radius or ulna	0051	32.9062	$1,716.09		$343.22
25392	T		Shorten radius & ulna	0050	23.3037	$1,215.31		$243.06
25393	T		Lengthen radius & ulna	0051	32.9062	$1,716.09		$343.22
25394	T		Repair carpal bone, shorten	0053	14.1760	$739.29	$253.49	$147.86
25400	T		Repair radius or ulna	0050	23.3037	$1,215.31		$243.06
25405	T		Repair/graft radius or ulna	0050	23.3037	$1,215.31		$243.06
25415	T		Repair radius & ulna	0050	23.3037	$1,215.31		$243.06
25420	T		Repair/graft radius & ulna	0051	32.9062	$1,716.09		$343.22
25425	T		Repair/graft radius or ulna	0051	32.9062	$1,716.09		$343.22

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25426	T		Repair/graft radius & ulna	0051	32.9062	$1,716.09		$343.22
25430	T		Vasc graft into carpal bone	0054	22.7223	$1,184.99		$237.00
25431	T		Repair nonunion carpal bone	0054	22.7223	$1,184.99		$237.00
25440	T		Repair/graft wrist bone	0051	32.9062	$1,716.09		$343.22
25441	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25442	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25443	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25444	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25445	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25446	T		Wrist replacement	0048	40.6289	$2,118.84	$695.60	$423.77
25447	T		Repair wrist joint(s)	0047	28.2842	$1,475.05	$537.03	$295.01
25449	T		Remove wrist joint implant	0047	28.2842	$1,475.05	$537.03	$295.01
25450	T		Revision of wrist joint	0051	32.9062	$1,716.09		$343.22
25455	T		Revision of wrist joint	0051	32.9062	$1,716.09		$343.22
25490	T		Reinforce radius	0051	32.9062	$1,716.09		$343.22
25491	T		Reinforce ulna	0051	32.9062	$1,716.09		$343.22
25492	T		Reinforce radius and ulna	0051	32.9062	$1,716.09		$343.22
25500	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25505	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25515	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25520	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25525	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25526	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25530	T		Treat fracture of ulna	0043	2.4999	$130.37		$26.07
25535	T		Treat fracture of ulna	0043	2.4999	$130.37		$26.07
25545	T		Treat fracture of ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25560	T		Treat fracture radius & ulna	0043	2.4999	$130.37		$26.07
25565	T		Treat fracture radius & ulna	0043	2.4999	$130.37		$26.07
25574	T		Treat fracture radius & ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25575	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25600	T		Treat fracture radius/ulna	0043	2.4999	$130.37		$26.07
25605	T		Treat fracture radius/ulna	0043	2.4999	$130.37		$26.07
25611	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25620	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25622	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25624	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25628	T		Treat wrist bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25630	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25635	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25645	T		Treat wrist bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25650	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25651	T		Pin ulnar styloid fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25652	T		Treat fracture ulnar styloid	0046	29.2920	$1,527.61	$535.76	$305.52
25660	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25670	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25671	T		Pin radioulnar dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25675	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25676	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25680	T		Treat wrist fracture	0043	2.4999	$130.37		$26.07
25685	T		Treat wrist fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25690	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25695	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25800	T		Fusion of wrist joint	0051	32.9062	$1,716.09		$343.22
25805	T		Fusion/graft of wrist joint	0051	32.9062	$1,716.09		$343.22
25810	T		Fusion/graft of wrist joint	0051	32.9062	$1,716.09		$343.22
25820	T		Fusion of hand bones	0053	14.1760	$739.29	$253.49	$147.86
25825	T		Fuse hand bones with graft	0054	22.7223	$1,184.99		$237.00
25830	T		Fusion, radioulnar jnt/ulna	0051	32.9062	$1,716.09		$343.22
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	18.6042	$970.23	$197.14	$194.05

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25924	C		Amputation follow-up surgery					
25927	C		Amputation of hand					
25929	T		Amputation follow-up surgery	0027	15.2225	$793.87	$329.72	$158.77
25931	C		Amputation follow-up surgery					
25999	T		Forearm or wrist surgery	0043	2.4999	$130.37		$26.07
26010	T		Drainage of finger abscess	0006	1.7926	$93.49	$24.12	$18.70
26011	T		Drainage of finger abscess	0007	10.0191	$522.51	$108.89	$104.50
26020	T		Drain hand tendon sheath	0053	14.1760	$739.29	$253.49	$147.86
26025	T		Drainage of palm bursa	0053	14.1760	$739.29	$253.49	$147.86
26030	T		Drainage of palm bursa(s)	0053	14.1760	$739.29	$253.49	$147.86
26034	T		Treat hand bone lesion	0053	14.1760	$739.29	$253.49	$147.86
26035	T		Decompress fingers/hand	0053	14.1760	$739.29	$253.49	$147.86
26037	T		Decompress fingers/hand	0053	14.1760	$739.29	$253.49	$147.86
26040	T		Release palm contracture	0054	22.7223	$1,184.99		$237.00
26045	T		Release palm contracture	0054	22.7223	$1,184.99		$237.00
26055	T		Incise finger tendon sheath	0053	14.1760	$739.29	$253.49	$147.86
26060	T		Incision of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26070	T		Explore/treat hand joint	0053	14.1760	$739.29	$253.49	$147.86
26075	T		Explore/treat finger joint	0053	14.1760	$739.29	$253.49	$147.86
26080	T		Explore/treat finger joint	0053	14.1760	$739.29	$253.49	$147.86
26100	T		Biopsy hand joint lining	0053	14.1760	$739.29	$253.49	$147.86
26105	T		Biopsy finger joint lining	0053	14.1760	$739.29	$253.49	$147.86
26110	T		Biopsy finger joint lining	0053	14.1760	$739.29	$253.49	$147.86
26115	T		Removel hand lesion subcut	0022	17.3930	$907.06	$354.45	$181.41
26116	T		Removel hand lesion, deep	0022	17.3930	$907.06	$354.45	$181.41
26117	T		Remove tumor, hand/finger	0022	17.3930	$907.06	$354.45	$181.41
26121	T		Release palm contracture	0054	22.7223	$1,184.99		$237.00
26123	T		Release palm contracture	0054	22.7223	$1,184.99		$237.00
26125	T		Release palm contracture	0054	22.7223	$1,184.99		$237.00
26130	T		Remove wrist joint lining	0053	14.1760	$739.29	$253.49	$147.86
26135	T		Revise finger joint, each	0054	22.7223	$1,184.99		$237.00
26140	T		Revise finger joint, each	0053	14.1760	$739.29	$253.49	$147.86
26145	T		Tendon excision, palm/finger	0053	14.1760	$739.29	$253.49	$147.86
26160	T		Remove tendon sheath lesion	0053	14.1760	$739.29	$253.49	$147.86
26170	T		Removal of palm tendon, each	0053	14.1760	$739.29	$253.49	$147.86
26180	T		Removal of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26185	T		Remove finger bone	0053	14.1760	$739.29	$253.49	$147.86
26200	T		Remove hand bone lesion	0053	14.1760	$739.29	$253.49	$147.86
26205	T		Remove/graft bone lesion	0054	22.7223	$1,184.99		$237.00
26210	T		Removal of finger lesion	0053	14.1760	$739.29	$253.49	$147.86
26215	T		Remove/graft finger lesion	0053	14.1760	$739.29	$253.49	$147.86
26230	T		Partial removal of hand bone	0053	14.1760	$739.29	$253.49	$147.86
26235	T		Partial removal, finger bone	0053	14.1760	$739.29	$253.49	$147.86
26236	T		Partial removal, finger bone	0053	14.1760	$739.29	$253.49	$147.86
26250	T		Extensive hand surgery	0053	14.1760	$739.29	$253.49	$147.86
26255	T		Extensive hand surgery	0054	22.7223	$1,184.99		$237.00
26260	T		Extensive finger surgery	0053	14.1760	$739.29	$253.49	$147.86
26261	T		Extensive finger surgery	0053	14.1760	$739.29	$253.49	$147.86
26262	T		Partial removal of finger	0053	14.1760	$739.29	$253.49	$147.86
26320	T		Removal of implant from hand	0021	13.9338	$726.66	$219.48	$145.33
26340	T		Manipulate finger w/anesth	0043	2.4999	$130.37		$26.07
26350	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26352	T		Repair/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26356	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26357	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26358	T		Repair/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26370	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26372	T		Repair/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26373	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26390	T		Revise hand/finger tendon	0054	22.7223	$1,184.99		$237.00
26392	T		Repair/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26410	T		Repair hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26412	T		Repair/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26415	T		Excision, hand/finger tendon	0054	22.7223	$1,184.99		$237.00
26416	T		Graft hand or finger tendon	0054	22.7223	$1,184.99		$237.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26418	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26420	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26426	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26428	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26432	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26433	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26434	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26437	T		Realignment of tendons	0053	14.1760	$739.29	$253.49	$147.86
26440	T		Release palm/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26442	T		Release palm & finger tendon	0054	22.7223	$1,184.99		$237.00
26445	T		Release hand/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26449	T		Release forearm/hand tendon	0054	22.7223	$1,184.99		$237.00
26450	T		Incision of palm tendon	0053	14.1760	$739.29	$253.49	$147.86
26455	T		Incision of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26460	T		Incise hand/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26471	T		Fusion of finger tendons	0053	14.1760	$739.29	$253.49	$147.86
26474	T		Fusion of finger tendons	0053	14.1760	$739.29	$253.49	$147.86
26476	T		Tendon lengthening	0053	14.1760	$739.29	$253.49	$147.86
26477	T		Tendon shortening	0053	14.1760	$739.29	$253.49	$147.86
26478	T		Lengthening of hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26479	T		Shortening of hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26480	T		Transplant hand tendon	0054	22.7223	$1,184.99		$237.00
26483	T		Transplant/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26485	T		Transplant palm tendon	0054	22.7223	$1,184.99		$237.00
26489	T		Transplant/graft palm tendon	0054	22.7223	$1,184.99		$237.00
26490	T		Revise thumb tendon	0054	22.7223	$1,184.99		$237.00
26492	T		Tendon transfer with graft	0054	22.7223	$1,184.99		$237.00
26494	T		Hand tendon/muscle transfer	0054	22.7223	$1,184.99		$237.00
26496	T		Revise thumb tendon	0054	22.7223	$1,184.99		$237.00
26497	T		Finger tendon transfer	0054	22.7223	$1,184.99		$237.00
26498	T		Finger tendon transfer	0054	22.7223	$1,184.99		$237.00
26499	T		Revision of finger	0054	22.7223	$1,184.99		$237.00
26500	T		Hand tendon reconstruction	0053	14.1760	$739.29	$253.49	$147.86
26502	T		Hand tendon reconstruction	0054	22.7223	$1,184.99		$237.00
26504	T		Hand tendon reconstruction	0054	22.7223	$1,184.99		$237.00
26508	T		Release thumb contracture	0053	14.1760	$739.29	$253.49	$147.86
26510	T		Thumb tendon transfer	0054	22.7223	$1,184.99		$237.00
26516	T		Fusion of knuckle joint	0054	22.7223	$1,184.99		$237.00
26517	T		Fusion of knuckle joints	0054	22.7223	$1,184.99		$237.00
26518	T		Fusion of knuckle joints	0054	22.7223	$1,184.99		$237.00
26520	T		Release knuckle contracture	0053	14.1760	$739.29	$253.49	$147.86
26525	T		Release finger contracture	0053	14.1760	$739.29	$253.49	$147.86
26530	T		Revise knuckle joint	0047	28.2842	$1,475.05	$537.03	$295.01
26531	T		Revise knuckle with implant	0048	40.6289	$2,118.84	$695.60	$423.77
26535	T		Revise finger joint	0047	28.2842	$1,475.05	$537.03	$295.01
26536	T		Revise/implant finger joint	0048	40.6289	$2,118.84	$695.60	$423.77
26540	T		Repair hand joint	0053	14.1760	$739.29	$253.49	$147.86
26541	T		Repair hand joint with graft	0054	22.7223	$1,184.99		$237.00
26542	T		Repair hand joint with graft	0053	14.1760	$739.29	$253.49	$147.86
26545	T		Reconstruct finger joint	0054	22.7223	$1,184.99		$237.00
26546	T		Repair nonunion hand	0054	22.7223	$1,184.99		$237.00
26548	T		Reconstruct finger joint	0054	22.7223	$1,184.99		$237.00
26550	T		Construct thumb replacement	0054	22.7223	$1,184.99		$237.00
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	22.7223	$1,184.99		$237.00
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	14.1760	$739.29	$253.49	$147.86
26561	T		Repair of web finger	0054	22.7223	$1,184.99		$237.00
26562	T		Repair of web finger	0054	22.7223	$1,184.99		$237.00
26565	T		Correct metacarpal flaw	0054	22.7223	$1,184.99		$237.00
26567	T		Correct finger deformity	0054	22.7223	$1,184.99		$237.00
26568	T		Lengthen metacarpal/finger	0054	22.7223	$1,184.99		$237.00
26580	T		Repair hand deformity	0054	22.7223	$1,184.99		$237.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26587	T		Reconstruct extra finger	0053	14.1760	$739.29	$253.49	$147.86
26590	T		Repair finger deformity	0054	22.7223	$1,184.99		$237.00
26591	T		Repair muscles of hand	0054	22.7223	$1,184.99		$237.00
26593	T		Release muscles of hand	0053	14.1760	$739.29	$253.49	$147.86
26596	T		Excision constricting tissue	0054	22.7223	$1,184.99		$237.00
26600	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26605	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26607	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26608	T		Treat metacarpal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26615	T		Treat metacarpal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26641	T		Treat thumb dislocation	0043	2.4999	$130.37		$26.07
26645	T		Treat thumb fracture	0043	2.4999	$130.37		$26.07
26650	T		Treat thumb fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26665	T		Treat thumb fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26670	T		Treat hand dislocation	0043	2.4999	$130.37		$26.07
26675	T		Treat hand dislocation	0043	2.4999	$130.37		$26.07
26676	T		Pin hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26685	T		Treat hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26686	T		Treat hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26700	T		Treat knuckle dislocation	0043	2.4999	$130.37		$26.07
26705	T		Treat knuckle dislocation	0043	2.4999	$130.37		$26.07
26706	T		Pin knuckle dislocation	0043	2.4999	$130.37		$26.07
26715	T		Treat knuckle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26720	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26725	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26727	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26735	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26740	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26742	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26746	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26750	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26755	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26756	T		Pin finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26765	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26770	T		Treat finger dislocation	0043	2.4999	$130.37		$26.07
26775	T		Treat finger dislocation	0045	12.9357	$674.61	$268.47	$134.92
26776	T		Pin finger dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26785	T		Treat finger dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26820	T		Thumb fusion with graft	0054	22.7223	$1,184.99		$237.00
26841	T		Fusion of thumb	0054	22.7223	$1,184.99		$237.00
26842	T		Thumb fusion with graft	0054	22.7223	$1,184.99		$237.00
26843	T		Fusion of hand joint	0054	22.7223	$1,184.99		$237.00
26844	T		Fusion/graft of hand joint	0054	22.7223	$1,184.99		$237.00
26850	T		Fusion of knuckle	0054	22.7223	$1,184.99		$237.00
26852	T		Fusion of knuckle with graft	0054	22.7223	$1,184.99		$237.00
26860	T		Fusion of finger joint	0054	22.7223	$1,184.99		$237.00
26861	T		Fusion of finger jnt, add-on	0054	22.7223	$1,184.99		$237.00
26862	T		Fusion/graft of finger joint	0054	22.7223	$1,184.99		$237.00
26863	T		Fuse/graft added joint	0054	22.7223	$1,184.99		$237.00
26910	T		Amputate metacarpal bone	0054	22.7223	$1,184.99		$237.00
26951	T		Amputation of finger/thumb	0053	14.1760	$739.29	$253.49	$147.86
26952	T		Amputation of finger/thumb	0053	14.1760	$739.29	$253.49	$147.86
26989	T		Hand/finger surgery	0043	2.4999	$130.37		$26.07
26990	T		Drainage of pelvis lesion	0049	18.6042	$970.23	$197.14	$194.05
26991	T		Drainage of pelvis bursa	0049	18.6042	$970.23	$197.14	$194.05
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	18.6042	$970.23	$197.14	$194.05
27001	T		Incision of hip tendon	0050	23.3037	$1,215.31		$243.06
27003	T		Incision of hip tendon	0050	23.3037	$1,215.31		$243.06
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	32.9062	$1,716.09		$343.22
27035	T		Denervation of hip joint	0052	40.7646	$2,125.91		$425.18

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0021	13.9338	$726.66	$219.48	$145.33
27041	T		Biopsy of soft tissues	0022	17.3930	$907.06	$354.45	$181.41
27047	T		Remove hip/pelvis lesion	0022	17.3930	$907.06	$354.45	$181.41
27048	T		Remove hip/pelvis lesion	0022	17.3930	$907.06	$354.45	$181.41
27049	T		Remove tumor, hip/pelvis	0022	17.3930	$907.06	$354.45	$181.41
27050	T		Biopsy of sacroiliac joint	0049	18.6042	$970.23	$197.14	$194.05
27052	T		Biopsy of hip joint	0049	18.6042	$970.23	$197.14	$194.05
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	18.6042	$970.23	$197.14	$194.05
27062	T		Remove femur lesion/bursa	0049	18.6042	$970.23	$197.14	$194.05
27065	T		Removal of hip bone lesion	0049	18.6042	$970.23	$197.14	$194.05
27066	T		Removal of hip bone lesion	0050	23.3037	$1,215.31		$243.06
27067	T		Remove/graft hip bone lesion	0050	23.3037	$1,215.31		$243.06
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	23.3037	$1,215.31		$243.06
27086	T		Remove hip foreign body	0020	7.1898	$374.96	$113.25	$74.99
27087	T		Remove hip foreign body	0049	18.6042	$970.23	$197.14	$194.05
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	23.3037	$1,215.31		$243.06
27098	T		Transfer tendon to pelvis	0050	23.3037	$1,215.31		$243.06
27100	T		Transfer of abdominal muscle	0051	32.9062	$1,716.09		$343.22
27105	T		Transfer of spinal muscle	0051	32.9062	$1,716.09		$343.22
27110	T		Transfer of iliopsoas muscle	0051	32.9062	$1,716.09		$343.22
27111	T		Transfer of iliopsoas muscle	0051	32.9062	$1,716.09		$343.22
27120	C		Reconstruction of hip socket					
27122	C		Reconstruction of hip socket					
27125	C		Partial hip replacement					
27130	C		Total hip arthroplasty					
27132	C		Total hip arthroplasty					
27134	C		Revise hip joint replacement					
27137	C		Revise hip joint replacement					
27138	C		Revise hip joint replacement					
27140	C		Transplant femur ridge					
27146	C		Incision of hip bone					
27147	C		Revision of hip bone					
27151	C		Incision of hip bones					
27156	C		Revision of hip bones					
27158	C		Revision of pelvis					
27161	C		Incision of neck of femur					
27165	C		Incision/fixation of femur					
27170	C		Repair/graft femur head/neck					
27175	C		Treat slipped epiphysis					
27176	C		Treat slipped epiphysis					
27177	C		Treat slipped epiphysis					
27178	C		Treat slipped epiphysis					
27179	C		Revise head/neck of femur					
27181	C		Treat slipped epiphysis					
27185	C		Revision of femur epiphysis					
27187	C		Reinforce hip bones					
27193	T		Treat pelvic ring fracture	0043	2.4999	$130.37		$26.07
27194	T		Treat pelvic ring fracture	0045	12.9357	$674.61	$268.47	$134.92
27200	T		Treat tail bone fracture	0043	2.4999	$130.37		$26.07
27202	T		Treat tail bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27215	C		Treat pelvic fracture(s)					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27216	T		Treat pelvic ring fracture	0050	23.3037	$1,215.31		$243.06
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	2.4999	$130.37		$26.07
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	23.3037	$1,215.31		$243.06
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27252	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27257	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27266	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27275	T		Manipulation of hip joint	0045	12.9357	$674.61	$268.47	$134.92
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	2.4999	$130.37		$26.07
27301	T		Drain thigh/knee lesion	0008	16.1430	$841.87		$168.37
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	18.6042	$970.23	$197.14	$194.05
27306	T		Incision of thigh tendon	0049	18.6042	$970.23	$197.14	$194.05
27307	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27310	T		Exploration of knee joint	0050	23.3037	$1,215.31		$243.06
27315	T		Partial removal, thigh nerve	0220	15.8136	$824.70		$164.94
27320	T		Partial removal, thigh nerve	0220	15.8136	$824.70		$164.94
27323	T		Biopsy, thigh soft tissues	0021	13.9338	$726.66	$219.48	$145.33
27324	T		Biopsy, thigh soft tissues	0022	17.3930	$907.06	$354.45	$181.41
27327	T		Removal of thigh lesion	0022	17.3930	$907.06	$354.45	$181.41
27328	T		Removal of thigh lesion	0022	17.3930	$907.06	$354.45	$181.41
27329	T		Remove tumor, thigh/knee	0022	17.3930	$907.06	$354.45	$181.41
27330	T		Biopsy, knee joint lining	0050	23.3037	$1,215.31		$243.06
27331	T		Explore/treat knee joint	0050	23.3037	$1,215.31		$243.06
27332	T		Removal of knee cartilage	0050	23.3037	$1,215.31		$243.06
27333	T		Removal of knee cartilage	0050	23.3037	$1,215.31		$243.06
27334	T		Remove knee joint lining	0050	23.3037	$1,215.31		$243.06
27335	T		Remove knee joint lining	0050	23.3037	$1,215.31		$243.06
27340	T		Removal of kneecap bursa	0049	18.6042	$970.23	$197.14	$194.05
27345	T		Removal of knee cyst	0049	18.6042	$970.23	$197.14	$194.05
27347	T		Remove knee cyst	0049	18.6042	$970.23	$197.14	$194.05
27350	T		Removal of kneecap	0050	23.3037	$1,215.31		$243.06
27355	T		Remove femur lesion	0050	23.3037	$1,215.31		$243.06
27356	T		Remove femur lesion/graft	0050	23.3037	$1,215.31		$243.06
27357	T		Remove femur lesion/graft	0050	23.3037	$1,215.31		$243.06
27358	T		Remove femur lesion/fixation	0050	23.3037	$1,215.31		$243.06
27360	T		Partial removal, leg bone(s)	0050	23.3037	$1,215.31		$243.06
27365	C		Extensive leg surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	17.3930	$907.06	$354.45	$181.41
27380	T		Repair of kneecap tendon	0049	18.6042	$970.23	$197.14	$194.05
27381	T		Repair/graft kneecap tendon	0049	18.6042	$970.23	$197.14	$194.05
27385	T		Repair of thigh muscle	0049	18.6042	$970.23	$197.14	$194.05
27386	T		Repair/graft of thigh muscle	0049	18.6042	$970.23	$197.14	$194.05
27390	T		Incision of thigh tendon	0049	18.6042	$970.23	$197.14	$194.05
27391	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27392	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27393	T		Lengthening of thigh tendon	0050	23.3037	$1,215.31		$243.06
27394	T		Lengthening of thigh tendons	0050	23.3037	$1,215.31		$243.06
27395	T		Lengthening of thigh tendons	0051	32.9062	$1,716.09		$343.22
27396	T		Transplant of thigh tendon	0050	23.3037	$1,215.31		$243.06
27397	T		Transplants of thigh tendons	0051	32.9062	$1,716.09		$343.22
27400	T		Revise thigh muscles/tendons	0051	32.9062	$1,716.09		$343.22
27403	T		Repair of knee cartilage	0050	23.3037	$1,215.31		$243.06
27405	T		Repair of knee ligament	0051	32.9062	$1,716.09		$343.22
27407	T		Repair of knee ligament	0051	32.9062	$1,716.09		$343.22
27409	T		Repair of knee ligaments	0051	32.9062	$1,716.09		$343.22
27418	T		Repair degenerated kneecap	0051	32.9062	$1,716.09		$343.22
27420	T		Revision of unstable kneecap	0051	32.9062	$1,716.09		$343.22
27422	T		Revision of unstable kneecap	0051	32.9062	$1,716.09		$343.22
27424	T		Revision/removal of kneecap	0051	32.9062	$1,716.09		$343.22
27425	T		Lateral retinacular release	0050	23.3037	$1,215.31		$243.06
27427	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27428	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27429	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27430	T		Revision of thigh muscles	0051	32.9062	$1,716.09		$343.22
27435	T		Incision of knee joint	0051	32.9062	$1,716.09		$343.22
27437	T		Revise kneecap	0047	28.2842	$1,475.05	$537.03	$295.01
27438	T		Revise kneecap with implant	0048	40.6289	$2,118.84	$695.60	$423.77
27440	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27441	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27442	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27443	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	147.8067	$7,708.27	$3,067.55	$1,541.65
27447	C		Total knee arthroplasty					
27448	C		Incision of thigh					
27450	C		Incision of thigh					
27454	C		Realignment of thigh bone					
27455	C		Realignment of knee					
27457	C		Realignment of knee					
27465	C		Shortening of thigh bone					
27466	C		Lengthening of thigh bone					
27468	C		Shorten/lengthen thighs					
27470	C		Repair of thigh					
27472	C		Repair/graft of thigh					
27475	C		Surgery to stop leg growth					
27477	C		Surgery to stop leg growth					
27479	C		Surgery to stop leg growth					
27485	C		Surgery to stop leg growth					
27486	C		Revise/replace knee joint					
27487	C		Revise/replace knee joint					
27488	C		Removal of knee prosthesis					
27495	C		Reinforce thigh					
27496	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27497	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27498	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27499	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27500	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27501	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27502	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27503	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27506	C		Treatment of thigh fracture					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27509	T		Treatment of thigh fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27510	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	2.4999	$130.37		$26.07
27517	T		Treat thigh fx growth plate	0043	2.4999	$130.37		$26.07
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	2.4999	$130.37		$26.07
27524	T		Treat kneecap fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27530	T		Treat knee fracture	0043	2.4999	$130.37		$26.07
27532	T		Treat knee fracture	0043	2.4999	$130.37		$26.07
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	2.4999	$130.37		$26.07
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	2.4999	$130.37		$26.07
27552	T		Treat knee dislocation	0045	12.9357	$674.61	$268.47	$134.92
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	2.4999	$130.37		$26.07
27562	T		Treat kneecap dislocation	0045	12.9357	$674.61	$268.47	$134.92
27566	T		Treat kneecap dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27570	T		Fixation of knee joint	0045	12.9357	$674.61	$268.47	$134.92
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	18.6042	$970.23	$197.14	$194.05
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	2.4999	$130.37		$26.07
27600	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27601	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27602	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27603	T		Drain lower leg lesion	0008	16.1430	$841.87		$168.37
27604	T		Drain lower leg bursa	0049	18.6042	$970.23	$197.14	$194.05
27605	T		Incision of achilles tendon	0055	17.6740	$921.72	$355.34	$184.34
27606	T		Incision of achilles tendon	0049	18.6042	$970.23	$197.14	$194.05
27607	T		Treat lower leg bone lesion	0049	18.6042	$970.23	$197.14	$194.05
27610	T		Explore/treat ankle joint	0050	23.3037	$1,215.31		$243.06
27612	T		Exploration of ankle joint	0050	23.3037	$1,215.31		$243.06
27613	T		Biopsy lower leg soft tissue	0020	7.1898	$374.96	$113.25	$74.99
27614	T		Biopsy lower leg soft tissue	0022	17.3930	$907.06	$354.45	$181.41
27615	T		Remove tumor, lower leg	0046	29.2920	$1,527.61	$535.76	$305.52
27618	T		Remove lower leg lesion	0021	13.9338	$726.66	$219.48	$145.33
27619	T		Remove lower leg lesion	0022	17.3930	$907.06	$354.45	$181.41
27620	T		Explore/treat ankle joint	0050	23.3037	$1,215.31		$243.06
27625	T		Remove ankle joint lining	0050	23.3037	$1,215.31		$243.06
27626	T		Remove ankle joint lining	0050	23.3037	$1,215.31		$243.06
27630	T		Removal of tendon lesion	0049	18.6042	$970.23	$197.14	$194.05
27635	T		Remove lower leg bone lesion	0050	23.3037	$1,215.31		$243.06
27637	T		Remove/graft leg bone lesion	0050	23.3037	$1,215.31		$243.06
27638	T		Remove/graft leg bone lesion	0050	23.3037	$1,215.31		$243.06
27640	T		Partial removal of tibia	0051	32.9062	$1,716.09		$343.22
27641	T		Partial removal of fibula	0050	23.3037	$1,215.31		$243.06
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	32.9062	$1,716.09		$343.22
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	32.9062	$1,716.09		$343.22
27652	T		Repair/graft achilles tendon	0051	32.9062	$1,716.09		$343.22

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27654	T		Repair of achilles tendon	0051	32.9062	$1,716.09		$343.22
27656	T		Repair leg fascia defect	0049	18.6042	$970.23	$197.14	$194.05
27658	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27659	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27664	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27665	T		Repair of leg tendon, each	0050	23.3037	$1,215.31		$243.06
27675	T		Repair lower leg tendons	0049	18.6042	$970.23	$197.14	$194.05
27676	T		Repair lower leg tendons	0050	23.3037	$1,215.31		$243.06
27680	T		Release of lower leg tendon	0050	23.3037	$1,215.31		$243.06
27681	T		Release of lower leg tendons	0050	23.3037	$1,215.31		$243.06
27685	T		Revision of lower leg tendon	0050	23.3037	$1,215.31		$243.06
27686	T		Revise lower leg tendons	0050	23.3037	$1,215.31		$243.06
27687	T		Revision of calf tendon	0050	23.3037	$1,215.31		$243.06
27690	T		Revise lower leg tendon	0051	32.9062	$1,716.09		$343.22
27691	T		Revise lower leg tendon	0051	32.9062	$1,716.09		$343.22
27692	T		Revise additional leg tendon	0051	32.9062	$1,716.09		$343.22
27695	T		Repair of ankle ligament	0050	23.3037	$1,215.31		$243.06
27696	T		Repair of ankle ligaments	0050	23.3037	$1,215.31		$243.06
27698	T		Repair of ankle ligament	0050	23.3037	$1,215.31		$243.06
27700	T		Revision of ankle joint	0047	28.2842	$1,475.05	$537.03	$295.01
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	18.6042	$970.23	$197.14	$194.05
27705	T		Incision of tibia	0051	32.9062	$1,716.09		$343.22
27707	T		Incision of fibula	0049	18.6042	$970.23	$197.14	$194.05
27709	T		Incision of tibia & fibula	0050	23.3037	$1,215.31		$243.06
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	23.3037	$1,215.31		$243.06
27732	T		Repair of fibula epiphysis	0050	23.3037	$1,215.31		$243.06
27734	T		Repair lower leg epiphyses	0050	23.3037	$1,215.31		$243.06
27740	T		Repair of leg epiphyses	0050	23.3037	$1,215.31		$243.06
27742	T		Repair of leg epiphyses	0051	32.9062	$1,716.09		$343.22
27745	T		Reinforce tibia	0051	32.9062	$1,716.09		$343.22
27750	T		Treatment of tibia fracture	0043	2.4999	$130.37		$26.07
27752	T		Treatment of tibia fracture	0043	2.4999	$130.37		$26.07
27756	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27758	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27759	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27760	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27762	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27766	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27780	T		Treatment of fibula fracture	0043	2.4999	$130.37		$26.07
27781	T		Treatment of fibula fracture	0043	2.4999	$130.37		$26.07
27784	T		Treatment of fibula fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27786	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27788	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27792	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27808	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27810	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27814	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27816	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27818	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27822	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27823	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27824	T		Treat lower leg fracture	0043	2.4999	$130.37		$26.07
27825	T		Treat lower leg fracture	0043	2.4999	$130.37		$26.07
27826	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27827	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27828	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27829	T		Treat lower leg joint	0046	29.2920	$1,527.61	$535.76	$305.52
27830	T		Treat lower leg dislocation	0043	2.4999	$130.37		$26.07
27831	T		Treat lower leg dislocation	0043	2.4999	$130.37		$26.07
27832	T		Treat lower leg dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27840	T		Treat ankle dislocation	0043	2.4999	$130.37		$26.07
27842	T		Treat ankle dislocation	0045	12.9357	$674.61	$268.47	$134.92
27846	T		Treat ankle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27848	T		Treat ankle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27860	T		Fixation of ankle joint	0045	12.9357	$674.61	$268.47	$134.92
27870	T		Fusion of ankle joint	0051	32.9062	$1,716.09		$343.22
27871	T		Fusion of tibiofibular joint	0051	32.9062	$1,716.09		$343.22
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	18.6042	$970.23	$197.14	$194.05
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	23.3037	$1,215.31		$243.06
27892	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27893	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27894	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27899	T		Leg/ankle surgery procedure	0043	2.4999	$130.37		$26.07
28001	T		Drainage of bursa of foot	0008	16.1430	$841.87		$168.37
28002	T		Treatment of foot infection	0049	18.6042	$970.23	$197.14	$194.05
28003	T		Treatment of foot infection	0049	18.6042	$970.23	$197.14	$194.05
28005	T		Treat foot bone lesion	0055	17.6740	$921.72	$355.34	$184.34
28008	T		Incision of foot fascia	0055	17.6740	$921.72	$355.34	$184.34
28010	T		Incision of toe tendon	0055	17.6740	$921.72	$355.34	$184.34
28011	T		Incision of toe tendons	0055	17.6740	$921.72	$355.34	$184.34
28020	T		Exploration of foot joint	0055	17.6740	$921.72	$355.34	$184.34
28022	T		Exploration of foot joint	0055	17.6740	$921.72	$355.34	$184.34
28024	T		Exploration of toe joint	0055	17.6740	$921.72	$355.34	$184.34
28030	T		Removal of foot nerve	0220	15.8136	$824.70		$164.94
28035	T		Decompression of tibia nerve	0220	15.8136	$824.70		$164.94
28043	T		Excision of foot lesion	0021	13.9338	$726.66	$219.48	$145.33
28045	T		Excision of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28046	T		Resection of tumor, foot	0055	17.6740	$921.72	$355.34	$184.34
28050	T		Biopsy of foot joint lining	0055	17.6740	$921.72	$355.34	$184.34
28052	T		Biopsy of foot joint lining	0055	17.6740	$921.72	$355.34	$184.34
28054	T		Biopsy of toe joint lining	0055	17.6740	$921.72	$355.34	$184.34
28060	T		Partial removal, foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28062	T		Removal of foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28070	T		Removal of foot joint lining	0056	22.1700	$1,156.19	$405.81	$231.24
28072	T		Removal of foot joint lining	0056	22.1700	$1,156.19	$405.81	$231.24
28080	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28086	T		Excise foot tendon sheath	0055	17.6740	$921.72	$355.34	$184.34
28088	T		Excise foot tendon sheath	0055	17.6740	$921.72	$355.34	$184.34
28090	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28092	T		Removal of toe lesions	0055	17.6740	$921.72	$355.34	$184.34
28100	T		Removal of ankle/heel lesion	0055	17.6740	$921.72	$355.34	$184.34
28102	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28103	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28104	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28106	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28107	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28108	T		Removal of toe lesions	0055	17.6740	$921.72	$355.34	$184.34
28110	T		Part removal of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28111	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28112	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28113	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28114	T		Removal of metatarsal heads	0055	17.6740	$921.72	$355.34	$184.34
28116	T		Revision of foot	0055	17.6740	$921.72	$355.34	$184.34
28118	T		Removal of heel bone	0055	17.6740	$921.72	$355.34	$184.34
28119	T		Removal of heel spur	0055	17.6740	$921.72	$355.34	$184.34
28120	T		Part removal of ankle/heel	0055	17.6740	$921.72	$355.34	$184.34

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28122	T		Partial removal of foot bone	0055	17.6740	$921.72	$355.34	$184.34
28124	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28126	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28130	T		Removal of ankle bone	0055	17.6740	$921.72	$355.34	$184.34
28140	T		Removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28150	T		Removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28153	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28160	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28171	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28173	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28175	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28190	T		Removal of foot foreign body	0019	3.7693	$196.57	$71.87	$39.31
28192	T		Removal of foot foreign body	0021	13.9338	$726.66	$219.48	$145.33
28193	T		Removal of foot foreign body	0021	13.9338	$726.66	$219.48	$145.33
28200	T		Repair of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28202	T		Repair/graft of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28208	T		Repair of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28210	T		Repair/graft of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28220	T		Release of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28222	T		Release of foot tendons	0055	17.6740	$921.72	$355.34	$184.34
28225	T		Release of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28226	T		Release of foot tendons	0055	17.6740	$921.72	$355.34	$184.34
28230	T		Incision of foot tendon(s)	0055	17.6740	$921.72	$355.34	$184.34
28232	T		Incision of toe tendon	0055	17.6740	$921.72	$355.34	$184.34
28234	T		Incision of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28238	T		Revision of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28240	T		Release of big toe	0055	17.6740	$921.72	$355.34	$184.34
28250	T		Revision of foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28260	T		Release of midfoot joint	0056	22.1700	$1,156.19	$405.81	$231.24
28261	T		Revision of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28262	T		Revision of foot and ankle	0056	22.1700	$1,156.19	$405.81	$231.24
28264	T		Release of midfoot joint	0056	22.1700	$1,156.19	$405.81	$231.24
28270	T		Release of foot contracture	0055	17.6740	$921.72	$355.34	$184.34
28272	T		Release of toe joint, each	0055	17.6740	$921.72	$355.34	$184.34
28280	T		Fusion of toes	0055	17.6740	$921.72	$355.34	$184.34
28285	T		Repair of hammertoe	0055	17.6740	$921.72	$355.34	$184.34
28286	T		Repair of hammertoe	0055	17.6740	$921.72	$355.34	$184.34
28288	T		Partial removal of foot bone	0056	22.1700	$1,156.19	$405.81	$231.24
28289	T		Repair hallux rigidus	0056	22.1700	$1,156.19	$405.81	$231.24
28290	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28292	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28293	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28294	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28296	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28297	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28298	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28299	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28300	T		Incision of heel bone	0056	22.1700	$1,156.19	$405.81	$231.24
28302	T		Incision of ankle bone	0056	22.1700	$1,156.19	$405.81	$231.24
28304	T		Incision of midfoot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28305	T		Incise/graft midfoot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28306	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28307	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28308	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28309	T		Incision of metatarsals	0056	22.1700	$1,156.19	$405.81	$231.24
28310	T		Revision of big toe	0055	17.6740	$921.72	$355.34	$184.34
28312	T		Revision of toe	0055	17.6740	$921.72	$355.34	$184.34
28313	T		Repair deformity of toe	0055	17.6740	$921.72	$355.34	$184.34
28315	T		Removal of sesamoid bone	0055	17.6740	$921.72	$355.34	$184.34
28320	T		Repair of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28322	T		Repair of metatarsals	0056	22.1700	$1,156.19	$405.81	$231.24
28340	T		Resect enlarged toe tissue	0055	17.6740	$921.72	$355.34	$184.34
28341	T		Resect enlarged toe	0055	17.6740	$921.72	$355.34	$184.34
28344	T		Repair extra toe(s)	0056	22.1700	$1,156.19	$405.81	$231.24
28345	T		Repair webbed toe(s)	0056	22.1700	$1,156.19	$405.81	$231.24

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28360	T		Reconstruct cleft foot	0056	22.1700	$1,156.19	$405.81	$231.24
28400	T		Treatment of heel fracture	0043	2.4999	$130.37		$26.07
28405	T		Treatment of heel fracture	0043	2.4999	$130.37		$26.07
28406	T		Treatment of heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28415	T		Treat heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28420	T		Treat/graft heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28430	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
28435	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
28436	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28445	T		Treat ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28450	T		Treat midfoot fracture, each	0043	2.4999	$130.37		$26.07
28455	T		Treat midfoot fracture, each	0043	2.4999	$130.37		$26.07
28456	T		Treat midfoot fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28465	T		Treat midfoot fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
28470	T		Treat metatarsal fracture	0043	2.4999	$130.37		$26.07
28475	T		Treat metatarsal fracture	0043	2.4999	$130.37		$26.07
28476	T		Treat metatarsal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28485	T		Treat metatarsal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28490	T		Treat big toe fracture	0043	2.4999	$130.37		$26.07
28495	T		Treat big toe fracture	0043	2.4999	$130.37		$26.07
28496	T		Treat big toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28505	T		Treat big toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28510	T		Treatment of toe fracture	0043	2.4999	$130.37		$26.07
28515	T		Treatment of toe fracture	0043	2.4999	$130.37		$26.07
28525	T		Treat toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28530	T		Treat sesamoid bone fracture	0043	2.4999	$130.37		$26.07
28531	T		Treat sesamoid bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28540	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28545	T		Treat foot dislocation	0045	12.9357	$674.61	$268.47	$134.92
28546	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28555	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28570	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28575	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28576	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28585	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28600	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28605	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28606	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28615	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28630	T		Treat toe dislocation	0043	2.4999	$130.37		$26.07
28635	T		Treat toe dislocation	0045	12.9357	$674.61	$268.47	$134.92
28636	T		Treat toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28645	T		Repair toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28660	T		Treat toe dislocation	0043	2.4999	$130.37		$26.07
28665	T		Treat toe dislocation	0045	12.9357	$674.61	$268.47	$134.92
28666	T		Treat toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28675	T		Repair of toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28705	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28715	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28725	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28730	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28735	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28737	T		Revision of foot bones	0055	17.6740	$921.72	$355.34	$184.34
28740	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28750	T		Fusion of big toe joint	0055	17.6740	$921.72	$355.34	$184.34
28755	T		Fusion of big toe joint	0055	17.6740	$921.72	$355.34	$184.34
28760	T		Fusion of big toe joint	0056	22.1700	$1,156.19	$405.81	$231.24
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28820	T		Amputation of toe	0055	17.6740	$921.72	$355.34	$184.34
28825	T		Partial amputation of toe	0055	17.6740	$921.72	$355.34	$184.34
28899	T		Foot/toes surgery procedure	0043	2.4999	$130.37		$26.07
29000	S		Application of body cast	0058	1.0368	$54.07		$10.81
29010	S		Application of body cast	0058	1.0368	$54.07		$10.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29015	S		Application of body cast	0058	1.0368	$54.07		$10.81
29020	S		Application of body cast	0058	1.0368	$54.07		$10.81
29025	S		Application of body cast	0058	1.0368	$54.07		$10.81
29035	S		Application of body cast	0058	1.0368	$54.07		$10.81
29040	S		Application of body cast	0058	1.0368	$54.07		$10.81
29044	S		Application of body cast	0058	1.0368	$54.07		$10.81
29046	S		Application of body cast	0058	1.0368	$54.07		$10.81
29049	S		Application of figure eight	0058	1.0368	$54.07		$10.81
29055	S		Application of shoulder cast	0058	1.0368	$54.07		$10.81
29058	S		Application of shoulder cast	0058	1.0368	$54.07		$10.81
29065	S		Application of long arm cast	0058	1.0368	$54.07		$10.81
29075	S		Application of forearm cast	0058	1.0368	$54.07		$10.81
29085	S		Apply hand/wrist cast	0058	1.0368	$54.07		$10.81
29086	S		Apply finger cast	0058	1.0368	$54.07		$10.81
29105	S		Apply long arm splint	0058	1.0368	$54.07		$10.81
29125	S		Apply forearm splint	0058	1.0368	$54.07		$10.81
29126	S		Apply forearm splint	0058	1.0368	$54.07		$10.81
29130	S		Application of finger splint	0058	1.0368	$54.07		$10.81
29131	S		Application of finger splint	0058	1.0368	$54.07		$10.81
29200	S		Strapping of chest	0058	1.0368	$54.07		$10.81
29220	S		Strapping of low back	0058	1.0368	$54.07		$10.81
29240	S		Strapping of shoulder	0058	1.0368	$54.07		$10.81
29260	S		Strapping of elbow or wrist	0058	1.0368	$54.07		$10.81
29280	S		Strapping of hand or finger	0058	1.0368	$54.07		$10.81
29305	S		Application of hip cast	0058	1.0368	$54.07		$10.81
29325	S		Application of hip casts	0058	1.0368	$54.07		$10.81
29345	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29355	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29358	S		Apply long leg cast brace	0058	1.0368	$54.07		$10.81
29365	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29405	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29425	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29435	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29440	S		Addition of walker to cast	0058	1.0368	$54.07		$10.81
29445	S		Apply rigid leg cast	0058	1.0368	$54.07		$10.81
29450	S		Application of leg cast	0058	1.0368	$54.07		$10.81
29505	S		Application, long leg splint	0058	1.0368	$54.07		$10.81
29515	S		Application lower leg splint	0058	1.0368	$54.07		$10.81
29520	S		Strapping of hip	0058	1.0368	$54.07		$10.81
29530	S		Strapping of knee	0058	1.0368	$54.07		$10.81
29540	S		Strapping of ankle	0058	1.0368	$54.07		$10.81
29550	S		Strapping of toes	0058	1.0368	$54.07		$10.81
29580	S		Application of paste boot	0058	1.0368	$54.07		$10.81
29590	S		Application of foot splint	0058	1.0368	$54.07		$10.81
29700	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29705	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29710	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29715	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29720	S		Repair of body cast	0058	1.0368	$54.07		$10.81
29730	S		Windowing of cast	0058	1.0368	$54.07		$10.81
29740	S		Wedging of cast	0058	1.0368	$54.07		$10.81
29750	S		Wedging of clubfoot cast	0058	1.0368	$54.07		$10.81
29799	S		Casting/strapping procedure	0058	1.0368	$54.07		$10.81
29800	T		Jaw arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29804	T		Jaw arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29805	T		Shoulder arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29806	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29807	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29819	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29820	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29821	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29822	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29823	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29824	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29825	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29826	T		Shoulder arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29827	T	NI	Arthroscop rotator cuff repr	0041	26.1234	$1,362.36		$272.47
29830	T		Elbow arthroscopy	0041	26.1234	$1,362.36		$272.47
29834	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29835	T		Elbow arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29836	T		Elbow arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29837	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29838	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29840	T		Wrist arthroscopy	0041	26.1234	$1,362.36		$272.47
29843	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29844	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29845	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29846	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29847	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29848	T		Wrist endoscopy/surgery	0041	26.1234	$1,362.36		$272.47
29850	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29851	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29855	T		Tibial arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29856	T		Tibial arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29860	T		Hip arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29861	T		Hip arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29862	T		Hip arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29863	T		Hip arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29870	T		Knee arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29871	T		Knee arthroscopy/drainage	0041	26.1234	$1,362.36		$272.47
29873	T	NI	Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29874	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29875	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29876	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29877	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29879	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29880	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29881	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29882	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29883	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29884	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29885	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29886	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29887	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29888	T		Knee arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29889	T		Knee arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29891	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29892	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29893	T		Scope, plantar fasciotomy	0055	17.6740	$921.72	$355.34	$184.34
29894	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29895	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29897	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29898	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29899	T	NI	Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29900	T		Mcp joint arthroscopy, dx	0053	14.1760	$739.29	$253.49	$147.86
29901	T		Mcp joint arthroscopy, surg	0053	14.1760	$739.29	$253.49	$147.86
29902	T		Mcp joint arthroscopy, surg	0053	14.1760	$739.29	$253.49	$147.86
29999	T		Arthroscopy of joint	0041	26.1234	$1,362.36		$272.47
30000	T		Drainage of nose lesion	0251	1.9089	$99.55		$19.91
30020	T		Drainage of nose lesion	0251	1.9089	$99.55		$19.91
30100	T		Intranasal biopsy	0252	5.8041	$302.69	$113.41	$60.54
30110	T		Removal of nose polyp(s)	0253	14.4473	$753.44	$282.29	$150.69
30115	T		Removal of nose polyp(s)	0253	14.4473	$753.44	$282.29	$150.69
30117	T		Removal of intranasal lesion	0253	14.4473	$753.44	$282.29	$150.69
30118	T		Removal of intranasal lesion	0254	20.1158	$1,049.06	$321.35	$209.81
30120	T		Revision of nose	0253	14.4473	$753.44	$282.29	$150.69
30124	T		Removal of nose lesion	0252	5.8041	$302.69	$113.41	$60.54
30125	T		Removal of nose lesion	0256	34.0302	$1,774.71		$354.94
30130	T		Removal of turbinate bones	0253	14.4473	$753.44	$282.29	$150.69
30140	T		Removal of turbinate bones	0254	20.1158	$1,049.06	$321.35	$209.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30150	T		Partial removal of nose	0256	34.0302	$1,774.71		$354.94
30160	T		Removal of nose	0256	34.0302	$1,774.71		$354.94
30200	T		Injection treatment of nose	0253	14.4473	$753.44	$282.29	$150.69
30210	T		Nasal sinus therapy	0252	5.8041	$302.69	$113.41	$60.54
30220	T		Insert nasal septal button	0252	5.8041	$302.69	$113.41	$60.54
30300	X		Remove nasal foreign body	0340	0.6492	$33.86		$6.77
30310	T		Remove nasal foreign body	0253	14.4473	$753.44	$282.29	$150.69
30320	T		Remove nasal foreign body	0253	14.4473	$753.44	$282.29	$150.69
30400	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30410	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30420	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30430	T		Revision of nose	0254	20.1158	$1,049.06	$321.35	$209.81
30435	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30450	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30460	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30462	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30465	T		Repair nasal stenosis	0256	34.0302	$1,774.71		$354.94
30520	T		Repair of nasal septum	0254	20.1158	$1,049.06	$321.35	$209.81
30540	T		Repair nasal defect	0256	34.0302	$1,774.71		$354.94
30545	T		Repair nasal defect	0256	34.0302	$1,774.71		$354.94
30560	T		Release of nasal adhesions	0251	1.9089	$99.55		$19.91
30580	T		Repair upper jaw fistula	0256	34.0302	$1,774.71		$354.94
30600	T		Repair mouth/nose fistula	0256	34.0302	$1,774.71		$354.94
30620	T		Intranasal reconstruction	0256	34.0302	$1,774.71		$354.94
30630	T		Repair nasal septum defect	0254	20.1158	$1,049.06	$321.35	$209.81
30801	T		Cauterization, inner nose	0252	5.8041	$302.69	$113.41	$60.54
30802	T		Cauterization, inner nose	0253	14.4473	$753.44	$282.29	$150.69
30901	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30903	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30905	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30906	T		Repeat control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30915	T		Ligation, nasal sinus artery	0091	26.7048	$1,392.68	$348.23	$278.54
30920	T		Ligation, upper jaw artery	0092	23.7882	$1,240.58	$505.37	$248.12
30930	T		Therapy, fracture of nose	0253	14.4473	$753.44	$282.29	$150.69
30999	T		Nasal surgery procedure	0251	1.9089	$99.55		$19.91
31000	T		Irrigation, maxillary sinus	0251	1.9089	$99.55		$19.91
31002	T		Irrigation, sphenoid sinus	0252	5.8041	$302.69	$113.41	$60.54
31020	T		Exploration, maxillary sinus	0254	20.1158	$1,049.06	$321.35	$209.81
31030	T		Exploration, maxillary sinus	0256	34.0302	$1,774.71		$354.94
31032	T		Explore sinus, remove polyps	0256	34.0302	$1,774.71		$354.94
31040	T		Exploration behind upper jaw	0254	20.1158	$1,049.06	$321.35	$209.81
31050	T		Exploration, sphenoid sinus	0256	34.0302	$1,774.71		$354.94
31051	T		Sphenoid sinus surgery	0256	34.0302	$1,774.71		$354.94
31070	T		Exploration of frontal sinus	0254	20.1158	$1,049.06	$321.35	$209.81
31075	T		Exploration of frontal sinus	0256	34.0302	$1,774.71		$354.94
31080	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31081	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31084	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31085	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31086	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31087	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31090	T		Exploration of sinuses	0256	34.0302	$1,774.71		$354.94
31200	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31201	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31205	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0071	0.9205	$48.00	$12.89	$9.60
31233	T		Nasal/sinus endoscopy, dx	0073	3.1976	$166.76	$73.38	$33.35
31235	T		Nasal/sinus endoscopy, dx	0074	12.8582	$670.57	$295.70	$134.11
31237	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31238	T		Nasal/sinus endoscopy, surg	0074	12.8582	$670.57	$295.70	$134.11
31239	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31240	T		Nasal/sinus endoscopy, surg	0074	12.8582	$670.57	$295.70	$134.11
31254	T		Revision of ethmoid sinus	0075	19.6604	$1,025.31	$445.92	$205.06

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31255	T		Removal of ethmoid sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31256	T		Exploration maxillary sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31267	T		Endoscopy, maxillary sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31276	T		Sinus endoscopy, surgical	0075	19.6604	$1,025.31	$445.92	$205.06
31287	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31288	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
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	5.8041	$302.69	$113.41	$60.54
31300	T		Removal of larynx lesion	0256	34.0302	$1,774.71		$354.94
31320	T		Diagnostic incision, larynx	0256	34.0302	$1,774.71		$354.94
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	34.0302	$1,774.71		$354.94
31420	T		Removal of epiglottis	0256	34.0302	$1,774.71		$354.94
31500	S		Insert emergency airway	0094	3.8371	$200.11	$67.63	$40.02
31502	T		Change of windpipe airway	0121	2.0833	$108.65	$43.80	$21.73
31505	T		Diagnostic laryngoscopy	0072	1.1628	$60.64	$26.68	$12.13
31510	T		Laryngoscopy with biopsy	0074	12.8582	$670.57	$295.70	$134.11
31511	T		Remove foreign body, larynx	0072	1.1628	$60.64	$26.68	$12.13
31512	T		Removal of larynx lesion	0074	12.8582	$670.57	$295.70	$134.11
31513	T		Injection into vocal cord	0072	1.1628	$60.64	$26.68	$12.13
31515	T		Laryngoscopy for aspiration	0074	12.8582	$670.57	$295.70	$134.11
31520	T		Diagnostic laryngoscopy	0072	1.1628	$60.64	$26.68	$12.13
31525	T		Diagnostic laryngoscopy	0074	12.8582	$670.57	$295.70	$134.11
31526	T		Diagnostic laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31527	T		Laryngoscopy for treatment	0075	19.6604	$1,025.31	$445.92	$205.06
31528	T		Laryngoscopy and dilation	0074	12.8582	$670.57	$295.70	$134.11
31529	T		Laryngoscopy and dilation	0074	12.8582	$670.57	$295.70	$134.11
31530	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31531	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31535	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31536	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31540	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31541	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31560	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31561	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31570	T		Laryngoscopy with injection	0074	12.8582	$670.57	$295.70	$134.11
31571	T		Laryngoscopy with injection	0075	19.6604	$1,025.31	$445.92	$205.06
31575	T		Diagnostic laryngoscopy	0071	0.9205	$48.00	$12.89	$9.60
31576	T		Laryngoscopy with biopsy	0075	19.6604	$1,025.31	$445.92	$205.06
31577	T		Remove foreign body, larynx	0073	3.1976	$166.76	$73.38	$33.35
31578	T		Removal of larynx lesion	0075	19.6604	$1,025.31	$445.92	$205.06
31579	T		Diagnostic laryngoscopy	0073	3.1976	$166.76	$73.38	$33.35
31580	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31582	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	14.4473	$753.44	$282.29	$150.69
31586	T		Treat larynx fracture	0256	34.0302	$1,774.71		$354.94
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31590	T		Reinnervate larynx	0256	34.0302	$1,774.71		$354.94
31595	T		Larynx nerve surgery	0256	34.0302	$1,774.71		$354.94
31599	T		Larynx surgery procedure	0254	20.1158	$1,049.06	$321.35	$209.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31600	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31601	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31603	T		Incision of windpipe	0252	5.8041	$302.69	$113.41	$60.54
31605	T		Incision of windpipe	0253	14.4473	$753.44	$282.29	$150.69
31610	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31611	T		Surgery/speech prosthesis	0254	20.1158	$1,049.06	$321.35	$209.81
31612	T		Puncture/clear windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31613	T		Repair windpipe opening	0254	20.1158	$1,049.06	$321.35	$209.81
31614	T		Repair windpipe opening	0256	34.0302	$1,774.71		$354.94
31615	T		Visualization of windpipe	0076	8.9533	$466.92	$189.82	$93.38
31622	T		Dx bronchoscope/wash	0076	8.9533	$466.92	$189.82	$93.38
31623	T		Dx bronchoscope/brush	0076	8.9533	$466.92	$189.82	$93.38
31624	T		Dx bronchoscope/lavage	0076	8.9533	$466.92	$189.82	$93.38
31625	T		Bronchoscopy w/biopsy(s)	0076	8.9533	$466.92	$189.82	$93.38
31628	T		Bronchoscopy/lung bx, each	0076	8.9533	$466.92	$189.82	$93.38
31629	T		Bronchoscopy/needle bx, each	0076	8.9533	$466.92	$189.82	$93.38
31630	T		Bronchoscopy dilate/fx repr	0076	8.9533	$466.92	$189.82	$93.38
31631	T		Bronchoscopy, dilate w/stent	0076	8.9533	$466.92	$189.82	$93.38
31635	T		Bronchoscopy w/fb removal	0076	8.9533	$466.92	$189.82	$93.38
31640	T		Bronchoscopy w/tumor excise	0076	8.9533	$466.92	$189.82	$93.38
31641	T		Bronchoscopy, treat blockage	0076	8.9533	$466.92	$189.82	$93.38
31643	T		Diag bronchoscope/catheter	0076	8.9533	$466.92	$189.82	$93.38
31645	T		Bronchoscopy, clear airways	0076	8.9533	$466.92	$189.82	$93.38
31646	T		Bronchoscopy, reclear airway	0076	8.9533	$466.92	$189.82	$93.38
31656	T		Bronchoscopy, inj for x-ray	0076	8.9533	$466.92	$189.82	$93.38
31700	T		Insertion of airway catheter	0072	1.1628	$60.64	$26.68	$12.13
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	3.1976	$166.76	$73.38	$33.35
31720	T		Clearance of airways	0072	1.1628	$60.64	$26.68	$12.13
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	3.1976	$166.76	$73.38	$33.35
31750	T		Repair of windpipe	0256	34.0302	$1,774.71		$354.94
31755	T		Repair of windpipe	0256	34.0302	$1,774.71		$354.94
31760	C		Repair of windpipe					
31766	C		Reconstruction of windpipe					
31770	C		Repair/graft of bronchus					
31775	C		Reconstruct bronchus					
31780	C		Reconstruct windpipe					
31781	C		Reconstruct windpipe					
31785	T		Remove windpipe lesion	0254	20.1158	$1,049.06	$321.35	$209.81
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	14.4473	$753.44	$282.29	$150.69
31825	T		Repair of windpipe defect	0254	20.1158	$1,049.06	$321.35	$209.81
31830	T		Revise windpipe scar	0254	20.1158	$1,049.06	$321.35	$209.81
31899	T		Airways surgical procedure	0076	8.9533	$466.92	$189.82	$93.38
32000	T		Drainage of chest	0070	3.3623	$175.35		$35.07
32002	T		Treatment of collapsed lung	0070	3.3623	$175.35		$35.07
32005	T		Treat lung lining chemically	0070	3.3623	$175.35		$35.07
32020	T		Insertion of chest tube	0070	3.3623	$175.35		$35.07
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32200	C		Drain, open, lung lesion					
32201	T		Drain, percut, lung lesion	0070	3.3623	$175.35		$35.07
32215	C		Treat chest lining					
32220	C		Release of lung					
32225	C		Partial release of lung					
32310	C		Removal of chest lining					
32320	C		Free/remove chest lining					
32400	T		Needle biopsy chest lining	0005	3.1201	$162.72	$71.59	$32.54
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	5.9882	$312.29	$137.40	$62.46
32420	T		Puncture/clear lung	0070	3.3623	$175.35		$35.07
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	27.5575	$1,437.15	$591.64	$287.43
32602	T		Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32603	T		Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32604	T		Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32605	T		Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32606	T		Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32650	C		Thoracoscopy, surgical					
32651	C		Thoracoscopy, surgical					
32652	C		Thoracoscopy, surgical					
32653	C		Thoracoscopy, surgical					
32654	C		Thoracoscopy, surgical					
32655	C		Thoracoscopy, surgical					
32656	C		Thoracoscopy, surgical					
32657	C		Thoracoscopy, surgical					
32658	C		Thoracoscopy, surgical					
32659	C		Thoracoscopy, surgical					
32660	C		Thoracoscopy, surgical					
32661	C		Thoracoscopy, surgical					
32662	C		Thoracoscopy, surgical					
32663	C		Thoracoscopy, surgical					
32664	C		Thoracoscopy, surgical					
32665	C		Thoracoscopy, surgical					
32800	C		Repair lung hernia					
32810	C		Close chest after drainage					
32815	C		Close bronchial fistula					
32820	C		Reconstruct injured chest					
32850	C		Donor pneumonectomy					
32851	C		Lung transplant, single					
32852	C		Lung transplant with bypass					
32853	C		Lung transplant, double					
32854	C		Lung transplant with bypass					
32900	C		Removal of rib(s)					
32905	C		Revise & repair chest wall					
32906	C		Revise & repair chest wall					
32940	C		Revision of lung					
32960	T		Therapeutic pneumothorax	0070	3.3623	$175.35		$35.07
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.3623	$175.35		$35.07
33010	T		Drainage of heart sac	0070	3.3623	$175.35		$35.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33011	T		Repeat drainage of heart sac	0070	3.3623	$175.35		$35.07
33015	C		Incision of heart sac					
33020	C		Incision of heart sac					
33025	C		Incision of heart sac					
33030	C		Partial removal of heart sac					
33031	C		Partial removal of heart sac					
33050	C		Removal of heart sac lesion					
33120	C		Removal of heart lesion					
33130	C		Removal of heart lesion					
33140	C		Heart revascularize (tmr)					
33141	C		Heart tmr w/other procedure					
33200	C		Insertion of heart pacemaker					
33201	C		Insertion of heart pacemaker					
33206	T		Insertion of heart pacemaker	0089	112.5555	$5,869.88	$1,722.59	$1,173.98
33207	T		Insertion of heart pacemaker	0089	112.5555	$5,869.88	$1,722.59	$1,173.98
33208	T		Insertion of heart pacemaker	0655	122.8654	$6,407.55		$1,281.51
33210	T		Insertion of heart electrode	0106	54.8243	$2,859.14		$571.83
33211	T		Insertion of heart electrode	0106	54.8243	$2,859.14		$571.83
33212	T		Insertion of pulse generator	0090	87.9631	$4,587.36	$1,651.45	$917.47
33213	T		Insertion of pulse generator	0654	91.8583	$4,790.50		$958.10
33214	T		Upgrade of pacemaker system	0655	122.8654	$6,407.55		$1,281.51
33215	T	NI	Reposition pacing-defib lead	0105	18.5945	$969.72	$370.40	$193.94
33216	T		Revise eltrd pacing-defib	0106	54.8243	$2,859.14		$571.83
33217	T		Insert lead pace-defib, dual	0106	54.8243	$2,859.14		$571.83
33218	T		Repair lead pace-defib, one	0106	54.8243	$2,859.14		$571.83
33220	T		Repair lead pace-defib, dual	0106	54.8243	$2,859.14		$571.83
33222	T		Revise pocket, pacemaker	0027	15.2225	$793.87	$329.72	$158.77
33223	T		Revise pocket, pacing-defib	0027	15.2225	$793.87	$329.72	$158.77
33224	T	NI	Insert pacing lead & connect	0976		$875.00		$175.00
33225	T	NI	L ventric pacing lead add-on	0977		$1,125.00		$225.00
33226	T	NI	Reposition l ventric lead	0105	18.5945	$969.72	$370.40	$193.94
33233	T		Removal of pacemaker system	0105	18.5945	$969.72	$370.40	$193.94
33234	T		Removal of pacemaker system	0105	18.5945	$969.72	$370.40	$193.94
33235	T		Removal pacemaker electrode	0105	18.5945	$969.72	$370.40	$193.94
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	T		Insert pulse generator	0107	326.2231	$17,012.86	$3,699.14	$3,402.57
33241	T		Remove pulse generator	0105	18.5945	$969.72	$370.40	$193.94
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	18.5945	$969.72	$370.40	$193.94
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	T		Eltrd/insert pace-defib	0108	443.5460	$23,131.37		$4,626.27
33250	C		Ablate heart dysrhythm focus					
33251	C		Ablate heart dysrhythm focus					
33253	C		Reconstruct atria					
33261	C		Ablate heart dysrhythm focus					
33282	S		Implant pat-active ht record	0680	56.1324	$2,927.36		$585.47
33284	T		Remove pat-active ht record	0109	7.4708	$389.61	$131.49	$77.92
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33406	C		Replacement of aortic valve					
33410	C		Replacement of aortic valve					
33411	C		Replacement of aortic valve					
33412	C		Replacement of aortic valve					
33413	C		Replacement of aortic valve					
33414	C		Repair of aortic valve					
33415	C		Revision, subvalvular tissue					
33416	C		Revise ventricle muscle					
33417	C		Repair of aortic valve					
33420	C		Revision of mitral valve					
33422	C		Revision of mitral valve					
33425	C		Repair of mitral valve					
33426	C		Repair of mitral valve					
33427	C		Repair of mitral valve					
33430	C		Replacement of mitral valve					
33460	C		Revision of tricuspid valve					
33463	C		Valvuloplasty, tricuspid					
33464	C		Valvuloplasty, tricuspid					
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N	NI	Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33619	C		Repair single ventricle					
33641	C		Repair heart septum defect					
33645	C		Revision of heart veins					
33647	C		Repair heart septum defects					
33660	C		Repair of heart defects					
33665	C		Repair of heart defects					
33670	C		Repair of heart chambers					
33681	C		Repair heart septum defect					
33684	C		Repair heart septum defect					
33688	C		Repair heart septum defect					
33690	C		Reinforce pulmonary artery					
33692	C		Repair of heart defects					
33694	C		Repair of heart defects					
33697	C		Repair of heart defects					
33702	C		Repair of heart defects					
33710	C		Repair of heart defects					
33720	C		Repair of heart defect					
33722	C		Repair of heart defect					
33730	C		Repair heart-vein defect(s)					
33732	C		Repair heart-vein defect					
33735	C		Revision of heart chamber					
33736	C		Revision of heart chamber					
33737	C		Revision of heart chamber					
33750	C		Major vessel shunt					
33755	C		Major vessel shunt					
33762	C		Major vessel shunt					
33764	C		Major vessel shunt & graft					
33766	C		Major vessel shunt					
33767	C		Major vessel shunt					
33770	C		Repair great vessels defect					
33771	C		Repair great vessels defect					
33774	C		Repair great vessels defect					
33775	C		Repair great vessels defect					
33776	C		Repair great vessels defect					
33777	C		Repair great vessels defect					
33778	C		Repair great vessels defect					
33779	C		Repair great vessels defect					
33780	C		Repair great vessels defect					
33781	C		Repair great vessels defect					
33786	C		Repair arterial trunk					
33788	C		Revision of pulmonary artery					
33800	C		Aortic suspension					
33802	C		Repair vessel defect					
33803	C		Repair vessel defect					
33813	C		Repair septal defect					
33814	C		Repair septal defect					
33820	C		Revise major vessel					
33822	C		Revise major vessel					
33824	C		Revise major vessel					
33840	C		Remove aorta constriction					
33845	C		Remove aorta constriction					
33851	C		Remove aorta constriction					
33852	C		Repair septal defect					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33919	C		Repair pulmonary atresia					
33920	C		Repair pulmonary atresia					
33922	C		Transect pulmonary artery					
33924	C		Remove pulmonary shunt					
33930	C		Removal of donor heart/lung					
33935	C		Transplantation, heart/lung					
33940	C		Removal of donor heart					
33945	C		Transplantation of heart					
33960	C		External circulation assist					
33961	C		External circulation assist					
33967	C		Insert ia percut device					
33968	C		Remove aortic assist device					
33970	C		Aortic circulation assist					
33971	C		Aortic circulation assist					
33973	C		Insert balloon device					
33974	C		Remove intra-aortic balloon					
33975	C		Implant ventricular device					
33976	C		Implant ventricular device					
33977	C		Remove ventricular device					
33978	C		Remove ventricular device					
33979	C		Insert intracorporeal device					
33980	C		Remove intracorporeal device					
33999	T		Cardiac surgery procedure	0070	3.3623	$175.35		$35.07
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34111	T		Removal of arm artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34203	T		Removal of leg artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34490	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34501	T		Repair valve, femoral vein	0088	32.5768	$1,698.91	$655.22	$339.78
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	32.5768	$1,698.91	$655.22	$339.78
34520	T		Cross-over vein graft	0088	32.5768	$1,698.91	$655.22	$339.78
34530	T		Leg vein fusion	0088	32.5768	$1,698.91	$655.22	$339.78
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		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, addl					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C	NI	Xpose for endoprosth, iliac					
34834	C	NI	Xpose, endoprosth, brachial					
34900	C	NI	Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	30.0284	$1,566.01		$313.20
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	20.6294	$1,075.84	$277.34	$215.17
35182	C		Repair blood vessel lesion					
35184	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35188	T		Repair blood vessel lesion	0088	32.5768	$1,698.91	$655.22	$339.78
35189	C		Repair blood vessel lesion					
35190	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35201	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35206	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35207	T		Repair blood vessel lesion	0088	32.5768	$1,698.91	$655.22	$339.78
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	20.6294	$1,075.84	$277.34	$215.17
35231	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35236	T		Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
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	20.6294	$1,075.84	$277.34	$215.17
35261	T		Repair blood vessel lesion	0653	30.0284	$1,566.01		$313.20
35266	T		Repair blood vessel lesion	0653	30.0284	$1,566.01		$313.20
35271	C		Repair blood vessel lesion					
35276	C		Repair blood vessel lesion					
35281	C		Repair blood vessel lesion					
35286	T		Repair blood vessel lesion	0653	30.0284	$1,566.01		$313.20
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	20.6294	$1,075.84	$277.34	$215.17
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	43.5067	$2,268.92		$453.78
35459	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35460	T		Repair venous blockage	0081	43.5067	$2,268.92		$453.78
35470	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35471	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35472	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35473	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35474	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35475	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35476	T		Repair venous blockage	0081	43.5067	$2,268.92		$453.78
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	43.5067	$2,268.92		$453.78
35485	T		Atherectomy, open	0081	43.5067	$2,268.92		$453.78
35490	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35491	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35492	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35493	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35494	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35495	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35500	T		Harvest vein for bypass	0081	43.5067	$2,268.92		$453.78
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					
35572	N	NI	Harvest femoropopliteal vein					
35582	C		Vein bypass graft					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					
35612	C		Artery bypass graft					
35616	C		Artery bypass graft					
35621	C		Artery bypass graft					
35623	C		Bypass graft, not vein					
35626	C		Artery bypass graft					
35631	C		Artery bypass graft					
35636	C		Artery bypass graft					
35641	C		Artery bypass graft					
35642	C		Artery bypass graft					
35645	C		Artery bypass graft					
35646	C		Artery bypass graft					
35647	C		Artery bypass graft					
35650	C		Artery bypass graft					
35651	C		Artery bypass graft					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35654	C		Artery bypass graft					
35656	C		Artery bypass graft					
35661	C		Artery bypass graft					
35663	C		Artery bypass graft					
35665	C		Artery bypass graft					
35666	C		Artery bypass graft					
35671	C		Artery bypass graft					
35681	C		Composite bypass graft					
35682	C		Composite bypass graft					
35683	C		Composite bypass graft					
35685	T		Bypass graft patency/patch	0093	20.6294	$1,075.84	$277.34	$215.17
35686	T		Bypass graft/av fist patency	0093	20.6294	$1,075.84	$277.34	$215.17
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	24.3211	$1,268.37	$459.35	$253.67
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	20.6294	$1,075.84	$277.34	$215.17
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	32.5768	$1,698.91	$655.22	$339.78
35876	T		Removal of clot in graft	0088	32.5768	$1,698.91	$655.22	$339.78
35879	T		Revise graft w/vein	0088	32.5768	$1,698.91	$655.22	$339.78
35881	T		Revise graft w/vein	0088	32.5768	$1,698.91	$655.22	$339.78
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	24.3211	$1,268.37	$459.35	$253.67
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4418	$127.34	$65.52	$25.47
36005	N		Injection ext venography					
36010	N		Place catheter in vein					
36011	N		Place catheter in vein					
36012	N		Place catheter in vein					
36013	N		Place catheter in artery					
36014	N		Place catheter in artery					
36015	N		Place catheter in artery					
36100	N		Establish access to artery					
36120	N		Establish access to artery					
36140	N		Establish access to artery					
36145	N		Artery to vein shunt					
36160	N		Establish access to aorta					
36200	N		Place catheter in aorta					
36215	N		Place catheter in artery					
36216	N		Place catheter in artery					
36217	N		Place catheter in artery					
36218	N		Place catheter in artery					
36245	N		Place catheter in artery					
36246	N		Place catheter in artery					
36247	N		Place catheter in artery					
36248	N		Place catheter in artery					
36260	T		Insertion of infusion pump	0119	89.3100	$4,657.61		$931.52
36261	T		Revision of infusion pump	0124	50.0861	$2,612.04		$522.41
36262	T		Removal of infusion pump	0109	7.4708	$389.61	$131.49	$77.92
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36415	E		Drawing blood					
36416	E	NI	Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.2229	$11.62	$3.51	$2.32
36425	T		Vein access cutdown > 1 yr	0035	0.2229	$11.62	$3.51	$2.32
36430	S		Blood transfusion service	0110	4.0309	$210.22		$42.04
36440	S		Bl push transfuse, 2 yr or <	0110	4.0309	$210.22		$42.04
36450	S		Bl exchange/transfuse, nb	0110	4.0309	$210.22		$42.04
36455	S		Bl exchange/transfuse non-nb	0110	4.0309	$210.22		$42.04
36460	S		Transfusion service, fetal	0110	4.0309	$210.22		$42.04
36468	T		Injection(s), spider veins	0098	1.6666	$86.91	$20.88	$17.38
36469	T		Injection(s), spider veins	0098	1.6666	$86.91	$20.88	$17.38
36470	T		Injection therapy of vein	0098	1.6666	$86.91	$20.88	$17.38
36471	T		Injection therapy of veins	0098	1.6666	$86.91	$20.88	$17.38
36481	N		Insertion of catheter, vein					
36488	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36489	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36490	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36491	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36493	X		Repositioning of cvc	0187	3.9534	$206.17	$90.71	$41.23
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S	NI	Apheresis wbc	0111	14.9803	$781.24	$217.61	$156.25
36512	S	NI	Apheresis rbc	0111	14.9803	$781.24	$217.61	$156.25
36513	S	NI	Apheresis platelets	0111	14.9803	$781.24	$217.61	$156.25
36514	S	NI	Apheresis plasma	0111	14.9803	$781.24	$217.61	$156.25
36515	S	NI	Apheresis, adsorp/reinfuse	0112	36.4236	$1,899.53	$612.47	$379.91
36516	S	NI	Apheresis, selective	0112	36.4236	$1,899.53	$612.47	$379.91
36520	S	DG	Plasma and/or cell exchange	0111	14.9803	$781.24	$217.61	$156.25
36521	S	DG	Apheresis w/ adsorp/reinfuse	0112	36.4236	$1,899.53	$612.47	$379.91
36522	S		Photopheresis	0112	36.4236	$1,899.53	$612.47	$379.91
36530	T		Insertion of infusion pump	0119	89.3100	$4,657.61		$931.52
36531	T		Revision of infusion pump	0124	50.0861	$2,612.04		$522.41
36532	T		Removal of infusion pump	0109	7.4708	$389.61	$131.49	$77.92
36533	T		Insertion of access device	0115	24.3211	$1,268.37	$459.35	$253.67
36534	T		Revision of access device	0109	7.4708	$389.61	$131.49	$77.92
36535	T		Removal of access device	0109	7.4708	$389.61	$131.49	$77.92
36536	T	NI	Remove cva device obstruct	0973		$250.00		$50.00
36537	T	NI	Remove cva lumen obstruct	0973		$250.00		$50.00
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	2.6453	$137.96		$27.59
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	11.4726	$598.31		$119.66
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0120	2.1802	$113.70	$30.75	$22.74
36800	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36810	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36815	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36819	T		Av fusion/uppr arm vein	0088	32.5768	$1,698.91	$655.22	$339.78
36820	T		Av fusion/forearm vein	0088	32.5768	$1,698.91	$655.22	$339.78
36821	T		Av fusion direct any site	0088	32.5768	$1,698.91	$655.22	$339.78
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	32.5768	$1,698.91	$655.22	$339.78
36830	T		Artery-vein graft	0088	32.5768	$1,698.91	$655.22	$339.78
36831	T		Open thrombect av fistula	0088	32.5768	$1,698.91	$655.22	$339.78
36832	T		Av fistula revision, open	0088	32.5768	$1,698.91	$655.22	$339.78
36833	T		Av fistula revision	0088	32.5768	$1,698.91	$655.22	$339.78
36834	T		Repair A-V aneurysm	0088	32.5768	$1,698.91	$655.22	$339.78
36835	T		Artery to vein shunt	0115	24.3211	$1,268.37	$459.35	$253.67
36860	T		External cannula declotting	0103	11.8408	$617.51	$223.63	$123.50
36861	T		Cannula declotting	0115	24.3211	$1,268.37	$459.35	$253.67
36870	T		Percut thrombect av fistula	0653	30.0284	$1,566.01		$313.20
37140	C		Revision of circulation					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37145	C		Revision of circulation					
37160	C		Revision of circulation					
37180	C		Revision of circulation					
37181	C		Splice spleen/kidney veins					
37182	C	NI	Insert hepatic shunt (tips)					
37183	C	NI	Remove hepatic shunt (tips)					
37195	C		Thrombolytic therapy, stroke					
37200	T		Transcatheter biopsy	0685	5.9882	$312.29	$137.40	$62.46
37201	T		Transcatheter therapy infuse	0676	4.1278	$215.27	$58.21	$43.05
37202	T		Transcatheter therapy infuse	0677	2.6453	$137.96		$27.59
37203	T		Transcatheter retrieval	0103	11.8408	$617.51	$223.63	$123.50
37204	T		Transcatheter occlusion	0115	24.3211	$1,268.37	$459.35	$253.67
37205	T		Transcatheter stent	0229	57.4599	$2,996.59	$771.23	$599.32
37206	T		Transcatheter stent add-on	0229	57.4599	$2,996.59	$771.23	$599.32
37207	T		Transcatheter stent	0229	57.4599	$2,996.59	$771.23	$599.32
37208	T		Transcatheter stent add-on	0229	57.4599	$2,996.59	$771.23	$599.32
37209	T		Exchange arterial catheter	0103	11.8408	$617.51	$223.63	$123.50
37250	S		Iv us first vessel add-on	0670	30.2416	$1,577.13	$571.17	$315.43
37251	S		Iv us each add vessel add-on	0670	30.2416	$1,577.13	$571.17	$315.43
37500	T	NI	Endoscopy ligate perf veins	0092	23.7882	$1,240.58	$505.37	$248.12
37501	T	NI	Vascular endoscopy procedure	0092	23.7882	$1,240.58	$505.37	$248.12
37565	T		Ligation of neck vein	0093	20.6294	$1,075.84	$277.34	$215.17
37600	T		Ligation of neck artery	0093	20.6294	$1,075.84	$277.34	$215.17
37605	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
37606	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
37607	T		Ligation of a-v fistula	0092	23.7882	$1,240.58	$505.37	$248.12
37609	T		Temporal artery procedure	0021	13.9338	$726.66	$219.48	$145.33
37615	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
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	26.7048	$1,392.68	$348.23	$278.54
37650	T		Revision of major vein	0091	26.7048	$1,392.68	$348.23	$278.54
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	26.7048	$1,392.68	$348.23	$278.54
37720	T		Removal of leg vein	0092	23.7882	$1,240.58	$505.37	$248.12
37730	T		Removal of leg veins	0092	23.7882	$1,240.58	$505.37	$248.12
37735	T		Removal of leg veins/lesion	0092	23.7882	$1,240.58	$505.37	$248.12
37760	T		Revision of leg veins	0091	26.7048	$1,392.68	$348.23	$278.54
37780	T		Revision of leg vein	0091	26.7048	$1,392.68	$348.23	$278.54
37785	T		Revise secondary varicosity	0091	26.7048	$1,392.68	$348.23	$278.54
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	29.2435	$1,525.08	$621.82	$305.02
37799	T		Vascular surgery procedure	0035	0.2229	$11.62	$3.51	$2.32
38100	C		Removal of spleen, total					
38101	C		Removal of spleen, partial					
38102	C		Removal of spleen, total					
38115	C		Repair of ruptured spleen					
38120	T		Laparoscopy, splenectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
38129	T		Laparoscope proc, spleen	0130	30.4644	$1,588.75	$659.53	$317.75
38200	N		Injection for spleen x-ray					
38204	E	NI	Bl donor search management					
38205	S	NI	Harvest allogenic stem cells	0111	14.9803	$781.24	$217.61	$156.25
38206	S	NI	Harvest auto stem cells	0111	14.9803	$781.24	$217.61	$156.25
38207	E	NI	Cryopreserve stem cells					
38208	E	NI	Thaw preserved stem cells					
38209	E	NI	Wash harvest stem cells					
38210	E	NI	T-cell depletion of harvest					
38211	E	NI	Tumor cell deplete of harvst					
38212	E	NI	Rbc depletion of harvest					
38213	E	NI	Platelet deplete of harvest					
38214	E	NI	Volume deplete of harvest					
38215	E	NI	Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	1.2306	$64.18		$12.84
38221	T		Bone marrow biopsy	0003	1.2306	$64.18		$12.84

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38230	S		Bone marrow collection	0123	6.4049	$334.02		$66.80
38231	S	DG	Stem cell collection	0111	14.9803	$781.24	$217.61	$156.25
38240	S		Bone marrow/stem transplant	0123	6.4049	$334.02		$66.80
38241	S		Bone marrow/stem transplant	0123	6.4049	$334.02		$66.80
38242	S	NI	Lymphocyte infuse transplant	0111	14.9803	$781.24	$217.61	$156.25
38300	T		Drainage, lymph node lesion	0008	16.1430	$841.87		$168.37
38305	T		Drainage, lymph node lesion	0008	16.1430	$841.87		$168.37
38308	T		Incision of lymph channels	0113	18.7496	$977.81		$195.56
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38505	T		Needle biopsy, lymph nodes	0005	3.1201	$162.72	$71.59	$32.54
38510	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38520	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38525	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38530	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38542	T		Explore deep node(s), neck	0114	36.1135	$1,883.36	$485.91	$376.67
38550	T		Removal, neck/armpit lesion	0113	18.7496	$977.81		$195.56
38555	T		Removal, neck/armpit lesion	0113	18.7496	$977.81		$195.56
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	40.2026	$2,096.61	$1,001.89	$419.32
38571	T		Laparoscopy, lymphadenectomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
38572	T		Laparoscopy, lymphadenectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
38589	T		Laparoscope proc, lymphatic	0130	30.4644	$1,588.75	$659.53	$317.75
38700	T		Removal of lymph nodes, neck	0113	18.7496	$977.81		$195.56
38720	T		Removal of lymph nodes, neck	0113	18.7496	$977.81		$195.56
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	36.1135	$1,883.36	$485.91	$376.67
38745	T		Remove armpit lymph nodes	0114	36.1135	$1,883.36	$485.91	$376.67
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	18.7496	$977.81		$195.56
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	4.0309	$210.22		$42.04
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	27.5575	$1,437.15	$591.64	$287.43
39499	C		Chest procedure					
39501	C		Repair diaphragm laceration					
39502	C		Repair paraesophageal hernia					
39503	C		Repair of diaphragm hernia					
39520	C		Repair of diaphragm hernia					
39530	C		Repair of diaphragm hernia					
39531	C		Repair of diaphragm hernia					
39540	C		Repair of diaphragm hernia					
39541	C		Repair of diaphragm hernia					
39545	C		Revision of diaphragm					
39560	C		Resect diaphragm, simple					
39561	C		Resect diaphragm, complex					
39599	C		Diaphragm surgery procedure					
40490	T		Biopsy of lip	0251	1.9089	$99.55		$19.91
40500	T		Partial excision of lip	0253	14.4473	$753.44	$282.29	$150.69
40510	T		Partial excision of lip	0254	20.1158	$1,049.06	$321.35	$209.81
40520	T		Partial excision of lip	0253	14.4473	$753.44	$282.29	$150.69
40525	T		Reconstruct lip with flap	0254	20.1158	$1,049.06	$321.35	$209.81
40527	T		Reconstruct lip with flap	0254	20.1158	$1,049.06	$321.35	$209.81

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40530	T		Partial removal of lip	0254	20.1158	$1,049.06	$321.35	$209.81
40650	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40652	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40654	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40700	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40701	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40702	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40720	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40761	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40799	T		Lip surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
40800	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
40801	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
40804	X		Removal, foreign body, mouth	0340	0.6492	$33.86		$6.77
40805	T		Removal, foreign body, mouth	0252	5.8041	$302.69	$113.41	$60.54
40806	T		Incision of lip fold	0251	1.9089	$99.55		$19.91
40808	T		Biopsy of mouth lesion	0251	1.9089	$99.55		$19.91
40810	T		Excision of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40812	T		Excise/repair mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40814	T		Excise/repair mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40816	T		Excision of mouth lesion	0254	20.1158	$1,049.06	$321.35	$209.81
40818	T		Excise oral mucosa for graft	0251	1.9089	$99.55		$19.91
40819	T		Excise lip or cheek fold	0252	5.8041	$302.69	$113.41	$60.54
40820	T		Treatment of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40830	T		Repair mouth laceration	0251	1.9089	$99.55		$19.91
40831	T		Repair mouth laceration	0252	5.8041	$302.69	$113.41	$60.54
40840	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40842	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40843	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40844	T		Reconstruction of mouth	0256	34.0302	$1,774.71		$354.94
40845	T		Reconstruction of mouth	0256	34.0302	$1,774.71		$354.94
40899	T		Mouth surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
41000	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41005	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41006	T		Drainage of mouth lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41007	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41008	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41009	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41010	T		Incision of tongue fold	0253	14.4473	$753.44	$282.29	$150.69
41015	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41016	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41017	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41018	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41100	T		Biopsy of tongue	0252	5.8041	$302.69	$113.41	$60.54
41105	T		Biopsy of tongue	0253	14.4473	$753.44	$282.29	$150.69
41108	T		Biopsy of floor of mouth	0252	5.8041	$302.69	$113.41	$60.54
41110	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41112	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41113	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41114	T		Excision of tongue lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41115	T		Excision of tongue fold	0252	5.8041	$302.69	$113.41	$60.54
41116	T		Excision of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41120	T		Partial removal of tongue	0254	20.1158	$1,049.06	$321.35	$209.81
41130	C		Partial removal of tongue					
41135	C		Tongue and neck surgery					
41140	C		Removal of tongue					
41145	C		Tongue removal, neck surgery					
41150	C		Tongue, mouth, jaw surgery					
41153	C		Tongue, mouth, neck surgery					
41155	C		Tongue, jaw, & neck surgery					
41250	T		Repair tongue laceration	0251	1.9089	$99.55		$19.91
41251	T		Repair tongue laceration	0252	5.8041	$302.69	$113.41	$60.54
41252	T		Repair tongue laceration	0252	5.8041	$302.69	$113.41	$60.54
41500	T		Fixation of tongue	0254	20.1158	$1,049.06	$321.35	$209.81
41510	T		Tongue to lip surgery	0253	14.4473	$753.44	$282.29	$150.69
41520	T		Reconstruction, tongue fold	0252	5.8041	$302.69	$113.41	$60.54

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41599	T		Tongue and mouth surgery	0251	1.9089	$99.55		$19.91
41800	T		Drainage of gum lesion	0251	1.9089	$99.55		$19.91
41805	T		Removal foreign body, gum	0254	20.1158	$1,049.06	$321.35	$209.81
41806	T		Removal foreign body,jawbone	0253	14.4473	$753.44	$282.29	$150.69
41820	T		Excision, gum, each quadrant	0252	5.8041	$302.69	$113.41	$60.54
41821	T		Excision of gum flap	0252	5.8041	$302.69	$113.41	$60.54
41822	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41823	T		Excision of gum lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41825	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41826	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41827	T		Excision of gum lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41828	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41830	T		Removal of gum tissue	0253	14.4473	$753.44	$282.29	$150.69
41850	T		Treatment of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41870	T		Gum graft	0254	20.1158	$1,049.06	$321.35	$209.81
41872	T		Repair gum	0253	14.4473	$753.44	$282.29	$150.69
41874	T		Repair tooth socket	0254	20.1158	$1,049.06	$321.35	$209.81
41899	T		Dental surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
42000	T		Drainage mouth roof lesion	0251	1.9089	$99.55		$19.91
42100	T		Biopsy roof of mouth	0252	5.8041	$302.69	$113.41	$60.54
42104	T		Excision lesion, mouth roof	0253	14.4473	$753.44	$282.29	$150.69
42106	T		Excision lesion, mouth roof	0253	14.4473	$753.44	$282.29	$150.69
42107	T		Excision lesion, mouth roof	0254	20.1158	$1,049.06	$321.35	$209.81
42120	T		Remove palate/lesion	0256	34.0302	$1,774.71		$354.94
42140	T		Excision of uvula	0252	5.8041	$302.69	$113.41	$60.54
42145	T		Repair palate, pharynx/uvula	0254	20.1158	$1,049.06	$321.35	$209.81
42160	T		Treatment mouth roof lesion	0253	14.4473	$753.44	$282.29	$150.69
42180	T		Repair palate	0251	1.9089	$99.55		$19.91
42182	T		Repair palate	0256	34.0302	$1,774.71		$354.94
42200	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42205	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42210	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42215	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42220	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42225	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42226	T		Lengthening of palate	0256	34.0302	$1,774.71		$354.94
42227	T		Lengthening of palate	0256	34.0302	$1,774.71		$354.94
42235	T		Repair palate	0253	14.4473	$753.44	$282.29	$150.69
42260	T		Repair nose to lip fistula	0254	20.1158	$1,049.06	$321.35	$209.81
42280	T		Preparation, palate mold	0251	1.9089	$99.55		$19.91
42281	T		Insertion, palate prosthesis	0253	14.4473	$753.44	$282.29	$150.69
42299	T		Palate/uvula surgery	0251	1.9089	$99.55		$19.91
42300	T		Drainage of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42305	T		Drainage of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42310	T		Drainage of salivary gland	0251	1.9089	$99.55		$19.91
42320	T		Drainage of salivary gland	0251	1.9089	$99.55		$19.91
42325	T		Create salivary cyst drain	0251	1.9089	$99.55		$19.91
42326	T		Create salivary cyst drain	0252	5.8041	$302.69	$113.41	$60.54
42330	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42335	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42340	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42400	T		Biopsy of salivary gland	0005	3.1201	$162.72	$71.59	$32.54
42405	T		Biopsy of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42408	T		Excision of salivary cyst	0253	14.4473	$753.44	$282.29	$150.69
42409	T		Drainage of salivary cyst	0253	14.4473	$753.44	$282.29	$150.69
42410	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42415	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42420	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42425	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	34.0302	$1,774.71		$354.94
42450	T		Excise sublingual gland	0254	20.1158	$1,049.06	$321.35	$209.81
42500	T		Repair salivary duct	0254	20.1158	$1,049.06	$321.35	$209.81
42505	T		Repair salivary duct	0256	34.0302	$1,774.71		$354.94
42507	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42508	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42509	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42510	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	14.4473	$753.44	$282.29	$150.69
42650	T		Dilation of salivary duct	0252	5.8041	$302.69	$113.41	$60.54
42660	T		Dilation of salivary duct	0252	5.8041	$302.69	$113.41	$60.54
42665	T		Ligation of salivary duct	0254	20.1158	$1,049.06	$321.35	$209.81
42699	T		Salivary surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
42700	T		Drainage of tonsil abscess	0251	1.9089	$99.55		$19.91
42720	T		Drainage of throat abscess	0253	14.4473	$753.44	$282.29	$150.69
42725	T		Drainage of throat abscess	0256	34.0302	$1,774.71		$354.94
42800	T		Biopsy of throat	0252	5.8041	$302.69	$113.41	$60.54
42802	T		Biopsy of throat	0253	14.4473	$753.44	$282.29	$150.69
42804	T		Biopsy of upper nose/throat	0253	14.4473	$753.44	$282.29	$150.69
42806	T		Biopsy of upper nose/throat	0254	20.1158	$1,049.06	$321.35	$209.81
42808	T		Excise pharynx lesion	0253	14.4473	$753.44	$282.29	$150.69
42809	X		Remove pharynx foreign body	0340	0.6492	$33.86		$6.77
42810	T		Excision of neck cyst	0254	20.1158	$1,049.06	$321.35	$209.81
42815	T		Excision of neck cyst	0256	34.0302	$1,774.71		$354.94
42820	T		Remove tonsils and adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42821	T		Remove tonsils and adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42825	T		Removal of tonsils	0258	19.8736	$1,036.43	$437.25	$207.29
42826	T		Removal of tonsils	0258	19.8736	$1,036.43	$437.25	$207.29
42830	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42831	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42835	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42836	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42842	T		Extensive surgery of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42844	T		Extensive surgery of throat	0256	34.0302	$1,774.71		$354.94
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	19.8736	$1,036.43	$437.25	$207.29
42870	T		Excision of lingual tonsil	0258	19.8736	$1,036.43	$437.25	$207.29
42890	T		Partial removal of pharynx	0256	34.0302	$1,774.71		$354.94
42892	T		Revision of pharyngeal walls	0256	34.0302	$1,774.71		$354.94
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	5.8041	$302.69	$113.41	$60.54
42950	T		Reconstruction of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42960	T		Control throat bleeding	0250	1.6376	$85.40	$29.89	$17.08
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	34.0302	$1,774.71		$354.94
42970	T		Control nose/throat bleeding	0250	1.6376	$85.40	$29.89	$17.08
42971	C		Control nose/throat bleeding					
42972	T		Control nose/throat bleeding	0253	14.4473	$753.44	$282.29	$150.69
42999	T		Throat surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
43020	T		Incision of esophagus	0252	5.8041	$302.69	$113.41	$60.54
43030	T		Throat muscle surgery	0253	14.4473	$753.44	$282.29	$150.69
43045	C		Incision of esophagus					
43100	C		Excision of esophagus lesion					
43101	C		Excision of esophagus lesion					
43107	C		Removal of esophagus					
43108	C		Removal of esophagus					
43112	C		Removal of esophagus					
43113	C		Removal of esophagus					
43116	C		Partial removal of esophagus					
43117	C		Partial removal of esophagus					
43118	C		Partial removal of esophagus					
43121	C		Partial removal of esophagus					
43122	C		Partial removal of esophagus					
43123	C		Partial removal of esophagus					
43124	C		Removal of esophagus					
43130	T		Removal of esophagus pouch	0254	20.1158	$1,049.06	$321.35	$209.81
43135	C		Removal of esophagus pouch					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43200	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43201	T	NI	Esoph scope w/submucous inj	0141	7.4126	$386.57	$143.38	$77.31
43202	T		Esophagus endoscopy, biopsy	0141	7.4126	$386.57	$143.38	$77.31
43204	T		Esoph scope w/sclerosis inj	0141	7.4126	$386.57	$143.38	$77.31
43205	T		Esophagus endoscopy/ligation	0141	7.4126	$386.57	$143.38	$77.31
43215	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43216	T		Esophagus endoscopy/lesion	0141	7.4126	$386.57	$143.38	$77.31
43217	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43219	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43220	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43226	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43227	T		Esoph endoscopy, repair	0141	7.4126	$386.57	$143.38	$77.31
43228	T		Esoph endoscopy, ablation	0141	7.4126	$386.57	$143.38	$77.31
43231	T		Esoph endoscopy w/us exam	0141	7.4126	$386.57	$143.38	$77.31
43232	T		Esoph endoscopy w/us fn bx	0141	7.4126	$386.57	$143.38	$77.31
43234	T		Upper GI endoscopy, exam	0141	7.4126	$386.57	$143.38	$77.31
43235	T		Uppr gi endoscopy, diagnosis	0141	7.4126	$386.57	$143.38	$77.31
43236	T	NI	Uppr gi scope w/submuc inj	0141	7.4126	$386.57	$143.38	$77.31
43239	T		Upper GI endoscopy, biopsy	0141	7.4126	$386.57	$143.38	$77.31
43240	T		Esoph endoscope w/drain cyst	0141	7.4126	$386.57	$143.38	$77.31
43241	T		Upper GI endoscopy with tube	0141	7.4126	$386.57	$143.38	$77.31
43242	T		Uppr gi endoscopy w/us fn bx	0141	7.4126	$386.57	$143.38	$77.31
43243	T		Upper gi endoscopy & inject	0141	7.4126	$386.57	$143.38	$77.31
43244	T		Upper GI endoscopy/ligation	0141	7.4126	$386.57	$143.38	$77.31
43245	T		Uppr gi scope dilate strictr	0141	7.4126	$386.57	$143.38	$77.31
43246	T		Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43247	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43248	T		Uppr gi endoscopy/guide wire	0141	7.4126	$386.57	$143.38	$77.31
43249	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43250	T		Upper GI endoscopy/tumor	0141	7.4126	$386.57	$143.38	$77.31
43251	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43255	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43256	T		Uppr gi endoscopy w stent	0141	7.4126	$386.57	$143.38	$77.31
43258	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43259	T		Endoscopic ultrasound exam	0141	7.4126	$386.57	$143.38	$77.31
43260	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43261	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43262	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43263	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43264	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43265	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43267	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43268	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43269	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43271	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43272	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43280	T		Laparoscopy, fundoplasty	0132	56.9948	$2,972.34	$1,239.22	$594.47
43289	T		Laparoscope proc, esoph	0130	30.4644	$1,588.75	$659.53	$317.75
43300	C		Repair of esophagus					
43305	C		Repair esophagus and fistula					
43310	C		Repair of esophagus					
43312	C		Repair esophagus and fistula					
43313	C		Esophagoplasty congenital					
43314	C		Tracheo-esophagoplasty cong					
43320	C		Fuse esophagus & stomach					
43324	C		Revise esophagus & stomach					
43325	C		Revise esophagus & stomach					
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					
43331	C		Repair of esophagus					
43340	C		Fuse esophagus & intestine					
43341	C		Fuse esophagus & intestine					
43350	C		Surgical opening, esophagus					
43351	C		Surgical opening, esophagus					
43352	C		Surgical opening, esophagus					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43360	C		Gastrointestinal repair					
43361	C		Gastrointestinal repair					
43400	C		Ligate esophagus veins					
43401	C		Esophagus surgery for veins					
43405	C		Ligate/staple esophagus					
43410	C		Repair esophagus wound					
43415	C		Repair esophagus wound					
43420	C		Repair esophagus opening					
43425	C		Repair esophagus opening					
43450	T		Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43453	T		Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43456	T		Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43458	T		Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43460	C		Pressure treatment esophagus					
43496	C		Free jejunum flap, microvasc					
43499	T		Esophagus surgery procedure	0141	7.4126	$386.57	$143.38	$77.31
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	7.4126	$386.57	$143.38	$77.31
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	56.9948	$2,972.34	$1,239.22	$594.47
43652	T		Laparoscopy, vagus nerve	0132	56.9948	$2,972.34	$1,239.22	$594.47
43653	T		Laparoscopy, gastrostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
43659	T		Laparoscope proc, stom	0130	30.4644	$1,588.75	$659.53	$317.75
43750	T		Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43752	E		Nasal/orogastric w/stent					
43760	T		Change gastrostomy tube	0121	2.0833	$108.65	$43.80	$21.73
43761	T		Reposition gastrostomy tube	0121	2.0833	$108.65	$43.80	$21.73
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	7.4126	$386.57	$143.38	$77.31
43831	T		Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43832	C		Place gastrostomy tube					
43840	C		Repair of stomach lesion					
43842	C		Gastroplasty for obesity					
43843	C		Gastroplasty for obesity					
43846	C		Gastric bypass for obesity					
43847	C		Gastric bypass for obesity					
43848	C		Revision gastroplasty					
43850	C		Revise stomach-bowel fusion					
43855	C		Revise stomach-bowel fusion					
43860	C		Revise stomach-bowel fusion					
43865	C		Revise stomach-bowel fusion					
43870	T		Repair stomach opening	0141	7.4126	$386.57	$143.38	$77.31
43880	C		Repair stomach-bowel fistula					
43999	T		Stomach surgery procedure	0141	7.4126	$386.57	$143.38	$77.31

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44005	C		Freeing of bowel adhesion					
44010	C		Incision of small bowel					
44015	C		Insert needle cath bowel					
44020	C		Explore small intestine					
44021	C		Decompress small bowel					
44025	C		Incision of large bowel					
44050	C		Reduce bowel obstruction					
44055	C		Correct malrotation of bowel					
44100	T		Biopsy of bowel	0141	7.4126	$386.57	$143.38	$77.31
44110	C		Excise intestine lesion(s)					
44111	C		Excision of bowel lesion(s)					
44120	C		Removal of small intestine					
44121	C		Removal of small intestine					
44125	C		Removal of small intestine					
44126	C		Enterectomy w/o taper, cong					
44127	C		Enterectomy w/taper, cong					
44128	C		Enterectomy cong, add-on					
44130	C		Bowel to bowel fusion					
44132	C		Enterectomy, cadaver donor					
44133	C		Enterectomy, live donor					
44135	C		Intestine transplnt, cadaver					
44136	C		Intestine transplant, live					
44139	C		Mobilization of colon					
44140	C		Partial removal of colon					
44141	C		Partial removal of colon					
44143	C		Partial removal of colon					
44144	C		Partial removal of colon					
44145	C		Partial removal of colon					
44146	C		Partial removal of colon					
44147	C		Partial removal of colon					
44150	C		Removal of colon					
44151	C		Removal of colon/ileostomy					
44152	C		Removal of colon/ileostomy					
44153	C		Removal of colon/ileostomy					
44155	C		Removal of colon/ileostomy					
44156	C		Removal of colon/ileostomy					
44160	C		Removal of colon					
44200	T		Laparoscopy, enterolysis	0131	40.2026	$2,096.61	$1,001.89	$419.32
44201	T		Laparoscopy, jejunostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T	NI	Lap part colectomy w/stoma	0132	56.9948	$2,972.34	$1,239.22	$594.47
44207	T	NI	L colectomy/coloproctostomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
44208	T	NI	L colectomy/coloproctostomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
44209	T	DG	Laparoscope proc, intestine	0130	30.4644	$1,588.75	$659.53	$317.75
44210	C	NI	Laparo total proctocolectomy					
44211	C	NI	Laparo total proctocolectomy					
44212	C	NI	Laparo total proctocolectomy					
44238	T	NI	Laparoscope proc, intestine	0130	30.4644	$1,588.75	$659.53	$317.75
44239	T	NI	Laparoscope proc, rectum	0130	30.4644	$1,588.75	$659.53	$317.75
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	15.2225	$793.87	$329.72	$158.77
44314	C		Revision of ileostomy					
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	15.2225	$793.87	$329.72	$158.77
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44361	T		Small bowel endoscopy/biopsy	0142	8.1393	$424.47	$152.78	$84.89
44363	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44364	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44365	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44366	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44369	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44370	T		Small bowel endoscopy/stent	0142	8.1393	$424.47	$152.78	$84.89
44372	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44373	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44376	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44377	T		Small bowel endoscopy/biopsy	0142	8.1393	$424.47	$152.78	$84.89
44378	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44379	T		S bowel endoscope w/stent	0142	8.1393	$424.47	$152.78	$84.89
44380	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44382	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44383	T		Ileoscopy w/stent	0142	8.1393	$424.47	$152.78	$84.89
44385	T		Endoscopy of bowel pouch	0143	7.9165	$412.85	$186.06	$82.57
44386	T		Endoscopy, bowel pouch/biop	0143	7.9165	$412.85	$186.06	$82.57
44388	T		Colon endoscopy	0143	7.9165	$412.85	$186.06	$82.57
44389	T		Colonoscopy with biopsy	0143	7.9165	$412.85	$186.06	$82.57
44390	T		Colonoscopy for foreign body	0143	7.9165	$412.85	$186.06	$82.57
44391	T		Colonoscopy for bleeding	0143	7.9165	$412.85	$186.06	$82.57
44392	T		Colonoscopy & polypectomy	0143	7.9165	$412.85	$186.06	$82.57
44393	T		Colonoscopy, lesion removal	0143	7.9165	$412.85	$186.06	$82.57
44394	T		Colonoscopy w/snare	0143	7.9165	$412.85	$186.06	$82.57
44397	T		Colonoscopy w/stent	0143	7.9165	$412.85	$186.06	$82.57
44500	T		Intro, gastrointestinal tube	0121	2.0833	$108.65	$43.80	$21.73
44602	C		Suture, small intestine					
44603	C		Suture, small intestine					
44604	C		Suture, large intestine					
44605	C		Repair of bowel lesion					
44615	C		Intestinal stricturoplasty					
44620	C		Repair bowel opening					
44625	C		Repair bowel opening					
44626	C		Repair bowel opening					
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N	NI	Intraop colon lavage add-on					
44799	T		Intestine surgery procedure	0142	8.1393	$424.47	$152.78	$84.89
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	30.4644	$1,588.75	$659.53	$317.75
44979	T		Laparoscope proc, app	0130	30.4644	$1,588.75	$659.53	$317.75
45000	T		Drainage of pelvic abscess	0149	16.3756	$854.00	$293.06	$170.80
45005	T		Drainage of rectal abscess	0148	3.4205	$178.38	$63.38	$35.68
45020	T		Drainage of rectal abscess	0149	16.3756	$854.00	$293.06	$170.80
45100	T		Biopsy of rectum	0149	16.3756	$854.00	$293.06	$170.80
45108	T		Removal of anorectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45121	C		Removal of rectum and colon					
45123	C		Partial proctectomy					
45126	C		Pelvic exenteration					
45130	C		Excision of rectal prolapse					
45135	C		Excision of rectal prolapse					
45136	C		Excise ileoanal reservior					
45150	T		Excision of rectal stricture	0150	21.2398	$1,107.68	$437.12	$221.54
45160	T		Excision of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
45170	T		Excision of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
45190	T		Destruction, rectal tumor	0150	21.2398	$1,107.68	$437.12	$221.54
45300	T		Proctosigmoidoscopy dx	0146	3.4302	$178.89	$64.40	$35.78
45303	T		Proctosigmoidoscopy dilate	0146	3.4302	$178.89	$64.40	$35.78
45305	T		Proctosigmoidoscopy w/bx	0146	3.4302	$178.89	$64.40	$35.78
45307	T		Proctosigmoidoscopy fb	0146	3.4302	$178.89	$64.40	$35.78
45308	T		Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45309	T		Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45315	T		Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45317	T		Proctosigmoidoscopy bleed	0146	3.4302	$178.89	$64.40	$35.78
45320	T		Proctosigmoidoscopy ablate	0147	7.0153	$365.85	$79.46	$73.17
45321	T		Proctosigmoidoscopy volvul	0147	7.0153	$365.85	$79.46	$73.17
45327	T		Proctosigmoidoscopy w/stent	0147	7.0153	$365.85	$79.46	$73.17
45330	T		Diagnostic sigmoidoscopy	0146	3.4302	$178.89	$64.40	$35.78
45331	T		Sigmoidoscopy and biopsy	0146	3.4302	$178.89	$64.40	$35.78
45332	T		Sigmoidoscopy w/fb removal	0146	3.4302	$178.89	$64.40	$35.78
45333	T		Sigmoidoscopy & polypectomy	0147	7.0153	$365.85	$79.46	$73.17
45334	T		Sigmoidoscopy for bleeding	0147	7.0153	$365.85	$79.46	$73.17
45335	T	NI	Sigmoidoscope w/submuc inj	0147	7.0153	$365.85	$79.46	$73.17
45337	T		Sigmoidoscopy & decompress	0147	7.0153	$365.85	$79.46	$73.17
45338	T		Sigmoidoscpy w/tumr remove	0147	7.0153	$365.85	$79.46	$73.17
45339	T		Sigmoidoscopy w/ablate tumr	0147	7.0153	$365.85	$79.46	$73.17
45340	T	NI	Sig w/balloon dilation	0147	7.0153	$365.85	$79.46	$73.17
45341	T		Sigmoidoscopy w/ultrasound	0147	7.0153	$365.85	$79.46	$73.17
45342	T		Sigmoidoscopy w/us guide bx	0147	7.0153	$365.85	$79.46	$73.17
45345	T		Sigmoidoscopy w/stent	0147	7.0153	$365.85	$79.46	$73.17
45355	T		Surgical colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45378	T		Diagnostic colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45379	T		Colonoscopy w/fb removal	0143	7.9165	$412.85	$186.06	$82.57
45380	T		Colonoscopy and biopsy	0143	7.9165	$412.85	$186.06	$82.57
45381	T	NI	Colonoscope, submucous inj	0143	7.9165	$412.85	$186.06	$82.57
45382	T		Colonoscopy/control bleeding	0143	7.9165	$412.85	$186.06	$82.57
45383	T		Lesion removal colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45384	T		Lesion remove colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45385	T		Lesion removal colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45386	T	NI	Colonoscope dilate stricture	0143	7.9165	$412.85	$186.06	$82.57
45387	T		Colonoscopy w/stent	0143	7.9165	$412.85	$186.06	$82.57
45500	T		Repair of rectum	0150	21.2398	$1,107.68	$437.12	$221.54
45505	T		Repair of rectum	0150	21.2398	$1,107.68	$437.12	$221.54
45520	T		Treatment of rectal prolapse	0098	1.6666	$86.91	$20.88	$17.38
45540	C		Correct rectal prolapse					
45541	C		Correct rectal prolapse					
45550	C		Repair rectum/remove sigmoid					
45560	T		Repair of rectocele	0150	21.2398	$1,107.68	$437.12	$221.54
45562	C		Exploration/repair of rectum					
45563	C		Exploration/repair of rectum					
45800	C		Repair rect/bladder fistula					
45805	C		Repair fistula w/colostomy					
45820	C		Repair rectourethral fistula					
45825	C		Repair fistula w/colostomy					
45900	T		Reduction of rectal prolapse	0148	3.4205	$178.38	$63.38	$35.68
45905	T		Dilation of anal sphincter	0149	16.3756	$854.00	$293.06	$170.80
45910	T		Dilation of rectal narrowing	0149	16.3756	$854.00	$293.06	$170.80
45915	T		Remove rectal obstruction	0148	3.4205	$178.38	$63.38	$35.68
45999	T		Rectum surgery procedure	0148	3.4205	$178.38	$63.38	$35.68
46020	T		Placement of seton	0148	3.4205	$178.38	$63.38	$35.68
46030	T		Removal of rectal marker	0148	3.4205	$178.38	$63.38	$35.68

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46040	T		Incision of rectal abscess	0155	10.1936	$531.61	$188.89	$106.32
46045	T		Incision of rectal abscess	0150	21.2398	$1,107.68	$437.12	$221.54
46050	T		Incision of anal abscess	0148	3.4205	$178.38	$63.38	$35.68
46060	T		Incision of rectal abscess	0150	21.2398	$1,107.68	$437.12	$221.54
46070	T		Incision of anal septum	0155	10.1936	$531.61	$188.89	$106.32
46080	T		Incision of anal sphincter	0149	16.3756	$854.00	$293.06	$170.80
46083	T		Incise external hemorrhoid	0148	3.4205	$178.38	$63.38	$35.68
46200	T		Removal of anal fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46210	T		Removal of anal crypt	0149	16.3756	$854.00	$293.06	$170.80
46211	T		Removal of anal crypts	0150	21.2398	$1,107.68	$437.12	$221.54
46220	T		Removal of anal tag	0149	16.3756	$854.00	$293.06	$170.80
46221	T		Ligation of hemorrhoid(s)	0148	3.4205	$178.38	$63.38	$35.68
46230	T		Removal of anal tags	0149	16.3756	$854.00	$293.06	$170.80
46250	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46255	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46257	T		Remove hemorrhoids & fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46258	T		Remove hemorrhoids & fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46260	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46261	T		Remove hemorrhoids & fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46262	T		Remove hemorrhoids & fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46270	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46275	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46280	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46285	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46288	T		Repair anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46320	T		Removal of hemorrhoid clot	0148	3.4205	$178.38	$63.38	$35.68
46500	T		Injection into hemorrhoid(s)	0155	10.1936	$531.61	$188.89	$106.32
46600	X		Diagnostic anoscopy	0340	0.6492	$33.86		$6.77
46604	T		Anoscopy and dilation	0147	7.0153	$365.85	$79.46	$73.17
46606	T		Anoscopy and biopsy	0147	7.0153	$365.85	$79.46	$73.17
46608	T		Anoscopy, remove for body	0147	7.0153	$365.85	$79.46	$73.17
46610	T		Anoscopy, remove lesion	0147	7.0153	$365.85	$79.46	$73.17
46611	T		Anoscopy	0147	7.0153	$365.85	$79.46	$73.17
46612	T		Anoscopy, remove lesions	0147	7.0153	$365.85	$79.46	$73.17
46614	T		Anoscopy, control bleeding	0147	7.0153	$365.85	$79.46	$73.17
46615	T		Anoscopy	0147	7.0153	$365.85	$79.46	$73.17
46700	T		Repair of anal stricture	0150	21.2398	$1,107.68	$437.12	$221.54
46705	C		Repair of anal stricture					
46706	T	NI	Repr of anal fistula w/glue	0148	3.4205	$178.38	$63.38	$35.68
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	21.2398	$1,107.68	$437.12	$221.54
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	21.2398	$1,107.68	$437.12	$221.54
46754	T		Removal of suture from anus	0149	16.3756	$854.00	$293.06	$170.80
46760	T		Repair of anal sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46761	T		Repair of anal sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46762	T		Implant artificial sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46900	T		Destruction, anal lesion(s)	0016	2.6162	$136.44	$57.31	$27.29
46910	T		Destruction, anal lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
46916	T		Cryosurgery, anal lesion(s)	0013	1.0756	$56.09	$14.20	$11.22
46917	T		Laser surgery, anal lesions	0695	18.6817	$974.27	$266.59	$194.85
46922	T		Excision of anal lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
46924	T		Destruction, anal lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
46934	T		Destruction of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46935	T		Destruction of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46936	T		Destruction of hemorrhoids	0149	16.3756	$854.00	$293.06	$170.80
46937	T		Cryotherapy of rectal lesion	0149	16.3756	$854.00	$293.06	$170.80

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46938	T		Cryotherapy of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
46940	T		Treatment of anal fissure	0149	16.3756	$854.00	$293.06	$170.80
46942	T		Treatment of anal fissure	0148	3.4205	$178.38	$63.38	$35.68
46945	T		Ligation of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46946	T		Ligation of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46999	T		Anus surgery procedure	0148	3.4205	$178.38	$63.38	$35.68
47000	T		Needle biopsy of liver	0685	5.9882	$312.29	$137.40	$62.46
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0005	3.1201	$162.72	$71.59	$32.54
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	30.4644	$1,588.75	$659.53	$317.75
47371	T		Laparo ablate liver cryosurg	0130	30.4644	$1,588.75	$659.53	$317.75
47379	T		Laparoscope procedure, liver	0130	30.4644	$1,588.75	$659.53	$317.75
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	0980		$1,875.00		$375.00
47399	T		Liver surgery procedure	0005	3.1201	$162.72	$71.59	$32.54
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	T		Incision of gallbladder	0152	10.0288	$523.01	$131.28	$104.60
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	10.0288	$523.01	$131.28	$104.60
47511	T		Insert bile duct drain	0152	10.0288	$523.01	$131.28	$104.60
47525	T		Change bile duct catheter	0122	10.7459	$560.41	$114.93	$112.08
47530	T		Revise/reinsert bile tube	0121	2.0833	$108.65	$43.80	$21.73
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47553	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47554	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47555	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47556	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47560	T		Laparoscopy w/cholangio	0130	30.4644	$1,588.75	$659.53	$317.75
47561	T		Laparo w/cholangio/biopsy	0130	30.4644	$1,588.75	$659.53	$317.75
47562	T		Laparoscopic cholecystectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
47563	T		Laparo cholecystectomy/graph	0131	40.2026	$2,096.61	$1,001.89	$419.32
47564	T		Laparo cholecystectomy/explr	0131	40.2026	$2,096.61	$1,001.89	$419.32
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	30.4644	$1,588.75	$659.53	$317.75
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	10.0288	$523.01	$131.28	$104.60
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47711	C		Excision of bile duct tumor					
47712	C		Excision of bile duct tumor					
47715	C		Excision of bile duct cyst					
47716	C		Fusion of bile duct cyst					
47720	C		Fuse gallbladder & bowel					
47721	C		Fuse upper gi structures					
47740	C		Fuse gallbladder & bowel					
47741	C		Fuse gallbladder & bowel					
47760	C		Fuse bile ducts and bowel					
47765	C		Fuse liver ducts & bowel					
47780	C		Fuse bile ducts and bowel					
47785	C		Fuse bile ducts and bowel					
47800	C		Reconstruction of bile ducts					
47801	C		Placement, bile duct support					
47802	C		Fuse liver duct & intestine					
47900	C		Suture bile duct injury					
47999	T		Bile tract surgery procedure	0152	10.0288	$523.01	$131.28	$104.60
48000	C		Drainage of abdomen					
48001	C		Placement of drain, pancreas					
48005	C		Resect/debride pancreas					
48020	C		Removal of pancreatic stone					
48100	C		Biopsy of pancreas, open					
48102	T		Needle biopsy, pancreas	0685	5.9882	$312.29	$137.40	$62.46
48120	C		Removal of pancreas lesion					
48140	C		Partial removal of pancreas					
48145	C		Partial removal of pancreas					
48146	C		Pancreatectomy					
48148	C		Removal of pancreatic duct					
48150	C		Partial removal of pancreas					
48152	C		Pancreatectomy					
48153	C		Pancreatectomy					
48154	C		Pancreatectomy					
48155	C		Removal of pancreas					
48160	E		Pancreas removal/transplant					
48180	C		Fuse pancreas and bowel					
48400	C		Injection, intraop add-on					
48500	C		Surgery of pancreatic cyst					
48510	C		Drain pancreatic pseudocyst					
48511	T		Drain pancreatic pseudocyst	0005	3.1201	$162.72	$71.59	$32.54
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	3.1201	$162.72	$71.59	$32.54
49000	C		Exploration of abdomen					
49002	C		Reopening of abdomen					
49010	C		Exploration behind abdomen					
49020	C		Drain abdominal abscess					
49021	C		Drain abdominal abscess					
49040	C		Drain, open, abdom abscess					
49041	C		Drain, percut, abdom abscess					
49060	C		Drain, open, retrop abscess					
49061	C		Drain, percut, retroper absc					
49062	C		Drain to peritoneal cavity					
49080	T		Puncture, peritoneal cavity	0070	3.3623	$175.35		$35.07
49081	T		Removal of abdominal fluid	0070	3.3623	$175.35		$35.07
49085	T		Remove abdomen foreign body	0153	19.5441	$1,019.24	$410.87	$203.85
49180	T		Biopsy, abdominal mass	0685	5.9882	$312.29	$137.40	$62.46
49200	T		Removal of abdominal lesion	0130	30.4644	$1,588.75	$659.53	$317.75
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49250	T		Excision of umbilicus	0153	19.5441	$1,019.24	$410.87	$203.85
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	30.4644	$1,588.75	$659.53	$317.75
49321	T		Laparoscopy, biopsy	0130	30.4644	$1,588.75	$659.53	$317.75
49322	T		Laparoscopy, aspiration	0130	30.4644	$1,588.75	$659.53	$317.75
49323	T		Laparo drain lymphocele	0130	30.4644	$1,588.75	$659.53	$317.75
49329	T		Laparo proc, abdm/per/oment	0130	30.4644	$1,588.75	$659.53	$317.75
49400	N		Air injection into abdomen					
49419	T	NI	Insrt abdom cath for chemotx	0119	89.3100	$4,657.61		$931.52
49420	T		Insert abdom drain, temp	0652	28.1292	$1,466.97		$293.39
49421	T		Insert abdom drain, perm	0652	28.1292	$1,466.97		$293.39
49422	T		Remove perm cannula/catheter	0105	18.5945	$969.72	$370.40	$193.94
49423	T		Exchange drainage catheter	0152	10.0288	$523.01	$131.28	$104.60
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	19.5441	$1,019.24	$410.87	$203.85
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	18.5945	$969.72	$370.40	$193.94
49491	T		Rpr hern preemie reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49492	T		Rpr ing hern premie, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49495	T		Rpr ing hernia baby, reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49496	T		Rpr ing hernia baby, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49500	T		Rpr ing hernia, init, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49501	T		Rpr ing hernia, init blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49505	T		Prp i/hern init reduc>5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49507	T		Prp i/hern init block>5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49520	T		Rerepair ing hernia, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49521	T		Rerepair ing hernia, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49525	T		Repair ing hernia, sliding	0154	25.7262	$1,341.65	$464.85	$268.33
49540	T		Repair lumbar hernia	0154	25.7262	$1,341.65	$464.85	$268.33
49550	T		Rpr rem hernia, init, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49553	T		Rpr fem hernia, init blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49555	T		Rerepair fem hernia, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49557	T		Rerepair fem hernia, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49560	T		Rpr ventral hern init, reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49561	T		Rpr ventral hern init, block	0154	25.7262	$1,341.65	$464.85	$268.33
49565	T		Rerepair ventrl hern, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49566	T		Rerepair ventrl hern, block	0154	25.7262	$1,341.65	$464.85	$268.33
49568	T		Hernia repair w/mesh	0154	25.7262	$1,341.65	$464.85	$268.33
49570	T		Rpr epigastric hern, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49572	T		Rpr epigastric hern, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49580	T		Rpr umbil hern, reduc < 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49582	T		Rpr umbil hern, block < 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49585	T		Rpr umbil hern, reduc > 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49587	T		Rpr umbil hern, block > 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49590	T		Repair spigilian hernia	0154	25.7262	$1,341.65	$464.85	$268.33
49600	T		Repair umbilical lesion	0154	25.7262	$1,341.65	$464.85	$268.33
49605	C		Repair umbilical lesion					
49606	C		Repair umbilical lesion					
49610	C		Repair umbilical lesion					
49611	C		Repair umbilical lesion					
49650	T		Laparo hernia repair initial	0131	40.2026	$2,096.61	$1,001.89	$419.32
49651	T		Laparo hernia repair recur	0131	40.2026	$2,096.61	$1,001.89	$419.32
49659	T		Laparo proc, hernia repair	0131	40.2026	$2,096.61	$1,001.89	$419.32
49900	C		Repair of abdominal wall					
49904	C	NI	Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	19.5441	$1,019.24	$410.87	$203.85
50010	C		Exploration of kidney					
50020	C		Renal abscess, open drain					
50021	T		Renal abscess, percut drain	0005	3.1201	$162.72	$71.59	$32.54
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	28.3714	$1,479.60		$295.92
50081	T		Removal of kidney stone	0163	28.3714	$1,479.60		$295.92
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	5.9882	$312.29	$137.40	$62.46
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					
50230	C		Removal kidney open, radical					
50234	C		Removal of kidney & ureter					
50236	C		Removal of kidney & ureter					
50240	C		Partial removal of kidney					
50280	C		Removal of kidney lesion					
50290	C		Removal of kidney lesion					
50300	C		Removal of donor kidney					
50320	C		Removal of donor kidney					
50340	C		Removal of kidney					
50360	C		Transplantation of kidney					
50365	C		Transplantation of kidney					
50370	C		Remove transplanted kidney					
50380	C		Reimplantation of kidney					
50390	T		Drainage of kidney lesion	0685	5.9882	$312.29	$137.40	$62.46
50392	T		Insert kidney drain	0161	15.7070	$819.14	$249.36	$163.83
50393	T		Insert ureteral tube	0161	15.7070	$819.14	$249.36	$163.83
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	15.7070	$819.14	$249.36	$163.83
50396	T		Measure kidney pressure	0164	1.1240	$58.62	$17.59	$11.72
50398	T		Change kidney tube	0122	10.7459	$560.41	$114.93	$112.08
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	30.4644	$1,588.75	$659.53	$317.75
50542	T	NI	Laparo ablate renal mass	0131	40.2026	$2,096.61	$1,001.89	$419.32
50543	T	NI	Laparo partial nephrectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
50544	T		Laparoscopy, pyeloplasty	0130	30.4644	$1,588.75	$659.53	$317.75
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	30.4644	$1,588.75	$659.53	$317.75
50551	T		Kidney endoscopy	0160	6.3080	$328.97	$105.06	$65.79
50553	T		Kidney endoscopy	0161	15.7070	$819.14	$249.36	$163.83
50555	T		Kidney endoscopy & biopsy	0160	6.3080	$328.97	$105.06	$65.79
50557	T		Kidney endoscopy & treatment	0162	20.5906	$1,073.82		$214.76
50559	T		Renal endoscopy/radiotracer	0160	6.3080	$328.97	$105.06	$65.79
50561	T		Kidney endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50562	T	NI	Renal scope w/tumor resect	0160	6.3080	$328.97	$105.06	$65.79
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50590	T		Fragmenting of kidney stone	0169	44.0978	$2,299.74	$1,115.69	$459.95
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	1.1240	$58.62	$17.59	$11.72
50688	T		Change of ureter tube	0121	2.0833	$108.65	$43.80	$21.73
50690	N		Injection for ureter x-ray					
50700	C		Revision of ureter					
50715	C		Release of ureter					
50722	C		Release of ureter					
50725	C		Release/revise ureter					
50727	C		Revise ureter					
50728	C		Revise ureter					
50740	C		Fusion of ureter & kidney					
50750	C		Fusion of ureter & kidney					
50760	C		Fusion of ureters					
50770	C		Splicing of ureters					
50780	C		Reimplant ureter in bladder					
50782	C		Reimplant ureter in bladder					
50783	C		Reimplant ureter in bladder					
50785	C		Reimplant ureter in bladder					
50800	C		Implant ureter in bowel					
50810	C		Fusion of ureter & bowel					
50815	C		Urine shunt to intestine					
50820	C		Construct bowel bladder					
50825	C		Construct bowel bladder					
50830	C		Revise urine flow					
50840	C		Replace ureter by bowel					
50845	C		Appendico-vesicostomy					
50860	C		Transplant ureter to skin					
50900	C		Repair of ureter					
50920	C		Closure ureter/skin fistula					
50930	C		Closure ureter/bowel fistula					
50940	C		Release of ureter					
50945	T		Laparoscopy ureterolithotomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
50947	T		Laparo new ureter/bladder	0131	40.2026	$2,096.61	$1,001.89	$419.32
50948	T		Laparo new ureter/bladder	0131	40.2026	$2,096.61	$1,001.89	$419.32
50949	T		Laparoscope proc, ureter	0130	30.4644	$1,588.75	$659.53	$317.75
50951	T		Endoscopy of ureter	0160	6.3080	$328.97	$105.06	$65.79
50953	T		Endoscopy of ureter	0160	6.3080	$328.97	$105.06	$65.79
50955	T		Ureter endoscopy & biopsy	0161	15.7070	$819.14	$249.36	$163.83
50957	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50959	T		Ureter endoscopy & tracer	0161	15.7070	$819.14	$249.36	$163.83
50961	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50970	T		Ureter endoscopy	0160	6.3080	$328.97	$105.06	$65.79
50972	T		Ureter endoscopy & catheter	0160	6.3080	$328.97	$105.06	$65.79
50974	T		Ureter endoscopy & biopsy	0161	15.7070	$819.14	$249.36	$163.83
50976	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50978	T		Ureter endoscopy & tracer	0161	15.7070	$819.14	$249.36	$163.83
50980	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
51000	T		Drainage of bladder	0165	12.2672	$639.75		$127.95
51005	T		Drainage of bladder	0164	1.1240	$58.62	$17.59	$11.72
51010	T		Drainage of bladder	0165	12.2672	$639.75		$127.95
51020	T		Incise & treat bladder	0162	20.5906	$1,073.82		$214.76
51030	T		Incise & treat bladder	0162	20.5906	$1,073.82		$214.76
51040	T		Incise & drain bladder	0162	20.5906	$1,073.82		$214.76
51045	T		Incise bladder/drain ureter	0160	6.3080	$328.97	$105.06	$65.79
51050	T		Removal of bladder stone	0162	20.5906	$1,073.82		$214.76
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	20.5906	$1,073.82		$214.76

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51080	T		Drainage of bladder abscess	0007	10.0191	$522.51	$108.89	$104.50
51500	T		Removal of bladder cyst	0154	25.7262	$1,341.65	$464.85	$268.33
51520	T		Removal of bladder lesion	0162	20.5906	$1,073.82		$214.76
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					
51600	N		Injection for bladder x-ray					
51605	N		Preparation for bladder xray					
51610	N		Injection for bladder x-ray					
51700	T		Irrigation of bladder	0164	1.1240	$58.62	$17.59	$11.72
51701	N	NI	Insert bladder catheter					
51702	N	NI	Insert temp bladder cath					
51703	N	NI	Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.0833	$108.65	$43.80	$21.73
51710	T		Change of bladder tube	0121	2.0833	$108.65	$43.80	$21.73
51715	T		Endoscopic injection/implant	0167	28.3230	$1,477.07	$555.84	$295.41
51720	T		Treatment of bladder lesion	0156	2.9747	$155.13	$46.55	$31.03
51725	T		Simple cystometrogram	0156	2.9747	$155.13	$46.55	$31.03
51726	T		Complex cystometrogram	0156	2.9747	$155.13	$46.55	$31.03
51736	T		Urine flow measurement	0164	1.1240	$58.62	$17.59	$11.72
51741	T		Electro-uroflowmetry, first	0164	1.1240	$58.62	$17.59	$11.72
51772	T		Urethra pressure profile	0164	1.1240	$58.62	$17.59	$11.72
51784	T		Anal/urinary muscle study	0164	1.1240	$58.62	$17.59	$11.72
51785	T		Anal/urinary muscle study	0164	1.1240	$58.62	$17.59	$11.72
51792	T		Urinary reflex study	0164	1.1240	$58.62	$17.59	$11.72
51795	T		Urine voiding pressure study	0164	1.1240	$58.62	$17.59	$11.72
51797	T		Intraabdominal pressure test	0164	1.1240	$58.62	$17.59	$11.72
51798	X	NI	Us urine capacity measure	0340	0.6492	$33.86		$6.77
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	20.5906	$1,073.82		$214.76
51900	C		Repair bladder/vagina lesion					
51920	C		Close bladder-uterus fistula					
51925	C		Hysterectomy/bladder repair					
51940	C		Correction of bladder defect					
51960	C		Revision of bladder & bowel					
51980	C		Construct bladder opening					
51990	T		Laparo urethral suspension	0131	40.2026	$2,096.61	$1,001.89	$419.32
51992	T		Laparo sling operation	0132	56.9948	$2,972.34	$1,239.22	$594.47
52000	T		Cystoscopy	0160	6.3080	$328.97	$105.06	$65.79
52001	T		Cystoscopy, removal of clots	0160	6.3080	$328.97	$105.06	$65.79
52005	T		Cystoscopy & ureter catheter	0161	15.7070	$819.14	$249.36	$163.83
52007	T		Cystoscopy and biopsy	0161	15.7070	$819.14	$249.36	$163.83
52010	T		Cystoscopy & duct catheter	0160	6.3080	$328.97	$105.06	$65.79
52204	T		Cystoscopy	0161	15.7070	$819.14	$249.36	$163.83
52214	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52224	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52234	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52235	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52240	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52250	T		Cystoscopy and radiotracer	0162	20.5906	$1,073.82		$214.76
52260	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52265	T		Cystoscopy and treatment	0160	6.3080	$328.97	$105.06	$65.79
52270	T		Cystoscopy & revise urethra	0161	15.7070	$819.14	$249.36	$163.83
52275	T		Cystoscopy & revise urethra	0161	15.7070	$819.14	$249.36	$163.83
52276	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52277	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52281	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52282	T		Cystoscopy, implant stent	0163	28.3714	$1,479.60		$295.92
52283	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52285	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52290	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52300	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52301	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52305	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52310	T		Cystoscopy and treatment	0160	6.3080	$328.97	$105.06	$65.79
52315	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52317	T		Remove bladder stone	0162	20.5906	$1,073.82		$214.76
52318	T		Remove bladder stone	0162	20.5906	$1,073.82		$214.76
52320	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52325	T		Cystoscopy, stone removal	0162	20.5906	$1,073.82		$214.76
52327	T		Cystoscopy, inject material	0162	20.5906	$1,073.82		$214.76
52330	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52332	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52334	T		Create passage to kidney	0162	20.5906	$1,073.82		$214.76
52341	T		Cysto w/ureter stricture tx	0162	20.5906	$1,073.82		$214.76
52342	T		Cysto w/up stricture tx	0162	20.5906	$1,073.82		$214.76
52343	T		Cysto w/renal stricture tx	0162	20.5906	$1,073.82		$214.76
52344	T		Cysto/uretero, stone remove	0162	20.5906	$1,073.82		$214.76
52345	T		Cysto/uretero w/up stricture	0162	20.5906	$1,073.82		$214.76
52346	T		Cystouretero w/renal strict	0162	20.5906	$1,073.82		$214.76
52347	T		Cystoscopy, resect ducts	0160	6.3080	$328.97	$105.06	$65.79
52351	T		Cystouretero & or pyeloscope	0160	6.3080	$328.97	$105.06	$65.79
52352	T		Cystouretero w/stone remove	0162	20.5906	$1,073.82		$214.76
52353	T		Cystouretero w/lithotripsy	0163	28.3714	$1,479.60		$295.92
52354	T		Cystouretero w/biopsy	0162	20.5906	$1,073.82		$214.76
52355	T		Cystouretero w/excise tumor	0162	20.5906	$1,073.82		$214.76
52400	T		Cystouretero w/congen repr	0162	20.5906	$1,073.82		$214.76
52450	T		Incision of prostate	0162	20.5906	$1,073.82		$214.76
52500	T		Revision of bladder neck	0162	20.5906	$1,073.82		$214.76
52510	T		Dilation prostatic urethra	0161	15.7070	$819.14	$249.36	$163.83
52601	T		Prostatectomy (TURP)	0163	28.3714	$1,479.60		$295.92
52606	T		Control postop bleeding	0162	20.5906	$1,073.82		$214.76
52612	T		Prostatectomy, first stage	0163	28.3714	$1,479.60		$295.92
52614	T		Prostatectomy, second stage	0163	28.3714	$1,479.60		$295.92
52620	T		Remove residual prostate	0163	28.3714	$1,479.60		$295.92
52630	T		Remove prostate regrowth	0163	28.3714	$1,479.60		$295.92
52640	T		Relieve bladder contracture	0162	20.5906	$1,073.82		$214.76
52647	T		Laser surgery of prostate	0163	28.3714	$1,479.60		$295.92
52648	T		Laser surgery of prostate	0163	28.3714	$1,479.60		$295.92
52700	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
53000	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53010	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53020	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53025	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53040	T		Drainage of urethra abscess	0166	15.4163	$803.98	$218.73	$160.80
53060	T		Drainage of urethra abscess	0166	15.4163	$803.98	$218.73	$160.80
53080	T		Drainage of urinary leakage	0166	15.4163	$803.98	$218.73	$160.80
53085	C		Drainage of urinary leakage					
53200	T		Biopsy of urethra	0166	15.4163	$803.98	$218.73	$160.80
53210	T		Removal of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53215	T		Removal of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53220	T		Treatment of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19
53230	T		Removal of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53235	T		Removal of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19
53240	T		Surgery for urethra pouch	0168	24.4665	$1,275.95	$405.60	$255.19
53250	T		Removal of urethra gland	0166	15.4163	$803.98	$218.73	$160.80
53260	T		Treatment of urethra lesion	0166	15.4163	$803.98	$218.73	$160.80
53265	T		Treatment of urethra lesion	0166	15.4163	$803.98	$218.73	$160.80
53270	T		Removal of urethra gland	0167	28.3230	$1,477.07	$555.84	$295.41
53275	T		Repair of urethra defect	0166	15.4163	$803.98	$218.73	$160.80
53400	T		Revise urethra, stage 1	0168	24.4665	$1,275.95	$405.60	$255.19
53405	T		Revise urethra, stage 2	0168	24.4665	$1,275.95	$405.60	$255.19
53410	T		Reconstruction of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	24.4665	$1,275.95	$405.60	$255.19
53425	T		Reconstruct urethra, stage 2	0168	24.4665	$1,275.95	$405.60	$255.19
53430	T		Reconstruction of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53431	T		Reconstruct urethra/bladder	0168	24.4665	$1,275.95	$405.60	$255.19
53440	T		Correct bladder function	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53442	T		Remove perineal prosthesis	0166	15.4163	$803.98	$218.73	$160.80
53444	T		Insert tandem cuff	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53445	T		Insert uro/ves nck sphincter	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53446	T		Remove uro sphincter	0168	24.4665	$1,275.95	$405.60	$255.19
53447	T		Remove/replace ur sphincter	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	24.4665	$1,275.95	$405.60	$255.19
53450	T		Revision of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53460	T		Revision of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53502	T		Repair of urethra injury	0166	15.4163	$803.98	$218.73	$160.80
53505	T		Repair of urethra injury	0167	28.3230	$1,477.07	$555.84	$295.41
53510	T		Repair of urethra injury	0166	15.4163	$803.98	$218.73	$160.80
53515	T		Repair of urethra injury	0168	24.4665	$1,275.95	$405.60	$255.19
53520	T		Repair of urethra defect	0168	24.4665	$1,275.95	$405.60	$255.19
53600	T		Dilate urethra stricture	0156	2.9747	$155.13	$46.55	$31.03
53601	T		Dilate urethra stricture	0164	1.1240	$58.62	$17.59	$11.72
53605	T		Dilate urethra stricture	0161	15.7070	$819.14	$249.36	$163.83
53620	T		Dilate urethra stricture	0165	12.2672	$639.75		$127.95
53621	T		Dilate urethra stricture	0164	1.1240	$58.62	$17.59	$11.72
53660	T		Dilation of urethra	0164	1.1240	$58.62	$17.59	$11.72
53661	T		Dilation of urethra	0164	1.1240	$58.62	$17.59	$11.72
53665	T		Dilation of urethra	0166	15.4163	$803.98	$218.73	$160.80
53670	N	DG	Insert urinary catheter					
53675	T	DG	Insert urinary catheter	0164	1.1240	$58.62	$17.59	$11.72
53850	T		Prostatic microwave thermotx	0675	48.5648	$2,532.70		$506.54
53852	T		Prostatic rf thermotx	0675	48.5648	$2,532.70		$506.54
53853	T		Prostatic water thermother	0977		$1,125.00		$225.00
53899	T		Urology surgery procedure	0164	1.1240	$58.62	$17.59	$11.72
54000	T		Slitting of prepuce	0166	15.4163	$803.98	$218.73	$160.80
54001	T		Slitting of prepuce	0166	15.4163	$803.98	$218.73	$160.80
54015	T		Drain penis lesion	0007	10.0191	$522.51	$108.89	$104.50
54050	T		Destruction, penis lesion(s)	0013	1.0756	$56.09	$14.20	$11.22
54055	T		Destruction, penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54056	T		Cryosurgery, penis lesion(s)	0012	0.7849	$40.93	$11.18	$8.19
54057	T		Laser surg, penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54060	T		Excision of penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54065	T		Destruction, penis lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
54100	T		Biopsy of penis	0021	13.9338	$726.66	$219.48	$145.33
54105	T		Biopsy of penis	0022	17.3930	$907.06	$354.45	$181.41
54110	T		Treatment of penis lesion	0181	29.2435	$1,525.08	$621.82	$305.02
54111	T		Treat penis lesion, graft	0181	29.2435	$1,525.08	$621.82	$305.02
54112	T		Treat penis lesion, graft	0181	29.2435	$1,525.08	$621.82	$305.02
54115	T		Treatment of penis lesion	0008	16.1430	$841.87		$168.37
54120	T		Partial removal of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54152	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54160	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54161	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54162	T		Lysis penil circumic lesion	0180	18.1004	$943.95	$304.87	$188.79
54163	T		Repair of circumcision	0180	18.1004	$943.95	$304.87	$188.79
54164	T		Frenulotomy of penis	0180	18.1004	$943.95	$304.87	$188.79
54200	T		Treatment of penis lesion	0156	2.9747	$155.13	$46.55	$31.03
54205	T		Treatment of penis lesion	0181	29.2435	$1,525.08	$621.82	$305.02
54220	T		Treatment of penis lesion	0156	2.9747	$155.13	$46.55	$31.03
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	12.2672	$639.75		$127.95
54235	T		Penile injection	0164	1.1240	$58.62	$17.59	$11.72
54240	T		Penis study	0164	1.1240	$58.62	$17.59	$11.72
54250	T		Penis study	0165	12.2672	$639.75		$127.95
54300	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54304	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54308	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54312	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54316	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54318	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54322	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54324	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54326	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54328	T		Revise penis/urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54344	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54348	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54352	T		Reconstruct urethra/penis	0181	29.2435	$1,525.08	$621.82	$305.02
54360	T		Penis plastic surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54380	T		Repair penis	0181	29.2435	$1,525.08	$621.82	$305.02
54385	T		Repair penis	0181	29.2435	$1,525.08	$621.82	$305.02
54390	C		Repair penis and bladder					
54400	T		Insert semi-rigid prosthesis	0182	95.4145	$4,975.96		$995.19
54401	T		Insert self-contd prosthesis	0182	95.4145	$4,975.96		$995.19
54405	T		Insert multi-comp penis pros	0182	95.4145	$4,975.96		$995.19
54406	T		Remove muti-comp penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54408	T		Repair multi-comp penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54410	T		Remove/replace penis prosth	0182	95.4145	$4,975.96		$995.19
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54416	T		Remv/repl penis contain pros	0182	95.4145	$4,975.96		$995.19
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54430	C		Revision of penis					
54435	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54440	T		Repair of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54450	T		Preputial stretching	0156	2.9747	$155.13	$46.55	$31.03
54500	T		Biopsy of testis	0005	3.1201	$162.72	$71.59	$32.54
54505	T		Biopsy of testis	0183	21.2592	$1,108.69		$221.74
54512	T		Excise lesion testis	0183	21.2592	$1,108.69		$221.74
54520	T		Removal of testis	0183	21.2592	$1,108.69		$221.74
54522	T		Orchiectomy, partial	0183	21.2592	$1,108.69		$221.74
54530	T		Removal of testis	0154	25.7262	$1,341.65	$464.85	$268.33
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	25.7262	$1,341.65	$464.85	$268.33
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	21.2592	$1,108.69		$221.74
54620	T		Suspension of testis	0183	21.2592	$1,108.69		$221.74
54640	T		Suspension of testis	0154	25.7262	$1,341.65	$464.85	$268.33
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	21.2592	$1,108.69		$221.74
54670	T		Repair testis injury	0183	21.2592	$1,108.69		$221.74
54680	T		Relocation of testis(es)	0183	21.2592	$1,108.69		$221.74
54690	T		Laparoscopy, orchiectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54692	T		Laparoscopy, orchiopexy	0132	56.9948	$2,972.34	$1,239.22	$594.47
54699	T		Laparoscope proc, testis	0130	30.4644	$1,588.75	$659.53	$317.75
54700	T		Drainage of scrotum	0183	21.2592	$1,108.69		$221.74
54800	T		Biopsy of epididymis	0004	1.7441	$90.96	$23.47	$18.19
54820	T		Exploration of epididymis	0183	21.2592	$1,108.69		$221.74
54830	T		Remove epididymis lesion	0183	21.2592	$1,108.69		$221.74
54840	T		Remove epididymis lesion	0183	21.2592	$1,108.69		$221.74
54860	T		Removal of epididymis	0183	21.2592	$1,108.69		$221.74
54861	T		Removal of epididymis	0183	21.2592	$1,108.69		$221.74
54900	T		Fusion of spermatic ducts	0183	21.2592	$1,108.69		$221.74
54901	T		Fusion of spermatic ducts	0183	21.2592	$1,108.69		$221.74
55000	T		Drainage of hydrocele	0004	1.7441	$90.96	$23.47	$18.19
55040	T		Removal of hydrocele	0154	25.7262	$1,341.65	$464.85	$268.33
55041	T		Removal of hydroceles	0154	25.7262	$1,341.65	$464.85	$268.33
55060	T		Repair of hydrocele	0183	21.2592	$1,108.69		$221.74
55100	T		Drainage of scrotum abscess	0007	10.0191	$522.51	$108.89	$104.50
55110	T		Explore scrotum	0183	21.2592	$1,108.69		$221.74
55120	T		Removal of scrotum lesion	0183	21.2592	$1,108.69		$221.74
55150	T		Removal of scrotum	0183	21.2592	$1,108.69		$221.74
55175	T		Revision of scrotum	0183	21.2592	$1,108.69		$221.74
55180	T		Revision of scrotum	0183	21.2592	$1,108.69		$221.74
55200	T		Incision of sperm duct	0183	21.2592	$1,108.69		$221.74
55250	T		Removal of sperm duct(s)	0183	21.2592	$1,108.69		$221.74
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	21.2592	$1,108.69		$221.74
55450	T		Ligation of sperm duct	0183	21.2592	$1,108.69		$221.74
55500	T		Removal of hydrocele	0183	21.2592	$1,108.69		$221.74
55520	T		Removal of sperm cord lesion	0183	21.2592	$1,108.69		$221.74
55530	T		Revise spermatic cord veins	0183	21.2592	$1,108.69		$221.74
55535	T		Revise spermatic cord veins	0154	25.7262	$1,341.65	$464.85	$268.33
55540	T		Revise hernia & sperm veins	0154	25.7262	$1,341.65	$464.85	$268.33
55550	T		Laparo ligate spermatic vein	0131	40.2026	$2,096.61	$1,001.89	$419.32
55559	T		Laparo proc, spermatic cord	0130	30.4644	$1,588.75	$659.53	$317.75
55600	C		Incise sperm duct pouch					
55605	C		Incise sperm duct pouch					
55650	C		Remove sperm duct pouch					
55680	T		Remove sperm pouch lesion	0183	21.2592	$1,108.69		$221.74
55700	T		Biopsy of prostate	0184	3.6918	$192.53	$96.27	$38.51
55705	T		Biopsy of prostate	0184	3.6918	$192.53	$96.27	$38.51
55720	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
55725	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	28.3714	$1,479.60		$295.92
55860	T		Surgical exposure, prostate	0165	12.2672	$639.75		$127.95
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C	NI	Laparo radical prostatectomy					
55870	T		Vag hyst w/enterocele repair	0197	1.5697	$81.86	$33.06	$16.37
55873	T		Cryoablate prostate	0674	62.9152	$3,281.09		$656.22
55899	T		Genital surgery procedure	0164	1.1240	$58.62	$17.59	$11.72
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	2.7228	$142.00	$39.11	$28.40
56420	T		Drainage of gland abscess	0192	2.7228	$142.00	$39.11	$28.40
56440	T		Surgery for vulva lesion	0194	18.0228	$939.91	$397.84	$187.98
56441	T		Lysis of labial lesion(s)	0193	14.4764	$754.96	$171.13	$150.99
56501	T		Destroy, vulva lesions, sim	0017	15.8233	$825.20	$227.84	$165.04

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
56515	T		Destroy vulva lesion/s compl	0695	18.6817	$974.27	$266.59	$194.85
56605	T		Biopsy of vulva/perineum	0019	3.7693	$196.57	$71.87	$39.31
56606	T		Biopsy of vulva/perineum	0019	3.7693	$196.57	$71.87	$39.31
56620	T		Partial removal of vulva	0195	23.7301	$1,237.55	$483.80	$247.51
56625	T		Complete removal of vulva	0195	23.7301	$1,237.55	$483.80	$247.51
56630	C		Extensive vulva surgery					
56631	C		Extensive vulva surgery					
56632	C		Extensive vulva surgery					
56633	C		Extensive vulva surgery					
56634	C		Extensive vulva surgery					
56637	C		Extensive vulva surgery					
56640	C		Extensive vulva surgery					
56700	T		Partial removal of hymen	0194	18.0228	$939.91	$397.84	$187.98
56720	T		Incision of hymen	0193	14.4764	$754.96	$171.13	$150.99
56740	T		Remove vagina gland lesion	0194	18.0228	$939.91	$397.84	$187.98
56800	T		Repair of vagina	0194	18.0228	$939.91	$397.84	$187.98
56805	T		Repair clitoris	0194	18.0228	$939.91	$397.84	$187.98
56810	T		Repair of perineum	0194	18.0228	$939.91	$397.84	$187.98
56820	T	NI	Exam of vulva w/scope	0188	1.0465	$54.58	$11.95	$10.92
56821	T	NI	Exam/biopsy of vulva w/scope	0189	1.5310	$79.84	$18.60	$15.97
57000	T		Exploration of vagina	0194	18.0228	$939.91	$397.84	$187.98
57010	T		Drainage of pelvic abscess	0194	18.0228	$939.91	$397.84	$187.98
57020	T		Drainage of pelvic fluid	0192	2.7228	$142.00	$39.11	$28.40
57022	T		I & d vaginal hematoma, pp	0007	10.0191	$522.51	$108.89	$104.50
57023	T		I & d vag hematoma, non-ob	0007	10.0191	$522.51	$108.89	$104.50
57061	T		Destroy vag lesions, simple	0194	18.0228	$939.91	$397.84	$187.98
57065	T		Destroy vag lesions, complex	0194	18.0228	$939.91	$397.84	$187.98
57100	T		Biopsy of vagina	0192	2.7228	$142.00	$39.11	$28.40
57105	T		Biopsy of vagina	0194	18.0228	$939.91	$397.84	$187.98
57106	T		Remove vagina wall, partial	0194	18.0228	$939.91	$397.84	$187.98
57107	T		Remove vagina tissue, part	0195	23.7301	$1,237.55	$483.80	$247.51
57109	T		Vaginectomy partial w/nodes	0202	45.5610	$2,376.05	$1,164.26	$475.21
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0194	18.0228	$939.91	$397.84	$187.98
57130	T		Remove vagina lesion	0194	18.0228	$939.91	$397.84	$187.98
57135	T		Remove vagina lesion	0194	18.0228	$939.91	$397.84	$187.98
57150	T		Treat vagina infection	0191	0.2035	$10.61	$3.08	$2.12
57155	T		Insert uteri tandems/ovoids	0192	2.7228	$142.00	$39.11	$28.40
57160	T		Insert pessary/other device	0188	1.0465	$54.58	$11.95	$10.92
57170	T		Fitting of diaphragm/cap	0191	0.2035	$10.61	$3.08	$2.12
57180	T		Treat vaginal bleeding	0192	2.7228	$142.00	$39.11	$28.40
57200	T		Repair of vagina	0194	18.0228	$939.91	$397.84	$187.98
57210	T		Repair vagina/perineum	0194	18.0228	$939.91	$397.84	$187.98
57220	T		Revision of urethra	0195	23.7301	$1,237.55	$483.80	$247.51
57230	T		Repair of urethral lesion	0194	18.0228	$939.91	$397.84	$187.98
57240	T		Repair bladder & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57250	T		Repair rectum & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57260	T		Repair of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57265	T		Extensive repair of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57268	T		Repair of bowel bulge	0195	23.7301	$1,237.55	$483.80	$247.51
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57284	T		Repair paravaginal defect	0195	23.7301	$1,237.55	$483.80	$247.51
57287	T		Revise/remove sling repair	0202	45.5610	$2,376.05	$1,164.26	$475.21
57288	T		Repair bladder defect	0202	45.5610	$2,376.05	$1,164.26	$475.21
57289	T		Repair bladder & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57291	T		Construction of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	23.7301	$1,237.55	$483.80	$247.51
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57310	T		Repair urethrovaginal lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57330	T		Repair bladder-vagina lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	18.0228	$939.91	$397.84	$187.98
57410	T		Pelvic examination	0194	18.0228	$939.91	$397.84	$187.98
57415	T		Remove vaginal foreign body	0194	18.0228	$939.91	$397.84	$187.98
57420	T	NI	Exam of vagina w/scope	0192	2.7228	$142.00	$39.11	$28.40
57421	T	NI	Exam/biopsy of vag w/scope	0192	2.7228	$142.00	$39.11	$28.40
57452	T		Examination of vagina	0189	1.5310	$79.84	$18.60	$15.97
57454	T		Vagina examination & biopsy	0192	2.7228	$142.00	$39.11	$28.40
57455	T	NI	Biopsy of cervix w/scope	0192	2.7228	$142.00	$39.11	$28.40
57456	T	NI	Endocerv curettage w/scope	0192	2.7228	$142.00	$39.11	$28.40
57460	T		Cervix excision	0193	14.4764	$754.96	$171.13	$150.99
57461	T	NI	Conz of cervix w/scope, leep	0194	18.0228	$939.91	$397.84	$187.98
57500	T		Biopsy of cervix	0192	2.7228	$142.00	$39.11	$28.40
57505	T		Endocervical curettage	0192	2.7228	$142.00	$39.11	$28.40
57510	T		Cauterization of cervix	0193	14.4764	$754.96	$171.13	$150.99
57511	T		Cryocautery of cervix	0189	1.5310	$79.84	$18.60	$15.97
57513	T		Laser surgery of cervix	0193	14.4764	$754.96	$171.13	$150.99
57520	T		Conization of cervix	0194	18.0228	$939.91	$397.84	$187.98
57522	T		Conization of cervix	0195	23.7301	$1,237.55	$483.80	$247.51
57530	T		Removal of cervix	0195	23.7301	$1,237.55	$483.80	$247.51
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	23.7301	$1,237.55	$483.80	$247.51
57555	T		Remove cervix/repair vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57556	T		Remove cervix, repair bowel	0195	23.7301	$1,237.55	$483.80	$247.51
57700	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
57720	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
57800	T		Dilation of cervical canal	0193	14.4764	$754.96	$171.13	$150.99
57820	T		D & c of residual cervix	0196	15.5035	$808.52	$338.23	$161.70
58100	T		Biopsy of uterus lining	0188	1.0465	$54.58	$11.95	$10.92
58120	T		Dilation and curettage	0196	15.5035	$808.52	$338.23	$161.70
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	23.7301	$1,237.55	$483.80	$247.51
58146	C	NI	Myomectomy abdom complex					
58150	C		Total hysterectomy					
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C	NI	Vag hyst complex					
58291	C	NI	Vag hyst incl t/o, complex					
58292	C	NI	Vag hyst t/o & repair, compl					
58293	C	NI	Vag hyst w/uro repair, compl					
58294	C	NI	Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	1.5310	$79.84	$18.60	$15.97
58321	T		Artificial insemination	0197	1.5697	$81.86	$33.06	$16.37
58322	T		Artificial insemination	0197	1.5697	$81.86	$33.06	$16.37
58323	T		Sperm washing	0197	1.5697	$81.86	$33.06	$16.37
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	18.0228	$939.91	$397.84	$187.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58346	T		Insert heyman uteri capsule	0192	2.7228	$142.00	$39.11	$28.40
58350	T		Reopen fallopian tube	0194	18.0228	$939.91	$397.84	$187.98
58353	T		Endometr ablate, thermal	0193	14.4764	$754.96	$171.13	$150.99
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					
58540	C		Revision of uterus					
58545	T	NI	Laparoscopic myomectomy	0130	30.4644	$1,588.75	$659.53	$317.75
58546	T	NI	Laparo-myomectomy, complex	0131	40.2026	$2,096.61	$1,001.89	$419.32
58550	T		Laparo-asst vag hysterectomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
58551	T	DG	Laparoscopy, remove myoma	0131	40.2026	$2,096.61	$1,001.89	$419.32
58552	T	NI	Laparo-vag hyst incl t/o	0131	40.2026	$2,096.61	$1,001.89	$419.32
58553	T	NI	Laparo-vag hyst, complex	0131	40.2026	$2,096.61	$1,001.89	$419.32
58554	T	NI	Laparo-vag hyst w/t/o, compl	0131	40.2026	$2,096.61	$1,001.89	$419.32
58555	T		Hysteroscopy, dx, sep proc	0194	18.0228	$939.91	$397.84	$187.98
58558	T		Hysteroscopy, biopsy	0190	19.0596	$993.98	$424.28	$198.80
58559	T		Hysteroscopy, lysis	0190	19.0596	$993.98	$424.28	$198.80
58560	T		Hysteroscopy, resect septum	0190	19.0596	$993.98	$424.28	$198.80
58561	T		Hysteroscopy, remove myoma	0190	19.0596	$993.98	$424.28	$198.80
58562	T		Hysteroscopy, remove fb	0190	19.0596	$993.98	$424.28	$198.80
58563	T		Hysteroscopy, ablation	0190	19.0596	$993.98	$424.28	$198.80
58578	T		Laparo proc, uterus	0190	19.0596	$993.98	$424.28	$198.80
58579	T		Hysteroscope procedure	0190	19.0596	$993.98	$424.28	$198.80
58600	T		Division of fallopian tube	0194	18.0228	$939.91	$397.84	$187.98
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	18.0228	$939.91	$397.84	$187.98
58660	T		Laparoscopy, lysis	0131	40.2026	$2,096.61	$1,001.89	$419.32
58661	T		Laparoscopy, remove adnexa	0131	40.2026	$2,096.61	$1,001.89	$419.32
58662	T		Laparoscopy, excise lesions	0131	40.2026	$2,096.61	$1,001.89	$419.32
58670	T		Laparoscopy, tubal cautery	0131	40.2026	$2,096.61	$1,001.89	$419.32
58671	T		Laparoscopy, tubal block	0131	40.2026	$2,096.61	$1,001.89	$419.32
58672	T		Laparoscopy, fimbrioplasty	0131	40.2026	$2,096.61	$1,001.89	$419.32
58673	T		Laparoscopy, salpingostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
58679	T		Laparo proc, oviduct-ovary	0130	30.4644	$1,588.75	$659.53	$317.75
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	23.7301	$1,237.55	$483.80	$247.51
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	23.7301	$1,237.55	$483.80	$247.51
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	14.4764	$754.96	$171.13	$150.99
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0195	23.7301	$1,237.55	$483.80	$247.51
58920	T		Partial removal of ovary(s)	0202	45.5610	$2,376.05	$1,164.26	$475.21
58925	T		Removal of ovarian cyst(s)	0202	45.5610	$2,376.05	$1,164.26	$475.21
58940	C		Removal of ovary(s)					
58943	C		Removal of ovary(s)					
58950	C		Resect ovarian malignancy					
58951	C		Resect ovarian malignancy					
58952	C		Resect ovarian malignancy					
58953	C		Tah, rad dissect for debulk					
58954	C		Tah rad debulk/lymph remove					
58960	C		Exploration of abdomen					
58970	T		Retrieval of oocyte	0194	18.0228	$939.91	$397.84	$187.98
58974	T		Transfer of embryo	0197	1.5697	$81.86	$33.06	$16.37
58976	T		Transfer of embryo	0197	1.5697	$81.86	$33.06	$16.37
58999	T		Genital surgery procedure	0191	0.2035	$10.61	$3.08	$2.12
59000	T		Amniocentesis, diagnostic	0198	1.2597	$65.69	$32.19	$13.14
59001	T		Amniocentesis, therapeutic	0198	1.2597	$65.69	$32.19	$13.14

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59012	T		Fetal cord puncture,prenatal	0198	1.2597	$65.69	$32.19	$13.14
59015	T		Chorion biopsy	0198	1.2597	$65.69	$32.19	$13.14
59020	T		Fetal contract stress test	0198	1.2597	$65.69	$32.19	$13.14
59025	T		Fetal non-stress test	0198	1.2597	$65.69	$32.19	$13.14
59030	T		Fetal scalp blood sample	0198	1.2597	$65.69	$32.19	$13.14
59050	E		Fetal monitor w/report					
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	40.2026	$2,096.61	$1,001.89	$419.32
59151	T		Treat ectopic pregnancy	0131	40.2026	$2,096.61	$1,001.89	$419.32
59160	T		D & c after delivery	0196	15.5035	$808.52	$338.23	$161.70
59200	T		Insert cervical dilator	0189	1.5310	$79.84	$18.60	$15.97
59300	T		Episiotomy or vaginal repair	0193	14.4764	$754.96	$171.13	$150.99
59320	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	E		Obstetrical care					
59409	T		Obstetrical care	0199	3.9146	$204.15	$57.16	$40.83
59410	E		Obstetrical care					
59412	T		Antepartum manipulation	0199	3.9146	$204.15	$57.16	$40.83
59414	T		Deliver placenta	0199	3.9146	$204.15	$57.16	$40.83
59425	E		Antepartum care only					
59426	E		Antepartum care only					
59430	E		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0199	3.9146	$204.15	$57.16	$40.83
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	15.3097	$798.42	$329.65	$159.68
59820	T		Care of miscarriage	0201	15.3097	$798.42	$329.65	$159.68
59821	T		Treatment of miscarriage	0201	15.3097	$798.42	$329.65	$159.68
59830	C		Treat uterus infection					
59840	T		Abortion	0200	15.1838	$791.85	$307.83	$158.37
59841	T		Abortion	0200	15.1838	$791.85	$307.83	$158.37
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.2597	$65.69	$32.19	$13.14
59870	T		Evacuate mole of uterus	0201	15.3097	$798.42	$329.65	$159.68
59871	T		Remove cerclage suture	0194	18.0228	$939.91	$397.84	$187.98
59898	T		Laparo proc, ob care/deliver	0130	30.4644	$1,588.75	$659.53	$317.75
59899	T		Maternity care procedure	0198	1.2597	$65.69	$32.19	$13.14
60000	T		Drain thyroid/tongue cyst	0252	5.8041	$302.69	$113.41	$60.54
60001	T		Aspirate/inject thyriod cyst	0004	1.7441	$90.96	$23.47	$18.19
60100	T		Biopsy of thyroid	0004	1.7441	$90.96	$23.47	$18.19
60200	T		Remove thyroid lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60210	T		Partial thyroid excision	0114	36.1135	$1,883.36	$485.91	$376.67
60212	T		Partial thyroid excision	0114	36.1135	$1,883.36	$485.91	$376.67
60220	T		Partial removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67
60225	T		Partial removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
60240	T		Removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67
60252	T		Removal of thyroid	0256	34.0302	$1,774.71		$354.94
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	34.0302	$1,774.71		$354.94
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60281	T		Remove thyroid duct lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60500	T		Explore parathyroid glands	0256	34.0302	$1,774.71		$354.94
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	17.3930	$907.06	$354.45	$181.41
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	30.4644	$1,588.75	$659.53	$317.75
60699	T		Endocrine surgery procedure	0114	36.1135	$1,883.36	$485.91	$376.67
61000	T		Remove cranial cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61001	T		Remove cranial cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61020	T		Remove brain cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61026	T		Injection into brain canal	0212	3.3139	$172.82	$79.53	$34.56
61050	T		Remove brain canal fluid	0212	3.3139	$172.82	$79.53	$34.56
61055	T		Injection into brain canal	0212	3.3139	$172.82	$79.53	$34.56
61070	T		Brain canal shunt procedure	0212	3.3139	$172.82	$79.53	$34.56
61105	C		Twist drill hole					
61107	C		Drill skull for implantation					
61108	C		Drill skull for drainage					
61120	C		Burr hole for puncture					
61140	C		Pierce skull for biopsy					
61150	C		Pierce skull for drainage					
61151	C		Pierce skull for drainage					
61154	C		Pierce skull & remove clot					
61156	C		Pierce skull for drainage					
61210	C		Pierce skull, implant device					
61215	T		Insert brain-fluid device	0224	34.0302	$1,774.71	$453.41	$354.94
61250	C		Pierce skull & explore					
61253	C		Pierce skull & explore					
61304	C		Open skull for exploration					
61305	C		Open skull for exploration					
61312	C		Open skull for drainage					
61313	C		Open skull for drainage					
61314	C		Open skull for drainage					
61315	C		Open skull for drainage					
61316	N	NI	Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C	NI	Decompressive craniotomy					
61323	C	NI	Decompressive lobectomy					
61330	T		Decompress eye socket	0256	34.0302	$1,774.71		$354.94
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	N	NI	Implt brain chemotx add-on					
61518	C		Removal of brain lesion					
61519	C		Remove brain lining lesion					
61520	C		Removal of brain lesion					
61521	C		Removal of brain lesion					
61522	C		Removal of brain abscess					
61524	C		Removal of brain lesion					
61526	C		Removal of brain lesion					
61530	C		Removal of brain lesion					
61531	C		Implant brain electrodes					
61533	C		Implant brain electrodes					
61534	C		Removal of brain lesion					
61535	C		Remove brain electrodes					
61536	C		Removal of brain lesion					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T	NI	Endovasc tempory vessel occl	0979		$1,625.00		$325.00
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	43.5067	$2,268.92		$453.78
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	15.8136	$824.70		$164.94
61791	T		Treat trigeminal tract	0204	2.0251	$105.61	$40.13	$21.12
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	9.2343	$481.58	$182.43	$96.32
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	25.8424	$1,347.71	$619.95	$269.54
61885	T		Implant neurostim one array	0222	227.7370	$11,876.71		$2,375.34
61886	T		Implant neurostim arrays	0222	227.7370	$11,876.71		$2,375.34
61888	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					
62010	C		Treatment of head injury					
62100	C		Repair brain fluid leakage					
62115	C		Reduction of skull defect					
62116	C		Reduction of skull defect					
62117	C		Reduction of skull defect					
62120	C		Repair skull cavity lesion					
62121	C		Incise skull repair					
62140	C		Repair of skull defect					
62141	C		Repair of skull defect					
62142	C		Remove skull plate/flap					
62143	C		Replace skull plate/flap					
62145	C		Repair of skull & brain					
62146	C		Repair of skull with graft					
62147	C		Repair of skull with graft					
62148	N	NI	Retr bone flap to fix skull					
62160	N	NI	Neuroendoscopy add-on					
62161	C	NI	Dissect brain w/scope					
62162	C	NI	Remove colloid cyst w/scope					
62163	C	NI	Neuroendoscopy w/fb removal					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62164	C	NI	Remove brain tumor w/scope					
62165	C	NI	Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.0833	$108.65	$43.80	$21.73
62200	C		Establish brain cavity shunt					
62201	C		Establish brain cavity shunt					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0121	2.0833	$108.65	$43.80	$21.73
62230	T		Replace/revise brain shunt	0224	34.0302	$1,774.71	$453.41	$354.94
62252	S		Csf shunt reprogram	0691	2.9166	$152.10	$83.65	$30.42
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	11.7924	$614.99	$276.76	$123.00
62264	T	NI	Epidural lysis on single day	0203	11.7924	$614.99	$276.76	$123.00
62268	T		Drain spinal cord cyst	0212	3.3139	$172.82	$79.53	$34.56
62269	T		Needle biopsy, spinal cord	0005	3.1201	$162.72	$71.59	$32.54
62270	T		Spinal fluid tap, diagnostic	0206	4.7867	$249.63	$75.55	$49.93
62272	T		Drain cerebro spinal fluid	0206	4.7867	$249.63	$75.55	$49.93
62273	T		Treat epidural spine lesion	0206	4.7867	$249.63	$75.55	$49.93
62280	T		Treat spinal cord lesion	0207	5.7654	$300.67	$123.69	$60.13
62281	T		Treat spinal cord lesion	0207	5.7654	$300.67	$123.69	$60.13
62282	T		Treat spinal canal lesion	0207	5.7654	$300.67	$123.69	$60.13
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0220	15.8136	$824.70		$164.94
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	3.3139	$172.82	$79.53	$34.56
62294	T		Injection into spinal artery	0212	3.3139	$172.82	$79.53	$34.56
62310	T		Inject spine c/t	0206	4.7867	$249.63	$75.55	$49.93
62311	T		Inject spine l/s (cd)	0206	4.7867	$249.63	$75.55	$49.93
62318	T		Inject spine w/cath, c/t	0206	4.7867	$249.63	$75.55	$49.93
62319	T		Inject spine w/cath l/s (cd)	0206	4.7867	$249.63	$75.55	$49.93
62350	T		Implant spinal canal cath	0223	41.0262	$2,139.56		$427.91
62351	T		Implant spinal canal cath	0208	38.4487	$2,005.14		$401.03
62355	T		Remove spinal canal catheter	0203	11.7924	$614.99	$276.76	$123.00
62360	T		Insert spine infusion device	0226	144.3474	$7,527.86		$1,505.57
62361	T		Implant spine infusion pump	0227	144.5122	$7,536.46		$1,507.29
62362	T		Implant spine infusion pump	0227	144.5122	$7,536.46		$1,507.29
62365	T		Remove spine infusion device	0203	11.7924	$614.99	$276.76	$123.00
62367	S		Analyze spine infusion pump	0691	2.9166	$152.10	$83.65	$30.42
62368	S		Analyze spine infusion pump	0691	2.9166	$152.10	$83.65	$30.42
63001	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63003	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63005	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63011	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63012	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63015	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63016	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63017	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63020	T		Neck spine disk surgery	0208	38.4487	$2,005.14		$401.03
63030	T		Low back disk surgery	0208	38.4487	$2,005.14		$401.03
63035	T		Spinal disk surgery add-on	0208	38.4487	$2,005.14		$401.03
63040	T		Laminotomy, single cervical	0208	38.4487	$2,005.14		$401.03
63042	T		Laminotomy, single lumbar	0208	38.4487	$2,005.14		$401.03
63043	C		Laminotomy, addl cervical					
63044	C		Laminotomy, addl lumbar					
63045	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63046	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63047	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63048	T		Remove spinal lamina add-on	0208	38.4487	$2,005.14		$401.03
63055	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03
63056	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63057	T		Decompress spine cord add-on	0208	38.4487	$2,005.14		$401.03
63064	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03
63066	T		Decompress spine cord add-on	0208	38.4487	$2,005.14		$401.03
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					
63600	T		Remove spinal cord lesion	0220	15.8136	$824.70		$164.94
63610	T		Stimulation of spinal cord	0220	15.8136	$824.70		$164.94
63615	T		Remove lesion of spinal cord	0220	15.8136	$824.70		$164.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63650	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
63655	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
63660	T		Revise/remove neuroelectrode	0687	25.8424	$1,347.71	$619.95	$269.54
63685	T		Implant neuroreceiver	0222	227.7370	$11,876.71		$2,375.34
63688	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
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	59.6207	$3,109.28	$696.46	$621.86
63744	T		Revision of spinal shunt	0228	59.6207	$3,109.28	$696.46	$621.86
63746	T		Removal of spinal shunt	0109	7.4708	$389.61	$131.49	$77.92
64400	T		N block inj, trigeminal	0204	2.0251	$105.61	$40.13	$21.12
64402	T		N block inj, facial	0204	2.0251	$105.61	$40.13	$21.12
64405	T		N block inj, occipital	0204	2.0251	$105.61	$40.13	$21.12
64408	T		N block inj, vagus	0204	2.0251	$105.61	$40.13	$21.12
64410	T		N block inj, phrenic	0204	2.0251	$105.61	$40.13	$21.12
64412	T		N block inj, spinal accessor	0204	2.0251	$105.61	$40.13	$21.12
64413	T		N block inj, cervical plexus	0204	2.0251	$105.61	$40.13	$21.12
64415	T		Injection for nerve block	0204	2.0251	$105.61	$40.13	$21.12
64416	T	NI	N block cont infuse, b plex	0204	2.0251	$105.61	$40.13	$21.12
64417	T		N block inj, axillary	0204	2.0251	$105.61	$40.13	$21.12
64418	T		N block inj, suprascapular	0204	2.0251	$105.61	$40.13	$21.12
64420	T		N block inj, intercost, sng	0207	5.7654	$300.67	$123.69	$60.13
64421	T		N block inj, intercost, mlt	0207	5.7654	$300.67	$123.69	$60.13
64425	T		N block inj ilio-ing/hypogi	0204	2.0251	$105.61	$40.13	$21.12
64430	T		N block inj, pudendal	0204	2.0251	$105.61	$40.13	$21.12
64435	T		N block inj, paracervical	0204	2.0251	$105.61	$40.13	$21.12
64445	T		Injection for nerve block	0204	2.0251	$105.61	$40.13	$21.12
64446	T	NI	N blk inj, sciatic, cont inf	0204	2.0251	$105.61	$40.13	$21.12
64447	T	NI	N block inj fem, single	0204	2.0251	$105.61	$40.13	$21.12
64448	T	NI	N block inj fem, cont inf	0204	2.0251	$105.61	$40.13	$21.12
64450	T		N block, other peripheral	0204	2.0251	$105.61	$40.13	$21.12
64470	T		Inj paravertebral c/t	0207	5.7654	$300.67	$123.69	$60.13
64472	T		Inj paravertebral c/t add-on	0207	5.7654	$300.67	$123.69	$60.13
64475	T		Inj paravertebral l/s	0207	5.7654	$300.67	$123.69	$60.13
64476	T		Inj paravertebral l/s add-on	0207	5.7654	$300.67	$123.69	$60.13
64479	T		Inj foramen epidural c/t	0207	5.7654	$300.67	$123.69	$60.13
64480	T		Inj foramen epidural add-on	0207	5.7654	$300.67	$123.69	$60.13
64483	T		Inj foramen epidural l/s	0207	5.7654	$300.67	$123.69	$60.13
64484	T		Inj foramen epidural add-on	0207	5.7654	$300.67	$123.69	$60.13
64505	T		N block, spenopalatine gangl	0204	2.0251	$105.61	$40.13	$21.12
64508	T		N block, carotid sinus s/p	0204	2.0251	$105.61	$40.13	$21.12
64510	T		N block, stellate ganglion	0207	5.7654	$300.67	$123.69	$60.13
64520	T		N block, lumbar/thoracic	0207	5.7654	$300.67	$123.69	$60.13
64530	T		N block inj, celiac pelus	0207	5.7654	$300.67	$123.69	$60.13
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64555	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64560	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64561	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64565	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64573	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64575	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64577	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64580	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64581	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64585	T		Revise/remove neuroelectrode	0687	25.8424	$1,347.71	$619.95	$269.54
64590	T		Implant neuroreceiver	0222	227.7370	$11,876.71		$2,375.34
64595	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
64600	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64605	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64610	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64612	T		Destroy nerve, face muscle	0204	2.0251	$105.61	$40.13	$21.12
64613	T		Destroy nerve, spine muscle	0204	2.0251	$105.61	$40.13	$21.12
64614	T		Destroy nerve, extrem musc	0204	2.0251	$105.61	$40.13	$21.12
64620	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64622	T		Destr paravertebrl nerve l/s	0203	11.7924	$614.99	$276.76	$123.00
64623	T		Destr paravertebral n add-on	0203	11.7924	$614.99	$276.76	$123.00
64626	T		Destr paravertebrl nerve c/t	0203	11.7924	$614.99	$276.76	$123.00
64627	T		Destr paravertebral n add-on	0203	11.7924	$614.99	$276.76	$123.00
64630	T		Injection treatment of nerve	0207	5.7654	$300.67	$123.69	$60.13
64640	T		Injection treatment of nerve	0207	5.7654	$300.67	$123.69	$60.13
64680	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64702	T		Revise finger/toe nerve	0220	15.8136	$824.70		$164.94
64704	T		Revise hand/foot nerve	0220	15.8136	$824.70		$164.94
64708	T		Revise arm/leg nerve	0220	15.8136	$824.70		$164.94
64712	T		Revision of sciatic nerve	0220	15.8136	$824.70		$164.94
64713	T		Revision of arm nerve(s)	0220	15.8136	$824.70		$164.94
64714	T		Revise low back nerve(s)	0220	15.8136	$824.70		$164.94
64716	T		Revision of cranial nerve	0220	15.8136	$824.70		$164.94
64718	T		Revise ulnar nerve at elbow	0220	15.8136	$824.70		$164.94
64719	T		Revise ulnar nerve at wrist	0220	15.8136	$824.70		$164.94
64721	T		Carpal tunnel surgery	0220	15.8136	$824.70		$164.94
64722	T		Relieve pressure on nerve(s)	0220	15.8136	$824.70		$164.94
64726	T		Release foot/toe nerve	0220	15.8136	$824.70		$164.94
64727	T		Internal nerve revision	0220	15.8136	$824.70		$164.94
64732	T		Incision of brow nerve	0220	15.8136	$824.70		$164.94
64734	T		Incision of cheek nerve	0220	15.8136	$824.70		$164.94
64736	T		Incision of chin nerve	0220	15.8136	$824.70		$164.94
64738	T		Incision of jaw nerve	0220	15.8136	$824.70		$164.94
64740	T		Incision of tongue nerve	0220	15.8136	$824.70		$164.94
64742	T		Incision of facial nerve	0220	15.8136	$824.70		$164.94
64744	T		Incise nerve, back of head	0220	15.8136	$824.70		$164.94
64746	T		Incise diaphragm nerve	0220	15.8136	$824.70		$164.94
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	15.8136	$824.70		$164.94
64763	C		Incise hip/thigh nerve					
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	15.8136	$824.70		$164.94
64772	T		Incision of spinal nerve	0220	15.8136	$824.70		$164.94
64774	T		Remove skin nerve lesion	0220	15.8136	$824.70		$164.94
64776	T		Remove digit nerve lesion	0220	15.8136	$824.70		$164.94
64778	T		Digit nerve surgery add-on	0220	15.8136	$824.70		$164.94
64782	T		Remove limb nerve lesion	0220	15.8136	$824.70		$164.94
64783	T		Limb nerve surgery add-on	0220	15.8136	$824.70		$164.94
64784	T		Remove nerve lesion	0220	15.8136	$824.70		$164.94
64786	T		Remove sciatic nerve lesion	0221	21.5208	$1,122.33	$463.62	$224.47
64787	T		Implant nerve end	0220	15.8136	$824.70		$164.94
64788	T		Remove skin nerve lesion	0220	15.8136	$824.70		$164.94
64790	T		Removal of nerve lesion	0220	15.8136	$824.70		$164.94
64792	T		Removal of nerve lesion	0221	21.5208	$1,122.33	$463.62	$224.47
64795	T		Biopsy of nerve	0220	15.8136	$824.70		$164.94
64802	T		Remove sympathetic nerves	0220	15.8136	$824.70		$164.94
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	15.8136	$824.70		$164.94
64821	T		Remove sympathetic nerves	0054	22.7223	$1,184.99		$237.00
64822	T		Remove sympathetic nerves	0054	22.7223	$1,184.99		$237.00
64823	T		Remove sympathetic nerves	0054	22.7223	$1,184.99		$237.00
64831	T		Repair of digit nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64832	T		Repair nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64834	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64835	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64836	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64837	T		Repair nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64840	T		Repair of leg nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64856	T		Repair/transpose nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64857	T		Repair arm/leg nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64858	T		Repair sciatic nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64859	T		Nerve surgery	0221	21.5208	$1,122.33	$463.62	$224.47
64861	T		Repair of arm nerves	0221	21.5208	$1,122.33	$463.62	$224.47
64862	T		Repair of low back nerves	0221	21.5208	$1,122.33	$463.62	$224.47
64864	T		Repair of facial nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64865	T		Repair of facial nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64872	T		Subsequent repair of nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64874	T		Repair & revise nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64876	T		Repair nerve/shorten bone	0221	21.5208	$1,122.33	$463.62	$224.47
64885	T		Nerve graft, head or neck	0221	21.5208	$1,122.33	$463.62	$224.47
64886	T		Nerve graft, head or neck	0221	21.5208	$1,122.33	$463.62	$224.47
64890	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64891	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64892	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64893	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64895	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64896	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64897	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64898	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64901	T		Nerve graft add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64902	T		Nerve graft add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64905	T		Nerve pedicle transfer	0221	21.5208	$1,122.33	$463.62	$224.47
64907	T		Nerve pedicle transfer	0221	21.5208	$1,122.33	$463.62	$224.47
64999	T		Nervous system surgery	0204	2.0251	$105.61	$40.13	$21.12
65091	T		Revise eye	0242	28.0517	$1,462.92	$597.36	$292.58
65093	T		Revise eye with implant	0241	20.6294	$1,075.84	$384.47	$215.17
65101	T		Removal of eye	0242	28.0517	$1,462.92	$597.36	$292.58
65103	T		Remove eye/insert implant	0242	28.0517	$1,462.92	$597.36	$292.58
65105	T		Remove eye/attach implant	0242	28.0517	$1,462.92	$597.36	$292.58
65110	T		Removal of eye	0242	28.0517	$1,462.92	$597.36	$292.58
65112	T		Remove eye/revise socket	0242	28.0517	$1,462.92	$597.36	$292.58
65114	T		Remove eye/revise socket	0242	28.0517	$1,462.92	$597.36	$292.58
65125	T		Revise ocular implant	0240	16.3078	$850.47	$315.31	$170.09
65130	T		Insert ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65135	T		Insert ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65140	T		Attach ocular implant	0242	28.0517	$1,462.92	$597.36	$292.58
65150	T		Revise ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65155	T		Reinsert ocular implant	0242	28.0517	$1,462.92	$597.36	$292.58
65175	T		Removal of ocular implant	0240	16.3078	$850.47	$315.31	$170.09
65205	S		Remove foreign body from eye	0698	0.9205	$48.00	$18.72	$9.60
65210	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65220	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65222	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65235	T		Remove foreign body from eye	0233	13.4202	$699.88	$266.33	$139.98
65260	T		Remove foreign body from eye	0236	19.4278	$1,013.18		$202.64
65265	T		Remove foreign body from eye	0236	19.4278	$1,013.18		$202.64
65270	T		Repair of eye wound	0240	16.3078	$850.47	$315.31	$170.09
65272	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65280	T		Repair of eye wound	0234	20.4259	$1,065.23	$511.31	$213.05
65285	T		Repair of eye wound	0234	20.4259	$1,065.23	$511.31	$213.05
65286	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65290	T		Repair of eye socket wound	0243	19.9705	$1,041.48	$431.39	$208.30
65400	T		Removal of eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65410	T		Biopsy of cornea	0233	13.4202	$699.88	$266.33	$139.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65420	T		Removal of eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65426	T		Removal of eye lesion	0234	20.4259	$1,065.23	$511.31	$213.05
65430	S		Corneal smear	0230	0.7364	$38.40	$14.97	$7.68
65435	T		Curette/treat cornea	0239	6.8119	$355.25	$115.94	$71.05
65436	T		Curette/treat cornea	0233	13.4202	$699.88	$266.33	$139.98
65450	S		Treatment of corneal lesion	0231	2.1705	$113.19	$50.94	$22.64
65600	T		Revision of cornea	0240	16.3078	$850.47	$315.31	$170.09
65710	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65730	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65750	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65755	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	35.6290	$1,858.09	$803.26	$371.62
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	13.4202	$699.88	$266.33	$139.98
65775	T		Correction of astigmatism	0233	13.4202	$699.88	$266.33	$139.98
65800	T		Drainage of eye	0233	13.4202	$699.88	$266.33	$139.98
65805	T		Drainage of eye	0233	13.4202	$699.88	$266.33	$139.98
65810	T		Drainage of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65815	T		Drainage of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65820	T		Relieve inner eye pressure	0232	4.4960	$234.47	$103.17	$46.89
65850	T		Incision of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65855	T		Laser surgery of eye	0247	4.7092	$245.59	$104.31	$49.12
65860	T		Incise inner eye adhesions	0247	4.7092	$245.59	$104.31	$49.12
65865	T		Incise inner eye adhesions	0233	13.4202	$699.88	$266.33	$139.98
65870	T		Incise inner eye adhesions	0234	20.4259	$1,065.23	$511.31	$213.05
65875	T		Incise inner eye adhesions	0234	20.4259	$1,065.23	$511.31	$213.05
65880	T		Incise inner eye adhesions	0233	13.4202	$699.88	$266.33	$139.98
65900	T		Remove eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65920	T		Remove implant of eye	0233	13.4202	$699.88	$266.33	$139.98
65930	T		Remove blood clot from eye	0234	20.4259	$1,065.23	$511.31	$213.05
66020	T		Injection treatment of eye	0233	13.4202	$699.88	$266.33	$139.98
66030	T		Injection treatment of eye	0233	13.4202	$699.88	$266.33	$139.98
66130	T		Remove eye lesion	0234	20.4259	$1,065.23	$511.31	$213.05
66150	T		Glaucoma surgery	0233	13.4202	$699.88	$266.33	$139.98
66155	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66160	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66165	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66170	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66172	T		Incision of eye	0673	25.9490	$1,353.27	$649.56	$270.65
66180	T		Implant eye shunt	0673	25.9490	$1,353.27	$649.56	$270.65
66185	T		Revise eye shunt	0673	25.9490	$1,353.27	$649.56	$270.65
66220	T		Repair eye lesion	0236	19.4278	$1,013.18		$202.64
66225	T		Repair/graft eye lesion	0673	25.9490	$1,353.27	$649.56	$270.65
66250	T		Follow-up surgery of eye	0233	13.4202	$699.88	$266.33	$139.98
66500	T		Incision of iris	0232	4.4960	$234.47	$103.17	$46.89
66505	T		Incision of iris	0232	4.4960	$234.47	$103.17	$46.89
66600	T		Remove iris and lesion	0233	13.4202	$699.88	$266.33	$139.98
66605	T		Removal of iris	0234	20.4259	$1,065.23	$511.31	$213.05
66625	T		Removal of iris	0233	13.4202	$699.88	$266.33	$139.98
66630	T		Removal of iris	0233	13.4202	$699.88	$266.33	$139.98
66635	T		Removal of iris	0234	20.4259	$1,065.23	$511.31	$213.05
66680	T		Repair iris & ciliary body	0234	20.4259	$1,065.23	$511.31	$213.05
66682	T		Repair iris & ciliary body	0234	20.4259	$1,065.23	$511.31	$213.05
66700	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66710	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66720	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66740	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66761	T		Revision of iris	0247	4.7092	$245.59	$104.31	$49.12
66762	T		Revision of iris	0247	4.7092	$245.59	$104.31	$49.12
66770	T		Removal of inner eye lesion	0247	4.7092	$245.59	$104.31	$49.12
66820	T		Incision, secondary cataract	0232	4.4960	$234.47	$103.17	$46.89
66821	T		After cataract laser surgery	0247	4.7092	$245.59	$104.31	$49.12

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66825	T		Reposition intraocular lens	0234	20.4259	$1,065.23	$511.31	$213.05
66830	T		Removal of lens lesion	0232	4.4960	$234.47	$103.17	$46.89
66840	T		Removal of lens material	0245	14.5442	$758.49	$251.21	$151.70
66850	T		Removal of lens material	0249	26.7242	$1,393.69	$524.67	$278.74
66852	T		Removal of lens material	0249	26.7242	$1,393.69	$524.67	$278.74
66920	T		Extraction of lens	0249	26.7242	$1,393.69	$524.67	$278.74
66930	T		Extraction of lens	0249	26.7242	$1,393.69	$524.67	$278.74
66940	T		Extraction of lens	0245	14.5442	$758.49	$251.21	$151.70
66982	T		Cataract surgery, complex	0246	22.2379	$1,159.73	$495.96	$231.95
66983	T		Cataract surg w/iol, 1 stage	0246	22.2379	$1,159.73	$495.96	$231.95
66984	T		Cataract surg w/iol, 1 stage	0246	22.2379	$1,159.73	$495.96	$231.95
66985	T		Insert lens prosthesis	0246	22.2379	$1,159.73	$495.96	$231.95
66986	T		Exchange lens prosthesis	0246	22.2379	$1,159.73	$495.96	$231.95
66990	N	NI	Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	4.4960	$234.47	$103.17	$46.89
67005	T		Partial removal of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67010	T		Partial removal of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67015	T		Release of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67025	T		Replace eye fluid	0236	19.4278	$1,013.18		$202.64
67027	T		Implant eye drug system	0237	33.2647	$1,734.79	$818.54	$346.96
67028	T		Injection eye drug	0235	5.0871	$265.30	$73.44	$53.06
67030	T		Incise inner eye strands	0236	19.4278	$1,013.18		$202.64
67031	T		Laser surgery, eye strands	0247	4.7092	$245.59	$104.31	$49.12
67036	T		Removal of inner eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67038	T		Strip retinal membrane	0237	33.2647	$1,734.79	$818.54	$346.96
67039	T		Laser treatment of retina	0237	33.2647	$1,734.79	$818.54	$346.96
67040	T		Laser treatment of retina	0672	37.9061	$1,976.84	$988.43	$395.37
67101	T		Repair detached retina	0235	5.0871	$265.30	$73.44	$53.06
67105	T		Repair detached retina	0248	4.2925	$223.86	$95.08	$44.77
67107	T		Repair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67108	T		Repair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67110	T		Repair detached retina	0235	5.0871	$265.30	$73.44	$53.06
67112	T		Rerepair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67115	T		Release encircling material	0236	19.4278	$1,013.18		$202.64
67120	T		Remove eye implant material	0236	19.4278	$1,013.18		$202.64
67121	T		Remove eye implant material	0237	33.2647	$1,734.79	$818.54	$346.96
67141	T		Treatment of retina	0235	5.0871	$265.30	$73.44	$53.06
67145	T		Treatment of retina	0248	4.2925	$223.86	$95.08	$44.77
67208	T		Treatment of retinal lesion	0235	5.0871	$265.30	$73.44	$53.06
67210	T		Treatment of retinal lesion	0248	4.2925	$223.86	$95.08	$44.77
67218	T		Treatment of retinal lesion	0236	19.4278	$1,013.18		$202.64
67220	T		Treatment of choroid lesion	0235	5.0871	$265.30	$73.44	$53.06
67221	T		Ocular photodynamic ther	0235	5.0871	$265.30	$73.44	$53.06
67225	T		Eye photodynamic ther add-on	0235	5.0871	$265.30	$73.44	$53.06
67227	T		Treatment of retinal lesion	0235	5.0871	$265.30	$73.44	$53.06
67228	T		Treatment of retinal lesion	0248	4.2925	$223.86	$95.08	$44.77
67250	T		Reinforce eye wall	0240	16.3078	$850.47	$315.31	$170.09
67255	T		Reinforce/graft eye wall	0237	33.2647	$1,734.79	$818.54	$346.96
67299	T		Eye surgery procedure	0235	5.0871	$265.30	$73.44	$53.06
67311	T		Revise eye muscle	0243	19.9705	$1,041.48	$431.39	$208.30
67312	T		Revise two eye muscles	0243	19.9705	$1,041.48	$431.39	$208.30
67314	T		Revise eye muscle	0243	19.9705	$1,041.48	$431.39	$208.30
67316	T		Revise two eye muscles	0243	19.9705	$1,041.48	$431.39	$208.30
67318	T		Revise eye muscle(s)	0243	19.9705	$1,041.48	$431.39	$208.30
67320	T		Revise eye muscle(s) add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67331	T		Eye surgery follow-up add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67332	T		Rerevise eye muscles add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67334	T		Revise eye muscle w/suture	0243	19.9705	$1,041.48	$431.39	$208.30
67335	T		Eye suture during surgery	0243	19.9705	$1,041.48	$431.39	$208.30
67340	T		Revise eye muscle add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67343	T		Release eye tissue	0243	19.9705	$1,041.48	$431.39	$208.30
67345	T		Destroy nerve of eye muscle	0238	2.9747	$155.13	$58.96	$31.03
67350	T		Biopsy eye muscle	0699	3.7596	$196.07	$88.23	$39.21
67399	T		Eye muscle surgery procedure	0243	19.9705	$1,041.48	$431.39	$208.30
67400	T		Explore/biopsy eye socket	0241	20.6294	$1,075.84	$384.47	$215.17

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67405	T		Explore/drain eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67412	T		Explore/treat eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67413	T		Explore/treat eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67414	T		Explr/decompress eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67415	T		Aspiration, orbital contents	0239	6.8119	$355.25	$115.94	$71.05
67420	T		Explore/treat eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67430	T		Explore/treat eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67440	T		Explore/drain eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67445	T		Explr/decompress eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67450	T		Explore/biopsy eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67500	S		Inject/treat eye socket	0231	2.1705	$113.19	$50.94	$22.64
67505	T		Inject/treat eye socket	0238	2.9747	$155.13	$58.96	$31.03
67515	T		Inject/treat eye socket	0239	6.8119	$355.25	$115.94	$71.05
67550	T		Insert eye socket implant	0242	28.0517	$1,462.92	$597.36	$292.58
67560	T		Revise eye socket implant	0241	20.6294	$1,075.84	$384.47	$215.17
67570	T		Decompress optic nerve	0242	28.0517	$1,462.92	$597.36	$292.58
67599	T		Orbit surgery procedure	0239	6.8119	$355.25	$115.94	$71.05
67700	T		Drainage of eyelid abscess	0238	2.9747	$155.13	$58.96	$31.03
67710	T		Incision of eyelid	0239	6.8119	$355.25	$115.94	$71.05
67715	T		Incision of eyelid fold	0240	16.3078	$850.47	$315.31	$170.09
67800	T		Remove eyelid lesion	0238	2.9747	$155.13	$58.96	$31.03
67801	T		Remove eyelid lesions	0239	6.8119	$355.25	$115.94	$71.05
67805	T		Remove eyelid lesions	0238	2.9747	$155.13	$58.96	$31.03
67808	T		Remove eyelid lesion(s)	0240	16.3078	$850.47	$315.31	$170.09
67810	T		Biopsy of eyelid	0238	2.9747	$155.13	$58.96	$31.03
67820	S		Revise eyelashes	0230	0.7364	$38.40	$14.97	$7.68
67825	T		Revise eyelashes	0238	2.9747	$155.13	$58.96	$31.03
67830	T		Revise eyelashes	0239	6.8119	$355.25	$115.94	$71.05
67835	T		Revise eyelashes	0240	16.3078	$850.47	$315.31	$170.09
67840	T		Remove eyelid lesion	0239	6.8119	$355.25	$115.94	$71.05
67850	T		Treat eyelid lesion	0239	6.8119	$355.25	$115.94	$71.05
67875	T		Closure of eyelid by suture	0239	6.8119	$355.25	$115.94	$71.05
67880	T		Revision of eyelid	0233	13.4202	$699.88	$266.33	$139.98
67882	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67900	T		Repair brow defect	0240	16.3078	$850.47	$315.31	$170.09
67901	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67902	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67903	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67904	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67906	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67908	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67909	T		Revise eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67911	T		Revise eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67914	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67915	T		Repair eyelid defect	0239	6.8119	$355.25	$115.94	$71.05
67916	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67917	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67921	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67922	T		Repair eyelid defect	0239	6.8119	$355.25	$115.94	$71.05
67923	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67924	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67930	T		Repair eyelid wound	0240	16.3078	$850.47	$315.31	$170.09
67935	T		Repair eyelid wound	0240	16.3078	$850.47	$315.31	$170.09
67938	S		Remove eyelid foreign body	0698	0.9205	$48.00	$18.72	$9.60
67950	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67961	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67966	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67971	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67973	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67974	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67975	T		Reconstruction of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67999	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
68020	T		Incise/drain eyelid lining	0240	16.3078	$850.47	$315.31	$170.09
68040	S		Treatment of eyelid lesions	0698	0.9205	$48.00	$18.72	$9.60
68100	T		Biopsy of eyelid lining	0232	4.4960	$234.47	$103.17	$46.89

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68110	T		Remove eyelid lining lesion	0699	3.7596	$196.07	$88.23	$39.21
68115	T		Remove eyelid lining lesion	0239	6.8119	$355.25	$115.94	$71.05
68130	T		Remove eyelid lining lesion	0233	13.4202	$699.88	$266.33	$139.98
68135	T		Remove eyelid lining lesion	0239	6.8119	$355.25	$115.94	$71.05
68200	S		Treat eyelid by injection	0698	0.9205	$48.00	$18.72	$9.60
68320	T		Revise/graft eyelid lining	0240	16.3078	$850.47	$315.31	$170.09
68325	T		Revise/graft eyelid lining	0242	28.0517	$1,462.92	$597.36	$292.58
68326	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68328	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68330	T		Revise eyelid lining	0233	13.4202	$699.88	$266.33	$139.98
68335	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68340	T		Separate eyelid adhesions	0240	16.3078	$850.47	$315.31	$170.09
68360	T		Revise eyelid lining	0234	20.4259	$1,065.23	$511.31	$213.05
68362	T		Revise eyelid lining	0234	20.4259	$1,065.23	$511.31	$213.05
68399	T		Eyelid lining surgery	0239	6.8119	$355.25	$115.94	$71.05
68400	T		Incise/drain tear gland	0238	2.9747	$155.13	$58.96	$31.03
68420	T		Incise/drain tear sac	0240	16.3078	$850.47	$315.31	$170.09
68440	T		Incise tear duct opening	0238	2.9747	$155.13	$58.96	$31.03
68500	T		Removal of tear gland	0241	20.6294	$1,075.84	$384.47	$215.17
68505	T		Partial removal, tear gland	0241	20.6294	$1,075.84	$384.47	$215.17
68510	T		Biopsy of tear gland	0240	16.3078	$850.47	$315.31	$170.09
68520	T		Removal of tear sac	0241	20.6294	$1,075.84	$384.47	$215.17
68525	T		Biopsy of tear sac	0240	16.3078	$850.47	$315.31	$170.09
68530	T		Clearance of tear duct	0240	16.3078	$850.47	$315.31	$170.09
68540	T		Remove tear gland lesion	0241	20.6294	$1,075.84	$384.47	$215.17
68550	T		Remove tear gland lesion	0242	28.0517	$1,462.92	$597.36	$292.58
68700	T		Repair tear ducts	0241	20.6294	$1,075.84	$384.47	$215.17
68705	T		Revise tear duct opening	0238	2.9747	$155.13	$58.96	$31.03
68720	T		Create tear sac drain	0242	28.0517	$1,462.92	$597.36	$292.58
68745	T		Create tear duct drain	0241	20.6294	$1,075.84	$384.47	$215.17
68750	T		Create tear duct drain	0242	28.0517	$1,462.92	$597.36	$292.58
68760	S		Close tear duct opening	0698	0.9205	$48.00	$18.72	$9.60
68761	S		Close tear duct opening	0231	2.1705	$113.19	$50.94	$22.64
68770	T		Close tear system fistula	0240	16.3078	$850.47	$315.31	$170.09
68801	S		Dilate tear duct opening	0231	2.1705	$113.19	$50.94	$22.64
68810	T		Probe nasolacrimal duct	0699	3.7596	$196.07	$88.23	$39.21
68811	T		Probe nasolacrimal duct	0240	16.3078	$850.47	$315.31	$170.09
68815	T		Probe nasolacrimal duct	0240	16.3078	$850.47	$315.31	$170.09
68840	T		Explore/irrigate tear ducts	0699	3.7596	$196.07	$88.23	$39.21
68850	N		Injection for tear sac x-ray					
68899	T		Tear duct system surgery	0699	3.7596	$196.07	$88.23	$39.21
69000	T		Drain external ear lesion	0006	1.7926	$93.49	$24.12	$18.70
69005	T		Drain external ear lesion	0007	10.0191	$522.51	$108.89	$104.50
69020	T		Drain outer ear canal lesion	0006	1.7926	$93.49	$24.12	$18.70
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	3.7693	$196.57	$71.87	$39.31
69105	T		Biopsy of external ear canal	0253	14.4473	$753.44	$282.29	$150.69
69110	T		Remove external ear, partial	0021	13.9338	$726.66	$219.48	$145.33
69120	T		Removal of external ear	0254	20.1158	$1,049.06	$321.35	$209.81
69140	T		Remove ear canal lesion(s)	0254	20.1158	$1,049.06	$321.35	$209.81
69145	T		Remove ear canal lesion(s)	0021	13.9338	$726.66	$219.48	$145.33
69150	T		Extensive ear canal surgery	0252	5.8041	$302.69	$113.41	$60.54
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6492	$33.86		$6.77
69205	T		Clear outer ear canal	0022	17.3930	$907.06	$354.45	$181.41
69210	X		Remove impacted ear wax	0340	0.6492	$33.86		$6.77
69220	T		Clean out mastoid cavity	0012	0.7849	$40.93	$11.18	$8.19
69222	T		Clean out mastoid cavity	0253	14.4473	$753.44	$282.29	$150.69
69300	T		Revise external ear	0254	20.1158	$1,049.06	$321.35	$209.81
69310	T		Rebuild outer ear canal	0256	34.0302	$1,774.71		$354.94
69320	T		Rebuild outer ear canal	0256	34.0302	$1,774.71		$354.94
69399	T		Outer ear surgery procedure	0251	1.9089	$99.55		$19.91
69400	T		Inflate middle ear canal	0251	1.9089	$99.55		$19.91
69401	T		Inflate middle ear canal	0251	1.9089	$99.55		$19.91
69405	T		Catheterize middle ear canal	0252	5.8041	$302.69	$113.41	$60.54

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69410	T		Inset middle ear (baffle)	0252	5.8041	$302.69	$113.41	$60.54
69420	T		Incision of eardrum	0251	1.9089	$99.55		$19.91
69421	T		Incision of eardrum	0253	14.4473	$753.44	$282.29	$150.69
69424	T		Remove ventilating tube	0252	5.8041	$302.69	$113.41	$60.54
69433	T		Create eardrum opening	0252	5.8041	$302.69	$113.41	$60.54
69436	T		Create eardrum opening	0253	14.4473	$753.44	$282.29	$150.69
69440	T		Exploration of middle ear	0254	20.1158	$1,049.06	$321.35	$209.81
69450	T		Eardrum revision	0256	34.0302	$1,774.71		$354.94
69501	T		Mastoidectomy	0256	34.0302	$1,774.71		$354.94
69502	T		Mastoidectomy	0254	20.1158	$1,049.06	$321.35	$209.81
69505	T		Remove mastoid structures	0256	34.0302	$1,774.71		$354.94
69511	T		Extensive mastoid surgery	0256	34.0302	$1,774.71		$354.94
69530	T		Extensive mastoid surgery	0256	34.0302	$1,774.71		$354.94
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	14.4473	$753.44	$282.29	$150.69
69550	T		Remove ear lesion	0256	34.0302	$1,774.71		$354.94
69552	T		Remove ear lesion	0256	34.0302	$1,774.71		$354.94
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69602	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69603	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69604	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69605	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69610	T		Repair of eardrum	0254	20.1158	$1,049.06	$321.35	$209.81
69620	T		Repair of eardrum	0254	20.1158	$1,049.06	$321.35	$209.81
69631	T		Repair eardrum structures	0256	34.0302	$1,774.71		$354.94
69632	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69633	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69635	T		Repair eardrum structures	0256	34.0302	$1,774.71		$354.94
69636	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69637	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69641	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69642	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69643	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69644	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69645	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69646	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69650	T		Release middle ear bone	0254	20.1158	$1,049.06	$321.35	$209.81
69660	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69661	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69662	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69666	T		Repair middle ear structures	0256	34.0302	$1,774.71		$354.94
69667	T		Repair middle ear structures	0256	34.0302	$1,774.71		$354.94
69670	T		Remove mastoid air cells	0256	34.0302	$1,774.71		$354.94
69676	T		Remove middle ear nerve	0256	34.0302	$1,774.71		$354.94
69700	T		Close mastoid fistula	0256	34.0302	$1,774.71		$354.94
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	34.0302	$1,774.71		$354.94
69714	T		Implant temple bone w/stimul	0256	34.0302	$1,774.71		$354.94
69715	T		Temple bne implnt w/stimulat	0256	34.0302	$1,774.71		$354.94
69717	T		Temple bone implant revision	0256	34.0302	$1,774.71		$354.94
69718	T		Revise temple bone implant	0256	34.0302	$1,774.71		$354.94
69720	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69725	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69740	T		Repair facial nerve	0256	34.0302	$1,774.71		$354.94
69745	T		Repair facial nerve	0256	34.0302	$1,774.71		$354.94
69799	T		Middle ear surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
69801	T		Incise inner ear	0256	34.0302	$1,774.71		$354.94
69802	T		Incise inner ear	0256	34.0302	$1,774.71		$354.94
69805	T		Explore inner ear	0256	34.0302	$1,774.71		$354.94
69806	T		Explore inner ear	0256	34.0302	$1,774.71		$354.94
69820	T		Establish inner ear window	0256	34.0302	$1,774.71		$354.94
69840	T		Revise inner ear window	0256	34.0302	$1,774.71		$354.94
69905	T		Remove inner ear	0256	34.0302	$1,774.71		$354.94
69910	T		Remove inner ear & mastoid	0256	34.0302	$1,774.71		$354.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69915	T		Incise inner ear nerve	0256	34.0302	$1,774.71		$354.94
69930	T		Implant cochlear device	0259	367.6466	$19,173.14	$9,394.83	$3,834.63
69949	T		Inner ear surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69960	T		Release inner ear canal	0256	34.0302	$1,774.71		$354.94
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.9089	$99.55		$19.91
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.8759	$202.13	$96.54	$40.43
70015	S		Contrast x-ray of brain	0274	3.8759	$202.13	$96.54	$40.43
70030	X		X-ray eye for foreign body	0260	0.7655	$39.92	$21.95	$7.98
70100	X		X-ray exam of jaw	0260	0.7655	$39.92	$21.95	$7.98
70110	X		X-ray exam of jaw	0260	0.7655	$39.92	$21.95	$7.98
70120	X		X-ray exam of mastoids	0260	0.7655	$39.92	$21.95	$7.98
70130	X		X-ray exam of mastoids	0260	0.7655	$39.92	$21.95	$7.98
70134	X		X-ray exam of middle ear	0261	1.2887	$67.21		$13.44
70140	X		X-ray exam of facial bones	0260	0.7655	$39.92	$21.95	$7.98
70150	X		X-ray exam of facial bones	0260	0.7655	$39.92	$21.95	$7.98
70160	X		X-ray exam of nasal bones	0260	0.7655	$39.92	$21.95	$7.98
70170	X		X-ray exam of tear duct	0263	1.8992	$99.05	$43.58	$19.81
70190	X		X-ray exam of eye sockets	0260	0.7655	$39.92	$21.95	$7.98
70200	X		X-ray exam of eye sockets	0260	0.7655	$39.92	$21.95	$7.98
70210	X		X-ray exam of sinuses	0260	0.7655	$39.92	$21.95	$7.98
70220	X		X-ray exam of sinuses	0260	0.7655	$39.92	$21.95	$7.98
70240	X		X-ray exam, pituitary saddle	0260	0.7655	$39.92	$21.95	$7.98
70250	X		X-ray exam of skull	0260	0.7655	$39.92	$21.95	$7.98
70260	X		X-ray exam of skull	0261	1.2887	$67.21		$13.44
70300	X		X-ray exam of teeth	0262	0.5717	$29.81	$9.82	$5.96
70310	X		X-ray exam of teeth	0262	0.5717	$29.81	$9.82	$5.96
70320	X		Full mouth x-ray of teeth	0262	0.5717	$29.81	$9.82	$5.96
70328	X		X-ray exam of jaw joint	0260	0.7655	$39.92	$21.95	$7.98
70330	X		X-ray exam of jaw joints	0260	0.7655	$39.92	$21.95	$7.98
70332	S		X-ray exam of jaw joint	0275	2.9747	$155.13	$69.09	$31.03
70336	S		Magnetic image, jaw joint	0335	6.2983	$328.46	$151.46	$65.69
70350	X		X-ray head for orthodontia	0260	0.7655	$39.92	$21.95	$7.98
70355	X		Panoramic x-ray of jaws	0260	0.7655	$39.92	$21.95	$7.98
70360	X		X-ray exam of neck	0260	0.7655	$39.92	$21.95	$7.98
70370	X		Throat x-ray & fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
70371	X		Speech evaluation, complex	0272	1.3372	$69.74	$38.36	$13.95
70373	X		Contrast x-ray of larynx	0263	1.8992	$99.05	$43.58	$19.81
70380	X		X-ray exam of salivary gland	0260	0.7655	$39.92	$21.95	$7.98
70390	X		X-ray exam of salivary duct	0264	2.8197	$147.05	$79.41	$29.41
70450	S		Ct head/brain w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70460	S		Ct head/brain w/dye	0283	4.5057	$234.98	$126.27	$47.00
70470	S		Ct head/brain w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70481	S		Ct orbit/ear/fossa w/dye	0283	4.5057	$234.98	$126.27	$47.00
70482	S		Ct orbit/ear/fossa w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70486	S		Ct maxillofacial w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70487	S		Ct maxillofacial w/dye	0283	4.5057	$234.98	$126.27	$47.00
70488	S		Ct maxillofacial w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70490	S		Ct soft tissue neck w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70491	S		Ct soft tissue neck w/dye	0283	4.5057	$234.98	$126.27	$47.00
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.3681	$279.95	$146.98	$55.99
70496	S		Ct angiography, head	0662	5.4553	$284.50	$156.47	$56.90
70498	S		Ct angiography, neck	0662	5.4553	$284.50	$156.47	$56.90
70540	S		Mri orbit/face/neck w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70542	S		Mri orbit/face/neck w/dye	0284	7.2382	$377.48	$201.02	$75.50
70543	S		Mri orbt/fac/nck w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70544	S		Mr angiography head w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70545	S		Mr angiography head w/dye	0284	7.2382	$377.48	$201.02	$75.50
70546	S		Mr angiograph head w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70547	S		Mr angiography neck w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70548	S		Mr angiography neck w/dye	0284	7.2382	$377.48	$201.02	$75.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70549	S		Mr angiograph neck w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70551	S		Mri brain w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70552	S		Mri brain w/dye	0284	7.2382	$377.48	$201.02	$75.50
70553	S		Mri brain w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
71010	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71015	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71020	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71021	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71022	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71023	X		Chest x-ray and fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
71030	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71034	X		Chest x-ray and fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
71035	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71040	X		Contrast x-ray of bronchi	0263	1.8992	$99.05	$43.58	$19.81
71060	X		Contrast x-ray of bronchi	0264	2.8197	$147.05	$79.41	$29.41
71090	X		X-ray & pacemaker insertion	0272	1.3372	$69.74	$38.36	$13.95
71100	X		X-ray exam of ribs	0260	0.7655	$39.92	$21.95	$7.98
71101	X		X-ray exam of ribs/chest	0260	0.7655	$39.92	$21.95	$7.98
71110	X		X-ray exam of ribs	0260	0.7655	$39.92	$21.95	$7.98
71111	X		X-ray exam of ribs/ chest	0261	1.2887	$67.21		$13.44
71120	X		X-ray exam of breastbone	0260	0.7655	$39.92	$21.95	$7.98
71130	X		X-ray exam of breastbone	0260	0.7655	$39.92	$21.95	$7.98
71250	S		Ct thorax w/o dye	0332	3.4398	$179.39	$91.27	$35.88
71260	S		Ct thorax w/dye	0283	4.5057	$234.98	$126.27	$47.00
71270	S		Ct thorax w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
71275	S		Ct angiography, chest	0662	5.4553	$284.50	$156.47	$56.90
71550	S		Mri chest w/o dye	0336	6.5987	$344.13	$176.94	$68.83
71551	S		Mri chest w/dye	0284	7.2382	$377.48	$201.02	$75.50
71552	S		Mri chest w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
71555	E		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.2887	$67.21		$13.44
72020	X		X-ray exam of spine	0260	0.7655	$39.92	$21.95	$7.98
72040	X		X-ray exam of neck spine	0260	0.7655	$39.92	$21.95	$7.98
72050	X		X-ray exam of neck spine	0261	1.2887	$67.21		$13.44
72052	X		X-ray exam of neck spine	0261	1.2887	$67.21		$13.44
72069	X		X-ray exam of trunk spine	0260	0.7655	$39.92	$21.95	$7.98
72070	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72072	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72074	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72080	X		X-ray exam of trunk spine	0260	0.7655	$39.92	$21.95	$7.98
72090	X		X-ray exam of trunk spine	0261	1.2887	$67.21		$13.44
72100	X		X-ray exam of lower spine	0260	0.7655	$39.92	$21.95	$7.98
72110	X		X-ray exam of lower spine	0261	1.2887	$67.21		$13.44
72114	X		X-ray exam of lower spine	0261	1.2887	$67.21		$13.44
72120	X		X-ray exam of lower spine	0260	0.7655	$39.92	$21.95	$7.98
72125	S		Ct neck spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72126	S		Ct neck spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72127	S		Ct neck spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72128	S		Ct chest spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72129	S		Ct chest spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72130	S		Ct chest spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72131	S		Ct lumbar spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72132	S		Ct lumbar spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72133	S		Ct lumbar spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72141	S		Mri neck spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72142	S		Mri neck spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72146	S		Mri chest spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72147	S		Mri chest spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72148	S		Mri lumbar spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72149	S		Mri lumbar spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72156	S		Mri neck spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72157	S		Mri chest spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72158	S		Mri lumbar spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7655	$39.92	$21.95	$7.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72190	X		X-ray exam of pelvis	0260	0.7655	$39.92	$21.95	$7.98
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
72192	S		Ct pelvis w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72193	S		Ct pelvis w/dye	0283	4.5057	$234.98	$126.27	$47.00
72194	S		Ct pelvis w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72195	S		Mri pelvis w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72196	S		Mri pelvis w/dye	0284	7.2382	$377.48	$201.02	$75.50
72197	S		Mri pelvis w/o & w/dye	0337	9.2440	$482.08	$240.77	$96.42
72198	E		Mr angio pelvis w/o&w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7655	$39.92	$21.95	$7.98
72202	X		X-ray exam sacroiliac joints	0260	0.7655	$39.92	$21.95	$7.98
72220	X		X-ray exam of tailbone	0260	0.7655	$39.92	$21.95	$7.98
72240	S		Contrast x-ray of neck spine	0274	3.8759	$202.13	$96.54	$40.43
72255	S		Contrast x-ray, thorax spine	0274	3.8759	$202.13	$96.54	$40.43
72265	S		Contrast x-ray, lower spine	0274	3.8759	$202.13	$96.54	$40.43
72270	S		Contrast x-ray of spine	0274	3.8759	$202.13	$96.54	$40.43
72275	S		Epidurography	0274	3.8759	$202.13	$96.54	$40.43
72285	S		X-ray c/t spine disk	0274	3.8759	$202.13	$96.54	$40.43
72295	S		X-ray of lower spine disk	0274	3.8759	$202.13	$96.54	$40.43
73000	X		X-ray exam of collar bone	0260	0.7655	$39.92	$21.95	$7.98
73010	X		X-ray exam of shoulder blade	0260	0.7655	$39.92	$21.95	$7.98
73020	X		X-ray exam of shoulder	0260	0.7655	$39.92	$21.95	$7.98
73030	X		X-ray exam of shoulder	0260	0.7655	$39.92	$21.95	$7.98
73040	S		Contrast x-ray of shoulder	0275	2.9747	$155.13	$69.09	$31.03
73050	X		X-ray exam of shoulders	0260	0.7655	$39.92	$21.95	$7.98
73060	X		X-ray exam of humerus	0260	0.7655	$39.92	$21.95	$7.98
73070	X		X-ray exam of elbow	0260	0.7655	$39.92	$21.95	$7.98
73080	X		X-ray exam of elbow	0260	0.7655	$39.92	$21.95	$7.98
73085	S		Contrast x-ray of elbow	0275	2.9747	$155.13	$69.09	$31.03
73090	X		X-ray exam of forearm	0260	0.7655	$39.92	$21.95	$7.98
73092	X		X-ray exam of arm, infant	0260	0.7655	$39.92	$21.95	$7.98
73100	X		X-ray exam of wrist	0260	0.7655	$39.92	$21.95	$7.98
73110	X		X-ray exam of wrist	0260	0.7655	$39.92	$21.95	$7.98
73115	S		Contrast x-ray of wrist	0275	2.9747	$155.13	$69.09	$31.03
73120	X		X-ray exam of hand	0260	0.7655	$39.92	$21.95	$7.98
73130	X		X-ray exam of hand	0260	0.7655	$39.92	$21.95	$7.98
73140	X		X-ray exam of finger(s)	0260	0.7655	$39.92	$21.95	$7.98
73200	S		Ct upper extremity w/o dye	0332	3.4398	$179.39	$91.27	$35.88
73201	S		Ct upper extremity w/dye	0283	4.5057	$234.98	$126.27	$47.00
73202	S		Ct uppr extremity w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
73218	S		Mri upper extremity w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73219	S		Mri upper extremity w/dye	0284	7.2382	$377.48	$201.02	$75.50
73220	S		Mri uppr extremity w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73221	S		Mri joint upr extrem w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73222	S		Mri joint upr extrem w/dye	0284	7.2382	$377.48	$201.02	$75.50
73223	S		Mri joint upr extr w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7655	$39.92	$21.95	$7.98
73510	X		X-ray exam of hip	0260	0.7655	$39.92	$21.95	$7.98
73520	X		X-ray exam of hips	0260	0.7655	$39.92	$21.95	$7.98
73525	S		Contrast x-ray of hip	0275	2.9747	$155.13	$69.09	$31.03
73530	X		X-ray exam of hip	0261	1.2887	$67.21		$13.44
73540	X		X-ray exam of pelvis & hips	0260	0.7655	$39.92	$21.95	$7.98
73542	S		X-ray exam, sacroiliac joint	0275	2.9747	$155.13	$69.09	$31.03
73550	X		X-ray exam of thigh	0260	0.7655	$39.92	$21.95	$7.98
73560	X		X-ray exam of knee, 1 or 2	0260	0.7655	$39.92	$21.95	$7.98
73562	X		X-ray exam of knee, 3	0260	0.7655	$39.92	$21.95	$7.98
73564	X		X-ray exam, knee, 4 or more	0260	0.7655	$39.92	$21.95	$7.98
73565	X		X-ray exam of knees	0260	0.7655	$39.92	$21.95	$7.98
73580	S		Contrast x-ray of knee joint	0275	2.9747	$155.13	$69.09	$31.03
73590	X		X-ray exam of lower leg	0260	0.7655	$39.92	$21.95	$7.98
73592	X		X-ray exam of leg, infant	0260	0.7655	$39.92	$21.95	$7.98
73600	X		X-ray exam of ankle	0260	0.7655	$39.92	$21.95	$7.98
73610	X		X-ray exam of ankle	0260	0.7655	$39.92	$21.95	$7.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73615	S		Contrast x-ray of ankle	0275	2.9747	$155.13	$69.09	$31.03
73620	X		X-ray exam of foot	0260	0.7655	$39.92	$21.95	$7.98
73630	X		X-ray exam of foot	0260	0.7655	$39.92	$21.95	$7.98
73650	X		X-ray exam of heel	0260	0.7655	$39.92	$21.95	$7.98
73660	X		X-ray exam of toe(s)	0260	0.7655	$39.92	$21.95	$7.98
73700	S		Ct lower extremity w/o dye	0332	3.4398	$179.39	$91.27	$35.88
73701	S		Ct lower extremity w/dye	0283	4.5057	$234.98	$126.27	$47.00
73702	S		Ct lwr extremity w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
73718	S		Mri lower extremity w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73719	S		Mri lower extremity w/dye	0284	7.2382	$377.48	$201.02	$75.50
73720	S		Mri lwr extremity w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73721	S		Mri jnt of lwr extre w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73722	S		Mri joint of lwr extr w/dye	0284	7.2382	$377.48	$201.02	$75.50
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73725	E		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74010	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74020	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74022	X		X-ray exam series, abdomen	0261	1.2887	$67.21		$13.44
74150	S		Ct abdomen w/o dye	0332	3.4398	$179.39	$91.27	$35.88
74160	S		Ct abdomen w/dye	0283	4.5057	$234.98	$126.27	$47.00
74170	S		Ct abdomen w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
74175	S		Ct angio abdom w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
74181	S		Mri abdomen w/o dye	0336	6.5987	$344.13	$176.94	$68.83
74182	S		Mri abdomen w/dye	0284	7.2382	$377.48	$201.02	$75.50
74183	S		Mri abdomen w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
74185	E		Mri angio, abdom w or w/o dy					
74190	X		X-ray exam of peritoneum	0263	1.8992	$99.05	$43.58	$19.81
74210	S		Contrst x-ray exam of throat	0276	1.5891	$82.87	$41.72	$16.57
74220	S		Contrast x-ray, esophagus	0276	1.5891	$82.87	$41.72	$16.57
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5891	$82.87	$41.72	$16.57
74235	S		Remove esophagus obstruction	0296	2.4127	$125.82	$69.20	$25.16
74240	S		X-ray exam, upper gi tract	0276	1.5891	$82.87	$41.72	$16.57
74241	S		X-ray exam, upper gi tract	0276	1.5891	$82.87	$41.72	$16.57
74245	S		X-ray exam, upper gi tract	0277	2.3546	$122.79	$60.47	$24.56
74246	S		Contrst x-ray uppr gi tract	0276	1.5891	$82.87	$41.72	$16.57
74247	S		Contrst x-ray uppr gi tract	0276	1.5891	$82.87	$41.72	$16.57
74249	S		Contrst x-ray uppr gi tract	0277	2.3546	$122.79	$60.47	$24.56
74250	S		X-ray exam of small bowel	0276	1.5891	$82.87	$41.72	$16.57
74251	S		X-ray exam of small bowel	0277	2.3546	$122.79	$60.47	$24.56
74260	S		X-ray exam of small bowel	0277	2.3546	$122.79	$60.47	$24.56
74270	S		Contrast x-ray exam of colon	0276	1.5891	$82.87	$41.72	$16.57
74280	S		Contrast x-ray exam of colon	0277	2.3546	$122.79	$60.47	$24.56
74283	S		Contrast x-ray exam of colon	0276	1.5891	$82.87	$41.72	$16.57
74290	S		Contrast x-ray, gallbladder	0276	1.5891	$82.87	$41.72	$16.57
74291	S		Contrast x-rays, gallbladder	0276	1.5891	$82.87	$41.72	$16.57
74300	X		X-ray bile ducts/pancreas	0263	1.8992	$99.05	$43.58	$19.81
74301	X		X-rays at surgery add-on	0263	1.8992	$99.05	$43.58	$19.81
74305	X		X-ray bile ducts/pancreas	0263	1.8992	$99.05	$43.58	$19.81
74320	X		Contrast x-ray of bile ducts	0264	2.8197	$147.05	$79.41	$29.41
74327	S		X-ray bile stone removal	0296	2.4127	$125.82	$69.20	$25.16
74328	N		X-ray bile duct endoscopy					
74329	N		X-ray for pancreas endoscopy					
74330	N		X-ray bile/panc endoscopy					
74340	X		X-ray guide for GI tube	0272	1.3372	$69.74	$38.36	$13.95
74350	X		X-ray guide, stomach tube	0263	1.8992	$99.05	$43.58	$19.81
74355	X		X-ray guide, intestinal tube	0263	1.8992	$99.05	$43.58	$19.81
74360	S		X-ray guide, GI dilation	0296	2.4127	$125.82	$69.20	$25.16
74363	S		X-ray, bile duct dilation	0297	7.6839	$400.72	$172.51	$80.14
74400	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74410	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74415	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74420	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74425	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74430	S		Contrast x-ray, bladder	0278	2.5290	$131.89	$66.07	$26.38
74440	S		X-ray, male genital tract	0278	2.5290	$131.89	$66.07	$26.38
74445	S		X-ray exam of penis	0278	2.5290	$131.89	$66.07	$26.38
74450	S		X-ray, urethra/bladder	0278	2.5290	$131.89	$66.07	$26.38
74455	S		X-ray, urethra/bladder	0278	2.5290	$131.89	$66.07	$26.38
74470	X		X-ray exam of kidney lesion	0264	2.8197	$147.05	$79.41	$29.41
74475	S		X-ray control, cath insert	0297	7.6839	$400.72	$172.51	$80.14
74480	S		X-ray control, cath insert	0296	2.4127	$125.82	$69.20	$25.16
74485	S		X-ray guide, GU dilation	0296	2.4127	$125.82	$69.20	$25.16
74710	X		X-ray measurement of pelvis	0260	0.7655	$39.92	$21.95	$7.98
74740	X		X-ray, female genital tract	0264	2.8197	$147.05	$79.41	$29.41
74742	X		X-ray, fallopian tube	0263	1.8992	$99.05	$43.58	$19.81
74775	S		X-ray exam of perineum	0278	2.5290	$131.89	$66.07	$26.38
75552	S		Heart mri for morph w/o dye	0336	6.5987	$344.13	$176.94	$68.83
75553	S		Heart mri for morph w/dye	0284	7.2382	$377.48	$201.02	$75.50
75554	S		Cardiac MRI/function	0335	6.2983	$328.46	$151.46	$65.69
75555	S		Cardiac MRI/limited study	0335	6.2983	$328.46	$151.46	$65.69
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75605	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75625	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75630	S		X-ray aorta, leg arteries	0280	15.2128	$793.36	$353.85	$158.67
75635	S		Ct angio abdominal arteries	0662	5.4553	$284.50	$156.47	$56.90
75650	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75658	S		Artery x-rays, arm	0280	15.2128	$793.36	$353.85	$158.67
75660	S		Artery x-rays, head & neck	0279	8.6432	$450.75	$174.57	$90.15
75662	S		Artery x-rays, head & neck	0279	8.6432	$450.75	$174.57	$90.15
75665	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75671	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75676	S		Artery x-rays, neck	0280	15.2128	$793.36	$353.85	$158.67
75680	S		Artery x-rays, neck	0280	15.2128	$793.36	$353.85	$158.67
75685	S		Artery x-rays, spine	0279	8.6432	$450.75	$174.57	$90.15
75705	S		Artery x-rays, spine	0279	8.6432	$450.75	$174.57	$90.15
75710	S		Artery x-rays, arm/leg	0280	15.2128	$793.36	$353.85	$158.67
75716	S		Artery x-rays, arms/legs	0280	15.2128	$793.36	$353.85	$158.67
75722	S		Artery x-rays, kidney	0280	15.2128	$793.36	$353.85	$158.67
75724	S		Artery x-rays, kidneys	0280	15.2128	$793.36	$353.85	$158.67
75726	S		Artery x-rays, abdomen	0280	15.2128	$793.36	$353.85	$158.67
75731	S		Artery x-rays, adrenal gland	0280	15.2128	$793.36	$353.85	$158.67
75733	S		Artery x-rays, adrenals	0280	15.2128	$793.36	$353.85	$158.67
75736	S		Artery x-rays, pelvis	0280	15.2128	$793.36	$353.85	$158.67
75741	S		Artery x-rays, lung	0279	8.6432	$450.75	$174.57	$90.15
75743	S		Artery x-rays, lungs	0280	15.2128	$793.36	$353.85	$158.67
75746	S		Artery x-rays, lung	0279	8.6432	$450.75	$174.57	$90.15
75756	S		Artery x-rays, chest	0279	8.6432	$450.75	$174.57	$90.15
75774	S		Artery x-ray, each vessel	0668	10.3292	$538.68	$237.76	$107.74
75790	S		Visualize A-V shunt	0281	5.2227	$272.37	$115.16	$54.47
75801	X		Lymph vessel x-ray, arm/leg	0264	2.8197	$147.05	$79.41	$29.41
75803	X		Lymph vessel x-ray,arms/legs	0264	2.8197	$147.05	$79.41	$29.41
75805	X		Lymph vessel x-ray, trunk	0264	2.8197	$147.05	$79.41	$29.41
75807	X		Lymph vessel x-ray, trunk	0264	2.8197	$147.05	$79.41	$29.41
75809	X		Nonvascular shunt, x-ray	0263	1.8992	$99.05	$43.58	$19.81
75810	S		Vein x-ray, spleen/liver	0279	8.6432	$450.75	$174.57	$90.15
75820	S		Vein x-ray, arm/leg	0281	5.2227	$272.37	$115.16	$54.47
75822	S		Vein x-ray, arms/legs	0281	5.2227	$272.37	$115.16	$54.47
75825	S		Vein x-ray, trunk	0279	8.6432	$450.75	$174.57	$90.15
75827	S		Vein x-ray, chest	0279	8.6432	$450.75	$174.57	$90.15
75831	S		Vein x-ray, kidney	0287	6.9863	$364.34	$114.51	$72.87
75833	S		Vein x-ray, kidneys	0279	8.6432	$450.75	$174.57	$90.15
75840	S		Vein x-ray, adrenal gland	0287	6.9863	$364.34	$114.51	$72.87
75842	S		Vein x-ray, adrenal glands	0287	6.9863	$364.34	$114.51	$72.87
75860	S		Vein x-ray, neck	0287	6.9863	$364.34	$114.51	$72.87
75870	S		Vein x-ray, skull	0287	6.9863	$364.34	$114.51	$72.87
75872	S		Vein x-ray, skull	0287	6.9863	$364.34	$114.51	$72.87
75880	S		Vein x-ray, eye socket	0287	6.9863	$364.34	$114.51	$72.87

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75885	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75887	S		Vein x-ray, liver	0280	15.2128	$793.36	$353.85	$158.67
75889	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75891	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	7.6839	$400.72	$172.51	$80.14
75896	S		X-rays, transcath therapy	0297	7.6839	$400.72	$172.51	$80.14
75898	X		Follow-up angiography	0264	2.8197	$147.05	$79.41	$29.41
75900	C		Arterial catheter exchange					
75901	X	NI	Remove cva device obstruct	0264	2.8197	$147.05	$79.41	$29.41
75902	X	NI	Remove cva lumen obstruct	0263	1.8992	$99.05	$43.58	$19.81
75940	X		X-ray placement, vein filter	0187	3.9534	$206.17	$90.71	$41.23
75945	S		Intravascular us	0267	2.4418	$127.34	$65.52	$25.47
75946	S		Intravascular us add-on	0267	2.4418	$127.34	$65.52	$25.47
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C	NI	Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0280	15.2128	$793.36	$353.85	$158.67
75961	S		Retrieval, broken catheter	0280	15.2128	$793.36	$353.85	$158.67
75962	S		Repair arterial blockage	0280	15.2128	$793.36	$353.85	$158.67
75964	S		Repair artery blockage, each	0280	15.2128	$793.36	$353.85	$158.67
75966	S		Repair arterial blockage	0280	15.2128	$793.36	$353.85	$158.67
75968	S		Repair artery blockage, each	0280	15.2128	$793.36	$353.85	$158.67
75970	S		Vascular biopsy	0280	15.2128	$793.36	$353.85	$158.67
75978	S		Repair venous blockage	0668	10.3292	$538.68	$237.76	$107.74
75980	S		Contrast xray exam bile duct	0296	2.4127	$125.82	$69.20	$25.16
75982	S		Contrast xray exam bile duct	0297	7.6839	$400.72	$172.51	$80.14
75984	X		Xray control catheter change	0264	2.8197	$147.05	$79.41	$29.41
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75993	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75994	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75995	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75996	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
76000	X		Fluoroscope examination	0272	1.3372	$69.74	$38.36	$13.95
76001	N		Fluoroscope exam, extensive					
76003	N		Needle localization by x-ray					
76005	N		Fluoroguide for spine inject					
76006	X		X-ray stress view	0260	0.7655	$39.92	$21.95	$7.98
76010	X		X-ray, nose to rectum	0260	0.7655	$39.92	$21.95	$7.98
76012	S		Percut vertebroplasty fluor	0274	3.8759	$202.13	$96.54	$40.43
76013	S		Percut vertebroplasty, ct	0274	3.8759	$202.13	$96.54	$40.43
76020	X		X-rays for bone age	0260	0.7655	$39.92	$21.95	$7.98
76040	X		X-rays, bone evaluation	0260	0.7655	$39.92	$21.95	$7.98
76061	X		X-rays, bone survey	0261	1.2887	$67.21		$13.44
76062	X		X-rays, bone survey	0261	1.2887	$67.21		$13.44
76065	X		X-rays, bone evaluation	0261	1.2887	$67.21		$13.44
76066	X		Joint survey, single view	0260	0.7655	$39.92	$21.95	$7.98
76070	E		CT scan, bone density study					
76071	S	NI	Ct bone density, peripheral	0282	1.6763	$87.42	$44.51	$17.48
76075	S		Dexa, axial skeleton study	0288	1.2984	$67.71		$13.54
76076	S		Dexa, peripheral study	0665	0.8236	$42.95		$8.59
76078	X		Radiographic absorptiometry	0261	1.2887	$67.21		$13.44
76080	X		X-ray exam of fistula	0263	1.8992	$99.05	$43.58	$19.81
76085	A		Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	1.8992	$99.05	$43.58	$19.81
76088	X		X-ray of mammary ducts	0263	1.8992	$99.05	$43.58	$19.81
76090	S		Mammogram, one breast	0271	0.6492	$33.86	$16.80	$6.77
76091	S		Mammogram, both breasts	0271	0.6492	$33.86	$16.80	$6.77
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	X		Stereotactic breast biopsy	0187	3.9534	$206.17	$90.71	$41.23
76096	X		X-ray of needle wire, breast	0289	1.8992	$99.05	$44.80	$19.81
76098	X		X-ray exam, breast specimen	0260	0.7655	$39.92	$21.95	$7.98

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76100	X		X-ray exam of body section	0261	1.2887	$67.21		$13.44
76101	X		Complex body section x-ray	0264	2.8197	$147.05	$79.41	$29.41
76102	X		Complex body section x-rays	0264	2.8197	$147.05	$79.41	$29.41
76120	X		Cine/video x-rays	0260	0.7655	$39.92	$21.95	$7.98
76125	X		Cine/video x-rays add-on	0260	0.7655	$39.92	$21.95	$7.98
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7655	$39.92	$21.95	$7.98
76350	N		Special x-ray contrast study					
76355	S		CAT scan for localization	0283	4.5057	$234.98	$126.27	$47.00
76360	S		CAT scan for needle biopsy	0283	4.5057	$234.98	$126.27	$47.00
76362	N		Cat scan for tissue ablation					
76370	S		CAT scan for therapy guide	0282	1.6763	$87.42	$44.51	$17.48
76375	S		3d/holograph reconstr add-on	0282	1.6763	$87.42	$44.51	$17.48
76380	S		CAT scan follow-up study	0282	1.6763	$87.42	$44.51	$17.48
76390	E		Mr spectroscopy					
76393	N		Mr guidance for needle place					
76394	N		Mri for tissue ablation					
76400	S		Magnetic image, bone marrow	0335	6.2983	$328.46	$151.46	$65.69
76490	N		Us for tissue ablation					
76496	X	NI	Fluoroscopic procedure	0272	1.3372	$69.74	$38.36	$13.95
76497	S	NI	Ct procedure	0282	1.6763	$87.42	$44.51	$17.48
76498	S	NI	Mri procedure	0335	6.2983	$328.46	$151.46	$65.69
76499	X		Radiographic procedure	0260	0.7655	$39.92	$21.95	$7.98
76506	S		Echo exam of head	0266	1.5988	$83.38	$45.86	$16.68
76511	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76512	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76513	S		Echo exam of eye, water bath	0265	0.9787	$51.04	$28.07	$10.21
76516	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76519	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76529	S		Echo exam of eye	0265	0.9787	$51.04	$28.07	$10.21
76536	S		Us exam of head and neck	0266	1.5988	$83.38	$45.86	$16.68
76604	S		Us exam, chest, b-scan	0266	1.5988	$83.38	$45.86	$16.68
76645	S		Us exam, breast(s)	0265	0.9787	$51.04	$28.07	$10.21
76700	S		Us exam, abdom, complete	0266	1.5988	$83.38	$45.86	$16.68
76705	S		Echo exam of abdomen	0266	1.5988	$83.38	$45.86	$16.68
76770	S		Us exam abdo back wall, comp	0266	1.5988	$83.38	$45.86	$16.68
76775	S		Us eam abdo back wall, lim	0266	1.5988	$83.38	$45.86	$16.68
76778	S		Us exam kidney transplant	0266	1.5988	$83.38	$45.86	$16.68
76800	S		Us exam, spinal canal	0266	1.5988	$83.38	$45.86	$16.68
76801	S	NI	Ob us < 14 wks, single fetus	0265	0.9787	$51.04	$28.07	$10.21
76802	S	NI	Ob us < 14 wks, addl fetus	0265	0.9787	$51.04	$28.07	$10.21
76805	S		Us exam, pg uterus, compl	0266	1.5988	$83.38	$45.86	$16.68
76810	S		Us exam, pg uterus, mult	0265	0.9787	$51.04	$28.07	$10.21
76811	S	NI	Ob us, detailed, sngl fetus	0267	2.4418	$127.34	$65.52	$25.47
76812	S	NI	Ob us, detailed, addl fetus	0266	1.5988	$83.38	$45.86	$16.68
76815	S		Us exam, pg uterus limit	0265	0.9787	$51.04	$28.07	$10.21
76816	S		Us exam pg uterus repeat	0265	0.9787	$51.04	$28.07	$10.21
76817	S	NI	Transvaginal us, obstetric	0265	0.9787	$51.04	$28.07	$10.21
76818	S		Fetal biophys profile w/nst	0266	1.5988	$83.38	$45.86	$16.68
76819	S		Fetal biophys profil w/o nst	0266	1.5988	$83.38	$45.86	$16.68
76825	S		Echo exam of fetal heart	0671	2.3643	$123.30	$64.12	$24.66
76826	S		Echo exam of fetal heart	0697	1.5697	$81.86	$42.57	$16.37
76827	S		Echo exam of fetal heart	0671	2.3643	$123.30	$64.12	$24.66
76828	S		Echo exam of fetal heart	0697	1.5697	$81.86	$42.57	$16.37
76830	S		Transvaginal us, non-ob	0266	1.5988	$83.38	$45.86	$16.68
76831	S		Echo exam, uterus	0266	1.5988	$83.38	$45.86	$16.68
76856	S		Us exam, pelvic, complete	0266	1.5988	$83.38	$45.86	$16.68
76857	S		Us exam, pelvic, limited	0265	0.9787	$51.04	$28.07	$10.21
76870	S		Us exam, scrotum	0266	1.5988	$83.38	$45.86	$16.68
76872	S		Echo exam, transrectal	0266	1.5988	$83.38	$45.86	$16.68
76873	S		Echograp trans r, pros study	0266	1.5988	$83.38	$45.86	$16.68
76880	S		Us exam, extremity	0266	1.5988	$83.38	$45.86	$16.68
76885	S		Us exam infant hips, dynamic	0266	1.5988	$83.38	$45.86	$16.68
76886	S		Us exam infant hips, static	0266	1.5988	$83.38	$45.86	$16.68
76930	S		Echo guide, cardiocentesis	0268	1.3856	$72.26		$14.45

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76932	S		Echo guide for heart biopsy	0268	1.3856	$72.26		$14.45
76936	S		Echo guide for artery repair	0268	1.3856	$72.26		$14.45
76941	S		Echo guide for transfusion	0268	1.3856	$72.26		$14.45
76942	S		Echo guide for biopsy	0268	1.3856	$72.26		$14.45
76945	S		Echo guide, villus sampling	0268	1.3856	$72.26		$14.45
76946	S		Echo guide for amniocentesis	0268	1.3856	$72.26		$14.45
76948	S		Echo guide, ova aspiration	0268	1.3856	$72.26		$14.45
76950	S		Echo guidance radiotherapy	0268	1.3856	$72.26		$14.45
76965	S		Echo guidance radiotherapy	0268	1.3856	$72.26		$14.45
76970	S		Ultrasound exam follow-up	0265	0.9787	$51.04	$28.07	$10.21
76975	S		GI endoscopic ultrasound	0266	1.5988	$83.38	$45.86	$16.68
76977	S		Us bone density measure	0265	0.9787	$51.04	$28.07	$10.21
76986	S		Ultrasound guide intraoper	0266	1.5988	$83.38	$45.86	$16.68
76999	S		Echo examination procedure	0265	0.9787	$51.04	$28.07	$10.21
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.6182	$84.39	$41.52	$16.88
77285	X		Set radiation therapy field	0305	3.6530	$190.51	$91.38	$38.10
77290	X		Set radiation therapy field	0305	3.6530	$190.51	$91.38	$38.10
77295	X		Set radiation therapy field	0310	13.6625	$712.51	$325.27	$142.50
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.6182	$84.39	$41.52	$16.88
77301	S		Radiotherapy dose plan, imrt	0712		$875.00		$175.00
77305	X		Teletx isodose plan simple	0304	1.6182	$84.39	$41.52	$16.88
77310	X		Teletx isodose plan intermed	0304	1.6182	$84.39	$41.52	$16.88
77315	X		Teletx isodose plan complex	0305	3.6530	$190.51	$91.38	$38.10
77321	X		Special teletx port plan	0305	3.6530	$190.51	$91.38	$38.10
77326	X		Radiation therapy dose plan	0305	3.6530	$190.51	$91.38	$38.10
77327	X		Brachytx isodose calc interm	0305	3.6530	$190.51	$91.38	$38.10
77328	X		Brachytx isodose plan compl	0305	3.6530	$190.51	$91.38	$38.10
77331	X		Special radiation dosimetry	0304	1.6182	$84.39	$41.52	$16.88
77332	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77333	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77334	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77336	X		Radiation physics consult	0304	1.6182	$84.39	$41.52	$16.88
77370	X		Radiation physics consult	0305	3.6530	$190.51	$91.38	$38.10
77399	X		External radiation dosimetry	0304	1.6182	$84.39	$41.52	$16.88
77401	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77402	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77403	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77404	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77406	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77407	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77408	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77409	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77411	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77412	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77413	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77414	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77416	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77417	X		Radiology port film(s)	0260	0.7655	$39.92	$21.95	$7.98
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	5.9785	$311.78		$62.36
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	10.0482	$524.02		$104.80
77522	S		Proton trmt, simple w/comp	0664	10.0482	$524.02		$104.80
77523	S		Proton trmt, intermediate	0650	12.0152	$626.60		$125.32
77525	S		Proton treatment, complex	0650	12.0152	$626.60		$125.32
77600	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77605	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77610	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77615	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77620	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77750	S		Infuse radioactive materials	0300	1.5794	$82.37		$16.47
77761	S		Apply intrcav radiat simple	0312	52.8864	$2,758.08		$551.62
77762	S		Apply intrcav radiat interm	0312	52.8864	$2,758.08		$551.62
77763	S		Apply intrcav radiat compl	0312	52.8864	$2,758.08		$551.62
77776	S		Apply interstit radiat simpl	0312	52.8864	$2,758.08		$551.62
77777	S		Apply interstit radiat inter	0312	52.8864	$2,758.08		$551.62
77778	S		Apply interstit radiat compl	0651	54.7177	$2,853.58		$570.72
77781	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77782	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77783	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77784	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77789	S		Apply surface radiation	0300	1.5794	$82.37		$16.47
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	21.0363	$1,097.06		$219.41
78000	S		Thyroid, single uptake	0290	2.0251	$105.61	$53.17	$21.12
78001	S		Thyroid, multiple uptakes	0290	2.0251	$105.61	$53.17	$21.12
78003	S		Thyroid suppress/stimul	0290	2.0251	$105.61	$53.17	$21.12
78006	S		Thyroid imaging with uptake	0291	3.9825	$207.69	$104.55	$41.54
78007	S		Thyroid image, mult uptakes	0292	4.2925	$223.86	$112.69	$44.77
78010	S		Thyroid imaging	0291	3.9825	$207.69	$104.55	$41.54
78011	S		Thyroid imaging with flow	0292	4.2925	$223.86	$112.69	$44.77
78015	S		Thyroid met imaging	0291	3.9825	$207.69	$104.55	$41.54
78016	S		Thyroid met imaging/studies	0292	4.2925	$223.86	$112.69	$44.77
78018	S		Thyroid met imaging, body	0292	4.2925	$223.86	$112.69	$44.77
78020	S		Thyroid met uptake	0666	2.9650	$154.63	$85.05	$30.93
78070	S		Parathyroid nuclear imaging	0292	4.2925	$223.86	$112.69	$44.77
78075	S		Adrenal nuclear imaging	0292	4.2925	$223.86	$112.69	$44.77
78099	S		Endocrine nuclear procedure	0291	3.9825	$207.69	$104.55	$41.54
78102	S		Bone marrow imaging, ltd	0291	3.9825	$207.69	$104.55	$41.54
78103	S		Bone marrow imaging, mult	0291	3.9825	$207.69	$104.55	$41.54
78104	S		Bone marrow imaging, body	0291	3.9825	$207.69	$104.55	$41.54
78110	S		Plasma volume, single	0290	2.0251	$105.61	$53.17	$21.12
78111	S		Plasma volume, multiple	0290	2.0251	$105.61	$53.17	$21.12
78120	S		Red cell mass, single	0290	2.0251	$105.61	$53.17	$21.12
78121	S		Red cell mass, multiple	0290	2.0251	$105.61	$53.17	$21.12
78122	S		Blood volume	0290	2.0251	$105.61	$53.17	$21.12
78130	S		Red cell survival study	0290	2.0251	$105.61	$53.17	$21.12
78135	S		Red cell survival kinetics	0290	2.0251	$105.61	$53.17	$21.12
78140	S		Red cell sequestration	0290	2.0251	$105.61	$53.17	$21.12
78160	S		Plasma iron turnover	0290	2.0251	$105.61	$53.17	$21.12
78162	S		Radioiron absorption exam	0290	2.0251	$105.61	$53.17	$21.12
78170	S		Red cell iron utilization	0290	2.0251	$105.61	$53.17	$21.12
78172	S		Total body iron estimation	0290	2.0251	$105.61	$53.17	$21.12
78185	S		Spleen imaging	0291	3.9825	$207.69	$104.55	$41.54
78190	S		Platelet survival, kinetics	0290	2.0251	$105.61	$53.17	$21.12
78191	S		Platelet survival	0292	4.2925	$223.86	$112.69	$44.77
78195	S		Lymph system imaging	0292	4.2925	$223.86	$112.69	$44.77
78199	S		Blood/lymph nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78201	S		Liver imaging	0291	3.9825	$207.69	$104.55	$41.54
78202	S		Liver imaging with flow	0291	3.9825	$207.69	$104.55	$41.54
78205	S		Liver imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78206	S		Liver image (3d) with flow	0292	4.2925	$223.86	$112.69	$44.77
78215	S		Liver and spleen imaging	0291	3.9825	$207.69	$104.55	$41.54
78216	S		Liver & spleen image/flow	0291	3.9825	$207.69	$104.55	$41.54
78220	S		Liver function study	0291	3.9825	$207.69	$104.55	$41.54
78223	S		Hepatobiliary imaging	0292	4.2925	$223.86	$112.69	$44.77
78230	S		Salivary gland imaging	0292	4.2925	$223.86	$112.69	$44.77
78231	S		Serial salivary imaging	0292	4.2925	$223.86	$112.69	$44.77
78232	S		Salivary gland function exam	0292	4.2925	$223.86	$112.69	$44.77
78258	S		Esophageal motility study	0291	3.9825	$207.69	$104.55	$41.54
78261	S		Gastric mucosa imaging	0291	3.9825	$207.69	$104.55	$41.54
78262	S		Gastroesophageal reflux exam	0292	4.2925	$223.86	$112.69	$44.77
78264	S		Gastric emptying study	0292	4.2925	$223.86	$112.69	$44.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0290	2.0251	$105.61	$53.17	$21.12
78271	S		Vit b-12 absrp exam, int fac	0290	2.0251	$105.61	$53.17	$21.12
78272	S		Vit B-12 absorp, combined	0290	2.0251	$105.61	$53.17	$21.12
78278	S		Acute GI blood loss imaging	0292	4.2925	$223.86	$112.69	$44.77
78282	S		GI protein loss exam	0290	2.0251	$105.61	$53.17	$21.12
78290	S		Meckel's divert exam	0292	4.2925	$223.86	$112.69	$44.77
78291	S		Leveen/shunt patency exam	0292	4.2925	$223.86	$112.69	$44.77
78299	S		GI nuclear procedure	0291	3.9825	$207.69	$104.55	$41.54
78300	S		Bone imaging, limited area	0291	3.9825	$207.69	$104.55	$41.54
78305	S		Bone imaging, multiple areas	0291	3.9825	$207.69	$104.55	$41.54
78306	S		Bone imaging, whole body	0291	3.9825	$207.69	$104.55	$41.54
78315	S		Bone imaging, 3 phase	0292	4.2925	$223.86	$112.69	$44.77
78320	S		Bone imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78350	X		Bone mineral, single photon	0261	1.2887	$67.21		$13.44
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78414	S		Non-imaging heart function	0290	2.0251	$105.61	$53.17	$21.12
78428	S		Cardiac shunt imaging	0291	3.9825	$207.69	$104.55	$41.54
78445	S		Vascular flow imaging	0291	3.9825	$207.69	$104.55	$41.54
78455	S		Venous thrombosis study	0290	2.0251	$105.61	$53.17	$21.12
78456	S		Acute venous thrombus image	0292	4.2925	$223.86	$112.69	$44.77
78457	S		Venous thrombosis imaging	0291	3.9825	$207.69	$104.55	$41.54
78458	S		Ven thrombosis images, bilat	0292	4.2925	$223.86	$112.69	$44.77
78459	E		Heart muscle imaging (PET)					
78460	S		Heart muscle blood, single	0286	6.5309	$340.59	$187.32	$68.12
78461	S		Heart muscle blood, multiple	0286	6.5309	$340.59	$187.32	$68.12
78464	S		Heart image (3d), single	0286	6.5309	$340.59	$187.32	$68.12
78465	S		Heart image (3d), multiple	0286	6.5309	$340.59	$187.32	$68.12
78466	S		Heart infarct image	0291	3.9825	$207.69	$104.55	$41.54
78468	S		Heart infarct image (ef)	0291	3.9825	$207.69	$104.55	$41.54
78469	S		Heart infarct image (3D)	0291	3.9825	$207.69	$104.55	$41.54
78472	S		Gated heart, planar, single	0286	6.5309	$340.59	$187.32	$68.12
78473	S		Gated heart, multiple	0286	6.5309	$340.59	$187.32	$68.12
78478	S		Heart wall motion add-on	0666	2.9650	$154.63	$85.05	$30.93
78480	S		Heart function add-on	0666	2.9650	$154.63	$85.05	$30.93
78481	S		Heart first pass, single	0286	6.5309	$340.59	$187.32	$68.12
78483	S		Heart first pass, multiple	0286	6.5309	$340.59	$187.32	$68.12
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0286	6.5309	$340.59	$187.32	$68.12
78496	S		Heart first pass add-on	0666	2.9650	$154.63	$85.05	$30.93
78499	S		Cardiovascular nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78580	S		Lung perfusion imaging	0291	3.9825	$207.69	$104.55	$41.54
78584	S		Lung V/Q image single breath	0292	4.2925	$223.86	$112.69	$44.77
78585	S		Lung V/Q imaging	0292	4.2925	$223.86	$112.69	$44.77
78586	S		Aerosol lung image, single	0291	3.9825	$207.69	$104.55	$41.54
78587	S		Aerosol lung image, multiple	0291	3.9825	$207.69	$104.55	$41.54
78588	S		Perfusion lung image	0292	4.2925	$223.86	$112.69	$44.77
78591	S		Vent image, 1 breath, 1 proj	0291	3.9825	$207.69	$104.55	$41.54
78593	S		Vent image, 1 proj, gas	0291	3.9825	$207.69	$104.55	$41.54
78594	S		Vent image, mult proj, gas	0291	3.9825	$207.69	$104.55	$41.54
78596	S		Lung differential function	0292	4.2925	$223.86	$112.69	$44.77
78599	S		Respiratory nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78600	S		Brain imaging, ltd static	0291	3.9825	$207.69	$104.55	$41.54
78601	S		Brain imaging, ltd w/ flow	0291	3.9825	$207.69	$104.55	$41.54
78605	S		Brain imaging, complete	0291	3.9825	$207.69	$104.55	$41.54
78606	S		Brain imaging, compl w/flow	0291	3.9825	$207.69	$104.55	$41.54
78607	S		Brain imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78608	E		Brain imaging (PET)					
78609	E		Brain imaging (PET)					
78610	S		Brain flow imaging only	0291	3.9825	$207.69	$104.55	$41.54
78615	S		Cerebral vascular flow image	0291	3.9825	$207.69	$104.55	$41.54
78630	S		Cerebrospinal fluid scan	0292	4.2925	$223.86	$112.69	$44.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78635	S		CSF ventriculography	0292	4.2925	$223.86	$112.69	$44.77
78645	S		CSF shunt evaluation	0292	4.2925	$223.86	$112.69	$44.77
78647	S		Cerebrospinal fluid scan	0292	4.2925	$223.86	$112.69	$44.77
78650	S		CSF leakage imaging	0292	4.2925	$223.86	$112.69	$44.77
78660	S		Nuclear exam of tear flow	0291	3.9825	$207.69	$104.55	$41.54
78699	S		Nervous system nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78700	S		Kidney imaging, static	0291	3.9825	$207.69	$104.55	$41.54
78701	S		Kidney imaging with flow	0291	3.9825	$207.69	$104.55	$41.54
78704	S		Imaging renogram	0291	3.9825	$207.69	$104.55	$41.54
78707	S		Kidney flow/function image	0291	3.9825	$207.69	$104.55	$41.54
78708	S		Kidney flow/function image	0292	4.2925	$223.86	$112.69	$44.77
78709	S		Kidney flow/function image	0292	4.2925	$223.86	$112.69	$44.77
78710	S		Kidney imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78715	S		Renal vascular flow exam	0291	3.9825	$207.69	$104.55	$41.54
78725	S		Kidney function study	0290	2.0251	$105.61	$53.17	$21.12
78730	S		Urinary bladder retention	0291	3.9825	$207.69	$104.55	$41.54
78740	S		Ureteral reflux study	0292	4.2925	$223.86	$112.69	$44.77
78760	S		Testicular imaging	0291	3.9825	$207.69	$104.55	$41.54
78761	S		Testicular imaging/flow	0291	3.9825	$207.69	$104.55	$41.54
78799	S		Genitourinary nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78800	S		Tumor imaging, limited area	0292	4.2925	$223.86	$112.69	$44.77
78801	S		Tumor imaging, mult areas	0292	4.2925	$223.86	$112.69	$44.77
78802	S		Tumor imaging, whole body	0292	4.2925	$223.86	$112.69	$44.77
78803	S		Tumor imaging (3D)	0292	4.2925	$223.86	$112.69	$44.77
78805	S		Abscess imaging, ltd area	0292	4.2925	$223.86	$112.69	$44.77
78806	S		Abscess imaging, whole body	0292	4.2925	$223.86	$112.69	$44.77
78807	S		Nuclear localization/abscess	0292	4.2925	$223.86	$112.69	$44.77
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	3.9825	$207.69	$104.55	$41.54
79000	S		Init hyperthyroid therapy	0294	4.0794	$212.74	$117.01	$42.55
79001	S		Repeat hyperthyroid therapy	0294	4.0794	$212.74	$117.01	$42.55
79020	S		Thyroid ablation	0294	4.0794	$212.74	$117.01	$42.55
79030	S		Thyroid ablation, carcinoma	0294	4.0794	$212.74	$117.01	$42.55
79035	S		Thyroid metastatic therapy	0294	4.0794	$212.74	$117.01	$42.55
79100	S		Hematopoetic nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79200	S		Intracavitary nuclear trmt	0294	4.0794	$212.74	$117.01	$42.55
79300	S		Interstitial nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79400	S		Nonhemato nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79420	S		Intravascular nuclear ther	0294	4.0794	$212.74	$117.01	$42.55
79440	S		Nuclear joint therapy	0294	4.0794	$212.74	$117.01	$42.55
79900	N		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0294	4.0794	$212.74	$117.01	$42.55
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					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function panel					
80090	A	DG	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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.4457	$23.24	$12.55	$4.65
80502	X		Lab pathology consultation	0342	0.2132	$11.12	$5.88	$2.22
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
82120	A		Amines, vaginal fluid qual					
82127	A		Amino acid, single qual					
82128	A		Amino acids, mult qual					
82131	A		Amino acids, single quant					
82135	A		Assay, aminolevulinic acid					
82136	A		Amino acids, quant, 2-5					
82139	A		Amino acids, quan, 6 or more					
82140	A		Assay of ammonia					
82143	A		Amniotic fluid scan					
82145	A		Assay of amphetamines					
82150	A		Assay of amylase					
82154	A		Androstanediol glucuronide					
82157	A		Assay of androstenedione					
82160	A		Assay of androsterone					
82163	A		Assay of angiotensin II					
82164	A		Angiotensin I enzyme test					
82172	A		Assay of apolipoprotein					
82175	A		Assay of arsenic					
82180	A		Assay of ascorbic acid					
82190	A		Atomic absorption					
82205	A		Assay of barbiturates					
82232	A		Assay of beta-2 protein					
82239	A		Bile acids, total					
82240	A		Bile acids, cholylglycine					
82247	A		Bilirubin, total					
82248	A		Bilirubin, direct					
82252	A		Fecal bilirubin test					
82261	A		Assay of biotinidase					
82270	A		Test for blood, feces					
82273	A		Test for blood, other source					
82274	A		Assay test for blood, fecal					
82286	A		Assay of bradykinin					
82300	A		Assay of cadmium					
82306	A		Assay of vitamin D					
82307	A		Assay of vitamin D					
82308	A		Assay of calcitonin					
82310	A		Assay of calcium					
82330	A		Assay of calcium					
82331	A		Calcium infusion test					
82340	A		Assay of calcium in urine					
82355	A		Calculus analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
82370	A		X-ray assay, calculus					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83785	A		Assay of manganese					
83788	A		Mass spectrometry qual					
83789	A		Mass spectrometry quant					
83805	A		Assay of meprobamate					
83825	A		Assay of mercury					
83835	A		Assay of metanephrines					
83840	A		Assay of methadone					
83857	A		Assay of methemalbumin					
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A	NI	Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					
83937	A		Assay of osteocalcin					
83945	A		Assay of oxalate					
83950	A		Oncoprotein, her-2/neu					
83970	A		Assay of parathormone					
83986	A		Assay of body fluid acidity					
83992	A		Assay for phencyclidine					
84022	A		Assay of phenothiazine					
84030	A		Assay of blood pku					
84035	A		Assay of phenylketones					
84060	A		Assay acid phosphatase					
84061	A		Phosphatase, forensic exam					
84066	A		Assay prostate phosphatase					
84075	A		Assay alkaline phosphatase					
84078	A		Assay alkaline phosphatase					
84080	A		Assay alkaline phosphatases					
84081	A		Amniotic fluid enzyme test					
84085	A		Assay of rbc pg6d enzyme					
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					
84106	A		Test for porphobilinogen					
84110	A		Assay of porphobilinogen					
84119	A		Test urine for porphyrins					
84120	A		Assay of urine porphyrins					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
84302	A	NI	Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars single quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
84485	A		Assay duodenal fluid trypsin					
84488	A		Test feces for trypsin					
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A	NI	Automated diff wbc count					
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85021	A	DG	Automated hemogram					
85022	A	DG	Automated hemogram					
85023	A	DG	Automated hemogram					
85024	A	DG	Automated hemogram					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85031	A	DG	Manual hemogram, cbc					
85032	A	NI	Manual cell count, each					
85041	A		Red blood cell (RBC) count					
85044	A		Reticulocyte count					
85045	A		Reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		White blood cell (WBC) count					
85049	A	NI	Automated platelet count					
85060	X		Blood smear interpretation	0342	0.2132	$11.12	$5.88	$2.22
85097	X		Bone marrow interpretation	0343	0.4457	$23.24	$12.55	$4.65
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degradation					
85379	A		Fibrin degradation, quant					
85380	A	NI	Fibrin degradation, vte					
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 neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85585	A	DG	Blood platelet estimation					
85590	A	DG	Platelet count, manual					
85595	A	DG	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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.4457	$23.24	$12.55	$4.65
86078	X		Physician blood bank service	0344	0.6201	$32.34	$17.46	$6.47
86079	X		Physician blood bank service	0344	0.6201	$32.34	$17.46	$6.47
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
86294	A		Immunoassay, tumor qual					
86300	A		Immunoassay, tumor ca 15-3					
86301	A		Immunoassay, tumor ca 19-9					
86304	A		Immunoassay, tumor, ca 125					
86308	A		Heterophile antibodies					
86309	A		Heterophile antibodies					
86310	A		Heterophile antibodies					
86316	A		Immunoassay, tumor other					
86317	A		Immunoassay,infectious agent					
86318	A		Immunoassay,infectious agent					
86320	A		Serum immunoelectrophoresis					
86325	A		Other immunoelectrophoresis					
86327	A		Immunoelectrophoresis assay					
86329	A		Immunodiffusion					
86331	A		Immunodiffusion ouchterlony					
86332	A		Immune complex assay					
86334	A		Immunofixation procedure					
86336	A		Inhibin A					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.1453	$7.58	$3.08	$1.52
86490	X		Coccidioidomycosis skin test	0341	0.1453	$7.58	$3.08	$1.52
86510	X		Histoplasmosis skin test	0341	0.1453	$7.58	$3.08	$1.52
86580	X		TB intradermal test	0341	0.1453	$7.58	$3.08	$1.52
86585	X		TB tine test	0341	0.1453	$7.58	$3.08	$1.52
86586	X		Skin test, unlisted	0341	0.1453	$7.58	$3.08	$1.52
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					
86631	A		Chlamydia antibody					
86632	A		Chlamydia igm antibody					
86635	A		Coccidioides antibody					
86638	A		Q fever antibody					
86641	A		Cryptococcus antibody					
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
86666	A		Ehrlichia antibody					
86668	A		Francisella tularensis					
86671	A		Fungus antibody					
86674	A		Giardia lamblia antibody					
86677	A		Helicobacter pylori					
86682	A		Helminth antibody					
86684	A		Hemophilus influenza					
86687	A		Htlv-i antibody					
86688	A		Htlv-ii antibody					
86689	A		HTLV/HIV confirmatory test					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.1938	$10.11	$3.10	$2.02
86860	X		RBC antibody elution	0346	0.5136	$26.78	$6.75	$5.36
86870	X		RBC antibody identification	0346	0.5136	$26.78	$6.75	$5.36
86880	X		Coombs test, direct	0341	0.1453	$7.58	$3.08	$1.52
86885	X		Coombs test, indirect, qual	0341	0.1453	$7.58	$3.08	$1.52
86886	X		Coombs test, indirect, titer	0341	0.1453	$7.58	$3.08	$1.52
86890	X		Autologous blood process	0347	1.1240	$58.62	$14.76	$11.72

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86891	X		Autologous blood, op salvage	0345	0.1938	$10.11	$3.10	$2.02
86900	X		Blood typing, ABO	0341	0.1453	$7.58	$3.08	$1.52
86901	X		Blood typing, Rh (D)	0345	0.1938	$10.11	$3.10	$2.02
86903	X		Blood typing, antigen screen	0345	0.1938	$10.11	$3.10	$2.02
86904	X		Blood typing, patient serum	0345	0.1938	$10.11	$3.10	$2.02
86905	X		Blood typing, RBC antigens	0345	0.1938	$10.11	$3.10	$2.02
86906	X		Blood typing, Rh phenotype	0345	0.1938	$10.11	$3.10	$2.02
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86915	S	DG	Bone marrow/stem cell prep	0110	4.0309	$210.22		$42.04
86920	X		Compatibility test	0346	0.5136	$26.78	$6.75	$5.36
86921	X		Compatibility test	0345	0.1938	$10.11	$3.10	$2.02
86922	X		Compatibility test	0346	0.5136	$26.78	$6.75	$5.36
86927	X		Plasma, fresh frozen	0346	0.5136	$26.78	$6.75	$5.36
86930	X		Frozen blood prep	0347	1.1240	$58.62	$14.76	$11.72
86931	X		Frozen blood thaw	0347	1.1240	$58.62	$14.76	$11.72
86932	X		Frozen blood freeze/thaw	0347	1.1240	$58.62	$14.76	$11.72
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.5136	$26.78	$6.75	$5.36
86950	X		Leukacyte transfusion	0347	1.1240	$58.62	$14.76	$11.72
86965	X		Pooling blood platelets	0346	0.5136	$26.78	$6.75	$5.36
86970	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86971	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86972	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86975	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86976	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86977	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86978	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86985	X		Split blood or products	0347	1.1240	$58.62	$14.76	$11.72
86999	X		Transfusion procedure	0345	0.1938	$10.11	$3.10	$2.02
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					
87045	A		Feces culture, bacteria					
87046	A		Stool cultr, bacteria, each					
87070	A		Culture, bacteria, other					
87071	A		Culture bacteri aerobic othr					
87073	A		Culture bacteria anaerobic					
87075	A		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		Culture type immunofluoresc					
87143	A		Culture typing, glc/hplc					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87169	A		Macroscopic exam parasite					
87172	A		Pinworm exam					
87176	A		Tissue homogenization, cultr					
87177	A		Ova and parasites smears					
87181	A		Microbe susceptible, diffuse					
87184	A		Microbe susceptible, disk					
87185	A		Microbe susceptible, enzyme					
87186	A		Microbe susceptible, mic					
87187	A		Microbe susceptible, mlc					
87188	A		Microbe suscept, macrobroth					
87190	A		Microbe suscept, mycobacteri					
87197	A		Bactericidal level, serum					
87198	A	DG	Cytomegalovirus antibody dfa					
87199	A	DG	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					
87255	A	NI	Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A	NI	Enterovirus antibody, dfa					
87270	A		Chlamydia trachomatis ag, if					
87271	A	NI	Cryptosporidum/gardia 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		H pylori ag, eia					
87340	A		Hepatitis b surface ag, eia					
87341	A		Hepatitis b surface, ag, eia					
87350	A		Hepatitis be ag, eia					
87380	A		Hepatitis delta ag, eia					
87385	A		Histoplasma capsul ag, eia					
87390	A		Hiv-1 ag, eia					
87391	A		Hiv-2 ag, eia					
87400	A		Influenza a/b, ag, eia					
87420	A		Resp syncytial ag, eia					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	0.4457	$23.24	$12.55	$4.65
88106	X		Cytopathology, fluids	0343	0.4457	$23.24	$12.55	$4.65
88107	X		Cytopathology, fluids	0343	0.4457	$23.24	$12.55	$4.65
88108	X		Cytopath, concentrate tech	0343	0.4457	$23.24	$12.55	$4.65
88125	X		Forensic cytopathology	0342	0.2132	$11.12	$5.88	$2.22
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	DG	Cytopath, c/v, thin lyr redo					
88145	A	DG	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	0.2132	$11.12	$5.88	$2.22
88161	X		Cytopath smear, other source	0343	0.4457	$23.24	$12.55	$4.65
88162	X		Cytopath smear, other source	0343	0.4457	$23.24	$12.55	$4.65
88164	A		Cytopath tbs, c/v, manual					
88165	A		Cytopath tbs, c/v, redo					
88166	A		Cytopath tbs, c/v, auto redo					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88167	A		Cytopath tbs, c/v, select					
88172	X		Cytopathology eval of fna	0343	0.4457	$23.24	$12.55	$4.65
88173	X		Cytopath eval, fna, report	0343	0.4457	$23.24	$12.55	$4.65
88174	A	NI	Cytopath, c/v auto, in fluid					
88175	A	NI	Cytopath c/v auto fluid redo					
88180	X		Cell marker study	0343	0.4457	$23.24	$12.55	$4.65
88182	X		Cell marker study	0344	0.6201	$32.34	$17.46	$6.47
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					
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	0.2132	$11.12	$5.88	$2.22
88300	X		Surgical path, gross	0342	0.2132	$11.12	$5.88	$2.22
88302	X		Tissue exam by pathologist	0342	0.2132	$11.12	$5.88	$2.22
88304	X		Tissue exam by pathologist	0343	0.4457	$23.24	$12.55	$4.65
88305	X		Tissue exam by pathologist	0343	0.4457	$23.24	$12.55	$4.65
88307	X		Tissue exam by pathologist	0344	0.6201	$32.34	$17.46	$6.47
88309	X		Tissue exam by pathologist	0344	0.6201	$32.34	$17.46	$6.47
88311	X		Decalcify tissue	0342	0.2132	$11.12	$5.88	$2.22
88312	X		Special stains	0342	0.2132	$11.12	$5.88	$2.22
88313	X		Special stains	0342	0.2132	$11.12	$5.88	$2.22
88314	X		Histochemical stain	0342	0.2132	$11.12	$5.88	$2.22
88318	X		Chemical histochemistry	0342	0.2132	$11.12	$5.88	$2.22
88319	X		Enzyme histochemistry	0342	0.2132	$11.12	$5.88	$2.22
88321	X		Microslide consultation	0342	0.2132	$11.12	$5.88	$2.22
88323	X		Microslide consultation	0343	0.4457	$23.24	$12.55	$4.65
88325	X		Comprehensive review of data	0344	0.6201	$32.34	$17.46	$6.47
88329	X		Path consult introp	0342	0.2132	$11.12	$5.88	$2.22
88331	X		Path consult intraop, 1 bloc	0343	0.4457	$23.24	$12.55	$4.65
88332	X		Path consult intraop, addl	0342	0.2132	$11.12	$5.88	$2.22
88342	X		Immunocytochemistry	0344	0.6201	$32.34	$17.46	$6.47
88346	X		Immunofluorescent study	0343	0.4457	$23.24	$12.55	$4.65
88347	X		Immunofluorescent study	0344	0.6201	$32.34	$17.46	$6.47
88348	X		Electron microscopy	0661	3.5077	$182.93	$100.61	$36.59
88349	X		Scanning electron microscopy	0661	3.5077	$182.93	$100.61	$36.59
88355	X		Analysis, skeletal muscle	0344	0.6201	$32.34	$17.46	$6.47
88356	X		Analysis, nerve	0344	0.6201	$32.34	$17.46	$6.47
88358	X		Analysis, tumor	0344	0.6201	$32.34	$17.46	$6.47
88362	X		Nerve teasing preparations	0343	0.4457	$23.24	$12.55	$4.65
88365	X		Tissue hybridization	0344	0.6201	$32.34	$17.46	$6.47
88371	A		Protein, western blot tissue					
88372	A		Protein analysis w/probe					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88380	A		Microdissection					
88399	A		Surgical pathology procedure					
88400	A		Bilirubin total transcut					
89050	A		Body fluid cell count					
89051	A		Body fluid cell count					
89055	A	NI	Leukocyte count, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.6279	$84.90	$42.45	$16.98
89105	X		Sample intestinal contents	0360	1.6279	$84.90	$42.45	$16.98
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89132	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89135	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89136	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89140	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89141	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89250	X		Fertilization of oocyte	0348	0.5523	$28.80		$5.76
89251	X		Culture oocyte w/embryos	0348	0.5523	$28.80		$5.76
89252	X		Assist oocyte fertilization	0348	0.5523	$28.80		$5.76
89253	X		Embryo hatching	0348	0.5523	$28.80		$5.76
89254	X		Oocyte identification	0348	0.5523	$28.80		$5.76
89255	X		Prepare embryo for transfer	0348	0.5523	$28.80		$5.76
89256	X		Prepare cryopreserved embryo	0348	0.5523	$28.80		$5.76
89257	X		Sperm identification	0348	0.5523	$28.80		$5.76
89258	X		Cryopreservation, embryo	0348	0.5523	$28.80		$5.76
89259	X		Cryopreservation, sperm	0348	0.5523	$28.80		$5.76
89260	X		Sperm isolation, simple	0348	0.5523	$28.80		$5.76
89261	X		Sperm isolation, complex	0348	0.5523	$28.80		$5.76
89264	X		Identify sperm tissue	0348	0.5523	$28.80		$5.76
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					
89320	A		Semen analysis, complete					
89321	A		Semen analysis & motility					
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89350	X		Sputum specimen collection	0344	0.6201	$32.34	$17.46	$6.47
89355	A		Exam feces for starch					
89360	X		Collect sweat for test	0344	0.6201	$32.34	$17.46	$6.47
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	0.7655	$39.92		$7.98
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	0356	0.7655	$39.92		$7.98
90376	K		Rabies ig, heat treated	0356	0.7655	$39.92		$7.98
90378	E		Rsv ig, im, 50mg					
90379	K		Rsv ig, iv	0356	0.7655	$39.92		$7.98
90384	E		Rh ig, full-dose, im					
90385	N		Rh ig, minidose, im					
90386	E		Rh ig, iv					
90389	N		Tetanus ig, im					
90393	N		Vaccina ig, im					
90396	N		Varicella-zoster ig, im					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90476	N		Adenovirus vaccine, type 4					
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	0356	0.7655	$39.92		$7.98
90585	N		Bcg vaccine, percut					
90586	N		Bcg vaccine, intravesical					
90632	N		Hep a vaccine, adult im					
90633	N		Hep a vacc, ped/adol, 2 dose					
90634	N		Hep a vacc, ped/adol, 3 dose					
90636	K		Hep a/hep b vacc, adult im	0355	0.2132	$11.12		$2.22
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90657	L		Flu vaccine, 6-35 mo, im					
90658	L		Flu vaccine, 3 yrs, im					
90659	L		Flu vaccine, whole, im					
90660	E		Flu vaccine, nasal					
90665	N		Lyme disease vaccine, im					
90669	E		Pneumococcal vacc, ped <5					
90675	N		Rabies vaccine, im					
90676	N		Rabies vaccine, id					
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	K		Typhoid vaccine, akd, sc	0356	0.7655	$39.92		$7.98
90700	N		Dtap vaccine, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	N		Measles-rubella vaccine, sc					
90709	K	DG	Rubella & mumps vaccine, sc	0356	0.7655	$39.92		$7.98
90710	N		Mmrv vaccine, sc					
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90716	N		Chicken pox vaccine, sc					
90717	N		Yellow fever vaccine, sc					
90718	N		Td vaccine > 7, im					
90719	N		Diphtheria vaccine, im					
90720	N		Dtp/hib vaccine, im					
90721	N		Dtap/hib vaccine, im					
90723	K		Dtap-hep b-ipv vaccine, im	0356	0.7655	$39.92		$7.98
90725	N		Cholera vaccine, injectable					
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	N		Meningococcal vaccine, sc					
90735	N		Encephalitis vaccine, sc					
90740	E		Hepb vacc, ill pat 3 dose im					
90743	E		Hep b vacc, adol, 2 dose, im					
90744	E		Hepb vacc ped/adol 3 dose im					
90746	E		Hep b vaccine, adult, im					
90747	E		Hepb vacc, ill pat 4 dose im					
90748	E		Hep b/hib vaccine, im					
90749	N		Vaccine toxoid					
90780	E		IV infusion therapy, 1 hour					
90781	E		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3973	$20.72		$4.14
90783	X		Injection, ia	0359	1.1337	$59.12		$11.82
90784	X		Injection, iv	0359	1.1337	$59.12		$11.82
90788	X		Injection of antibiotic	0359	1.1337	$59.12		$11.82
90799	X		Ther/prophylactic/dx inject	0352	0.2229	$11.62		$2.32

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90801	S		Psy dx interview	0323	1.8410	$96.01	$21.26	$19.20
90802	S		Intac psy dx interview	0323	1.8410	$96.01	$21.26	$19.20
90804	S		Psytx, office, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90806	S		Psytx, off, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90808	S		Psytx, office, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90809	S		Psytx, off, 75-80, w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90810	S		Intac psytx, off, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90811	S		Intac psytx, 20-30, w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90812	S		Intac psytx, off, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90814	S		Intac psytx, off, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90815	S		Intac psytx, 75-80 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90816	S		Psytx, hosp, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90818	S		Psytx, hosp, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90821	S		Psytx, hosp, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90823	S		Intac psytx, hosp, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90826	S		Intac psytx, hosp, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90828	S		Intac psytx, hosp, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90845	S		Psychoanalysis	0323	1.8410	$96.01	$21.26	$19.20
90846	S		Family psytx w/o patient	0324	2.4612	$128.35		$25.67
90847	S		Family psytx w/patient	0324	2.4612	$128.35		$25.67
90849	S		Multiple family group psytx	0325	1.4244	$74.28	$18.27	$14.86
90853	S		Group psychotherapy	0325	1.4244	$74.28	$18.27	$14.86
90857	S		Intac group psytx	0325	1.4244	$74.28	$18.27	$14.86
90862	X		Medication management	0374	1.1434	$59.63	$9.97	$11.93
90865	S		Narcosynthesis	0323	1.8410	$96.01	$21.26	$19.20
90870	S		Electroconvulsive therapy	0320	4.2635	$222.35	$80.06	$44.47
90871	S		Electroconvulsive therapy	0320	4.2635	$222.35	$80.06	$44.47
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.8410	$96.01	$21.26	$19.20
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	1.3275	$69.23	$12.40	$13.85
90901	S		Biofeedback train, any meth	0321	1.2112	$63.17	$21.78	$12.63
90911	S		Biofeedback peri/uro/rectal	0321	1.2112	$63.17	$21.78	$12.63
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	4.8352	$252.16		$50.43
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	4.8352	$252.16		$50.43
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	3.3914	$176.86	$83.23	$35.37

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
91010	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91011	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91012	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91020	X		Gastric motility	0361	3.3914	$176.86	$83.23	$35.37
91030	X		Acid perfusion of esophagus	0361	3.3914	$176.86	$83.23	$35.37
91032	X		Esophagus, acid reflux test	0361	3.3914	$176.86	$83.23	$35.37
91033	X		Prolonged acid reflux test	0361	3.3914	$176.86	$83.23	$35.37
91052	X		Gastric analysis test	0361	3.3914	$176.86	$83.23	$35.37
91055	X		Gastric intubation for smear	0360	1.6279	$84.90	$42.45	$16.98
91060	X		Gastric saline load test	0360	1.6279	$84.90	$42.45	$16.98
91065	X		Breath hydrogen test	0360	1.6279	$84.90	$42.45	$16.98
91100	X		Pass intestine bleeding tube	0360	1.6279	$84.90	$42.45	$16.98
91105	X		Gastric intubation treatment	0360	1.6279	$84.90	$42.45	$16.98
91122	T		Anal pressure record	0156	2.9747	$155.13	$46.55	$31.03
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.6279	$84.90	$42.45	$16.98
91133	X		Electrogastrography w/test	0360	1.6279	$84.90	$42.45	$16.98
91299	X		Gastroenterology procedure	0360	1.6279	$84.90	$42.45	$16.98
92002	V		Eye exam, new patient	0601	0.9690	$50.53		$10.11
92004	V		Eye exam, new patient	0602	1.4631	$76.30		$15.26
92012	V		Eye exam established pat	0600	0.8430	$43.96		$8.79
92014	V		Eye exam & treatment	0602	1.4631	$76.30		$15.26
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	3.7596	$196.07	$88.23	$39.21
92019	S		Eye exam & treatment	0698	0.9205	$48.00	$18.72	$9.60
92020	S		Special eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92060	S		Special eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92065	S		Orthoptic/pleoptic training	0230	0.7364	$38.40	$14.97	$7.68
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7364	$38.40	$14.97	$7.68
92082	S		Visual field examination(s)	0698	0.9205	$48.00	$18.72	$9.60
92083	S		Visual field examination(s)	0698	0.9205	$48.00	$18.72	$9.60
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92130	S		Water provocation tonography	0698	0.9205	$48.00	$18.72	$9.60
92135	S		Opthalmic dx imaging	0230	0.7364	$38.40	$14.97	$7.68
92136	S		Ophthalmic biometry	0230	0.7364	$38.40	$14.97	$7.68
92140	S		Glaucoma provocative tests	0698	0.9205	$48.00	$18.72	$9.60
92225	S		Special eye exam, initial	0698	0.9205	$48.00	$18.72	$9.60
92226	S		Special eye exam, subsequent	0698	0.9205	$48.00	$18.72	$9.60
92230	T		Eye exam with photos	0699	3.7596	$196.07	$88.23	$39.21
92235	T		Eye exam with photos	0699	3.7596	$196.07	$88.23	$39.21
92240	S		Icg angiography	0231	2.1705	$113.19	$50.94	$22.64
92250	S		Eye exam with photos	0230	0.7364	$38.40	$14.97	$7.68
92260	S		Ophthalmoscopy/dynamometry	0230	0.7364	$38.40	$14.97	$7.68
92265	S		Eye muscle evaluation	0231	2.1705	$113.19	$50.94	$22.64
92270	S		Electro-oculography	0698	0.9205	$48.00	$18.72	$9.60
92275	S		Electroretinography	0231	2.1705	$113.19	$50.94	$22.64
92283	S		Color vision examination	0230	0.7364	$38.40	$14.97	$7.68
92284	S		Dark adaptation eye exam	0698	0.9205	$48.00	$18.72	$9.60
92285	S		Eye photography	0230	0.7364	$38.40	$14.97	$7.68
92286	S		Internal eye photography	0698	0.9205	$48.00	$18.72	$9.60
92287	S		Internal eye photography	0231	2.1705	$113.19	$50.94	$22.64
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92312	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92313	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92316	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92317	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92325	X		Modification of contact lens	0362	2.8391	$148.06		$29.61
92326	X		Replacement of contact lens	0362	2.8391	$148.06		$29.61
92330	S		Fitting of artificial eye	0230	0.7364	$38.40	$14.97	$7.68
92335	N		Fitting of artificial eye					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92353	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92354	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92355	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92358	X		Eye prosthesis service	0362	2.8391	$148.06		$29.61
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.8391	$148.06		$29.61
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	0.7364	$38.40	$14.97	$7.68
92502	T		Ear and throat examination	0251	1.9089	$99.55		$19.91
92504	N		Ear microscopy examination					
92506	A		Speech/hearing evaluation					
92507	A		Speech/hearing therapy					
92508	A		Speech/hearing therapy					
92510	A		Rehab for ear implant					
92511	T		Nasopharyngoscopy	0071	0.9205	$48.00	$12.89	$9.60
92512	X		Nasal function studies	0363	1.0852	$56.59	$20.94	$11.32
92516	X		Facial nerve function test	0660	1.5891	$82.87	$30.66	$16.57
92520	X		Laryngeal function studies	0660	1.5891	$82.87	$30.66	$16.57
92525	A	DG	Oral function evaluation					
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92542	X		Positional nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92543	X		Caloric vestibular test	0660	1.5891	$82.87	$30.66	$16.57
92544	X		Optokinetic nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92545	X		Oscillating tracking test	0363	1.0852	$56.59	$20.94	$11.32
92546	X		Sinusoidal rotational test	0660	1.5891	$82.87	$30.66	$16.57
92547	X		Supplemental electrical test	0363	1.0852	$56.59	$20.94	$11.32
92548	X		Posturography	0660	1.5891	$82.87	$30.66	$16.57
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4457	$23.24	$9.06	$4.65
92553	X		Audiometry, air & bone	0365	1.2112	$63.17	$18.95	$12.63
92555	X		Speech threshold audiometry	0364	0.4457	$23.24	$9.06	$4.65
92556	X		Speech audiometry, complete	0364	0.4457	$23.24	$9.06	$4.65
92557	X		Comprehensive hearing test	0365	1.2112	$63.17	$18.95	$12.63
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					
92561	X		Bekesy audiometry, diagnosis	0365	1.2112	$63.17	$18.95	$12.63
92562	X		Loudness balance test	0364	0.4457	$23.24	$9.06	$4.65
92563	X		Tone decay hearing test	0364	0.4457	$23.24	$9.06	$4.65
92564	X		Sisi hearing test	0364	0.4457	$23.24	$9.06	$4.65
92565	X		Stenger test, pure tone	0364	0.4457	$23.24	$9.06	$4.65
92567	X		Tympanometry	0364	0.4457	$23.24	$9.06	$4.65
92568	X		Acoustic reflex testing	0364	0.4457	$23.24	$9.06	$4.65
92569	X		Acoustic reflex decay test	0364	0.4457	$23.24	$9.06	$4.65
92571	X		Filtered speech hearing test	0364	0.4457	$23.24	$9.06	$4.65
92572	X		Staggered spondaic word test	0364	0.4457	$23.24	$9.06	$4.65
92573	X		Lombard test	0364	0.4457	$23.24	$9.06	$4.65
92575	X		Sensorineural acuity test	0365	1.2112	$63.17	$18.95	$12.63
92576	X		Synthetic sentence test	0364	0.4457	$23.24	$9.06	$4.65
92577	X		Stenger test, speech	0365	1.2112	$63.17	$18.95	$12.63
92579	X		Visual audiometry (vra)	0365	1.2112	$63.17	$18.95	$12.63
92582	X		Conditioning play audiometry	0365	1.2112	$63.17	$18.95	$12.63

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92583	X		Select picture audiometry	0364	0.4457	$23.24	$9.06	$4.65
92584	X		Electrocochleography	0660	1.5891	$82.87	$30.66	$16.57
92585	S		Auditor evoke potent, compre	0216	2.8972	$151.09	$67.98	$30.22
92586	S		Auditor evoke potent, limit	0218	1.0077	$52.55		$10.51
92587	X		Evoked auditory test	0363	1.0852	$56.59	$20.94	$11.32
92588	X		Evoked auditory test	0660	1.5891	$82.87	$30.66	$16.57
92589	X		Auditory function test(s)	0364	0.4457	$23.24	$9.06	$4.65
92590	E		Hearing aid exam, one ear					
92591	E		Hearing aid exam, both ears					
92592	E		Hearing aid check, one ear					
92593	E		Hearing aid check, both ears					
92594	E		Electro hearng aid test, one					
92595	E		Electro hearng aid tst, both					
92596	X		Ear protector evaluation	0365	1.2112	$63.17	$18.95	$12.63
92597	E		Voice Prosthetic Evaluation					
92598	E	DG	Voice Prosthetic Modification					
92599	X	DG	ENT procedure/service	0364	0.4457	$23.24	$9.06	$4.65
92601	A	NI	Cochlear implt f/up exam < 7					
92602	A	NI	Reprogram cochlear implt < 7					
92603	A	NI	Cochlear implt f/up exam 7 >					
92604	A	NI	Reprogram cochlear implt 7 >					
92605	A	NI	Eval for nonspeech device rx					
92606	A	NI	Non-speech device service					
92607	A	NI	Ex for speech device rx, 1hr					
92608	A	NI	Ex for speech device rx addl					
92609	A	NI	Use of speech device service					
92610	A	NI	Evaluate swallowing function					
92611	A	NI	Motion fluoroscopy/swallow					
92612	A	NI	Endoscopy swallow tst (fees)					
92613	E	NI	Endoscopy swallow tst (fees)					
92614	A	NI	Laryngoscopic sensory test					
92615	E	NI	Eval laryngoscopy sense tst					
92616	A	NI	Fees w/laryngeal sense test					
92617	E	NI	Interprt fees/laryngeal test					
92700	X	NI	Ent procedure/service	0364	0.4457	$23.24	$9.06	$4.65
92950	S		Heart/lung resuscitation cpr	0094	3.8371	$200.11	$67.63	$40.02
92953	S		Temporary external pacing	0094	3.8371	$200.11	$67.63	$40.02
92960	S		Cardioversion electric, ext	0679	5.4069	$281.98	$95.30	$56.40
92961	S		Cardioversion, electric, int	0679	5.4069	$281.98	$95.30	$56.40
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	0676	4.1278	$215.27	$58.21	$43.05
92978	S		Intravasc us, heart add-on	0670	30.2416	$1,577.13	$571.17	$315.43
92979	S		Intravasc us, heart add-on	0670	30.2416	$1,577.13	$571.17	$315.43
92980	T		Insert intracoronary stent	0104	76.5486	$3,992.09		$798.42
92981	T		Insert intracoronary stent	0104	76.5486	$3,992.09		$798.42
92982	T		Coronary artery dilation	0083	51.9755	$2,710.57		$542.11
92984	T		Coronary artery dilation	0083	51.9755	$2,710.57		$542.11
92986	T		Revision of aortic valve	0083	51.9755	$2,710.57		$542.11
92987	T		Revision of mitral valve	0083	51.9755	$2,710.57		$542.11
92990	T		Revision of pulmonary valve	0083	51.9755	$2,710.57		$542.11
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	86.4321	$4,507.52	$1,293.59	$901.50
92996	T		Coronary atherectomy add-on	0082	86.4321	$4,507.52	$1,293.59	$901.50
92997	T		Pul art balloon repr, percut	0081	43.5067	$2,268.92		$453.78
92998	T		Pul art balloon repr, percut	0081	43.5067	$2,268.92		$453.78
93000	E		Electrocardiogram, complete					
93005	S		Electrocardiogram, tracing	0099	0.3682	$19.20		$3.84
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	E		Report on transmitted ecg					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93015	E		Cardiovascular stress test					
93016	E		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	1.6085	$83.88	$41.44	$16.78
93018	E		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	1.6085	$83.88	$41.44	$16.78
93025	X		Microvolt t-wave assess	0100	1.6085	$83.88	$41.44	$16.78
93040	E		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3682	$19.20		$3.84
93042	E		Rhythm ECG, report					
93224	E		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93226	X		ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93227	E		ECG monitor/review, 24 hrs					
93230	E		ECG monitor/report, 24 hrs					
93231	X		Ecg monitor/record, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93232	X		ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93233	E		ECG monitor/review, 24 hrs					
93235	E		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93237	E		ECG monitor/review, 24 hrs					
93268	E		ECG record/review					
93270	X		ECG recording	0097	1.0077	$52.55	$23.80	$10.51
93271	X		Ecg/monitoring and analysis	0097	1.0077	$52.55	$23.80	$10.51
93272	E		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3682	$19.20		$3.84
93303	S		Echo transthoracic	0269	3.2170	$167.77	$87.24	$33.55
93304	S		Echo transthoracic	0697	1.5697	$81.86	$42.57	$16.37
93307	S		Echo exam of heart	0269	3.2170	$167.77	$87.24	$33.55
93308	S		Echo exam of heart	0697	1.5697	$81.86	$42.57	$16.37
93312	S		Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93313	S		Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93316	S		Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	5.3003	$276.42	$146.79	$55.28
93320	S		Doppler echo exam, heart	0671	2.3643	$123.30	$64.12	$24.66
93321	S		Doppler echo exam, heart	0697	1.5697	$81.86	$42.57	$16.37
93325	S		Doppler color flow add-on	0697	1.5697	$81.86	$42.57	$16.37
93350	S		Echo transthoracic	0269	3.2170	$167.77	$87.24	$33.55
93501	T		Right heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93503	T		Insert/place heart catheter	0103	11.8408	$617.51	$223.63	$123.50
93505	T		Biopsy of heart lining	0103	11.8408	$617.51	$223.63	$123.50
93508	T		Cath placement, angiography	0080	35.2996	$1,840.91	$838.92	$368.18
93510	T		Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93511	T		Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93514	T		Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93524	T		Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93526	T		Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93527	T		Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93528	T		Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93529	T		Rt, lt heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93530	T		Rt heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93531	T		R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93532	T		R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93533	T		R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	N		Heart flow reserve measure					
93572	N		Heart flow reserve measure					
93580	T	NI	Transcath closure of asd	0981		$2,250.00		$450.00
93581	T	NI	Transcath closure of vsd	0981		$2,250.00		$450.00
93600	T		Bundle of His recording	0087	39.3983	$2,054.66		$410.93
93602	T		Intra-atrial recording	0087	39.3983	$2,054.66		$410.93
93603	T		Right ventricular recording	0087	39.3983	$2,054.66		$410.93
93609	T		Map tachycardia, add-on	0087	39.3983	$2,054.66		$410.93
93610	T		Intra-atrial pacing	0087	39.3983	$2,054.66		$410.93
93612	T		Intraventricular pacing	0087	39.3983	$2,054.66		$410.93
93613	T		Electrophys map 3d, add-on	0087	39.3983	$2,054.66		$410.93
93615	T		Esophageal recording	0087	39.3983	$2,054.66		$410.93
93616	T		Esophageal recording	0087	39.3983	$2,054.66		$410.93
93618	T		Heart rhythm pacing	0087	39.3983	$2,054.66		$410.93
93619	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93620	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93621	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93622	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93623	T		Stimulation, pacing heart	0087	39.3983	$2,054.66		$410.93
93624	S		Electrophysiologic study	0084	9.3312	$486.63		$97.33
93631	T		Heart pacing, mapping	0087	39.3983	$2,054.66		$410.93
93640	S		Evaluation heart device	0084	9.3312	$486.63		$97.33
93641	S		Electrophysiology evaluation	0084	9.3312	$486.63		$97.33
93642	S		Electrophysiology evaluation	0084	9.3312	$486.63		$97.33
93650	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93651	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93652	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93660	S		Tilt table evaluation	0101	4.2247	$220.32	$105.27	$44.06
93662	S		Intracardiac ecg (ice)	0670	30.2416	$1,577.13	$571.17	$315.43
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3682	$19.20		$3.84
93720	E		Total body plethysmography					
93721	X		Plethysmography tracing	0368	1.0562	$55.08	$27.55	$11.02
93722	E		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93727	S		Analyze ilr system	0690	0.4263	$22.23	$10.63	$4.45
93731	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93732	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93733	S		Telephone analy, pacemaker	0690	0.4263	$22.23	$10.63	$4.45
93734	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93735	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93736	S		Telephone analy, pacemaker	0690	0.4263	$22.23	$10.63	$4.45
93740	X		Temperature gradient studies	0367	0.5814	$30.32	$15.16	$6.06
93741	S		Analyze ht pace device sngl	0689	0.5814	$30.32		$6.06
93742	S		Analyze ht pace device sngl	0689	0.5814	$30.32		$6.06
93743	S		Analyze ht pace device dual	0689	0.5814	$30.32		$6.06
93744	S		Analyze ht pace device dual	0689	0.5814	$30.32		$6.06
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0077	$52.55	$23.80	$10.51
93788	E		Ambulatory BP analysis					
93790	E		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.6105	$31.84	$16.73	$6.37
93798	S		Cardiac rehab/monitor	0095	0.6105	$31.84	$16.73	$6.37
93799	S		Cardiovascular procedure	0096	1.7054	$88.94	$48.15	$17.79
93875	S		Extracranial study	0096	1.7054	$88.94	$48.15	$17.79
93880	S		Extracranial study	0267	2.4418	$127.34	$65.52	$25.47
93882	S		Extracranial study	0267	2.4418	$127.34	$65.52	$25.47
93886	S		Intracranial study	0267	2.4418	$127.34	$65.52	$25.47
93888	S		Intracranial study	0266	1.5988	$83.38	$45.86	$16.68
93922	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93923	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93924	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93925	S		Lower extremity study	0267	2.4418	$127.34	$65.52	$25.47
93926	S		Lower extremity study	0267	2.4418	$127.34	$65.52	$25.47
93930	S		Upper extremity study	0267	2.4418	$127.34	$65.52	$25.47
93931	S		Upper extremity study	0266	1.5988	$83.38	$45.86	$16.68
93965	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93970	S		Extremity study	0267	2.4418	$127.34	$65.52	$25.47
93971	S		Extremity study	0267	2.4418	$127.34	$65.52	$25.47
93975	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93976	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93978	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93979	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93980	S		Penile vascular study	0267	2.4418	$127.34	$65.52	$25.47
93981	S		Penile vascular study	0267	2.4418	$127.34	$65.52	$25.47
93990	S		Doppler flow testing	0267	2.4418	$127.34	$65.52	$25.47
94010	X		Breathing capacity test	0368	1.0562	$55.08	$27.55	$11.02
94014	X		Patient recorded spirometry	0367	0.5814	$30.32	$15.16	$6.06
94015	X		Patient recorded spirometry	0367	0.5814	$30.32	$15.16	$6.06
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	1.0562	$55.08	$27.55	$11.02
94070	X		Evaluation of wheezing	0369	2.5871	$134.92	$44.18	$26.98
94150	X		Vital capacity test	0367	0.5814	$30.32	$15.16	$6.06
94200	X		Lung function test (MBC/MVV)	0367	0.5814	$30.32	$15.16	$6.06
94240	X		Residual lung capacity	0368	1.0562	$55.08	$27.55	$11.02
94250	X		Expired gas collection	0367	0.5814	$30.32	$15.16	$6.06
94260	X		Thoracic gas volume	0368	1.0562	$55.08	$27.55	$11.02
94350	X		Lung nitrogen washout curve	0368	1.0562	$55.08	$27.55	$11.02
94360	X		Measure airflow resistance	0367	0.5814	$30.32	$15.16	$6.06
94370	X		Breath airway closing volume	0367	0.5814	$30.32	$15.16	$6.06
94375	X		Respiratory flow volume loop	0367	0.5814	$30.32	$15.16	$6.06
94400	X		CO2 breathing response curve	0367	0.5814	$30.32	$15.16	$6.06
94450	X		Hypoxia response curve	0367	0.5814	$30.32	$15.16	$6.06
94620	X		Pulmonary stress test/simple	0368	1.0562	$55.08	$27.55	$11.02
94621	X		Pulm stress test/complex	0369	2.5871	$134.92	$44.18	$26.98
94640	S		Airway inhalation treatment	0077	0.2907	$15.16	$8.34	$3.03
94642	S		Aerosol inhalation treatment	0078	0.6492	$33.86	$14.55	$6.77
94650	S	DG	Pressure breathing (IPPB)	0077	0.2907	$15.16	$8.34	$3.03
94651	S	DG	Pressure breathing (IPPB)	0077	0.2907	$15.16	$8.34	$3.03
94652	C	DG	Pressure breathing (IPPB)					
94656	S		Initial ventilator mgmt	0079	1.6376	$85.40		$17.08
94657	S		Continued ventilator mgmt	0079	1.6376	$85.40		$17.08
94660	S		Pos airway pressure, CPAP	0068	2.0736	$108.14	$59.48	$21.63
94662	S		Neg press ventilation, cnp	0079	1.6376	$85.40		$17.08
94664	S		Aerosol or vapor inhalations	0077	0.2907	$15.16	$8.34	$3.03
94665	S	DG	Aerosol or vapor inhalations	0077	0.2907	$15.16	$8.34	$3.03
94667	S		Chest wall manipulation	0077	0.2907	$15.16	$8.34	$3.03
94668	S		Chest wall manipulation	0077	0.2907	$15.16	$8.34	$3.03
94680	X		Exhaled air analysis, o2	0367	0.5814	$30.32	$15.16	$6.06
94681	X		Exhaled air analysis, o2/co2	0368	1.0562	$55.08	$27.55	$11.02
94690	X		Exhaled air analysis	0367	0.5814	$30.32	$15.16	$6.06
94720	X		Monoxide diffusing capacity	0368	1.0562	$55.08	$27.55	$11.02
94725	X		Membrane diffusion capacity	0368	1.0562	$55.08	$27.55	$11.02
94750	X		Pulmonary compliance study	0367	0.5814	$30.32	$15.16	$6.06
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	0.5814	$30.32	$15.16	$6.06
94772	X		Breath recording, infant	0369	2.5871	$134.92	$44.18	$26.98
94799	X		Pulmonary service/procedure	0367	0.5814	$30.32	$15.16	$6.06
95004	X		Percut allergy skin tests	0370	0.7752	$40.43	$11.58	$8.09
95010	X		Percut allergy titrate test	0370	0.7752	$40.43	$11.58	$8.09
95015	X		Id allergy titrate-drug/bug	0370	0.7752	$40.43	$11.58	$8.09
95024	X		Id allergy test, drug/bug	0370	0.7752	$40.43	$11.58	$8.09
95027	X		Skin end point titration	0370	0.7752	$40.43	$11.58	$8.09

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95028	X		Id allergy test-delayed type	0370	0.7752	$40.43	$11.58	$8.09
95044	X		Allergy patch tests	0370	0.7752	$40.43	$11.58	$8.09
95052	X		Photo patch test	0370	0.7752	$40.43	$11.58	$8.09
95056	X		Photosensitivity tests	0370	0.7752	$40.43	$11.58	$8.09
95060	X		Eye allergy tests	0370	0.7752	$40.43	$11.58	$8.09
95065	X		Nose allergy test	0370	0.7752	$40.43	$11.58	$8.09
95070	X		Bronchial allergy tests	0369	2.5871	$134.92	$44.18	$26.98
95071	X		Bronchial allergy tests	0369	2.5871	$134.92	$44.18	$26.98
95075	X		Ingestion challenge test	0361	3.3914	$176.86	$83.23	$35.37
95078	X		Provocative testing	0370	0.7752	$40.43	$11.58	$8.09
95115	X		Immunotherapy, one injection	0352	0.2229	$11.62		$2.32
95117	X		Immunotherapy injections	0353	0.3973	$20.72		$4.14
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	0.5039	$26.28		$5.26
95145	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95146	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95147	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95148	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95149	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95165	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95170	X		Antigen therapy services	0371	0.5039	$26.28		$5.26
95180	X		Rapid desensitization	0370	0.7752	$40.43	$11.58	$8.09
95199	X		Allergy immunology services	0370	0.7752	$40.43	$11.58	$8.09
95250	T		Glucose monitoring, cont	0972		$150.00		$30.00
95805	S		Multiple sleep latency test	0209	11.3369	$591.23	$280.58	$118.25
95806	S		Sleep study, unattended	0213	3.2557	$169.79	$70.41	$33.96
95807	S		Sleep study, attended	0209	11.3369	$591.23	$280.58	$118.25
95808	S		Polysomnography, 1-3	0209	11.3369	$591.23	$280.58	$118.25
95810	S		Polysomnography, 4 or more	0209	11.3369	$591.23	$280.58	$118.25
95811	S		Polysomnography w/cpap	0209	11.3369	$591.23	$280.58	$118.25
95812	S		Electroencephalogram (EEG)	0213	3.2557	$169.79	$70.41	$33.96
95813	S		Eeg, over 1 hour	0213	3.2557	$169.79	$70.41	$33.96
95816	S		Electroencephalogram (EEG)	0214	2.2286	$116.22	$58.12	$23.24
95819	S		Electroencephalogram (EEG)	0214	2.2286	$116.22	$58.12	$23.24
95822	S		Sleep electroencephalogram	0214	2.2286	$116.22	$58.12	$23.24
95824	S		Eeg, cerebral death only	0214	2.2286	$116.22	$58.12	$23.24
95827	S		Night electroencephalogram	0209	11.3369	$591.23	$280.58	$118.25
95829	S		Surgery electrocorticogram	0214	2.2286	$116.22	$58.12	$23.24
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	1.0077	$52.55		$10.51
95858	S		Tensilon test & myogram	0218	1.0077	$52.55		$10.51
95860	S		Muscle test, one limb	0218	1.0077	$52.55		$10.51
95861	S		Muscle test, 2 limbs	0218	1.0077	$52.55		$10.51
95863	S		Muscle test, 3 limbs	0218	1.0077	$52.55		$10.51
95864	S		Muscle test, 4 limbs	0218	1.0077	$52.55		$10.51
95867	S		Muscle test, head or neck	0218	1.0077	$52.55		$10.51
95868	S		Muscle test cran nerve bilat	0218	1.0077	$52.55		$10.51
95869	S		Muscle test, thor paraspinal	0215	0.5814	$30.32	$15.76	$6.06
95870	S		Muscle test, nonparaspinal	0218	1.0077	$52.55		$10.51
95872	S		Muscle test, one fiber	0218	1.0077	$52.55		$10.51
95875	S		Limb exercise test	0215	0.5814	$30.32	$15.76	$6.06
95900	S		Motor nerve conduction test	0218	1.0077	$52.55		$10.51
95903	S		Motor nerve conduction test	0218	1.0077	$52.55		$10.51

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95904	S		Sense nerve conduction test	0215	0.5814	$30.32	$15.76	$6.06
95920	S		Intraop nerve test add-on	0216	2.8972	$151.09	$67.98	$30.22
95921	S		Autonomic nerv function test	0218	1.0077	$52.55		$10.51
95922	S		Autonomic nerv function test	0218	1.0077	$52.55		$10.51
95923	S		Autonomic nerv function test	0215	0.5814	$30.32	$15.76	$6.06
95925	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95926	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95927	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95930	S		Visual evoked potential test	0218	1.0077	$52.55		$10.51
95933	S		Blink reflex test	0215	0.5814	$30.32	$15.76	$6.06
95934	S		H-reflex test	0215	0.5814	$30.32	$15.76	$6.06
95936	S		H-reflex test	0215	0.5814	$30.32	$15.76	$6.06
95937	S		Neuromuscular junction test	0218	1.0077	$52.55		$10.51
95950	S		Ambulatory eeg monitoring	0213	3.2557	$169.79	$70.41	$33.96
95951	S		EEG monitoring/videorecord	0209	11.3369	$591.23	$280.58	$118.25
95953	S		EEG monitoring/computer	0209	11.3369	$591.23	$280.58	$118.25
95954	S		EEG monitoring/giving drugs	0214	2.2286	$116.22	$58.12	$23.24
95955	S		EEG during surgery	0214	2.2286	$116.22	$58.12	$23.24
95956	S		Eeg monitoring, cable/radio	0214	2.2286	$116.22	$58.12	$23.24
95957	S		EEG digital analysis	0214	2.2286	$116.22	$58.12	$23.24
95958	S		EEG monitoring/function test	0213	3.2557	$169.79	$70.41	$33.96
95961	S		Electrode stimulation, brain	0216	2.8972	$151.09	$67.98	$30.22
95962	S		Electrode stim, brain add-on	0216	2.8972	$151.09	$67.98	$30.22
95965	S		Meg, spontaneous	0717		$2,250.00		$450.00
95966	S		Meg, evoked, single	0714		$1,375.00		$275.00
95967	S		Meg, evoked, each addl	0712		$875.00		$175.00
95970	S		Analyze neurostim, no prog	0692	6.2595	$326.44	$179.54	$65.29
95971	S		Analyze neurostim, simple	0692	6.2595	$326.44	$179.54	$65.29
95972	S		Analyze neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95973	S		Analyze neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95974	S		Cranial neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95975	S		Cranial neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95990	T	NI	Spin/brain pump refil & main	0125	2.0639	$107.63		$21.53
95999	S		Neurological procedure	0215	0.5814	$30.32	$15.76	$6.06
96000	S		Motion analysis, video/3d	0708		$150.00		$30.00
96001	S		Motion test w/ft press meas	0708		$150.00		$30.00
96002	S		Dynamic surface emg	0708		$150.00		$30.00
96003	S		Dynamic fine wire emg	0708		$150.00		$30.00
96004	E		Phys review of motion tests					
96100	X		Psychological testing	0373	2.2577	$117.74		$23.55
96105	X		Assessment of aphasia	0373	2.2577	$117.74		$23.55
96110	X		Developmental test, lim	0373	2.2577	$117.74		$23.55
96111	X		Developmental test, extend	0373	2.2577	$117.74		$23.55
96115	X		Neurobehavior status exam	0373	2.2577	$117.74		$23.55
96117	X		Neuropsych test battery	0373	2.2577	$117.74		$23.55
96150	S		Assess lth/behave, init	0322	1.3275	$69.23	$12.40	$13.85
96151	S		Assess hlth/behave, subseq	0322	1.3275	$69.23	$12.40	$13.85
96152	S		Intervene hlth/behave, indiv	0322	1.3275	$69.23	$12.40	$13.85
96153	S		Intervene hlth/behave, group	0322	1.3275	$69.23	$12.40	$13.85
96154	S		Interv hlth/behav, fam w/pt	0322	1.3275	$69.23	$12.40	$13.85
96155	S		Interv hlth/behav fam no pt	0322	1.3275	$69.23	$12.40	$13.85
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96520	T		Port pump refill & main	0125	2.0639	$107.63		$21.53
96530	T		Pump refilling, maintenance	0125	2.0639	$107.63		$21.53
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	0.3779	$19.71	$7.09	$3.94
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.3779	$19.71	$7.09	$3.94
96912	S		Photochemotherapy with UV-A	0001	0.3779	$19.71	$7.09	$3.94
96913	S		Photochemotherapy, UV-A or B	0683	1.8992	$99.05	$35.65	$19.81
96920	T	NI	Laser tx, skin < 250 sq cm	0012	0.7849	$40.93	$11.18	$8.19
96921	T	NI	Laser tx, skin 250-500 sq cm	0012	0.7849	$40.93	$11.18	$8.19
96922	T	NI	Laser tx, skin > 500 sq cm	0013	1.0756	$56.09	$14.20	$11.22
96999	T		Dermatological procedure	0010	0.6589	$34.36	$10.08	$6.87
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
97003	A		Ot evaluation					
97004	A		Ot re-evaluation					
97005	E		Athletic train eval					
97006	E		Athletic train reeval					
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	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(s) care, selective					
97602	N		Wound(s) 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
98925	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98926	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98927	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98928	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98929	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98940	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
98941	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
98942	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
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					
99026	E	NI	In-hospital on call service					
99027	E	NI	Out-of-hosp on call service					
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					
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	0.2035	$10.61	$3.08	$2.12
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	0.5329	$27.79	$10.09	$5.56
99199	E		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.8430	$43.96		$8.79
99202	V		Office/outpatient visit, new	0600	0.8430	$43.96		$8.79
99203	V		Office/outpatient visit, new	0601	0.9690	$50.53		$10.11
99204	V		Office/outpatient visit, new	0602	1.4631	$76.30		$15.26
99205	V		Office/outpatient visit, new	0602	1.4631	$76.30		$15.26
99211	V		Office/outpatient visit, est	0600	0.8430	$43.96		$8.79
99212	V		Office/outpatient visit, est	0600	0.8430	$43.96		$8.79
99213	V		Office/outpatient visit, est	0601	0.9690	$50.53		$10.11
99214	V		Office/outpatient visit, est	0602	1.4631	$76.30		$15.26
99215	V		Office/outpatient visit, est	0602	1.4631	$76.30		$15.26
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.8430	$43.96		$8.79
99242	V		Office consultation	0600	0.8430	$43.96		$8.79
99243	V		Office consultation	0601	0.9690	$50.53		$10.11
99244	V		Office consultation	0602	1.4631	$76.30		$15.26
99245	V		Office consultation	0602	1.4631	$76.30		$15.26
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	0.8430	$43.96		$8.79
99272	V		Confirmatory consultation	0600	0.8430	$43.96		$8.79
99273	V		Confirmatory consultation	0601	0.9690	$50.53		$10.11
99274	V		Confirmatory consultation	0602	1.4631	$76.30		$15.26
99275	V		Confirmatory consultation	0602	1.4631	$76.30		$15.26
99281	V		Emergency dept visit	0610	1.4147	$73.78	$19.57	$14.76
99282	V		Emergency dept visit	0610	1.4147	$73.78	$19.57	$14.76
99283	V		Emergency dept visit	0611	2.5290	$131.89	$36.47	$26.38
99284	V		Emergency dept visit	0612	4.3410	$226.39	$54.14	$45.28
99285	V		Emergency dept visit	0612	4.3410	$226.39	$54.14	$45.28
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	9.9610	$519.48	$150.55	$103.90
99292	N		Critical care, addl 30 min					
99293	C	NI	Ped critical care, initial					
99294	C	NI	Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99297	C	DG	Neonatal critical care					
99298	C		Neonatal critical care					
99299	C	NI	Ic, lbw infant 1500-2500 gm					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	V		Initial care, normal newborn	0600	0.8430	$43.96		$8.79
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	3.8371	$200.11	$67.63	$40.02
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					
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	DG	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	DG	Home visit, nos					
99551	E		Home infus, pain mgmt, iv/sc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
99600	E	NI	Home visit nos					
A0021	E		Outside state ambulance serv					
A0080	E		Noninterest escort in non er					
A0090	E		Interest escort in non er					
A0100	E		Nonemergency transport taxi					
A0110	E		Nonemergency transport bus					
A0120	E		Noner transport mini-bus					
A0130	E		Noner transport wheelch van					
A0140	E		Nonemergency transport air					
A0160	E		Noner transport case worker					
A0170	E		Noner transport parking fees					
A0180	E		Noner transport lodgng recip					
A0190	E		Noner transport meals recip					
A0200	E		Noner transport lodgng escrt					
A0210	E		Noner transport meals escort					
A0225	A		Neonatal emergency transport					
A0380	A		Basic life support mileage					
A0382	A		Basic support routine suppls					
A0384	A		Bls defibrillation supplies					
A0390	A		Advanced life support mileag					
A0392	A		Als defibrillation supplies					
A0394	A		Als IV drug therapy supplies					
A0396	A		Als esophageal intub suppls					
A0398	A		Als routine disposble suppls					
A0420	A		Ambulance waiting 1/2 hr					
A0422	A		Ambulance 02 life sustaining					
A0424	A		Extra ambulance attendant					
A0425	A		Ground mileage					
A0426	A		Als 1					
A0427	A		ALS1-emergency					
A0428	A		bls					
A0429	A		BLS-emergency					
A0430	A		Fixed wing air transport					
A0431	A		Rotary wing air transport					
A0432	A		PI volunteer ambulance co					
A0433	A		als 2					
A0434	A		Specialty care transport					
A0435	A		Fixed wing air mileage					
A0436	A		Rotary wing air mileage					
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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CPT/ HCPCS	Status indicator	Condition	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					
A4266	E	NI	Diaphragm					
A4267	E	NI	Male condom					
A4268	E	NI	Female condom					
A4269	E	NI	Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E	NI	Replacement breastpump tube					
A4282	E	NI	Replacement breastpump adpt					
A4283	E	NI	Replacement breastpump cap					
A4284	E	NI	Replcmnt breast pump shield					
A4285	E	NI	Replcmnt breast pump bottle					
A4286	E	NI	Replcmnt breastpump lok ring					
A4290	E		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		Implantable access syst perc					
A4305	A		Drug delivery system >=50 ML					
A4306	A		Drug delivery system <=5 ML					
A4310	A		Insert tray w/o bag/cath					
A4311	A		Catheter w/o bag 2-way latex					
A4312	A		Cath w/o bag 2-way silicone					
A4313	A		Catheter w/bag 3-way					
A4314	A		Cath w/drainage 2-way latex					
A4315	A		Cath w/drainage 2-way silcne					
A4316	A		Cath w/drainage 3-way					
A4319	A		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					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lubricant for cath insertion					
A4333	A		Urinary cath anchor device					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4347	A		Male external catheter					
A4348	A		Male ext cath extended wear					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4360	A	DG	Adult incontinence garment					
A4361	A		Ostomy face plate					
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	DG	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	DG	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	DG	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					
A4405	A	NI	Nonpectin based ostomy paste					
A4406	A	NI	Pectin based ostomy paste					
A4407	A	NI	Ext wear ost skn barr <=4sq≧					
A4408	A	NI	Ext wear ost skn barr >4sq≧					
A4409	A	NI	Ost skn barr w flng <=4 sq≧					
A4410	A	NI	Ost skn barr w flng >4sq≧					
A4413	A	NI	2 pc drainable ost pouch					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4414	A	NI	Ostomy sknbarr w flng <=4sq≧					
A4415	A	NI	Ostomy skn barr w flng >4sq≧					
A4421	A		Ostomy supply misc					
A4422	A	NI	Ost pouch absorbent material					
A4450	A	NI	Non-waterproof tape					
A4452	A	NI	Waterproof tape					
A4454	A	DG	Tape all types all sizes					
A4455	A		Adhesive remover per ounce					
A4458	E	NI	Reusable enema bag					
A4460	A	DG	Elastic compression bandage					
A4462	A		Abdmnl drssng holder/binder					
A4464	A	DG	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					
A4521	E	NI	Adult size diaper sm each					
A4522	E	NI	Adult size diaper med each					
A4523	E	NI	Adult size diaper lg each					
A4524	E	NI	Adult size diaper xl each					
A4525	E	NI	Adult size brief sm each					
A4526	E	NI	Adult size brief med each					
A4527	E	NI	Adult size brief lg each					
A4528	E	NI	Adult size brief xl each					
A4529	E	NI	Child size diaper sm/med ea					
A4530	E	NI	Child size diaper lg each					
A4531	E	NI	Child size brief sm/med each					
A4532	E	NI	Child size brief lg each					
A4533	E	NI	Youth size diaper each					
A4534	E	NI	Youth size brief each					
A4535	E	NI	Disp incont liner/shield ea					
A4536	E	NI	Prot underwr wshbl any sz ea					
A4537	E	NI	Under pad reusable any sz ea					
A4538	E	NI	Diaper sv ea reusable diaper					
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	DG	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					
A4606	A	NI	Oxygen probe used w oximeter					
A4608	A		Transtracheal oxygen cath					
A4609	A	NI	Trach suction cath clsed sys					
A4610	A	NI	Trach sctn cath 72h clsedsys					
A4611	A		Heavy duty battery					
A4612	A		Battery cables					
A4613	A		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	A		Cannula nasal					
A4616	A		Tubing (oxygen) per foot					
A4617	A		Mouth piece					
A4618	A		Breathing circuits					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A4632	A	NI	Infus pump rplcemnt battery					
A4633	A	NI	Uvl replacement bulb					
A4634	A	NI	Replacement bulb th lightbox					
A4635	A		Underarm crutch pad					
A4636	A		Handgrip for cane etc					
A4637	A		Repl tip cane/crutch/walker					
A4639	A	NI	Infrared ht sys replcmnt pad					
A4640	A		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	N		Satumomab pendetide per dose					
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					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A	NI	PD catheter anchor belt					
A4656	A		Dialysis needle					
A4657	A		Dialysis syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
A4706	A		Bicarbonate conc sol per gal					
A4707	A		Bicarbonate conc pow per pac					
A4708	A		Acetate conc sol per gallon					
A4709	A		Acid conc sol per gallon					
A4712	A		Sterile water inj per 10 ml					
A4714	A		Treated water per gallon					
A4719	A		≧Y set≧ tubing					
A4720	A		Dialysat sol fld vol > 249cc					
A4721	A		Dialysat sol fld vol > 999cc					
A4722	A		Dialys sol fld vol > 1999cc					
A4723	A		Dialys sol fld vol > 2999cc					
A4724	A		Dialys sol fld vol > 3999cc					
A4725	A		Dialys sol fld vol > 4999cc					
A4726	A		Dialys sol fld vol > 5999cc					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4801	A	DG	Heparin per 1000 units					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A	NI	Sterile, gloves per pair					
A4931	A	NI	Reusable oral thermometer					
A4932	E	NI	Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		Drnble ostomy pouch w/o barr					
A5063	A		Drain ostomy pouch w/flange					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
A5081	A		Continent stoma plug					
A5082	A		Continent stoma catheter					
A5093	A		Ostomy accessory convex inse					
A5102	A		Bedside drain btl w/wo tube					
A5105	A		Urinary suspensory					
A5112	A		Urinary leg bag					
A5113	A		Latex leg strap					
A5114	A		Foam/fabric leg strap					
A5119	A		Skin barrier wipes box pr 50					
A5121	A		Solid skin barrier 6x6					
A5122	A		Solid skin barrier 8x8					
A5123	A	DG	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					
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	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A	NI	Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					
A6208	A		Contact layer > 48 sq in					
A6209	A		Foam drsg <=16 sq in w/o bdr					
A6210	A		Foam drg >16<=48 sq in w/o b					
A6211	A		Foam drg > 48 sq in w/o brdr					
A6212	A		Foam drg <=16 sq in w/border					
A6213	A		Foam drg >16<=48 sq in w/bdr					
A6214	A		Foam drg > 48 sq in w/border					
A6215	A		Foam dressing wound filler					
A6216	A		Non-sterile gauze<=16 sq in					
A6217	A		Non-sterile gauze>16<=48 sq					
A6218	A		Non-sterile gauze > 48 sq in					
A6219	A		Gauze <= 16 sq in w/border					
A6220	A		Gauze >16 <=48 sq in w/bordr					
A6221	A		Gauze > 48 sq in w/border					
A6222	A		Gauze <=16 in no w/sal w/o b					
A6223	A		Gauze >16<=48 no w/sal w/o b					
A6224	A		Gauze > 48 in no w/sal w/o b					
A6228	A		Gauze <= 16 sq in water/sal					
A6229	A		Gauze >16<=48 sq in watr/sal					
A6230	A		Gauze > 48 sq in water/salne					
A6231	A		Hydrogel dsg<=16 sq in					
A6232	A		Hydrogel dsg>16<=48 sq in					
A6233	A		Hydrogel dressing >48 sq in					
A6234	A		Hydrocolld drg <=16 w/o bdr					
A6235	A		Hydrocolld drg >16<=48 w/o b					
A6236	A		Hydrocolld drg > 48 in w/o b					
A6237	A		Hydrocolld drg <=16 in w/bdr					
A6238	A		Hydrocolld drg >16<=48 w/bdr					
A6239	A		Hydrocolld drg > 48 in w/bdr					
A6240	A		Hydrocolld drg filler paste					
A6241	A		Hydrocolloid drg filler dry					
A6242	A		Hydrogel drg <=16 in w/o bdr					
A6243	A		Hydrogel drg >16<=48 w/o bdr					
A6244	A		Hydrogel drg >48 in w/o bdr					
A6245	A		Hydrogel drg <= 16 in w/bdr					
A6246	A		Hydrogel drg >16<=48 in w/b					
A6247	A		Hydrogel drg > 48 sq in w/b					
A6248	A		Hydrogel drsg gel filler					
A6250	A		Skin seal protect moisturizr					
A6251	A		Absorpt drg <=16 sq in w/o b					
A6252	A		Absorpt drg >16 <=48 w/o bdr					
A6253	A		Absorpt drg > 48 sq in w/o b					
A6254	A		Absorpt drg <=16 sq in w/bdr					
A6255	A		Absorpt drg >16<=48 in w/bdr					
A6256	A		Absorpt drg > 48 sq in w/bdr					
A6257	A		Transparent film <= 16 sq in					
A6258	A		Transparent film >16<=48 in					
A6259	A		Transparent film > 48 sq in					
A6260	A		Wound cleanser any type/size					
A6261	A		Wound filler gel/paste /oz					
A6262	A		Wound filler dry form / gram					
A6263	A	DG	Non-sterile elastic gauze/yd					
A6264	A	DG	Non-sterile no elastic gauze					
A6265	A	DG	Tape per 18 sq inches					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6405	A	DG	Sterile elastic gauze /yd					
A6406	A	DG	Sterile non-elastic gauze/yd					
A6410	A	NI	Sterile eye pad					
A6411	A	NI	Non-sterile eye pad					
A6412	E	NI	Occlusive eye patch					
A6421	A	NI	Pad bandage >=3 <5in w /roll					
A6422	A	NI	Conf bandage ns >=3<5≧w/roll					
A6424	A	NI	Conf bandage ns >=5≧w /roll					
A6426	A	NI	Conf bandage s >=3<5≧ w/roll					
A6428	A	NI	Conf bandage s >=5≧ w /roll					
A6430	A	NI	Lt compres bdg >=3<5≧w /roll					
A6432	A	NI	Lt compres bdg >=5≧w /roll					
A6434	A	NI	Mo compres bdg >=3<5≧w /roll					
A6436	A	NI	Hi compres bdg >=3<5≧w /roll					
A6438	A	NI	Self-adher bdg >=3<5≧w /roll					
A6440	A	NI	Zinc paste bdg >=3<5≧w /roll					
A6501	A	NI	Compres burngarment bodysuit					
A6502	A	NI	Compres burngarment chinstrp					
A6503	A	NI	Compres burngarment facehood					
A6504	A	NI	Cmprsburngarment glove-wrist					
A6505	A	NI	Cmprsburngarment glove-elbow					
A6506	A	NI	Cmprsburngrmnt glove-axilla					
A6507	A	NI	Cmprs burngarment foot-knee					
A6508	A	NI	Cmprs burngarment foot-thigh					
A6509	A	NI	Compres burn garment jacket					
A6510	A	NI	Compres burn garment leotard					
A6511	A	NI	Compres burn garment panty					
A6512	A	NI	Compres burn garment, noc					
A7000	A		Disposable canister for pump					
A7001	A		Nondisposable pump canister					
A7002	A		Tubing used w suction pump					
A7003	A		Nebulizer administration set					
A7004	A		Disposable nebulizer sml vol					
A7005	A		Nondisposable nebulizer set					
A7006	A		Filtered nebulizer admin set					
A7007	A		Lg vol nebulizer disposable					
A7008	A		Disposable nebulizer prefill					
A7009	A		Nebulizer reservoir bottle					
A7010	A		Disposable corrugated tubing					
A7011	A		Nondispos corrugated tubing					
A7012	A		Nebulizer water collec devic					
A7013	A		Disposable compressor filter					
A7014	A		Compressor nondispos filter					
A7015	A		Aerosol mask used w nebulize					
A7016	A		Nebulizer dome & mouthpiece					
A7017	A		Nebulizer not used w oxygen					
A7018	A		Water distilled w/nebulizer					
A7019	A		Saline solution dispenser					
A7020	A		Sterile H2O or NSS w lgv neb					
A7025	A	NI	Replace chest compress vest					
A7026	A	NI	Replace chst cmprss sys hose					
A7030	A	NI	CPAP full face mask					
A7031	A	NI	Replacement facemask interfa					
A7032	A	NI	Replacement nasal cushion					
A7033	A	NI	Replacement nasal pillows					
A7034	A	NI	Nasal application device					
A7035	A	NI	Pos airway press headgear					
A7036	A	NI	Pos airway press chinstrap					
A7037	A	NI	Pos airway pressure tubing					
A7038	A	NI	Pos airway pressure filter					
A7039	A	NI	Filter, non disposable w pap					
A7042	A	NI	Implanted pleural catheter					
A7043	A	NI	Vacuum drainagebottle/tubing					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7044	A	NI	PAP oral interface					
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					
A9270	E		Non-covered item or service					
A9300	E		Exercise equipment					
A9500	N		Technetium TC 99m sestamibi					
A9502	N		Technetium TC99M tetrofosmin					
A9503	N		Technetium TC 99m medronate					
A9504	N		Technetium tc 99m apcitide					
A9505	N		Thallous chloride TL 201/mci					
A9507	K		Indium/111 capromab pendetid	1604	16.4434	$857.54		$171.51
A9508	K		Iobenguane sulfate I-131	1045	1.5697	$81.86		$16.37
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	5.6006	$292.08		$58.42
A9512	N	NI	Technetium tc99m pertechnetate					
A9513	N	NI	Technetium tc-99m mebrofenin					
A9514	N	NI	Technetium tc99m pyrophosphate					
A9515	N	NI	Technetium tc-99m pentetate					
A9516	N	NI	I-123 sodium iodide capsule					
A9517	N	NI	I-131 sodium iodide capsule					
A9518	K	NI	I-131 sodium iodide solution	1348	0.9399	$49.02		$9.80
A9519	N	NI	Technetium tc-99m macroag albu					
A9520	N	NI	Technetium tc-99m sulfur clld					
A9521	K	NI	Technetium tc-99m exametazine	1096	4.4379	$231.44		$46.29
A9522	E	NI	Indium111ibritumomabtiuxetan					
A9523	E	NI	Yttrium90ibritumomabtiuxetan					
A9524	N	NI	Iodinated I-131 serumalbumin					
A9600	K		Strontium-89 chloride	0701	8.9920	$468.94		$93.79
A9603	N	NI	I-131sodiumiodidecap per mci					
A9605	K		Samarium sm153 lexidronamm	0702	14.6218	$762.54		$152.51
A9699	N	NI	Noc therapeutic radiopharm					
A9700	G		Echocardiography Contrast	9016		$118.75		$17.75
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					
B4086	A		Gastrostomy/jejunostomy tube					
B4100	E	NI	Food thickener oral					
B4150	A		Enteral formulae category i					
B4151	A		Enteral formulae cat1natural					
B4152	A		Enteral formulae category ii					
B4153	A		Enteral formulae categoryIII					
B4154	A		Enteral formulae category IV					
B4155	A		Enteral formulae category v					
B4156	A		Enteral formulae category vi					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4189	A		Parenteral sol amino acid &					
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-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	2.3352	$121.78		$24.36
C1011	K		Platelets, HLA-m, L/R, unit	1011	9.5831	$499.77		$99.95
C1012	K	DG	PLATELET CONC, L/R, Irrad	0954	2.2868	$119.26		$23.85
C1013	K	DG	PLATELET CONC, L/R, Unit	1013	0.9496	$49.52		$9.90
C1014	K	DG	Platelet,Aph/Pher, L/R, unit	9501	7.8390	$408.81		$81.76
C1015	K	NI	Plt, pher,L/R,CMV, irrad	1020	9.4959	$495.22		$99.04
C1016	K		BLOOD,L/R,FROZ/DEGLY/Washed	1016	5.7848	$301.68		$60.34
C1017	K		Plt, APH/PHER,L/R,CMV-NEG	1017	7.5386	$393.15		$78.63
C1018	K		Blood, L/R, IRRADIATED	1018	2.5387	$132.40		$26.48
C1020	K	NI	RBC, frz/deg/wsh, L/R, irrad	1021	6.4436	$336.04		$67.21
C1021	K	NI	RBC, L/R, CMV neg, irrad	1022	3.8565	$201.12		$40.22
C1022	K	NI	Plasma, frz within 24 hour	0955	1.8217	$95.00		$19.00
C1058	N	DG	TC 99M oxidronate, per vial					
C1064	N	DG	I-131 cap, each add mCi					
C1065	N	DG	I-131 sol, each add mCi					
C1066	N	DG	IN 111 satumomab pendetide					
C1079	N		CO 57/58 per 0.5 uCi					
C1087	N	DG	I-123 per 100 uCi					
C1088	T		LASER OPTIC TR Sys	0980		$1,875.00		$375.00
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	4.7092	$245.59		$49.12
C1092	K		IN 111 pentetate per 0.5 mCi	1092	4.4379	$231.44		$46.29
C1094	N	DG	TC99Malbumin aggr,per 1.0mCi					
C1096	K	DG	TC 99M EXAMETAZIME, PER Dose	1096	4.4379	$231.44		$46.29
C1097	N	DG	TC 99M MEBROFENIN, PER Vial					
C1098	N	DG	TC 99M PENTETATE, PER Vial					
C1099	N	DG	TC 99M PYROPHOSPHATE,PER Via.					
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	11.4726	$598.31		$119.66
C1166	N		CYTARABINE LIPOSOMAL, 10 mg					
C1167	K		EPIRUBICIN HCL, 2 mg	1167	0.3294	$17.18		$3.44
C1178	K		BUSULFAN IV, 6 Mg	1178	0.4845	$25.27		$5.05
C1188	N	DG	I-131 cap, per 1-5 mCi					
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	N		TC 99M SUCCIMER, PER Vial					
C1202	N	DG	TC 99M SULFUR COLLOID, Vial					
C1207	K	DG	OCTREOTIDE ACETATE DEPOT 1mg.	1207	1.4244	$74.28		$14.86
C1300	S		HYPERBARIC Oxygen	0659	3.2364	$168.78		$33.76
C1305	K		Apligraf	1305	13.0520	$680.67		$136.13
C1348	K	DG	I-131 sol, per 1-6 mCi	1348	0.9399	$49.02		$9.80
C1713	D	DNG	Anchor/screw bn/bn,tis/bn					
C1714	D	DNG	Cath, trans atherectomy, dir					
C1715	D	DNG	Brachytherapy needle					
C1716	K		Brachytx seed, Gold 198	1716	0.4360	$22.74		$4.55
C1717	D	DNG	Brachytx seed, HDR Ir-192					
C1718	K		Brachytx seed, Iodine 125	1718	0.6008	$31.33		$6.27
C1719	K		Brachytx seed,Non-HDR Ir-192	1719	0.5232	$27.29		$5.46
C1720	K		Brachytx seed, Palladium 103	1720	0.8430	$43.96		$8.79

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1721	D	DNG	AICD, dual chamber					
C1722	D	DNG	AICD, single chamber					
C1724	D	DNG	Cath, trans atherec,rotation					
C1725	D	DNG	Cath, translumin non-laser					
C1726	D	DNG	Cath, bal dil, non-vascular					
C1727	D	DNG	Cath, bal tis dis, non-vas					
C1728	D	DNG	Cath, brachytx seed adm					
C1729	D	DNG	Cath, drainage					
C1730	D	DNG	Cath, EP, 19 or few elect					
C1731	D	DNG	Cath, EP, 20 or more elec					
C1732	D	DNG	Cath, EP, diag/abl, 3D/vect					
C1733	D	DNG	Cath, EP, othr than cool-tip					
C1750	D	DNG	Cath, hemodialysis,long-term					
C1751	D	DNG	Cath, inf, per/cent/midline					
C1752	D	DNG	Cath,hemodialysis,short-term					
C1753	D	DNG	Cath, intravas ultrasound					
C1754	D	DNG	Catheter, intradiscal					
C1755	D	DNG	Catheter, intraspinal					
C1756	D	DNG	Cath, pacing, transesoph					
C1757	D	DNG	Cath, thrombectomy/embolect					
C1758	D	DNG	Catheter, ureteral					
C1759	D	DNG	Cath, intra echocardiography					
C1760	D	DNG	Closure dev, vasc					
C1762	D	DNG	Conn tiss, human(inc fascia)					
C1763	D	DNG	Conn tiss, non-human					
C1764	D	DNG	Event recorder, cardiac					
C1765	H		Adhesion barrier	1765				
C1766	D	DNG	Intro/sheath,strble,non-peel					
C1767	D	DNG	Generator, neurostim, imp					
C1768	D	DNG	Graft, vascular					
C1769	D	DNG	Guide wire					
C1770	D	DNG	Imaging coil, MR, insertable					
C1771	D	DNG	Rep dev, urinary, w/sling					
C1772	D	DNG	Infusion pump, programmable					
C1773	D	DNG	Ret dev, insertable					
C1774	K		Darbepoetin alfa, 1 mcg	0734	0.0454	$2.37		$.47
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	7.5289	$392.64		$78.53
C1776	D	DNG	Joint device (implantable)					
C1777	D	DNG	Lead, AICD, endo single coil					
C1778	D	DNG	Lead, neurostimulator					
C1779	D	DNG	Lead, pmkr, transvenous VDD					
C1780	D	DNG	Lens, intraocular (new tech)					
C1781	D	DNG	Mesh (implantable)					
C1782	D	DNG	Morcellator					
C1783	H		Ocular imp, aqueous drain dev	1783				
C1784	D	DNG	Ocular dev, intraop, det ret					
C1785	D	DNG	Pmkr, dual, rate-resp					
C1786	D	DNG	Pmkr, single, rate-resp					
C1787	D	DNG	Patient progr, neurostim					
C1788	D	DNG	Port, indwelling, imp					
C1789	D	DNG	Prosthesis, breast, imp					
C1813	D	DNG	Prosthesis, penile, inflatab					
C1815	D	DNG	Pros, urinary sph, imp					
C1816	D	DNG	Receiver/transmitter, neuro					
C1817	D	DNG	Septal defect imp sys					
C1874	D	DNG	Stent, coated/cov w/del sys					
C1875	D	DNG	Stent, coated/cov w/o del sy					
C1876	D	DNG	Stent, non-coa/non-cov w/del					
C1877	D	DNG	Stent, non-coat/cov w/o del					
C1878	D	DNG	Matrl for vocal cord					
C1879	D	DNG	Tissue marker, implantable					
C1880	D	DNG	Vena cava filter					
C1881	D	DNG	Dialysis access system					
C1882	D	DNG	AICD, other than sing/dual					
C1883	D	DNG	Adapt/ext, pacing/neuro lead					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1885	D	DNG	Cath, translumin angio laser					
C1887	D	DNG	Catheter, guiding					
C1888	H		Endovas non-cardiac abl cath	1888				
C1891	D	DNG	Infusion pump,non-prog, perm					
C1892	D	DNG	Intro/sheath,fixed,peel-away					
C1893	D	DNG	Intro/sheath, fixed,non-peel					
C1894	D	DNG	Intro/sheath, non-laser					
C1895	D	DNG	Lead, AICD, endo dual coil					
C1896	D	DNG	Lead, AICD, non sing/dual					
C1897	D	DNG	Lead, neurostim test kit					
C1898	D	DNG	Lead, pmkr, other than trans					
C1899	D	DNG	Lead, pmkr/AICD combination					
C1900	H		Lead coronary venous	1900				
C2614	H	NI	Probe, perc lumb disc	2614				
C2615	D	DNG	Sealant, pulmonary, liquid					
C2616	K		Brachytx seed, Yttrium-90	2616	8.8370	$460.86		$92.17
C2617	D	DNG	Stent, non-cor, tem w/o del					
C2618	H		Probe, cryoablation	2618				
C2619	D	DNG	Pmkr, dual, non rate-resp					
C2620	D	DNG	Pmkr, single, non rate-resp					
C2621	D	DNG	Pmkr, other than sing/dual					
C2622	D	DNG	Prosthesis, penile, non-inf					
C2625	D	DNG	Stent, non-cor, tem w/del sy					
C2626	D	DNG	Infusion pump, non-prog,temp					
C2627	D	DNG	Cath, suprapubic/cystoscopic					
C2628	D	DNG	Catheter, occlusion					
C2629	D	DNG	Intro/sheath, laser					
C2630	D	DNG	Cath, EP, cool-tip					
C2631	D	DNG	Rep dev, urinary, w/o sling					
C2632	H	NI	Brachytx sol, I-125, per mCi	2632				
C8900	S		MRA w/cont, abd	0284	7.2382	$377.48	$201.02	$75.50
C8901	S		MRA w/o cont, abd	0336	6.5987	$344.13	$176.94	$68.83
C8902	S		MRA w/o fol w/cont, abd	0337	9.2440	$482.08	$240.77	$96.42
C8903	S		MRI w/cont, breast, uni	0284	7.2382	$377.48	$201.02	$75.50
C8904	S		MRI w/o cont, breast, uni	0336	6.5987	$344.13	$176.94	$68.83
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.2440	$482.08	$240.77	$96.42
C8906	S		MRI w/cont, breast, bi	0284	7.2382	$377.48	$201.02	$75.50
C8907	S		MRI w/o cont, breast, bi	0336	6.5987	$344.13	$176.94	$68.83
C8908	S		MRI w/o fol w/cont, breast,	0337	9.2440	$482.08	$240.77	$96.42
C8909	S		MRA w/cont, chest	0284	7.2382	$377.48	$201.02	$75.50
C8910	S		MRA w/o cont, chest	0336	6.5987	$344.13	$176.94	$68.83
C8911	S		MRA w/o fol w/cont, chest	0337	9.2440	$482.08	$240.77	$96.42
C8912	S		MRA w/cont, lwr ext	0284	7.2382	$377.48	$201.02	$75.50
C8913	S		MRA w/o cont, lwr ext	0336	6.5987	$344.13	$176.94	$68.83
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.2440	$482.08	$240.77	$96.42
C9000	K		Na chromateCr51, per 0.25mCi	9000	1.8798	$98.03		$19.61
C9003	K		Palivizumab, per 50 mg	9003	8.5657	$446.71		$89.34
C9007	N		Baclofen Intrathecal kit-1am					
C9008	N		Baclofen Refill Kit-500mcg					
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7267	$37.90		$7.58
C9010	K		Baclofen Refill Kit--4000mcg	9010	0.9205	$48.00		$9.60
C9013	N		Co 57 cobaltous chloride					
C9019	G	DG	Caspofungin acetate, 5 mg	9019		$34.20		$5.11
C9020	K	DG	Sirolimussolution, 1 mg	9020	0.0581	$3.03		$.61
C9100	N	DG	Iodinated I-131 Albumin					
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105	1.5116	$78.83		$15.77
C9108	K	DG	Thyrotropin alfa, 1.1 mg	9108	7.5870	$395.67		$79.13
C9109	K		Tirofiban hcl, 6.25 mg	9109	2.1996	$114.71		$22.94
C9110	G	DG	Alemtuzumab, per 10mg/ml	9110		$511.22		$76.41
C9111	G		Inj, bivalirudin, 250mg vial	9111		$397.81		$56.46
C9112	G		Perflutren lipid micro, 2ml	9112		$4.94		$.74
C9113	G		Inj pantoprazole sodium, via	9113		$22.80		$3.41
C9114	G	DG	Nesiritide, per 1.5 mg vial	9114		$433.20		$64.75

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9115	G	DG	Inj, zoledronic acid, 2 mg	9115		$406.78		$60.80
C9116	G	NI	Ertapenem sodium, per 1 gm	9116		$45.31		$6.77
C9117	E	DG	Y-90 ibritumomab tiuxetan					
C9118	E	DG	IN-111 ibritumomab tiuxetan					
C9119	G	NI	Injection, pegfilgrastim	9119		$2,802.50		$418.90
C9120	G	NI	Injection, fulvestrant	9120		$87.58		$13.09
C9121	G	NI	Injection, argatroban	9121		$14.25		$2.13
C9200	G		Orcel, per 36 cm2	9200		$1,135.25		$169.69
C9201	G		Dermagraft, per 37.5 sq cm	9201		$577.60		$86.34
C9503	K		Fresh frozen plasma, ea unit	9503	1.3372	$69.74		$13.95
C9701	T		Stretta System	0980		$1,875.00		$375.00
C9703	T		Bard Endoscopic Suturing Sys	0979		$1,625.00		$325.00
C9708	T	DG	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	4.7770	$249.13		$49.83
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E	NI	Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	4.7770	$249.13		$49.83
D0250	S		Extraoral first film	0330	4.7770	$249.13		$49.83
D0260	S		Extraoral ea additional film	0330	4.7770	$249.13		$49.83
D0270	S		Dental bitewing single film	0330	4.7770	$249.13		$49.83
D0272	S		Dental bitewings two films	0330	4.7770	$249.13		$49.83
D0274	S		Dental bitewings four films	0330	4.7770	$249.13		$49.83
D0277	S		Vert bitewings-sev to eight	0330	4.7770	$249.13		$49.83
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	4.7770	$249.13		$49.83
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	4.7770	$249.13		$49.83
D0473	S		Micro exam, prep & report	0330	4.7770	$249.13		$49.83
D0474	S		Micro w exam of surg margins	0330	4.7770	$249.13		$49.83
D0480	S		Cytopath smear prep & report	0330	4.7770	$249.13		$49.83
D0501	S	DG	Histopathologic examinations	0330	4.7770	$249.13		$49.83
D0502	S		Other oral pathology procedu	0330	4.7770	$249.13		$49.83
D0999	S		Unspecified diagnostic proce	0330	4.7770	$249.13		$49.83
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	4.7770	$249.13		$49.83
D1515	S		Fixed bilat space maintainer	0330	4.7770	$249.13		$49.83
D1520	S		Remove unilat space maintain	0330	4.7770	$249.13		$49.83
D1525	S		Remove bilat space maintain	0330	4.7770	$249.13		$49.83
D1550	S		Recement space maintainer	0330	4.7770	$249.13		$49.83
D2110	E	DG	Amalgam one surface primary					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2120	E	DG	Amalgam two surfaces primary					
D2130	E	DG	Amalgam three surfaces prima					
D2131	E	DG	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	DG	Composite resin crown					
D2337	E	DG	Compo resin crown ant-perm					
D2380	E	DG	Resin one surf poster primar					
D2381	E	DG	Resin two surf poster primar					
D2382	E	DG	Resin three/more surf post p					
D2385	E	DG	Resin one surf poster perman					
D2386	E	DG	Resin two surf poster perman					
D2387	E	DG	Resin three/more surf post p					
D2388	E	DG	Resin four/more, post perm					
D2390	E	NI	Ant resin-based cmpst crown					
D2391	E	NI	Post 1 srfc resinbased cmpst					
D2392	E	NI	Post 2 srfc resinbased cmpst					
D2393	E	NI	Post 3 srfc resinbased cmpst					
D2394	E	NI	Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					
D2642	E		Dental onlay porcelin 2 surf					
D2643	E		Dental onlay porcelin 3 surf					
D2644	E		Dental onlay porc 4/more sur					
D2650	E		Inlay composite/resin one su					
D2651	E		Inlay composite/resin two su					
D2652	E		Dental inlay resin 3/mre sur					
D2662	E		Dental onlay resin 2 surface					
D2663	E		Dental onlay resin 3 surface					
D2664	E		Dental onlay resin 4/mre sur					
D2710	E		Crown resin laboratory					
D2720	E		Crown resin w/ high noble me					
D2721	E		Crown resin w/ base metal					
D2722	E		Crown resin w/ noble metal					
D2740	E		Crown porcelain/ceramic subs					
D2750	E		Crown porcelain w/ h noble m					
D2751	E		Crown porcelain fused base m					
D2752	E		Crown porcelain w/ noble met					
D2780	E		Crown 3/4 cast hi noble met					
D2781	E		Crown 3/4 cast base metal					
D2782	E		Crown 3/4 cast noble metal					
D2783	E		Crown 3/4 porcelain/ceramic					
D2790	E		Crown full cast high noble m					
D2791	E		Crown full cast base metal					
D2792	E		Crown full cast noble metal					
D2799	E		Provisional crown					
D2910	E		Dental recement inlay					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	4.7770	$249.13		$49.83
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	4.7770	$249.13		$49.83
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	4.7770	$249.13		$49.83
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	4.7770	$249.13		$49.83
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4220	E	DG	Gingival curettage per quadr					
D4240	E		Gingival flap proc w/ planin					
D4241	E	NI	Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	4.7770	$249.13		$49.83
D4261	E	NI	Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	4.7770	$249.13		$49.83
D4264	S		Bone replce graft each add	0330	4.7770	$249.13		$49.83
D4265	E	NI	Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	4.7770	$249.13		$49.83
D4270	S		Pedicle soft tissue graft pr	0330	4.7770	$249.13		$49.83
D4271	S		Free soft tissue graft proc	0330	4.7770	$249.13		$49.83
D4273	S		Subepithelial tissue graft	0330	4.7770	$249.13		$49.83

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4274	E		Distal/proximal wedge proc					
D4275	E	NI	Soft tissue allograft					
D4276	E	NI	Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E	NI	Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	4.7770	$249.13		$49.83
D4381	S		Localized chemo delivery	0330	4.7770	$249.13		$49.83
D4910	E		Periodontal maint procedures					
D4920	E		Unscheduled dressing change					
D4999	E		Unspecified periodontal proc					
D5110	E		Dentures complete maxillary					
D5120	E		Dentures complete mandible					
D5130	E		Dentures immediat maxillary					
D5140	E		Dentures immediat mandible					
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E	NI	Replc tth&acrlc on mtl frmwk					
D5671	E	NI	Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	4.7770	$249.13		$49.83
D5912	S		Facial moulage complete	0330	4.7770	$249.13		$49.83
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	4.7770	$249.13		$49.83
D5984	S		Radiation shield	0330	4.7770	$249.13		$49.83
D5985	S		Radiation cone locator	0330	4.7770	$249.13		$49.83
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	4.7770	$249.13		$49.83
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6020	E		Odontics abutment placement					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E	NI	Implnt/abtmnt spprt remv dnt					
D6054	E	NI	Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					
D6080	E		Implant maintenance					
D6090	E		Repair implant					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
D6253	E	NI	Provisional pontic					
D6519	E	DG	Inlay/onlay porce/ceramic					
D6520	E	DG	Dental retainer two surfaces					
D6530	E	DG	Retainer metallic 3+ surface					
D6543	E	DG	Dental retainr onlay 3 surf					
D6544	E	DG	Dental retainr onlay 4/more					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E	NI	Porcelain/ceramic inlay 2srf					
D6601	E	NI	Porc/ceram inlay >= 3 surfac					
D6602	E	NI	Cst hgh nble mtl inlay 2 srf					
D6603	E	NI	Cst hgh nble mtl inlay >=3sr					
D6604	E	NI	Cst bse mtl inlay 2 surfaces					
D6605	E	NI	Cst bse mtl inlay >= 3 surfa					
D6606	E	NI	Cast noble metal inlay 2 sur					
D6607	E	NI	Cst noble mtl inlay >=3 surf					
D6608	E	NI	Onlay porc/crmc 2 surfaces					
D6609	E	NI	Onlay porc/crmc >=3 surfaces					
D6610	E	NI	Onlay cst hgh nbl mtl 2 srfc					
D6611	E	NI	Onlay cst hgh nbl mtl >=3srf					
D6612	E	NI	Onlay cst base mtl 2 surface					
D6613	E	NI	Onlay cst base mtl >=3 surfa					
D6614	E	NI	Onlay cst nbl mtl 2 surfaces					
D6615	E	NI	Onlay cst nbl mtl >=3 surfac					
D6720	E		Retain crown resin w hi nble					
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E	NI	Provisional retainer crown					
D6920	S		Dental connector bar	0330	4.7770	$249.13		$49.83
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E	NI	Pediatric partial denture fx					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6999	E		Fixed prosthodontic proc					
D7110	S	DG	Oral surgery single tooth	0330	4.7770	$249.13		$49.83
D7111	S	NI	Coronal remnants deciduous t	0330	4.7770	$249.13		$49.83
D7120	S	DG	Each add tooth extraction	0330	4.7770	$249.13		$49.83
D7130	S	DG	Tooth root removal	0330	4.7770	$249.13		$49.83
D7140	S	NI	Extraction erupted tooth/exr	0330	4.7770	$249.13		$49.83
D7210	S		Rem imp tooth w mucoper flp	0330	4.7770	$249.13		$49.83
D7220	S		Impact tooth remov soft tiss	0330	4.7770	$249.13		$49.83
D7230	S		Impact tooth remov part bony	0330	4.7770	$249.13		$49.83
D7240	S		Impact tooth remov comp bony	0330	4.7770	$249.13		$49.83
D7241	S		Impact tooth rem bony w/comp	0330	4.7770	$249.13		$49.83
D7250	S		Tooth root removal	0330	4.7770	$249.13		$49.83
D7260	S		Oral antral fistula closure	0330	4.7770	$249.13		$49.83
D7261	S	NI	Primary closure sinus perf	0330	4.7770	$249.13		$49.83
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	E		Exposure tooth aid eruption					
D7282	E	NI	Mobilize erupted/malpos toot					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E	NI	Cytology sample collection					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	4.7770	$249.13		$49.83
D7310	E		Alveoplasty w/ extraction					
D7320	E		Alveoplasty w/o extraction					
D7340	E		Vestibuloplasty ridge extens					
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E	NI	Excision benign lesion>1.25c					
D7412	E	NI	Excision benign lesion compl					
D7413	E	NI	Excision malig lesion<=1.25c					
D7414	E	NI	Excision malig lesion>1.25cm					
D7415	E	NI	Excision malig les complicat					
D7420	E	DG	Lesion > 1.25 cm					
D7430	E	DG	Exc benign tumor to 1.25 cm					
D7431	E	DG	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					
D7472	E	NI	Removal of torus palatinus					
D7473	E	NI	Remove torus mandibularis					
D7480	E	DG	Partial ostectomy					
D7485	E	NI	Surg reduct osseoustuberosit					
D7490	E		Mandible resection					
D7510	E		I&d absc intraoral soft tiss					
D7520	E		I&d abscess extraoral					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E	NI	Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					

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D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E	NI	Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	4.7770	$249.13		$49.83
D7941	E		Bone cutting ramus closed					
D7943	E		Cutting ramus open w/graft					
D7944	E		Bone cutting segmented					
D7945	E		Bone cutting body mandible					
D7946	E		Reconstruction maxilla total					
D7947	E		Reconstruct maxilla segment					
D7948	E		Reconstruct midface no graft					
D7949	E		Reconstruct midface w/graft					
D7950	E		Mandible graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E	NI	Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E	NI	Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	4.7770	$249.13		$49.83
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	4.7770	$249.13		$49.83
D9940	S		Dental occlusal guard	0330	4.7770	$249.13		$49.83
D9941	E		Fabrication athletic guard					
D9950	S		Occlusion analysis	0330	4.7770	$249.13		$49.83
D9951	S		Limited occlusal adjustment	0330	4.7770	$249.13		$49.83
D9952	S		Complete occlusal adjustment	0330	4.7770	$249.13		$49.83
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					
E0117	A	NI	Underarm springassist crutch					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E0196	A		Gel pressure mattress					
E0197	A		Air pressure pad for mattres					
E0198	A		Water pressure pad for mattr					
E0199	A		Dry pressure pad for mattres					
E0200	A		Heat lamp without stand					
E0202	A		Phototherapy light w/ photom					
E0203	A	NI	Therapeutic lightbox tabletp					
E0205	A		Heat lamp with stand					
E0210	A		Electric heat pad standard					
E0215	A		Electric heat pad moist					
E0217	A		Water circ heat pad w pump					
E0218	E		Water circ cold pad w pump					
E0220	A		Hot water bottle					
E0221	A		Infrared heating pad system					
E0225	A		Hydrocollator unit					
E0230	A		Ice cap or collar					
E0231	E		Wound warming device					
E0232	E		Warming card for NWT					
E0235	A		Paraffin bath unit portable					
E0236	A		Pump for water circulating p					
E0238	A		Heat pad non-electric moist					
E0239	A		Hydrocollator unit portable					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E0305	A		Rails bed side half length					
E0310	A		Rails bed side full length					
E0315	E		Bed accessory brd/tbl/supprt					
E0316	A		Bed safety enclosure					
E0325	A		Urinal male jug-type					
E0326	A		Urinal female jug-type					
E0350	E		Control unit bowel system					
E0352	E		Disposable pack w/bowel syst					
E0370	E		Air elevator for heel					
E0371	A		Nonpower mattress overlay					
E0372	A		Powered air mattress overlay					
E0373	A		Nonpowered pressure mattress					
E0424	A		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	A		Portable gaseous 02					
E0434	A		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	A		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	A		Oxygen contents, gaseous					
E0442	A		Oxygen contents, liquid					
E0443	A		Portable 02 contents, gas					
E0444	A		Portable 02 contents, liquid					
E0445	A	NI	Oximeter non-invasive					
E0450	A		Volume vent stationary/porta					
E0454	A	NI	Pressure ventilator					
E0455	A		Oxygen tent excl croup/ped t					
E0457	A		Chest shell					
E0459	A		Chest wrap					
E0460	A		Neg press vent portabl/statn					
E0461	A	NI	Vol vent noninvasive interfa					
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					
E0483	A	NI	Chest compression gen system					
E0484	A	NI	Non-elec oscillatory pep dvc					
E0500	A		Ippb all types					
E0550	A		Humidif extens supple w ippb					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	A		Vaporizer room type					
E0606	A		Drainage board postural					
E0607	A		Blood glucose monitor home					
E0608	A	DG	Apnea monitor					
E0610	A		Pacemaker monitr audible/vis					
E0615	A		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	A		Automatic ext defibrillator					
E0618	A	NI	Apnea monitor					
E0619	A	NI	Apnea monitor w recorder					
E0620	A		Cap bld skin piercing laser					
E0621	A		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	A		Seat lift incorp lift-chair					
E0628	A		Seat lift for pt furn-electr					
E0629	A		Seat lift for pt furn-non-el					
E0630	A		Patient lift hydraulic					
E0635	A		Patient lift electric					
E0636	A	NI	PT support & positioning sys					
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	DG	Ultraviolet cabinet					
E0691	A	NI	Uvl pnl 2 sq ft or less					
E0692	A	NI	Uvl sys panel 4 ft					
E0693	A	NI	Uvl sys panel 6 ft					
E0694	A	NI	Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	A	NI	Helmet w face guard prefab					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0749	N		Elec osteogen stim implanted					
E0752	E		Neurostimulator electrode					
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					
E0761	E	NI	Nontherm electromgntc device					
E0765	E		Nerve stimulator for tx n&v					
E0776	A		Iv pole					
E0779	A		Amb infusion pump mechanical					
E0780	A		Mech amb infusion pump <8hrs					
E0781	A		External ambulatory infus pu					
E0782	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					
E1011	A	NI	Ped wc modify width adjustm					
E1012	A	NI	Int seat sys planar ped w/c					
E1013	A	NI	Int seat sys contour ped w/c					
E1014	A	NI	Reclining back add ped w/c					
E1015	A	NI	Shock absorber for man w/c					
E1016	A	NI	Shock absorber for power w/c					
E1017	A	NI	HD shck absrbr for hd man wc					
E1018	A	NI	HD shck absrber for hd powwc					
E1020	A	NI	Residual limb support system					
E1025	A	NI	Pedwc lat/thor sup nocontour					
E1026	A	NI	Pedwc contoured lat/thor sup					
E1027	A	NI	Ped wc lat/ant support					
E1031	A		Rollabout chair with casters					
E1035	E		Patient transfer system					
E1037	A	NI	Transport chair, ped size					
E1038	A	NI	Transport chair, adult size					
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					
E1161	A	NI	Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	A		Whlchr moto ful arm leg rest					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E1231	A	NI	Rigid ped w/c tilt-in-space					
E1232	A	NI	Folding ped wc tilt-in-space					
E1233	A	NI	Rig ped wc tltnspc w/o seat					
E1234	A	NI	Fld ped wc tltnspc w/o seat					
E1235	A	NI	Rigid ped wc adjustable					
E1236	A	NI	Folding ped wc adjustable					
E1237	A	NI	Rgd ped wc adjstabl w/o seat					
E1238	A	NI	Fld ped wc adjstabl w/o seat					
E1240	A		Whchr litwt det arm leg rest					
E1250	A		Wheelchair lightwt fixed arm					
E1260	A		Wheelchair lightwt foot rest					
E1270	A		Wheelchair lightweight leg r					
E1280	A		Whchr h-duty det arm leg res					
E1285	A		Wheelchair heavy duty fixed					
E1290	A		Wheelchair hvy duty detach a					
E1295	A		Wheelchair heavy duty fixed					
E1296	A		Wheelchair special seat heig					
E1297	A		Wheelchair special seat dept					
E1298	A		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	A		Whirlpool non-portable					
E1340	A		Repair for DME, per 15 min					
E1353	A		Oxygen supplies regulator					
E1355	A		Oxygen supplies stand/rack					
E1372	A		Oxy suppl heater for nebuliz					
E1390	A		Oxygen concentrator					
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					
E1530	A		Replacement air bubble detec					
E1540	A		Replacement pressure alarm					
E1550	A		Bath conductivity meter					
E1560	A		Replace blood leak detector					
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o puri sys					
E1615	A		Deionizer H2O puri system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1638	A	DG	Peri dialysis heating pad					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	A		Jaw motion rehab system					
E1701	A		Repl cushions for jaw motion					
E1702	A		Repl measr scales jaw motion					
E1800	A		Adjust elbow ext/flex device					
E1801	A		SPS elbow device					
E1802	A	NI	Adjst forearm pro/sup device					
E1805	A		Adjust wrist ext/flex device					
E1806	A		SPS wrist device					
E1810	A		Adjust knee ext/flex device					
E1811	A		SPS knee device					
E1815	A		Adjust ankle ext/flex device					
E1816	A		SPS ankle device					
E1818	A		SPS forearm device					
E1820	A		Soft interface material					
E1821	A		Replacement interface SPSD					
E1825	A		Adjust finger ext/flex devc					
E1830	A		Adjust toe ext/flex device					
E1840	A		Adj shoulder ext/flex device					
E1902	A		AAC non-electronic board					
E2000	A		Gastric suction pump hme mdl					
E2100	A		Bld glucose monitor w voice					
E2101	A		Bld glucose monitor w lance					
G0001	A		Drawing blood for specimen					
G0002	X	DG	Temporary urinary catheter	0340	0.6492	$33.86		$6.77
G0004	E	DG	ECG transm phys review & int					
G0005	X	DG	ECG 24 hour recording	0097	1.0077	$52.55	$23.80	$10.51
G0006	X	DG	ECG transmission & analysis	0097	1.0077	$52.55	$23.80	$10.51
G0007	N	DG	ECG phy review & interpret					
G0008	L		Admin influenza virus vac					
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.2132	$11.12		$2.22
G0015	X	DG	Post symptom ECG tracing	0097	1.0077	$52.55	$23.80	$10.51
G0025	N		Collagen skin test kit					
G0026	A	DG	Fecal leukocyte examination					
G0027	A	DG	Semen analysis					
G0030	S		PET imaging prev PET single	0285	18.1294	$945.47	$409.56	$189.09
G0031	S		PET imaging prev PET multple	0285	18.1294	$945.47	$409.56	$189.09
G0032	S		PET follow SPECT 78464 singl	0285	18.1294	$945.47	$409.56	$189.09
G0033	S		PET follow SPECT 78464 mult	0285	18.1294	$945.47	$409.56	$189.09
G0034	S		PET follow SPECT 76865 singl	0285	18.1294	$945.47	$409.56	$189.09
G0035	S		PET follow SPECT 78465 mult	0285	18.1294	$945.47	$409.56	$189.09
G0036	S		PET follow cornry angio sing	0285	18.1294	$945.47	$409.56	$189.09
G0037	S		PET follow cornry angio mult	0285	18.1294	$945.47	$409.56	$189.09
G0038	S		PET follow myocard perf sing	0285	18.1294	$945.47	$409.56	$189.09
G0039	S		PET follow myocard perf mult	0285	18.1294	$945.47	$409.56	$189.09
G0040	S		PET follow stress echo singl	0285	18.1294	$945.47	$409.56	$189.09
G0041	S		PET follow stress echo mult	0285	18.1294	$945.47	$409.56	$189.09
G0042	S		PET follow ventriculogm sing	0285	18.1294	$945.47	$409.56	$189.09
G0043	S		PET follow ventriculogm mult	0285	18.1294	$945.47	$409.56	$189.09
G0044	S		PET following rest ECG singl	0285	18.1294	$945.47	$409.56	$189.09
G0045	S		PET following rest ECG mult	0285	18.1294	$945.47	$409.56	$189.09
G0046	S		PET follow stress ECG singl	0285	18.1294	$945.47	$409.56	$189.09
G0047	S		PET follow stress ECG mult	0285	18.1294	$945.47	$409.56	$189.09
G0050	S	DG	Residual urine by ultrasound	0265	0.9787	$51.04	$28.07	$10.21
G0101	V		CA screen;pelvic/breast exam	0600	0.8430	$43.96		$8.79
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.3255	$121.28		$30.32
G0105	T		Colorectal scrn; hi risk ind	0158	7.0638	$368.38		$92.10
G0106	S		Colon CA screen;barium enema	0157	2.5387	$132.40		$26.48
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.7364	$38.40	$14.97	$7.68
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7364	$38.40	$14.97	$7.68
G0120	S		Colon ca scrn; barium enema	0157	2.5387	$132.40		$26.48
G0121	T		Colon ca scrn not hi rsk ind	0158	7.0638	$368.38		$92.10
G0122	E		Colon ca scrn; barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0125	S		PET img WhBD sgl pulm ring	0714		$1,375.00		$275.00
G0127	T		Trim nail(s)	0009	0.6298	$32.84	$8.34	$6.57
G0128	E		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	4.6026	$240.03	$48.17	$48.01
G0130	X		Single energy x-ray study	0260	0.7655	$39.92	$21.95	$7.98
G0131	S	DG	CT scan, bone density study	0288	1.2984	$67.71		$13.54
G0132	S	DG	CT scan, bone density study	0665	0.8236	$42.95		$8.59
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					
G0166	T		Extrnl counterpulse, per tx	0678	2.2189	$115.72		$23.14
G0167	E		Hyperbaric oz tx;no md reqrd					
G0168	X		Wound closure by adhesive	0340	0.6492	$33.86		$6.77
G0173	S		Stereo radoisurgery,complete	0721		$5,500.00		$1,100.00
G0175	V		OPPS Service,sched team conf	0602	1.4631	$76.30		$15.26
G0176	P		OPPS/PHP;activity therapy	0033	4.6026	$240.03	$48.17	$48.01
G0177	P		OPPS/PHP; train & educ serv	0033	4.6026	$240.03	$48.17	$48.01
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0185	T	DG	Transpuppillary thermotx	0235	5.0871	$265.30	$73.44	$53.06
G0186	T		Dstry eye lesn,fdr vssl tech	0235	5.0871	$265.30	$73.44	$53.06
G0187	T	DG	Dstry mclr drusen,photocoag	0235	5.0871	$265.30	$73.44	$53.06
G0192	N	DG	Immunization oral/intranasal					
G0193	A	DG	Endoscopicstudyswallowfunctn					
G0194	A	DG	Sensorytestingendoscopicstud					
G0195	A	DG	Clinicalevalswallowingfunct					
G0196	A	DG	Evalofswallowingwithradioopa					
G0197	A	DG	Evalofptforprescipspeechdevi					
G0198	A	DG	Patientadapation&trainforspe					
G0199	A	DG	Reevaluationofpatientusespec					
G0200	A	DG	Evalofpatientprescipofvoicep					
G0201	A	DG	Modifortraininginusevoicepro					
G0202	A		Screeningmammographydigital					
G0204	S		Diagnosticmammographydigital	0669	0.8915	$46.49		$9.30
G0206	S		Diagnosticmammographydigital	0669	0.8915	$46.49		$9.30
G0210	S		PET img whbd ring dxlung ca	0714		$1,375.00		$275.00
G0211	S		PET img whbd ring init lung	0714		$1,375.00		$275.00
G0212	S		PET img whbd ring restag lun	0714		$1,375.00		$275.00
G0213	S		PET img whbd ring dx colorec	0714		$1,375.00		$275.00

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0214	S		PET img whbd ring init colre	0714		$1,375.00		$275.00
G0215	S		PET img whbd restag col	0714		$1,375.00		$275.00
G0216	S		PET img whbd ring dx melanom	0714		$1,375.00		$275.00
G0217	S		PET img whbd ring init melan	0714		$1,375.00		$275.00
G0218	S		PET img whbd ring restag mel	0714		$1,375.00		$275.00
G0219	E		PET img whbd ring noncov ind					
G0220	S		PET img whbd ring dx lymphom	0714		$1,375.00		$275.00
G0221	S		PET img whbd ring init lymph	0714		$1,375.00		$275.00
G0222	S		PET img whbd ring resta lymp	0714		$1,375.00		$275.00
G0223	S		PET img whbd reg ring dx hea	0714		$1,375.00		$275.00
G0224	S		PETimg whbd reg ring ini hea	0714		$1,375.00		$275.00
G0225	S		PET img whbd ring restag hea	0714		$1,375.00		$275.00
G0226	S		PET img whbd dx esophag	0714		$1,375.00		$275.00
G0227	S		PET img whbd ring ini esopha	0714		$1,375.00		$275.00
G0228	S		PET img whbd ring restg esop	0714		$1,375.00		$275.00
G0229	S		PET img metabolic brain ring	0714		$1,375.00		$275.00
G0230	S		PET myocard viability ring	0714		$1,375.00		$275.00
G0231	S		PET WhBD colorec; gamma cam	0714		$1,375.00		$275.00
G0232	S		PET whbd lymphoma; gamma cam	0714		$1,375.00		$275.00
G0233	S		PET whbd melanoma; gamma cam	0714		$1,375.00		$275.00
G0234	S		PET WhBD pulm nod; gamma cam	0714		$1,375.00		$275.00
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	DG	Critic care by MD transport					
G0241	A	DG	Each additional 30 minutes					
G0242	S		Multisource photon ster plan	0714		$1,375.00		$275.00
G0243	S		Multisour photon stero treat	0721		$5,500.00		$1,100.00
G0244	S		Observ care by facility topt	0339	7.2188	$376.47		$75.29
G0245	V		Initial Foot Exam PTLOPS	0600	0.8430	$43.96		$8.79
G0246	V		Follow-up Eval of Foot PTLOPS	0600	0.8430	$43.96		$8.79
G0247	T		Routine footcare w LOPS	0009	0.6298	$32.84	$8.34	$6.57
G0248	S		Demonstrate use home INR mon	0708		$150.00		$30.00
G0249	S		Provide test material,equipm	0708		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S	NI	Linear acc based stero radio	0713		$1,125.00		$225.00
G0252	S	NI	PET imaging initial dx	0714		$1,375.00		$275.00
G0253	S	NI	PET image brst dection recur	0714		$1,375.00		$275.00
G0254	S	NI	PET image brst eval to tx	0714		$1,375.00		$275.00
G0255	E	NI	Current percep threshold tst					
G0256	T	NF	Prostate brachy w palladium	0649	115.0167	$5,998.24		$1,199.65
G0257	S	NF	Unsched dialysis ESRD pt hos	0170	4.8352	$252.16		$50.43
G0258	X	DG	IV infusion during obs stay	0340	0.6492	$33.86		$6.77
G0259	N	NF	Inject for sacroiliac joint					
G0260	T	NF	Inj for sacroiliac jt anesth	0204	2.0251	$105.61	$40.13	$21.12
G0261	T	NF	Prostate brachy w iodine see	0684	98.8349	$5,154.34		$1,030.87
G0262	S	NI	Sm intestinal image capsule	0711		$625.00		$125.00
G0263	N	NF	Adm with CHF, CP, asthma					
G0264	V	NF	Assmt otr CHF, CP, asthma	0600	0.8430	$43.96		$8.79
G0265	A	NI	Cryopresevation Freeze+stora					
G0266	A	NI	Thawing + expansion froz cel					
G0267	A	NI	Bone marrow or psc harvest					
G0268	X	NI	Removal of impacted wax md	0340	0.6492	$33.86		$6.77
G0269	N	NI	Occlusive device in vein art					
G0270	A	NI	MNT subs tx for change dx					
G0271	A	NI	Group MNT 2 or more 30 mins					
G0272	X	NI	Naso/oro gastric tube pl MD	0272	1.3372	$69.74	$38.36	$13.95
G0273	S	NI	Pretx planning, non-Hodgkins	0718		$2,750.00		$550.00
G0274	S	NI	Radiopharm tx, non-Hodgkins	0725		$20,000.00		$4,000.00
G0275	N	NI	Renal angio, cardiac cath					
G0278	N	NI	Iliac art angio,cardiac cath					
G0279	A	NI	Excorp shock tx, elbow epi					
G0280	A	NI	Excorp shock tx other than					
G0281	A	NI	Elec stim unattend for press					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0282	A	NI	Elect stim wound care not pd					
G0283	A	NI	Elec stim other than wound					
G0288	T	NI	Recon, CTA for surg plan	0975		$625.00		$125.00
G0289	N	NI	Arthro, loose body + chondro					
G0290	E	NF	Drug-eluting stents, single					
G0291	E	NF	Drug-eluting stents,each add					
G0292	S	NI	Adm exp drugs,clinical trial	0708		$150.00		$30.00
G0293	S	NI	Non-cov surg proc,clin trial	0710		$400.00		$80.00
G0294	S	NI	Non-cov proc, clinical trial	0707		$75.00		$15.00
G0295	E	NI	Electromagnetic therapy onc					
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					
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					
H0031	E	NI	MH health assess by non-md					
H0032	E	NI	MH svc plan dev by non-md					
H0033	E	NI	Oral med adm direct observe					
H0034	E	NI	Med trng & support per 15min					
H0035	E	NI	MH partial hosp tx under 24h					
H0036	E	NI	Comm psy face-face per 15min					
H0037	E	NI	Comm psy sup tx pgm per diem					
H0038	E	NI	Self-help/peer svc per 15min					
H0039	E	NI	Asser com tx face-face/15min					
H0040	E	NI	Assert comm tx pgm per diem					
H0041	E	NI	Fos c chld non-ther per diem					
H0042	E	NI	Fos c chld non-ther per mon					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
H0043	E	NI	Supported housing, per diem					
H0044	E	NI	Supported housing, per month					
H0045	E	NI	Respite not-in-home per diem					
H0046	E	NI	Mental health service, nos					
H0047	E	NI	Alcohol/drug abuse svc nos					
H0048	E	NI	Spec coll non-blood:a/d test					
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					
H1010	E	NI	Nonmed family planning ed					
H1011	E	NI	Family assessment					
H2000	E	NI	Comp multidisipln evaluation					
H2001	E	NI	Rehabilitation program 1/2 d					
J0120	N		Tetracyclin injection					
J0130	K		Abciximab injection	1605	5.8526	$305.22		$61.04
J0150	N		Injection adenosine 6 MG					
J0151	K		Adenosine injection	0917	3.1986	$166.81		$33.36
J0170	N		Adrenalin epinephrin inject					
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	F		Alglucerase injection					
J0207	K		Amifostine	7000	4.5057	$234.98		$47.00
J0210	N		Methyldopate hcl injection					
J0256	F		Alpha 1 proteinase inhibitor					
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	K	DG	Amphotericin B lipid complex	7001	2.3449	$122.29		$24.46
J0287	K	NI	Amphotericin b lipid complex	9024	0.4167	$21.73		$4.35
J0288	N	NI	Ampho b cholesteryl sulfate					
J0289	N	NI	Amphotericin b liposome inj					
J0290	N		Ampicillin 500 MG inj					
J0295	N		Ampicillin sodium per 1.5 gm					
J0300	N		Amobarbital 125 MG inj					
J0330	N		Succinycholine chloride inj					
J0350	N		Injection anistreplase 30 u					
J0360	N		Hydralazine hcl injection					
J0380	N		Inj metaraminol bitartrate					
J0390	N		Chloroquine injection					
J0395	N		Arbutamine HCl injection					
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	N		Baclofen 10 MG injection					
J0476	E		Baclofen intrathecal trial					
J0500	N		Dicyclomine 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	K		Botulinum toxin a per unit	0902	0.0484	$2.52		$.50
J0587	G		Botulinum toxin type B	9018		$8.79		$1.31
J0592	N	NI	Buprenorphine hydrochloride					
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0630	N		Calcitonin salmon injection					
J0635	N	DG	Calcitriol injection					
J0636	N	NI	Inj calcitriol per 0.1 mcg					
J0637	G	NI	Caspofungin acetate	9019		$34.20		$5.11
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
J0710	N		Cephapirin sodium injection					
J0713	N		Inj ceftazidime per 500 mg					
J0715	N		Ceftizoxime sodium / 500 MG					
J0720	N		Chloramphenicol sodium injec					
J0725	N		Chorionic gonadotropin/1000u					
J0735	N		Clonidine hydrochloride					
J0740	N		Cidofovir injection					
J0743	N		Cilastatin sodium injection					
J0744	N		Ciprofloxacin iv					
J0745	N		Inj codeine phosphate /30 MG					
J0760	N		Colchicine injection					
J0770	N		Colistimethate sodium inj					
J0780	N		Prochlorperazine injection					
J0800	N		Corticotropin injection					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903	4.7383	$247.11		$49.42
J0880	E	NI	Darbepoetin alfa injection					
J0895	N		Deferoxamine mesylate inj					
J0900	N		Testosterone enanthate inj					
J0945	N		Brompheniramine maleate inj					
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1050	N	DG	Medroxyprogesterone inj					
J1051	N	NI	Medroxyprogesterone inj					
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N	NI	Inj dexamethasone acetate					
J1095	N	DG	Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	N		Inj dihydroergotamine mesylt					
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	N		Dyphylline injection					
J1190	K		Dexrazoxane HCl injection	0726	2.2577	$117.74		$23.55
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	N		Dipyridamole injection					
J1250	N		Inj dobutamine HCL/250 mg					
J1260	N		Dolasetron mesylate					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	N		Eptifibatide injection					
J1330	N		Ergonovine maleate injection					
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	N		Inj estrogen conjugate 25 MG					
J1435	N		Injection estrone per 1 MG					
J1436	N		Etidronate disodium inj					
J1438	N		Etanercept injection					
J1440	K		Filgrastim 300 mcg injection	0728	2.1027	$109.66		$21.93
J1441	K		Filgrastim 480 mcg injection	7049	3.2267	$168.28		$33.66
J1450	N		Fluconazole					
J1452	N		Intraocular Fomivirsen na					
J1455	N		Foscarnet sodium injection					
J1460	N		Gamma globulin 1 CC inj					
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	K	DG	Immune globulin 500 mg	0905	0.8333	$43.46		$8.69
J1563	E		IV immune globulin					
J1564	K	NI	Immune globulin 10 mg	9021	0.0097	$.51		$.10
J1565	K		RSV-ivig	0906	0.5911	$30.83		$6.17
J1570	N		Ganciclovir sodium injection					
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1600	N		Gold sodium thiomaleate inj					
J1610	N		Glucagon hydrochloride/1 MG					
J1620	N		Gonadorelin hydroch/ 100 mcg					
J1626	N		Granisetron HCl injection					
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N	NI	Fondaparinux sodium					
J1655	N		Tinzaparin sodium injection					
J1670	N		Tetanus immune globulin inj					
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					
J1730	N		Diazoxide injection					
J1742	N		Ibutilide fumarate injection					
J1745	K		Infliximab injection	7043	0.7364	$38.40		$7.68
J1750	N		Iron dextran					
J1755	N	DG	Iron sucrose injection					
J1756	N	NI	Iron sucrose injection					
J1785	K		Injection imiglucerase /unit	0916	0.0484	$2.52		$.50
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N	NI	Insulin injection					
J1817	N	NI	Insulin for insulin pump use					
J1820	N	DG	Insulin injection					
J1825	K		Interferon beta-1a	0909	2.7906	$145.53		$29.11

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1830	K		Interferon beta-1b / .25 MG	0910	1.9864	$103.59		$20.72
J1835	N		Itraconazole injection					
J1840	N		Kanamycin sulfate 500 MG inj					
J1850	N		Kanamycin sulfate 75 MG inj					
J1885	N		Ketorolac tromethamine inj					
J1890	N		Cephalothin sodium injection					
J1910	N		Kutapressin injection					
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800	3.7984	$198.09		$39.62
J1955	E		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2000	N		Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	N		Linezolid injection					
J2060	N		Lorazepam injection					
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	N		Inj milrinone lactate / 5 ML					
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2300	N		Inj nalbuphine hydrochloride					
J2310	N		Inj naloxone hydrochloride					
J2320	N		Nandrolone decanoate 50 MG					
J2321	N		Nandrolone decanoate 100 MG					
J2322	N		Nandrolone decanoate 200 MG					
J2324	G	NI	Nesiritide	9114		$433.20		$64.75
J2352	K		Octreotide acetate injection	7031	1.2694	$66.20		$13.24
J2355	K		Oprelvekin injection	7011	2.7325	$142.50		$28.50
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	N		Ondansetron hcl injection					
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730	3.2654	$170.29		$34.06
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2500	N	DG	Paricalcitol					
J2501	N	NI	Paricalcitol					
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	A		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	N		Inj desmopressin acetate					
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium injeciton					
J2710	N		Neostigmine methylslfte inj					
J2720	N		Inj protamine sulfate/10 MG					
J2725	N		Inj protirelin per 250 mcg					
J2730	N		Pralidoxime chloride inj					
J2760	N		Phentolaine mesylate inj					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2765	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2788	K	NI	Rho d immune globulin 50 mcg	9023	0.0484	$2.52		$.50
J2790	N		Rho d immune globulin inj					
J2792	K		Rho(D) immune globulin h, sd	1609	0.2229	$11.62		$2.32
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	N		Sargramostim injection					
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					
J2915	N	DG	NA Ferric Gluconate Complex					
J2916	N	NI	Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034	0.7170	$37.39		$7.48
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005	12.6547	$659.96		$131.99
J2995	N		Inj streptokinase /250000 IU					
J2997	N		Alteplase recombinant					
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	N		Sumatriptan succinate / 6 MG					
J3070	N		Pentazocine hcl injection					
J3100	K		Tenecteplase injection	9002	27.5963	$1,439.17		$287.83
J3105	N		Terbutaline sulfate inj					
J3120	N		Testosterone enanthate inj					
J3130	N		Testosterone enanthate inj					
J3140	N		Testosterone suspension inj					
J3150	N		Testosteron propionate inj					
J3230	N		Chlorpromazine hcl injection					
J3240	K		Thyrotropin injection	9108	7.5870	$395.67		$79.13
J3245	K		Tirofiban hydrochloride	7041	4.9417	$257.71		$51.54
J3250	N		Trimethobenzamide hcl inj					
J3260	N		Tobramycin sulfate injection					
J3265	N		Injection torsemide 10 mg/ml					
J3280	N		Thiethylperazine maleate inj					
J3301	N		Triamcinolone acetonide inj					
J3302	N		Triamcinolone diacetate inj					
J3303	N		Triamcinolone hexacetonl inj					
J3305	K		Inj trimetrexate glucoronate	7045	1.3081	$68.22		$13.64
J3310	N		Perphenazine injeciton					
J3315	E	NI	Triptorelin pamoate					
J3320	N		Spectinomycn di-hcl inj					
J3350	N		Urea injection					
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	N		Urokinase 250,000 IU inj					
J3370	N		Vancomycin hcl injection					
J3395	K		Verteporfin injection	1203	16.5209	$861.58		$172.32
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3487	G	NI	Zoledronic acid	9115		$406.78		$60.80
J3490	N		Drugs unclassified injection					
J3520			Edetate disodium per 150 mg					
J3530	N		Nasal vaccine inhalation					
J3535	E		Metered dose inhaler drug					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J3570	E		Laetrile amygdalin vit B17					
J3590	N	NI	Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					
J7100	N		Dextran 40 infusion					
J7110	N		Dextran 75 infusion					
J7120	N		Ringers lactate infusion					
J7130	N		Hypertonic saline solution					
J7190	K		Factor viii	0925	0.0097	$.51		$.10
J7191	K		Factor VIII (porcine)	0926	0.0291	$1.52		$.30
J7192	K		Factor viii recombinant	0927	0.0194	$1.01		$.20
J7193	K		Factor IX non-recombinant	0931	0.0097	$.51		$.10
J7194	K		Factor ix complex	0928	0.0097	$.51		$.10
J7195	K		Factor IX recombinant	0932	0.0194	$1.01		$.20
J7197	K		Antithrombin iii injection	0930	0.0194	$1.01		$.20
J7198	K		Anti-inhibitor	0929	0.0194	$1.01		$.20
J7199	E		Hemophilia clot factor noc					
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7308	N		Aminolevulinic acid hcl top					
J7310	N		Ganciclovir long act implant					
J7316	N	DG	Sodium hyaluronate injection					
J7317	N	NI	Sodium hyaluronate injection					
J7320	K		Hylan G-F 20 injection	1611	2.3643	$123.30		$24.66
J7330	K		Cultured chondrocytes implnt	1059	114.2706	$5,959.33		$1,191.87
J7340	E		Metabolic active D/E tissue					
J7342	N	NI	Metabolically active tissue					
J7350	N	NI	Injectable human tissue					
J7500	N		Azathioprine oral 50mg					
J7501	N		Azathioprine parenteral					
J7502	K		Cyclosporine oral 100 mg	0888	0.0484	$2.52		$.50
J7504	K		Lymphocyte immune globulin	0890	3.3429	$174.34		$34.87
J7505	K		Monoclonal antibodies	7038	6.9572	$362.82		$72.56
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891	0.0291	$1.52		$.30
J7508	E		Tacrolimus oral per 5 MG					
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104	2.6356	$137.45		$27.49
J7513	K		Daclizumab, parenteral	1612	4.3991	$229.42		$45.88
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015	0.0291	$1.52		$.30
J7520	K		Sirolimus, oral	9020	0.0581	$3.03		$.61
J7525	N		Tacrolimus injection					
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		Beclomethasone inhalatn sol					
J7624	A		Betamethasone 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					
J7633	N	NI	Budesonide concentrated sol					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	N		Oral busulfan					
J8520	K		Capecitabine, oral, 150 mg	7042	0.0291	$1.52		$.30
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802	0.5523	$28.80		$5.76
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolmide	1086	0.0581	$3.03		$.61
J8999	E		Oral prescription drug chemo					
J9000	N		Doxorubic hcl 10 MG vl chemo					
J9001	K		Doxorubicin hcl liposome inj	7046	4.3894	$228.91		$45.78
J9010	G	NI	Alemtuzumab injection	9110		$511.22		$76.41
J9015	K		Aldesleukin/single use vial	0807	7.2867	$380.01		$76.00
J9017	G		Arsenic trioxide	9012		$31.35		$4.69
J9020	N		Asparaginase injection					
J9031	N		Bcg live intravesical vac					
J9040	K		Bleomycin sulfate injection	0857	3.1879	$166.25		$33.25
J9045	K		Carboplatin injection	0811	1.4922	$77.82		$15.56
J9050	K		Carmus bischl nitro inj	0812	1.5310	$79.84		$15.97
J9060	K		Cisplatin 10 MG injection	0813	0.4263	$22.23		$4.45
J9062	E		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858	0.7946	$41.44		$8.29
J9070	N		Cyclophosphamide 100 MG inj					
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	N		Cyclophosphamide lyophilized					
J9094	E		Cyclophosphamide lyophilized					
J9095	E		Cyclophosphamide lyophilized					
J9096	E		Cyclophosphamide lyophilized					
J9097	E		Cyclophosphamide lyophilized					
J9100	N		Cytarabine hcl 100 MG inj					
J9110	E		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	N		Dacarbazine 10 MG inj					
J9140	E		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820	1.9379	$101.06		$20.21
J9151	K		Daunorubicin citrate liposom	0821	2.9069	$151.60		$30.32
J9160	K		Denileukin diftitox, 300 mcg	1084	12.1315	$632.67		$126.53
J9165	K		Diethylstilbestrol injection	0822	2.0251	$105.61		$21.12
J9170	K		Docetaxel	0823	3.8953	$203.14		$40.63
J9180	E		Epirubicin HCl injection					
J9181	N		Etoposide 10 MG inj					
J9182	E		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842	3.2848	$171.31		$34.26

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827	2.2189	$115.72		$23.14
J9201	K		Gemcitabine HCl	0828	1.2984	$67.71		$13.54
J9202	K		Goserelin acetate implant	0810	5.5619	$290.06		$58.01
J9206	K		Irinotecan injection	0830	1.7538	$91.46		$18.29
J9208	K		Ifosfomide injection	0831	1.9186	$100.06		$20.01
J9209	K		Mesna injection	0732	0.5039	$26.28		$5.26
J9211	K		Idarubicin hcl injection	0832	4.8642	$253.67		$50.73
J9212	N		Interferon alfacon-1					
J9213	N		Interferon alfa-2a inj					
J9214	N		Interferon alfa-2b inj					
J9215	N		Interferon alfa-n3 inj					
J9216	K		Interferon gamma 1-b inj	0838	3.0426	$158.67		$31.73
J9217	K		Leuprolide acetate suspnsion	9217	6.5696	$342.61		$68.52
J9218	K		Leuprolide acetate injeciton	0861	0.7752	$40.43		$8.09
J9219	G		Leuprolide acetate implant	7051		$5,399.80		$807.13
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840	4.5348	$236.49		$47.30
J9250	N		Methotrexate sodium inj					
J9260	E		Methotrexate sodium inj					
J9265	K		Paclitaxel injection	0863	2.3158	$120.77		$24.15
J9266	K		Pegaspargase/singl dose vial	0843	8.8079	$459.34		$91.87
J9268	K		Pentostatin injection	0844	19.8833	$1,036.93		$207.39
J9270	N		Plicamycin (mithramycin) inj					
J9280	K		Mitomycin 5 MG inj	0862	1.1337	$59.12		$11.82
J9290	E		Mitomycin 20 MG inj					
J9291	E		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	2.9263	$152.61		$30.52
J9300	F		Gemtuzumab ozogamicin					
J9310	K		Rituximab cancer treatment	0849	5.4941	$286.52		$57.30
J9320	N		Streptozocin injection					
J9340	N		Thiotepa injection					
J9350	K		Topotecan	0852	7.7130	$402.24		$80.45
J9355	K		Trastuzumab	1613	0.6298	$32.84		$6.57
J9357	K		Valrubicin, 200 mg	1614	3.5658	$185.96		$37.19
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	E		Vincristine sulfate 2 MG inj					
J9380	E		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855	1.0756	$56.09		$11.22
J9600	K		Porfimer sodium	0856	29.6117	$1,544.28		$308.86
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					
K0009	A		Other manual wheelchair/base					
K0010	A		Stnd wt frame power whlchr					
K0011	A		Stnd wt pwr whlchr w control					
K0012	A		Ltwt portbl power whlchr					
K0014	A		Other power whlchr base					
K0015	A		Detach non-adjus hght armrst					
K0016	A		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	DG	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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CPT/ HCPCS	Status indicator	Condition	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	DG	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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
K0101	A	DG	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	DG	Nasal application device					
K0184	A	DG	Nasal pillow or face seal					
K0185	A	DG	Pos airway pressure headgear					
K0186	A	DG	Pos airway prssure chinstrap					
K0187	A	DG	Pos airway pressure tubing					
K0188	A	DG	Pos airway pressure filter					
K0189	A	DG	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		SGD prerecorded msg <= 8 min					
K0542	A		SGD prerecorded msg > 8 min					
K0543	A		SGD msg formed by spelling					
K0544	A		SGD w multi methods msg/accs					
K0545	A		SGD sftwre prgrm for PC/PDA					
K0546	A		SGD accessory,mounting systm					
K0547	A		SGD accessory NOC					
K0548	A		Insulin lispro					
K0549	A		Hosp bed hvy dty xtra wide					
K0550	A		Hosp bed xtra hvy dty x wide					
K0551	A	DG	Residual limb support system					
K0556	A	NI	Socket insert w lock mech					
K0557	A	NI	Socket insert w/o lock mech					
K0558	A	NI	Intl custm cong/atyp insert					
K0559	A	NI	Initial custom socket insert					
K0581	A	NI	Ost pch clsd w barrier/filtr					
K0582	A	NI	Ost pch w bar/bltinconv/fltr					
K0583	A	NI	Ost pch clsd w/o bar w filtr					
K0584	A	NI	Ost pch for bar w flange/flt					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0585	A	NI	Ost pch clsd for bar w lk fl					
K0586	A	NI	Ost pch for bar w lk fl/fltr					
K0587	A	NI	Ost pch drain w bar & filter					
K0588	A	NI	Ost pch drain for barrier fl					
K0589	A	NI	Ost pch drain 2 piece system					
K0590	A	NI	Ost pch drain/barr lk flng/f					
K0591	A	NI	Urine ost pouch w faucet/tap					
K0592	A	NI	Urine ost pouch w bltinconv					
K0593	A	NI	Ost urine pch w b/bltin conv					
K0594	A	NI	Ost pch urine w barrier/tapv					
K0595	A	NI	Os pch urine w bar/fange/tap					
K0596	A	NI	Urine ost pch bar w lock fln					
K0597	A	NI	Ost pch urine w lock flng/ft					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
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	DG	TLSO flex surgical support					
L0310	A	DG	Tlso flexible custom fabrica					
L0315	A	DG	Tlso flex elas rigid post pa					
L0317	A	DG	Tlso flex hypext elas post p					
L0320	A	DG	Tlso a-p contrl w apron frnt					
L0321	A	DG	Tlso anti-post-cntrl prefab					
L0330	A	DG	Tlso ant-pos-lateral control					
L0331	A	DG	Tlso ant-post-lat cntrl prfb					
L0340	A	DG	Tlso a-p-l-rotary with apron					
L0350	A	DG	Tlso flex compress jacket cu					
L0360	A	DG	Tlso flex compress jacket mo					
L0370	A	DG	Tlso a-p-l-rotary hyperexten					
L0380	A	DG	Tlso a-p-l-rot w/ pos extens					
L0390	A	DG	Tlso a-p-l control molded					
L0391	A	DG	Tlso ant-post-lat-rot cntrl					
L0400	A	DG	Tlso a-p-l w interface mater					
L0410	A	DG	Tlso a-p-l two piece constr					
L0420	A	DG	Tlso a-p-l 2 piece w interfa					
L0430	A	DG	Tlso a-p-l w interface custm					
L0440	A	DG	Tlso a-p-l overlap frnt cust					
L0450	A	NI	TLSO flex prefab thoracic					
L0452	A	NI	tlso flex custom fab thoraci					
L0454	A	NI	TLSO flex prefab sacrococ-T9					
L0456	A	NI	TLSO flex prefab					
L0458	A	NI	TLSO 2Mod symphis-xipho pre					
L0460	A	NI	TLSO2Mod symphysis-stern pre					
L0462	A	NI	TLSO 3Mod sacro-scap pre					
L0464	A	NI	TLSO 4Mod sacro-scap pre					
L0466	A	NI	TLSO rigid frame pre soft ap					
L0468	A	NI	TLSO rigid frame prefab pelv					
L0470	A	NI	TLSO rigid frame pre subclav					
L0472	A	NI	TLSO rigid frame hyperex pre					
L0474	A	NI	TLSO rigid frame pre pelvic					
L0476	A	NI	TLSO flexion compres jac pre					
L0478	A	NI	TLSO flexion compres jac cus					
L0480	A	NI	TLSO rigid plastic custom fa					
L0482	A	NI	TLSO rigid lined custom fab					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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L0484	A	NI	TLSO rigid plastic cust fab					
L0486	A	NI	TLSO rigidlined cust fab two					
L0488	A	NI	TLSO rigid lined pre one pie					
L0490	A	NI	TLSO rigid plastic pre one					
L0500	A		Lso flex surgical support					
L0510	A		Lso flexible custom fabricat					
L0515	A		Lso flex elas w/ rig post pa					
L0520	A		Lso a-p-l control with apron					
L0530	A		Lso ant-pos control w apron					
L0540	A		Lso lumbar flexion a-p-l					
L0550	A		Lso a-p-l control molded					
L0560	A		Lso a-p-l w interface					
L0561	A		Prefab lso					
L0565	A		Lso a-p-l control custom					
L0600	A		Sacroiliac flex surg support					
L0610	A		Sacroiliac flexible custm fa					
L0620	A		Sacroiliac semi-rig w apron					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
L0900	A	DG	Torso/ptosis support					
L0910	A	DG	Torso & ptosis supp custm fa					
L0920	A	DG	Torso/pendulous abd support					
L0930	A	DG	Pendulous abdomen supp custm					
L0940	A	DG	Torso/postsurgical support					
L0950	A	DG	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	DG	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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A	NI	HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					
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					
L1836	A	NI	Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					
L1844	A		Ko w/adj jt rot cntrl molded					
L1845	A		Ko w/ adj flex/ext rotat cus					
L1846	A		Ko w adj flex/ext rotat mold					
L1847	A		KO adjustable w air chambers					
L1850	A		Ko swedish type					
L1855	A		Ko plas doub upright jnt mol					
L1858	A		Ko polycentric pneumatic pad					
L1860	A		Ko supracondylar socket mold					
L1870	A		Ko doub upright lacers molde					
L1880	A		Ko doub upright cuffs/lacers					
L1885	A		Knee upright w/resistance					
L1900	A		Afo sprng wir drsflx calf bd					
L1901	A	NI	Prefab ankle orthosis					
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/					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2030	A		Kafo dbl solid stirrup w/o j					
L2035	A		KAFO plastic pediatric size					
L2036	A		Kafo plas doub free knee mol					
L2037	A		Kafo plas sing free knee mol					
L2038	A		Kafo w/o joint multi-axis an					
L2039	A		KAFO,plstic,medlat rotat con					
L2040	A		Hkafo torsion bil rot straps					
L2050	A		Hkafo torsion cable hip pelv					
L2060	A		Hkafo torsion ball bearing j					
L2070	A		Hkafo torsion unilat rot str					
L2080	A		Hkafo unilat torsion cable					
L2090	A		Hkafo unilat torsion ball br					
L2102	E		Afo tibial fx cast plstr mol					
L2104	E		Afo tib fx cast synthetic mo					
L2106	A		Afo tib fx cast plaster mold					
L2108	A		Afo tib fx cast molded to pt					
L2112	A		Afo tibial fracture soft					
L2114	A		Afo tib fx semi-rigid					
L2116	A		Afo tibial fracture rigid					
L2122	E		Kafo fem fx cast plaster mol					
L2124	E		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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	DG	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	DG	Mens surgical boot each					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230			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					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3650	A		Shlder fig 8 abduct restrain					
L3651	A	NI	Prefab shoulder orthosis					
L3652	A	NI	Prefab dbl shoulder orthosis					
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					
L3701	A	NI	Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A	NI	Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	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					
L3909	A	NI	Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A	NI	Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L4386	A	NI	Non-pneumatic walking splint					
L4392	A		Replace AFO soft interface					
L4394	A		Replace foot drop spint					
L4396	A		Static AFO					
L4398	A		Foot drop splint recumbent					
L5000	A		Sho insert w arch toe filler					
L5010	A		Mold socket ank hgt w/ toe f					
L5020	A		Tibial tubercle hgt w/ toe f					
L5050	A		Ank symes mold sckt sach ft					
L5060	A		Symes met fr leath socket ar					
L5100	A		Molded socket shin sach foot					
L5105	A		Plast socket jts/thgh lacer					
L5150	A		Mold sckt ext knee shin sach					
L5160	A		Mold socket bent knee shin s					
L5200	A		Kne sing axis fric shin sach					
L5210	A		No knee/ankle joints w/ ft b					
L5220	A		No knee joint with artic ali					
L5230	A		Fem focal defic constant fri					
L5250	A		Hip canad sing axi cons fric					
L5270	A		Tilt table locking hip sing					
L5280	A		Hemipelvect canad sing axis					
L5301	A		BK mold socket SACH ft endo					
L5311	A		Knee disart, SACH ft, endo					
L5321	A		AK open end SACH					
L5331	A		Hip disart canadian SACH ft					
L5341	A		Hemipelvectomy canadian SACH					
L5400	A		Postop dress & 1 cast chg bk					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5410	A		Postop dsg bk ea add cast ch					
L5420	A		Postop dsg & 1 cast chg ak/d					
L5430	A		Postop dsg ak ea add cast ch					
L5450	A		Postop app non-wgt bear dsg					
L5460	A		Postop app non-wgt bear dsg					
L5500	A		Init bk ptb plaster direct					
L5505	A		Init ak ischal plstr direct					
L5510	A		Prep BK ptb plaster molded					
L5520	A		Perp BK ptb thermopls direct					
L5530	A		Prep BK ptb thermopls molded					
L5535	A		Prep BK ptb open end socket					
L5540	A		Prep BK ptb laminated socket					
L5560	A		Prep AK ischial plast molded					
L5570	A		Prep AK ischial direct form					
L5580	A		Prep AK ischial thermo mold					
L5585	A		Prep AK ischial open end					
L5590	A		Prep AK ischial laminated					
L5595	A		Hip disartic sach thermopls					
L5600	A		Hip disart sach laminat mold					
L5610	A		Above knee hydracadence					
L5611	A		Ak 4 bar link w/fric swing					
L5613	A		Ak 4 bar ling w/hydraul swig					
L5614	A		4-bar link above knee w/swng					
L5616	A		Ak univ multiplex sys frict					
L5617	A		AK/BK self-aligning unit ea					
L5618	A		Test socket symes					
L5620	A		Test socket below knee					
L5622	A		Test socket knee disarticula					
L5624	A		Test socket above knee					
L5626	A		Test socket hip disarticulat					
L5628	A		Test socket hemipelvectomy					
L5629	A		Below knee acrylic socket					
L5630	A		Syme typ expandabl wall sckt					
L5631	A		Ak/knee disartic acrylic soc					
L5632	A		Symes type ptb brim design s					
L5634	A		Symes type poster opening so					
L5636	A		Symes type medial opening so					
L5637	A		Below knee total contact					
L5638	A		Below knee leather socket					
L5639	A		Below knee wood socket					
L5640	A		Knee disarticulat leather so					
L5642	A		Above knee leather socket					
L5643	A		Hip flex inner socket ext fr					
L5644	A		Above knee wood socket					
L5645	A		Bk flex inner socket ext fra					
L5646	A		Below knee air cushion socke					
L5647	A		Below knee suction socket					
L5648	A		Above knee air cushion socke					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5660	A	DG	Sock insrt syme silicone gel					
L5661	A		Multi-durometer symes					
L5662	A	DG	Socket insert bk silicone ge					
L5663	A	DG	Sock knee disartic silicone					
L5664	A	DG	Socket insert ak silicone ge					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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 cover BK					
L5705	A		Custom shape cover AK					
L5706	A		Custom shape cvr knee disart					
L5707	A		Custom shape cvr hip disart					
L5710	A		Kne-shin exo sng axi mnl loc					
L5711	A		Knee-shin exo mnl lock ultra					
L5712	A		Knee-shin exo frict swg & st					
L5714	A		Knee-shin exo variable frict					
L5716	A		Knee-shin exo mech stance ph					
L5718	A		Knee-shin exo frct swg & sta					
L5722	A		Knee-shin pneum swg frct exo					
L5724	A		Knee-shin exo fluid swing ph					
L5726	A		Knee-shin ext jnts fld swg e					
L5728	A		Knee-shin fluid swg & stance					
L5780	A		Knee-shin pneum/hydra pneum					
L5781	A	NI	Lower limb pros vacuum pump					
L5782	A	NI	HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5846	A		Knee-shin sys microprocessor					
L5847	A		Microprocessor cntrl feature					
L5848	A	NI	Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					
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					
L5995	A	NI	Lower ext pros heavyduty fea					
L5999	A		Lowr extremity prosthes NOS					
L6000	A		Par hand robin-aids thum rem					
L6010	A		Hand robin-aids little/ring					
L6020	A		Part hand robin-aids no fing					
L6025	A	NI	Part hand disart myoelectric					
L6050	A		Wrst MLd sck flx hng tri pad					
L6055	A		Wrst mold sock w/exp interfa					
L6100	A		Elb mold sock flex hinge pad					
L6110	A		Elbow mold sock suspension t					
L6120	A		Elbow mold doub 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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L6638	A	NI	Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A	NI	Multipo locking shoulder jnt					
L6647	A	NI	Shoulder lock actuator					
L6648	A	NI	Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					
L6686	A		Suction socket					
L6687	A		Frame typ socket bel elbow/w					
L6688	A		Frame typ sock above elb/dis					
L6689	A		Frame typ socket shoulder di					
L6690	A		Frame typ sock interscap-tho					
L6691	A		Removable insert each					
L6692	A		Silicone gel insert or equal					
L6693	A		Lockingelbow forearm cntrbal					
L6700	A		Terminal device model #3					
L6705	A		Terminal device model #5					
L6710	A		Terminal device model #5x					
L6715	A		Terminal device model #5xa					
L6720	A		Terminal device model #6					
L6725	A		Terminal device model #7					
L6730	A		Terminal device model #7lo					
L6735	A		Terminal device model #8					
L6740	A		Terminal device model #8x					
L6745	A		Terminal device model #88x					
L6750	A		Terminal device model #10p					
L6755	A		Terminal device model #10x					
L6765	A		Terminal device model #12p					
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model#555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A	NI	Replacemnt lithium ionbatter					
L7368	A	NI	Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Vacuum erection system					
L8000	A		Mastectomy bra					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.1434	$59.63	$9.97	$11.93
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
P2028	A		Cephalin floculation test					
P2029	A		Congo red blood test					
P2031	E		Hair analysis					
P2033	A		Blood thymol turbidity					
P2038	A		Blood mucoprotein					
P3000	A		Screen pap by tech w md supv					
P3001	E		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950	1.6860	$87.93		$17.59
P9011	E		Blood split unit					
P9012	K		Cryoprecipitate each unit	0952	0.5620	$29.31		$5.86
P9016	K		RBC leukocytes reduced	0954	2.2868	$119.26		$23.85
P9017	K		One donor fresh frozn plasma	0955	1.8217	$95.00		$19.00
P9019	K		Platelets, each unit	0957	0.7946	$41.44		$8.29
P9020	K		Plaelet rich plasma unit	0958	1.0271	$53.56		$10.71
P9021	K		Red blood cells unit	0959	1.6569	$86.41		$17.28
P9022	K		Washed red blood cells unit	0960	3.0813	$160.69		$32.14
P9023	K		Frozen plasma, pooled, sd	0949	2.3837	$124.31		$24.86
P9031	K		Platelets leukocytes reduced	1013	0.9496	$49.52		$9.90
P9032	K		Platelets, irradiated	9500	1.4341	$74.79		$14.96
P9033	K		Platelets leukoreduced irrad	0954	2.2868	$119.26		$23.85
P9034	K		Platelets, pheresis	9501	7.8390	$408.81		$81.76
P9035	K		Platelet pheres leukoreduced	9501	7.8390	$408.81		$81.76
P9036	K		Platelet pheresis irradiated	9502	8.5076	$443.68		$88.74
P9037	K		Plate pheres leukoredu irrad	1019	7.7905	$406.28		$81.26
P9038	K		RBC irradiated	9505	2.0833	$108.65		$21.73
P9039	K		RBC deglycerolized	9504	3.5174	$183.44		$36.69
P9040	K		RBC leukoreduced irradiated	9504	3.5174	$183.44		$36.69
P9041	K		Albumin (human),5%, 50ml	0961	0.9980	$52.05		$10.41
P9043	K		Plasma protein fract,5%,50ml	0956	1.7829	$92.98		$18.60
P9044	K		Cryoprecipitatereducedplasma	1009	0.7170	$37.39		$7.48
P9045	K		Albumin (human), 5%, 250 ml	0963	4.9708	$259.23		$51.85
P9046	K		Albumin (human), 25%, 20 ml	0964	1.0756	$56.09		$11.22
P9047	K		Albumin (human), 25%, 50ml	0965	2.6840	$139.97		$27.99
P9048	K		Plasmaprotein fract,5%,250ml	0966	8.9145	$464.90		$92.98
P9050	K		Granulocytes, pheresis unit	9506	23.9432	$1,248.66		$249.73
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	1.6085	$83.88	$41.44	$16.78
Q0081	T		Infusion ther other than che	0120	2.1802	$113.70	$30.75	$22.74
Q0083	S		Chemo by other than infusion	0116	0.7752	$40.43		$8.09
Q0084	S		Chemotherapy by infusion	0117	3.6046	$187.98	$48.28	$37.60
Q0085	S		Chemo by both infusion and o	0118	5.4844	$286.02	$72.03	$57.20
Q0086	A		Physical therapy evaluation/					
Q0091	T		Obtaining screen pap smear	0191	0.2035	$10.61	$3.08	$2.12
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733	0.1744	$9.10		$1.82
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					
Q0165	E		Prochlorperazine maleate10mg					
Q0166	N		Granisetron HCl 1 mg oral					
Q0167	N		Dronabinol 2.5mg oral					
Q0168	E		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	E		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	E		Chlorpromazine HCl 25mg oral					
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	E		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	E		Hydroxyzine pamoate 50mg					
Q0179	N		Ondansetron HCl 8mg oral					
Q0180	N		Dolasetron mesylate oral					
Q0181	E		Unspecified oral anti-emetic					
Q0183	N		Nonmetabolic active tissue					
Q0184	N		Metabolically active tissue					
Q0187	K		Factor viia recombinant	1409	20.7844	$1,083.93		$216.79
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	N		Elliotts b solution per ml					
Q2003	N		Aprotinin, 10,000 kiu					
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024	2.2965	$119.76		$23.95
Q2006	K		Digoxin immune fab (ovine)	7025	4.9805	$259.74		$51.95
Q2007	N		Ethanolamine oleate 100 mg					
Q2008	N		Fomepizole, 15 mg					
Q2009	N		Fosphenytoin, 50 mg					
Q2010	N		Glatiramer acetate, per dose					
Q2011	K		Hemin, per 1 mg	7030	0.0097	$.51		$.10
Q2012	N		Pegademase bovine, 25 iu					
Q2013	N		Pentastarch 10% solution					
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035	1.9573	$102.08		$20.42
Q2018	N		Urofollitropin, 75 iu					
Q2019	K		Basiliximab	1615	13.3621	$696.85		$139.37
Q2020	E		Histrelin acetate					
Q2021	N		Lepirudin					
Q2022	K		VonWillebrandFactrCmplxperIU	1618	0.0194	$1.01		$.20
Q3001	N		Brachytherapy Radioelements					
Q3002	N		Gallium ga 67					
Q3003	K		Technetium tc99m bicisate	1620	3.8759	$202.13		$40.43
Q3004	N		Xenon xe 133					
Q3005	N		Technetium tc99m mertiatide					
Q3006	N		Technetium tc99m glucepatate					
Q3007	N		Sodium phosphate p32					
Q3008	K		Indium 111-in pentetreotide	1625	8.2169	$428.52		$85.70
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	1.5891	$82.87		$16.57
Q3012	N		Cyanocobalamin cobalt co57					
Q3014	A		Telehealth facility fee					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3017	E	DG	ALS assessment					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3021	K	NI	Ped hepatitis b vaccine inj	0355	0.2132	$11.12		$2.22
Q3022	K	NI	Hepatitis b vaccine adult ds	0356	0.7655	$39.92		$7.98
Q3023	K	NI	Injection hepatitis Bvaccine	0356	0.7655	$39.92		$7.98
Q3025	K	NI	IM inj interferon beta 1-a	9022	0.9302	$48.51		$9.70
Q3026	N	NI	Subc inj interferon beta-1a					
Q4001	A		Cast sup body cast plaster					
Q4002	A		Cast sup body cast fiberglas					
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					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
T1016	E	NI	Case management					
T1017	E	NI	Targeted case management					
T1018	E	NI	School-based IEP ser bundled					
T1019	E	NI	Personal care ser per 15 min					
T1020	E	NI	Personal care ser per diem					
T1021	E	NI	HH Aide or cn aide per visit					
T1022	E	NI	Contracted services per day					
T1023	E	NI	Program intake assessment					
T1024	E	NI	Team evaluation & management					
T1025	E	NI	Ped compr care pkg, per diem					
T1026	E	NI	Ped compr care pkg, per hour					
T1027	E	NI	Family training & counseling					
T1028	E	NI	Home environment assessment					
T1029	E	NI	Dwelling lead investigation					
T1030	E	NI	RN home care per diem					
T1031	E	NI	LPN home care per diem					
T1500	E	NI	Reusable diaper/pant					
T1502	E	NI	Medication admin visit					
T1999	E	NI	NOC retail items andsupplies					
T2001	E	NI	N-et; patient attend/escort					
T2002	E	NI	N-et; per diem					
T2003	E	NI	N-et; encounter/trip					
T2004	E	NI	N-et; commerc carrier pass					
T2005	E	NI	N-et; stretcher van					
T2006	E	NI	Amb response & trt, no trans					
T2007	E	NI	Non-emer transport wait time					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					
V2100	A		Lens spher single plano 4.00					
V2101	A		Single visn sphere 4.12-7.00					
V2102	A		Singl visn sphere 7.12-20.00					
V2103	A		Spherocylindr 4.00d/12-2.00d					
V2104	A		Spherocylindr 4.00d/2.12-4d					
V2105	A		Spherocylinder 4.00d/4.25-6d					
V2106	A		Spherocylinder 4.00d/>6.00d					
V2107	A		Spherocylinder 4.25d/12-2d					
V2108	A		Spherocylinder 4.25d/2.12-4d					
V2109	A		Spherocylinder 4.25d/4.25-6d					
V2110	A		Spherocylinder 4.25d/over 6d					
V2111	A		Spherocylindr 7.25d/.25-2.25					
V2112	A		Spherocylindr 7.25d/2.25-4d					
V2113	A		Spherocylindr 7.25d/4.25-6d					
V2114	A		Spherocylinder over 12.00d					
V2115	A		Lens lenticular bifocal					
V2116	A		Nonaspheric lens bifocal					
V2117	A		Aspheric lens bifocal					

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CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
V5095	E	NI	Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E	NI	Hearing aid noc					
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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ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Ambulance	Ambulance Fee Schedule.
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule.
A	Durable Medical Equipment, Prosthetics and Orthotics (excluding implanted DME and prosthetics).	DMEPOS Fee Schedule.
A	EPO for ESRD Patients	National Rate.
A	Physical, Occupational and Speech Therapy	Physician Fee Schedule.
A	Physician Services for ESRD Patients	Physician Fee Schedule.
A	Screening Mammography	Physician Fee Schedule.
C	Inpatient Procedures	Not Payable under OPPS; Admit Patient; Bill as Inpatient.
D	Deleted Code	Deleted Effective Beginning of Calendar Year.
E	Non-Covered Items and Services, Codes not Reportable in Hospital Outpatient Settings.	Not Paid Under Medicare or When Performed in a Hospital Outpatient Setting.
F	Corneal tissue acquisition; orphan drugs	Paid at Reasonable Cost.
G	Drug/Biological Pass-Through	Paid Under OPPS; Separate APC Payment Includes Pass Through Amount.
H	Device Category Pass-Through	Paid Under OPPS; Separate Cost Based Pass Through Payment.
K	Non Pass-Through Drug/Biological, Radiopharmaceutical Agents, Certain Brachytherapy seeds.	Paid Under OPPS; Separate APC.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Paid reasonable cost; not subject to deductible or coinsurance.
N	Items and Services Packaged into APC Rate	Paid under OPPS; Payment Is Packaged Into Payment for Other Services.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Indicator	Service	Status
P	Partial Hospitalization	Paid under OPPS; Per Diem APC.
S	Significant Procedure, Not Discounted When Multiple	Paid Under OPPS; Separate APC.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under OPPS; Separate APC.
V	Visit to Clinic or Emergency Department	Paid Under OPPS; Separate APC .
X	Ancillary Service	Paid Under OPPS; Separate APC.

ADDENDUM D1.—CODE CONDITIONS

Code condition	Descriptor
DG	Deleted code with a grace period; payment will be made under the deleted code in accord with the status indicator during the standard grace period.
DNG	Deleted code with no grace period; payment will not be made under the deleted code after January 1, 2003.
NF	New code final APC assignment; comments were accepted on a proposed APC assignment in the NPRM; APC assignment is no longer open to comment.
NI	New code interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck/chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1-2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip arthroplasty
27132	C	Total hip arthroplasty
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh
27472	C	Repair/graft of thigh

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
31760	C	Repair of windpipe

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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
31766	C	Reconstruction of windpipe
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
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

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CPT/HCPCS	Status indicator	Description
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
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

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CPT/HCPCS	Status indicator	Description
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects
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

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CPT/HCPCS	Status indicator	Description
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Major vessel shunt
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
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

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CPT/HCPCS	Status indicator	Description
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
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
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

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CPT/HCPCS	Status indicator	Description
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
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

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CPT/HCPCS	Status indicator	Description
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
37182	C	Insert hepatic shunt (tips)
37183	C	Remove hepatic shunt (tips)
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
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

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CPT/HCPCS	Status indicator	Description
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Parital removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty 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

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CPT/HCPCS	Status indicator	Description
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/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

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CPT/HCPCS	Status indicator	Description
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal 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

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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
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
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
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, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas

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CPT/HCPCS	Status indicator	Description
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49201	C	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
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Renal abscess, open drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney

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CPT/HCPCS	Status indicator	Description
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove k/ureter
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy/radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes

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CPT/HCPCS	Status indicator	Description
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
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy

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CPT/HCPCS	Status indicator	Description
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58146	C	Myomectomy abdom complex
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	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
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion

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CPT/HCPCS	Status indicator	Description
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
61322	C	Decompressive craniotomy
61323	C	Decompressive lobectomy
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit/remove lesion
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
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

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CPT/HCPCS	Status indicator	Description
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
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

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CPT/HCPCS	Status indicator	Description
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
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, addl cervical
63044	C	Laminotomy, addl lumbar
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
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

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CPT/HCPCS	Status indicator	Description
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
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
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
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
0033T	C	Endovasc taa repr incl subcl
0034T	C	Endovasc taa repr w/o subcl
0035T	C	Insert endovasc prosth, taa
0036T	C	Endovasc prosth, taa, add-on
0037T	C	Artery transpose/endovas taa
0038T	C	Rad endovasc taa rpr w/cover
0039T	C	Rad s/i, endovasc taa repair
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
0040T	C	Rad s/i, endovasc taa prosth
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
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

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ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX [2]	0.7827
Taylor, TX	
0060 Aguadilla, PR	0.4587
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9600
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0594
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY [2]	0.8542
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9390
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7883
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9735
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9225
Blair, PA	
0320 Amarillo, TX	0.9034
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2490
Anchorage, AK	
0440 Ann Arbor, MI	1.1103
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8044
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI [2]	0.9162

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR [2]	0.4356
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9876
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0211
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA [1]	0.9991
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1017
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8325
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0264
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX [1]	0.9637
Bastrop, TX	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9899
Kern, CA	
0720 Baltimore, MD [1]	0.9929
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9664
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3202
Barnstable, MA	
0760 Baton Rouge, LA	0.8294
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8324
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2282
Whatcom, WA	
0870 Benton Harbor, MI	0.9106
Berrien, MI	
0875 Bergen-Passaic, NJ [1]	1.2207
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9022
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8757
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY [2]	0.8542
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9222
Blount, AL	
Jefferson, AL	
St. Clair, AL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Shelby, AL	
1010 Bismarck, ND	0.7972
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8907
Monroe, IN	
1040 Bloomington-Normal, IL	0.9109
McLean, IL	
1080 Boise City, ID	0.9310
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals) [1 2]	1.1288
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals) [1]	1.1235
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	0.9689
Boulder, CO	
1145 Brazoria, TX	0.8535
Brazoria, TX	
1150 Bremerton, WA	1.0944
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8880
Cameron, TX	
1260 Bryan-College Station, TX	0.8821
Brazos, TX	
1280 Buffalo-Niagara Falls, NY [1]	0.9365
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0052
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4408
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8932
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9690
Natrona, WY	
1360 Cedar Rapids, IA	0.9056
Linn, IA	
1400 Champaign-Urbana, IL	1.0635
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9235
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8898
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC [1]	0.9850
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0438
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.8976
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY [2]	0.9007
Laramie, WY	
1600 Chicago, IL [1]	1.1044
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA [2]	0.9840
Butte, CA	
1640 Cincinnati, OH-KY-IN [1]	0.9389
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	0.8419
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH [1]	0.9670
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9916
El Paso, CO	
1740 Columbia, MO	0.8515
Boone, MO	
1760 Columbia, SC	0.9307
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8374
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH [1]	0.9751
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8729
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1453
Benton, OR	
1900 Cumberland, MD-WV (MD Hospitals) [2]	0.8946
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospitals) [2]	0.7975
Allegany, MD	
Mineral, WV	
1920 Dallas, TX [1]	0.9998
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8859
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8835
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9282
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9062
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8973
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL [2]	0.8204
Macon, IL	
2080 Denver, CO [1]	1.0601
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8827

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI [1]	1.0448
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8158
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9356
Kent, DE	
2200 Dubuque, IA	0.8795
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0368
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0684
Dutchess, NY	
2290 Eau Claire, WI [2]	0.9162
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9265
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9722
Elkhart, IN	
2335 Elmira, NY [2]	0.8542
Chemung, NY	
2340 Enid, OK	0.8376
Garfield, OK	
2360 Erie, PA	0.8925
Erie, PA	
2400 Eugene-Springfield, OR	1.0944
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals) [2]	0.8755
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8177
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9684
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8992
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8100
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0682
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1135
Genesee, MI	
2650 Florence, AL	0.7819
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8780
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0066
Larimer, CO	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
2680 Ft. Lauderdale, FL [1]	1.0704
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9680
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9931
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7895
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9693
Okaloosa, FL	
2760 Fort Wayne, IN	0.9457
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX [1]	0.9446
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0216
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8599
Etowah, AL	
2900 Gainesville, FL	0.9871
Alachua, FL	
2920 Galveston-Texas City, TX	0.9465
Galveston, TX	
2960 Gary, IN	0.9584
Lake, IN	
Porter, IN	
2975 Glens Falls, NY [2]	0.8542
Warren, NY	
Washington, NY	
2980 Goldsboro, NC Wayne, NC	0.8892
2985 Grand Forks, ND-MN	0.9243
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9679
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI [1]	0.9548
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8966
Cascade, MT	
3060 Greeley, CO	0.9336
Weld, CO	
3080 Green Bay, WI	0.9668
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC [1]	0.9282
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9174

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9122
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9268
Washington, MD	
3200 Hamilton-Middletown, OH	0.9418
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9223
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT [1 2]	1.2394
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS [2]	0.7680
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9028
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1457
Honolulu, HI	
3350 Houma, LA	0.8385
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX [1]	0.9892
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9636
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8903
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN [1]	0.9717
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9587
Johnson, IA	
3520 Jackson, MI	0.9532
Jackson, MI	
3560 Jackson, MS	0.8607

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9275
Madison, TN	
Chester, TN	
3600 Jacksonville, FL [1]	0.9381
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC [2]	0.8666
Onslow, NC	
3610 Jamestown, NY [2]	0.8542
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9849
Rock, WI	
3640 Jersey City, NJ	1.1190
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8337
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) [2]	0.8504
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA [2]	0.8462
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7843
Craighead, AR	
3710 Joplin, MO	0.8613
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0595
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL [2]	0.8204
Kankakee, IL	
3760 Kansas City, KS-MO [1]	0.9736
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	0.9686
Kenosha, WI	
3810 Killeen-Temple, TX	0.9570
Bell, TX	
Coryell, TX	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
3840 Knoxville, TN	0.8970
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9038
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9400
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8475
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9278
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7965
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9357
Polk, FL	
4000 Lancaster, PA	0.9078
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9726
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8472
Webb, TX	
4100 Las Cruces, NM [2]	0.8872
Dona Ana, NM	
4120 Las Vegas, NV-AZ [1]	1.1521
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7923
Douglas, KS	
4200 Lawton, OK	0.8315
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9179
Androscoggin, ME	
4280 Lexington, KY	0.8581
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9892
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.9097
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8629
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA [1]	1.2011

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Los Angeles, CA	
4520 Louisville, KY-IN [1]	0.9276
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.9646
Lubbock, TX	
4640 Lynchburg, VA	0.9219
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9250
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0467
Dane, WI	
4800 Mansfield, OH	0.8900
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4914
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8428
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0498
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	1.0253
Brevard, Fl	
4920 Memphis, TN-AR-MS [1]	0.8920
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA [2]	0.9840
Merced, CA	
5000 Miami, FL [1]	0.9815
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ [1]	1.1213
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI [1]	0.9893
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI [1]	1.0903
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.9157
Missoula, MT	
5160 Mobile, AL	0.8110
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0498
Stanislaus, CA	
5190 Monmouth-Ocean, NJ [1]	1.0814
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8137
Ouachita, LA	
5240 Montgomery, AL	0.7734
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9284
Delaware, IN	
5330 Myrtle Beach, SC	0.8976
Horry, SC	
5345 Naples, FL	0.9754
Collier, FL	
5360 Nashville, TN [1]	0.9578
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY [1]	1.3357
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury- Danbury, CT [1]	1.2459
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT [2]	1.2394
New London, CT	
5560 New Orleans, LA [1]	0.9046
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY [1]	1.4414
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ [1]	1.1406
Essex, NJ	
Morris, NJ	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1387
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC [1]	0.8574
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 Oakland, CA [1]	1.5185
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9402
Marion, FL	
5800 Odessa-Midland, TX	0.9397
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK [1]	0.8900
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0960
Thurston, WA	
5920 Omaha, NE-IA	0.9978
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA [1]	1.1594
Orange, CA	
5960 Orlando, FL [1]	0.9640
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8344
Daviess, KY	
6015 Panama City, FL	0.8865
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8127
Washington, OH	
Wood, WV	
6020 Parkersburg-Marietta, WV-OH (OH Hospitals) [2]	0.8613
Washington, OH	
Wood, WV	
6080 Pensacola, FL [2]	0.8814
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8739
Peoria, IL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ [1]	1.0713
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ [1]	0.9820
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7962
Jefferson, AR	
6280 Pittsburgh, PA [1]	0.9365
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA [2]	1.1288
Berkshire, MA	
6340 Pocatello, ID	0.9674
Bannock, ID	
6360 Ponce, PR	0.5169
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9794
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA [1]	1.0684
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI [1]	1.0854
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9984
Utah, UT	
6560 Pueblo, CO [2]	0.9015
Pueblo, CO	
6580 Punta Gorda, FL	0.9218
Charlotte, FL	
6600 Racine, WI	0.9334
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC [1]	0.9990
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6660 Rapid City, SD	0.8846
Pennington, SD	
6680 Reading, PA	0.9295
Berks, PA	
6690 Redding, CA	1.1135
Shasta, CA	
6720 Reno, NV	1.0648
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1491
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9477
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 Riverside-San Bernardino, CA [1]	1.1365
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8614
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.2139
Olmsted, MN	
6840 Rochester, NY [1]	0.9194
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9625
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9228
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA [1]	1.1513
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9650
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9785
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO [2]	0.8026
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL [1]	0.8855
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0367
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4623
Monterey, CA	
7160 Salt Lake City-Ogden, UT [1]	0.9945
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8374
Tom Green, TX	
7240 San Antonio, TX [1]	0.8753
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA [1]	1.1135
San Diego, CA	
7360 San Francisco, CA [1]	1.4142
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA [1]	1.4145
Santa Clara, CA	
7440 San Juan-Bayamon, PR [1]	0.4741
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	1.1271
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0481
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3646
Santa Cruz, CA	
7490 Santa Fe, NM	1.0712
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3046
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9449
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9376
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8599
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA [1]	1.1474
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA [2]	0.8462
Mercer, PA	
7620 Sheboygan, WI [2]	0.9162
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9255
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8987
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9046
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9257
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9802
St. Joseph, IN	
7840 Spokane, WA	1.0852
Spokane, WA	
7880 Springfield, IL	0.8659
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8424
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA [2]	1.1288
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8941
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8804
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0650
San Joaquin, CA	
8140 Sumter, SC [2]	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9714
Cayuga, NY	
Madison, NY	
Onondaga, NY	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Oswego, NY	
8200 Tacoma, WA	1.0940
Pierce, WA	
8240 Tallahassee, FL [2]	0.8814
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL [1]	0.9171
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN [2]	0.8755
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8126
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9810
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9199
Shawnee, KS	
8480 Trenton, NJ	1.0432
Mercer, NJ	
8520 Tucson, AZ	0.8911
Pima, AZ	
8560 Tulsa, OK	0.8332
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8203
Tuscaloosa, AL	
8640 Tyler, TX	0.9521
Smith, TX	
8680 Utica-Rome, NY [2]	0.8542
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3421
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1096
Ventura, CA	
8750 Victoria, TX	0.8756
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0031
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA [2]	0.9840
Tulare, CA	
8800 Waco, TX	0.8088
McLennan, TX	
8840 Washington, DC-MD-VA-WV [1]	1.0851
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	0.8902
Black Hawk, IA	
8940 Wausau, WI	0.9782
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL [1]	0.9939
Palm Beach, FL	
9000 Wheeling, WV-OH (WV Hospitals) [2]	0.7975
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 Wheeling, WV-OH (OH Hospitals) [2]	0.8613
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9520
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8498
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8544
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1173
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9640
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0569
Yakima, WA	
9270 Yolo, CA [2]	0.9840
Yolo, CA	
9280 York, PA	0.9026
York, PA	
9320 Youngstown-Warren, OH	0.9358
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0276
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8589
Yuma, AZ	

[1] Large Urban Area.

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2003.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7727
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079
Louisiana	0.7647
Maine	0.8874
Maryland	0.8946
Massachusetts	1.1288
Michigan	0.9013
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8026
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	.....
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island [1]	.....
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7827
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Abilene, TX	0.7827
Akron, OH	0.9600
Albany, GA	1.0427
Albuquerque, NM	0.9390
Alexandria, LA	0.7883
Allentown-Bethlehem-Easton, PA	0.9735
Altoona, PA	0.9225
Amarillo, TX	0.8884
Anchorage, AK	1.2490
Ann Arbor, MI	1.1103
Anniston, AL	0.7910
Asheville, NC	0.9575
Athens, GA	1.0066
Atlanta, GA	0.9889
Augusta-Aiken, GA-SC	0.9887
Austin-San Marcos, TX	0.9637
Barnstable-Yarmouth, MA	1.2943
Baton Rouge, LA	0.8190
Bellingham, WA	1.1642
Benton Harbor, MI	0.9106
Bergen-Passaic, NJ	1.2207
Billings, MT	0.9022
Biloxi-Gulfport-Pascagoula, MS	0.8368
Binghamton, NY	0.8462
Birmingham, AL	0.9222
Bismarck, ND	0.7972
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1235
Burlington, VT	0.9572
Caguas, PR	0.4408
Casper, WY	0.9586
Champaign-Urbana, IL	0.9772
Charleston-North Charleston, SC	0.9235
Charleston, WV	0.8649
Charlotte-Gastonia-Rock Hill, NC-SC	0.9743
Charlottesville, VA	1.0120
Chattanooga, TN-GA	0.8843
Chicago, IL	1.0905
Cincinnati, OH-KY-IN	0.9389
Clarksville-Hopkinsville, TN-KY	0.8419
Cleveland-Lorain-Elyria, OH	0.9670
Columbia, MO	0.8515
Columbia, SC	0.9194
Columbus, GA-AL (GA Hospitals)	0.8230
Columbus, GA-AL (AL Hospitals)	0.7985
Columbus, OH	0.9549
Corpus Christi, TX	0.8729
Dallas, TX	0.9998
Davenport-Moline-Rock Island, IA-IL	0.8835
Dayton-Springfield, OH	0.9282
Denver, CO	1.0484
Des Moines, IA	0.8827
Detroit, MI	1.0448
Dothan, AL	0.8158
Dover, DE	0.9254
Duluth-Superior, MN-WI	1.0368
Eau Claire, WI	0.9162
Elkhart-Goshen, IN	0.9516
Erie, PA	0.8761
Eugene-Springfield, OR	1.0944
Fargo-Moorhead, ND-MN	0.9468
Fayetteville, NC	0.8992
Flagstaff, AZ-UT	1.0131
Flint, MI	1.0963
Florence, AL	0.7819
Florence, SC	0.8780
Fort Collins-Loveland, CO	1.0066
Ft. Lauderdale, FL	1.0704

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Fort Pierce-Port St. Lucie, FL	0.9931
Fort Smith, AR-OK	0.7738
Fort Walton Beach, FL	0.9430
Forth Worth-Arlington, TX	0.9446
Gadsden, AL	0.8599
Gainesville, FL	0.9871
Grand Forks, ND-MN	0.9243
Grand Junction, CO	0.9679
Grand Rapids-Muskegon-Holland, MI	0.9548
Great Falls, MT	0.8966
Greeley, CO	0.9336
Green Bay, WI	0.9668
Greensboro-Winston-Salem-High Point, NC	0.9129
Greenville, NC	0.9174
Harrisburg-Lebanon-Carlisle, PA	0.9223
Hartford, CT	1.1549
Hattiesburg, MS	0.7680
Hickory-Morganton-Lenoir, NC	0.8926
Houston, TX	0.9792
Huntington-Ashland, WV-KY-OH	0.9167
Huntsville, AL	0.8771
Indianapolis, IN	0.9717
Iowa City, IA	0.9442
Jackson, MS	0.8607
Jackson, TN	0.9002
Jacksonville, FL	0.9237
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8504
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8337
Jonesboro, AR (AR Hospitals)	0.7843
Jonesboro, AR (MO Hospitals)	0.8026
Joplin, MO	0.8613
Kalamazoo-Battlecreek, MI	1.0400
Kansas City, KS-MO	0.9736
Knoxville, TN	0.8970
Kokomo, IN	0.9038
Lafayette, LA	0.8316
Lakeland-Winter Haven, FL	0.9357
Las Vegas, NV-AZ	1.1521
Lawton, OK	0.8077
Lexington, KY	0.8581
Lima, OH	0.9483
Lincoln, NE	0.9711
Little Rock-North Little Rock, AR	0.8951
Longview-Marshall, TX	0.8629
Los Angeles-Long Beach, CA	1.2011
Louisville, KY-IN	0.9163
Lubbock, TX	0.9646
Lynchburg, VA	0.8909
Macon, GA	0.9250
Madison, WI	1.0467
Medford-Ashland, OR	1.0303
Memphis, TN-AR-MS	0.8712
Miami, FL	0.9815
Milwaukee-Waukesha, WI	0.9893
Minneapolis-St. Paul, MN-WI	1.0903
Missoula, MT	0.9047
Mobile, AL	0.8110
Modesto, CA	1.0498
Monmouth-Ocean, NJ	1.0814
Monroe, LA	0.8137
Montgomery, AL	0.7734
Nashville, TN	0.9375
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2459
New London-Norwich, CT	1.1626

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
New Orleans, LA	0.9046
New York, NY	1.4220
Newark, NJ	1.1406
Newburgh, NY-PA	1.0747
Norfolk-Virginia Beach-Newport News, VA-NC	0.8666
Oakland, CA	1.5185
Odessa-Midland, TX	0.9180
Oklahoma City, OK	0.8900
Omaha, NE-IA	0.9978
Orange County, CA	1.1594
Orlando, FL	0.9640
Peoria-Pekin, IL	0.8739
Philadelphia, PA-NJ	1.0713
Phoenix-Mesa, AZ	0.9820
Pine Bluff, AR	0.7798
Pittsburgh, PA	0.9224
Pittsfield, MA	0.9863
Pocatello, ID	0.9674
Portland, ME	0.9620
Portland-Vancouver, OR-WA	1.0684
Provo-Orem, UT	0.9984
Raleigh-Durham-Chapel Hill, NC	0.9990
Rapid City, SD	0.8846
Reading, PA	0.9108
Redding, CA	1.1135
Reno, NV	1.0466
Richland-Kennewick-Pasco, WA	1.0800
Richmond-Petersburg, VA	0.9477
Roanoke, VA	0.8614
Rochester, MN	1.2139
Rockford, IL	0.9399
Sacramento, CA	1.1513
Saginaw-Bay City-Midland, MI	0.9543
St. Cloud, MN	0.9785
St. Joseph, MO	0.8240
St. Louis, MO-IL	0.8855
Salinas, CA	1.4623
Salt Lake City-Ogden, UT	0.9945
San Antonio, TX	0.8753
San Diego, CA	1.1135
Santa Fe, NM	0.9891
Santa Rosa, CA	1.2761
Sarasota-Bradenton, FL	0.9449
Savannah, GA	0.9376
Seattle-Bellevue-Everett, WA	1.1474
Sherman-Denison, TX	0.9008
Shreveport-Bossier City, LA	0.8987
Sioux City, IA-NE	0.8647
Sioux Falls, SD	0.9059
South Bend, IN	0.9802
Spokane, WA	1.0663
Springfield, IL	0.8659
Springfield, MO	0.8153
Stockton-Lodi, CA	1.0650
Syracuse, NY	0.9612
Tampa-St. Petersburg-Clearwater, FL	0.9171
Texarkana,AR-Texarkana, TX	0.8126
Toledo, OH	0.9810
Topeka, KS	0.9031
Tucson, AZ	0.8911
Tulsa, OK	0.8332
Tuscaloosa, AL	0.8203
Tyler, TX	0.9195
Vallejo-Fairfield-Napa, CA	1.3421
Victoria, TX	0.8756
Waco, TX	0.8088
Washington, DC-MD-VA-WV	1.0851

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Waterloo-Cedar Falls, IA	0.8902
Wausau, WI	0.9782
West Palm Beach-Boca Raton, FL	0.9939
Wichita, KS	0.9179
Wichita Falls, TX	0.8498
Wilmington-Newark, DE-MD	1.0862
Wilmington, NC	0.9425
York, PA	0.9026
Youngstown-Warren, OH	0.9358

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Rural Alabama	0.7727
Rural Florida	0.8814
Rural Illinois (IA Hospitals)	0.8315
Rural Illinois (MO Hospitals)	0.8204
Rural Kentucky	0.8079
Rural Louisiana	0.7647
Rural Michigan	0.9013
Rural Minnesota	0.9151
Rural Missouri	0.8026

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Rural Montana	0.8481
Rural Nebraska	0.8204
Rural Nevada	0.9117
Rural Texas	0.7827
Rural Washington	1.0179
Rural Wyoming	0.9007

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Federal Register

Friday,
November 1, 2002

Part III

Department of Education

34 CFR Parts 600, 668, et al.
Federal Student Aid Programs; Final Rule

DEPARTMENT OF EDUCATION

34 CFR Parts 600, 668, 673, 674, 675, 682, 685, 690, and 694

RIN 1845–AA23

Federal Student Aid Programs

AGENCY: Office of Postsecondary Education, Department of Education.

ACTION: Final regulations.

SUMMARY: The Secretary amends the Institutional Eligibility Under the Higher Education Act of 1965, as Amended; Student Assistance General Provisions; General Provisions for the Federal Perkins Loan Program, Federal Work-Study Program, and Federal Supplemental Educational Opportunity Grant Program; Federal Perkins Loan (Perkins Loan) Program; Federal Work-Study (FWS) Programs; Federal Family Education Loan (FFEL) Program; William D. Ford Federal Direct Loan (Direct Loan) Program; Federal Pell Grant Program; and Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) regulations. The Secretary is amending these regulations to reduce administrative burden for program participants, and to provide them with greater flexibility to serve students and borrowers.

DATES: *Effective Date:* Except for the amendment to section 694.10, these regulations are effective July 1, 2003. The amendment to section 694.10 becomes effective December 2, 2002.

Implementation Date: The Secretary has determined, in accordance with section 482(c)(2)(A) of the Higher Education Act of 1965, as amended (HEA) (20 U.S.C. 1089(c)(2)(A)), that institutions, lenders, guaranty agencies, and state grant agencies that administer Title IV, HEA programs may, at their discretion, choose to implement all of the provisions of these final rules on or after November 1, 2002. For further information, see ''Implementation Date of These Regulations'' under the **SUPPLEMENTARY INFORMATION** section of this preamble.

FOR FURTHER INFORMATION CONTACT: For provisions related to the Title IV loan programs (Perkins Loan Program, FFEL Program, and Direct Loan Program): Ms. Gail McLarnon, U.S. Department of Education, 1990 K Street, NW, (8th Floor) Washington, DC 20006, Telephone: (202) 219–7048 or via the Internet: *Gail.McLarnon@ed.gov.*

For other provisions: Ms. Wendy Macias, U.S. Department of Education, 1990 K Street, NW, (8th Floor), Washington, DC, 20006, Telephone: (202) 502–7526 or via the Internet: *Wendy.Macias@ed.gov.*

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 August 6, 2002, and August 8, 2002, the Secretary published in the **Federal Register** two separate notices of proposed rulemaking (NPRMs) (67 FR 51036 and 67 FR 51718, respectively) for the Federal student assistance programs authorized by Title IV of the HEA. This document contains the final regulations for the rules that were proposed in both of these NPRMs.

The August 6, 2002 NPRM included proposed rules for the Student Assistance General Provisions, Perkins Loan Program, FFEL Program, and Direct Loan Program regulations.

In the preamble to the August 6, 2002 NPRM, the Secretary discussed on pages 51037 through 51046 the major changes proposed to improve the Federal student assistance programs. These included the following:

- Amending § 668.35 to state the conditions under which a borrower who is subject to a judgment obtained on a Title IV loan may regain eligibility for additional Title IV student financial assistance. [page 51037]
- Amending §§ 674.39, 682.405, and 685.211 to exclude from rehabilitation defaulted Perkins Loan, FFEL, and Direct Loan program loans on which a judgment has been obtained. [page 51037]
- Amending §§ 674.19, 682.402, and 682.414 to clarify the record retention requirements for promissory notes under the Perkins Loan and FFEL programs. [page 51038]
- Amending §§ 674.34, 682.210, and, by reference, 685.204, to modify the way loan holders in the Perkins Loan, FFEL, and Direct Loan programs calculate Federal postsecondary educational loan debt for purposes of determining a borrower's eligibility for an economic hardship deferment. [page 51039]
- Amending §§ 674.42, 682.604, and 685.304 to clarify that entities other than the institution may provide initial and exit loan counseling on the institution's behalf and to provide consistency in the information that must be disclosed to borrowers. [page 51039]
- Amending §§ 682.204 and 685.203 to clarify loan limits for separate stand-alone programs in the FFEL and Direct Loan programs. [page 51039]
- Amending § 682.210 and, by reference, § 685.204 to make it easier for borrowers in the FFEL and Direct Loan programs to certify eligibility for an unemployment deferment. [page 51040]
- Amending §§ 682.402, 685.212, and 685.220 to expand the instances where FFEL and Direct Loan program borrowers can have a portion of a consolidation loan discharged. [page 51040]
- Amending §§ 674.2 and 674.16 to provide for the use of a Master Promissory Note (MPN) in the Perkins Loan Program. [page 51041]
- Amending §§ 674.9 and 674.47 to modify the low-balance write-off options for institutions that participate in the Perkins Loan Program. [page 51042]
- Amending § 674.17 to clarify that when an institution participating in the Perkins Loan Program closes, or otherwise leaves the program, that institution must assign its outstanding loans to the Secretary and liquidate its Perkins Loan fund according to the Secretary's instructions. [page 51042]
- Amending §§ 674.33 and 674.42 to clarify the conditions under which an institution must coordinate minimum repayment options when a Perkins Loan borrower has received loans from more than one institution. [page 51042]
- Amending § 674.42 to provide flexibility to institutions that participate in the Perkins Loan Program in providing copies of promissory notes to borrowers. [page 51042]
- Amending § 674.43 to provide institutions increased flexibility in assessing late fees in the Perkins Loan Program. [page 51043]
- Amending § 674.45 to clarify when an institution that participates in the Perkins Loan Program must report a defaulted account to a national credit bureau. [page 51043]
- Amending § 674.46 to simplify the requirements for an institution that participates in the Perkins Loan Program to determine if it should initiate litigation against a defaulted borrower. [page 51043]
- Amending § 674.50 to provide consistency within the regulations for the assignment to the Secretary of Perkins loans. [page 51043]
- Amending § 682.200 to revise the definition of lender to clarify the treatment of loans held by trustee lenders. [page 51044]
- Amending § 682.209 to allow an FFEL lender to establish a borrower's first payment due date up to 60 days after the borrower enters repayment, to provide increased flexibility to FFEL

lenders when they receive updates to a borrower's enrollment status from an institution, and to provide a simplified method for a borrower in the FFEL Program to ask a lender to increase the length of the repayment period. [page 51044]

• Amending § 682.211 to simplify the process by which a lender and a borrower in the FFEL Program may agree to a discretionary forbearance. [page 51044]

• Amending § 682.402 to clarify that a State guaranty agency is not required to file a proof of claim in a bankruptcy filing and may instruct lenders not to file a proof of claim if filing a proof of claim would waive the State's sovereign immunity. [page 51045]

• Amending § 682.402 to provide that a guaranty agency may take up to 90 days to review a total and permanent disability discharge claim under the FFEL Program. [page 51045]

• Amending §§ 668.183 and 668.193 to revise, for purposes of calculating an institution's cohort default rate, the definition of a defaulted loan. [page 51045]

• Amending § 685.102 to modify the provisions governing the expiration of a Master Promissory Note in the Direct Loan Program. [page 51046]

The August 8, 2002 NPRM included proposed rules for the Institutional Eligibility Under the Higher Education Act of 1965, as Amended; Student Assistance General Provisions; General Provisions for the Federal Perkins Loan Program, Federal Work-Study Program, and Federal Supplemental Educational Opportunity Grant Program; FWS Programs; FFEL Program; Direct Loan Program; Federal Pell Grant Program; and GEAR UP regulations.

In the preamble to the August 8, 2002 NPRM, the Secretary discussed on pages 51720 through 51733 the major changes proposed to improve the Federal student assistance programs. These included the following:

• Amending § 600.8 to reflect that the statutory provision that a branch campus must be in existence for two years before seeking to be designated as a main campus applies only to proprietary institutions of higher education and postsecondary vocational institutions. [page 51720]

• Amending §§ 600.21, 600.31, and 668.174 to provide clarification and additional flexibility to the change of ownership provisions by expanding the definition of family members and broadening the transactions that are not considered to be a change of ownership. [page 51720]

• Amending §§ 668.2, 668.3, and 668.8 to remove the so-called ''12-hour'' rule that defined a week of instructional time for credit hour nonterm and nonstandard term educational programs. [page 51720]

• Amending §§ 668.4, 682.603, 685.301, and 690.75 to revise the definition of payment period for credit hour nonterm educational programs and to clarify the definition of a payment period when a student withdraws and then returns to school. [page 51721]

• Amending § 668.14 to clarify the statutory program participation agreement provision concerning incentive payment restrictions. [page 51722]

• Amending § 668.22 to clarify when an institution is considered to be one that is required to take attendance for purposes of determining a student's last date of attendance. [page 51725]

• Amending § 668.22 to simplify the definition of a leave of absence and to allow for multiple leaves of absence not to exceed 180 days in any 12-month period. [page 51726]

• Amending §§ 668.35, 673.5, and 690.79 to provide consistent requirements for handling Title IV overpayments, including a provision under which, in most cases, a student who owes an overpayment of a Title IV grant or loan of less than $25 does not lose eligibility for additional Title IV aid. [page 51726]

• Amending §§ 668.32 and 668.151 to eliminate the provision that limits the duration of a passing score on an approved ability-to-benefit (ATB) test to 12 months before a student initially receives Title IV aid. [page 51728]

• Amending § 668.164 to clarify when an institution is required to make a late disbursement and to provide increased flexibility for an institution to make a late disbursement to a student. [page 51728]

• Amending § 668.165 to eliminate the requirement that an institution must confirm the receipt of a notice sent electronically to a student or parent. [page 51730]

• Amending §§ 668.171 and 668.173 to establish clear requirements for returning unearned Title IV program funds and the conditions under which an institution must submit a letter of credit if it does not return those funds in a timely manner. [page 51730]

• Amending §§ 675.2 and 675.21 to provide greater flexibility for the employment of FWS students by proprietary institutions. [page 51731]

• Amending § 694.10 to remove language in the GEAR UP regulations related to the packaging of GEAR UP scholarships by institutions. [page 51732]

We strongly encourage the reader to refer to the preambles of both the August 6, 2002, and August 8, 2002, NPRMs for a full discussion of the topics proposed in those NPRMs and finalized in this document.

These final regulations contain a few changes from the NPRMs. We fully explain these changes in the *Analysis of Comments and Changes* elsewhere in this preamble.

Implementation Date of These Regulations

Section 482(c) of the HEA requires that regulations affecting programs under Title IV of the HEA be published in final form by November 1 prior to the start of the award year (July 1) to which they apply. However, that section also permits the Secretary to designate any regulation as one that an entity subject to the regulation may choose to implement earlier and the conditions under which the entity may implement the provisions early.

Note: Section 482 does not apply to the GEAR UP program (34 CFR part 694).

In response to our request in the NPRMs for suggestions on which provisions the Secretary should designate for early implementation, most of the commenters supported making all of the provisions available for early implementation at the discretion of the regulated entity. Therefore, consistent with the intent of this regulatory effort to reduce burden and to provide greater flexibility, the Secretary is using the authority granted him under section 482(c) to designate all of the regulations subject to that section included in this document for early implementation at the discretion of each institution, lender, guaranty agency, or state agency, as appropriate.

In accordance with the authority provided by section 482(c) of the HEA, the Secretary has determined that for some provisions, there are conditions that must be met in order for an institution, lender, guaranty agency, or state agency, as appropriate, to implement those provisions early. The conditions are—

Provision: Sections 674.34 and 682.210 that modify the formula used by Title IV loan holders when calculating a borrower's eligibility for an economic hardship deferment.

Condition: Until the Secretary has announced the approval of revised deferment forms, loan holders must provide alternative methods by which borrowers provide them with the loan detail information needed to perform the calculation using the modified formula.

Provision: Section 682.210 that modifies the information that a borrower must provide to a loan holder when requesting an unemployment deferment.

Condition: Until the Secretary has announced the approval of a revised deferment form, loan holders must provide alternative methods by which borrowers certify their eligibility for an unemployment deferment under the revised rules.

Provision: Sections 674.2 and 674.16 that provide for a Master Promissory Note (MPN) in the Federal Perkins Loan Program.

Condition: Implementation cannot occur until the Secretary has announced the approval of the Perkins MPN.

Provision: Section 668.22 that clarifies when an institution is considered to be one that is required to take attendance.

Condition: An institution must apply these provisions to all students who withdraw on or after the institution's implementation of these regulations.

Provision: Section 668.22 that provides increased flexibility in the granting of leaves of absence under the Return of Title IV Funds regulations.

Condition: An institution must apply these provisions to all students who are granted a leave of absence on or after the institution's implementation of these regulations.

Analysis of Comments and Changes

The regulations in this document were developed through the use of negotiated rulemaking. Section 492 of the HEA requires that, before publishing any proposed regulations to implement programs under Title IV of the HEA, the Secretary obtain public involvement in the development of the proposed regulations. After obtaining advice and recommendations, the Secretary must conduct a negotiated rulemaking process to develop the proposed regulations. All proposed regulations must conform to agreements resulting from the negotiated rulemaking process unless the Secretary reopens that process or explains any departure from the agreements to the negotiated rulemaking participants.

These regulations were published in proposed form on August 6, 2002, and on August 8, 2002, following the completion of the negotiated rulemaking process. The Secretary invited comments on the proposed regulations by October 7 for both NPRMs. We received 32 comments on the August 6, 2002 NPRM and 55 comments on the August 8, 2002 NPRM. In addition to their general support of our efforts to simplify the regulations and to reduce regulatory burden on students, borrowers, institutions, lenders, and guaranty agencies, the overwhelming majority of the commenters on both NPRMs also expressed support for the individual proposals included in the NPRMs.

We also received several comments on changes in the negotiated rulemaking process. Most of the commenters expressed appreciation to the Department of Education (Department) for the new scope and structure of the negotiated rulemaking process. Some commenters, however, felt that the Department should have included representatives of certain other organizations in the negotiations, but did not question the constituencies identified. Other commenters expressed the view that the Department should have excluded—and should exclude from future negotiations—individuals or groups that failed to negotiate in good faith and blocked consensus. We note that all organizations had an opportunity to submit institutional nominees and to form coalitions within the constituency groups identified and all nominations were carefully considered to achieve a balanced product. In creating the negotiating committees, the Department encouraged nominations of individuals from coalitions of individuals and organizations representing the constituencies. Moreover, the Department encouraged nominations of individuals who are actively involved in administering the Federal student financial assistance programs or whose interests are significantly affected by the regulations. We, and most of the commenters, believe that the Department was successful in assuring that individuals directly involved in administering the Federal student financial assistance programs appropriately represented the constituencies. In structuring future negotiations, however, the Department will take the comments received into consideration.

An analysis of the comments and of the changes in the regulations since publication of the NPRMs follows. We group major issues according to subject, with appropriate sections of the regulations referenced in parentheses. Generally, we do not address technical and other minor changes—and suggested changes the law does not authorize the Secretary to make.

Change of Ownership (Sections 600.21, 600.31, and 668.174)

Comments: One commenter requested that the preamble discussion clarify that a transfer by an owner to a family member does not require the family member acquiring the institution to have previously worked there.

Discussion: The commenter is correct that the exception does not require a family member of the owner to have worked at the institution.

Changes: None.

Definition of Academic Year—''12-Hour Rule'' (Sections 668.2, 668.3, and 668.8)

Comments: Most of the comments we received supported the proposed change that would eliminate the so-called ''12-hour'' rule for determining a week of instructional time for credit hour nonterm and nonstandard term educational programs. Most commenters were very supportive of the proposal to use a single standard for all educational programs by extending the current ''one-day'' rule used for term-based and clock hour programs to credit hour nonterm and nonstandard term programs. One commenter specifically noted that the 12-hour rule acted as an impediment to increasing access to higher education. Others noted that the 12-hour rule was at odds with the educational advantages that flexible program calendars and formats, including web-based programs, provide to working adults. Two commenters noted that the Web-based Education Commission, chartered by the Higher Education Amendments of 1998, called for the elimination of the 12-hour rule. Another commenter noted that the House of Representatives' Committee on Education and the Workforce called the 12-hour rule ''outdated and obsolete.'' Finally, a commenter, in support of the proposed change, agreed that the 12-hour rule sometimes results in disparities in the amount of Title IV, HEA program funding that students receive for the same amount of academic credit.

Discussion: We appreciate the commenters' support.

Changes: None.

Comments: A number of commenters expressed concern with the proposal or requested that we not proceed with this change to the regulations. None of these commenters suggested alternatives or modifications to the proposal that was included in the NPRM.

Several commenters suggested that the issue should await the reauthorization of the HEA, so that Congress could consider it in conjunction with other issues related to distance and other nontraditional modes of instruction. One commenter noted that an independent study of the use of the credit hour in postsecondary education was being undertaken and that the results of that study could help inform Congress on this and related issues. One commenter specifically

stated that Congress should address issues of cost of attendance and disbursement schedules for students enrolled in nontraditional programs.

Discussion: We created the one-day rule and the 12-hour rule to implement the statutory condition that an academic year consist of at least 30 weeks of instructional time. We believe that the 12-hour rule had many unintended consequences and believe that one single standard is preferable for the reasons we stated in the preamble to the August 8, 2002 NPRM. Since the original establishment of the rule was a regulatory action, we believe that it does not require any legislative action. Therefore, we see no need to wait for Congress to deal with this issue in the next reauthorization of the HEA. This change will allow Title IV, HEA program eligibility to be determined on the same basis regardless of how a student's academic program is structured. Thus it provides for consistent and equitable treatment for individuals seeking a postsecondary education. We note that nothing prevents Congress from taking further action on this or any other issue. Finally, we do not see the change to the one-day rule from the 12-hour rule as having any effect on how Congress should address issues of cost of attendance and disbursements in nontraditional programs.

Changes: None.

Comments: One commenter suggested that changing from the 12-hour rule to the one-day rule would add a new category of eligible programs, and therefore a new group of eligible students who would compete with students in more traditional programs for scarce Title IV grant funding.

Discussion: We disagree with the commenter. Programs that previously were covered by the 12-hour rule were eligible to participate in the Title IV, HEA programs. Therefore, we do not believe that this change will result in an increased number of students receiving Title IV assistance. Under the one-day rule, students enrolled in those programs would be able to receive the same amount of assistance that students in term-based programs currently do.

Changes: None.

Comments: A few commenters disagreed with the proposal to eliminate the 12-hour rule, based upon their view that, while not perfect, the requirement that a nonterm or nonstandard term academic program include at least 12 hours of instruction per week provides some assurance that the program provides sufficient educational content to make the student's and taxpayer's investment worthwhile. One commenter questioned whether educational quality can be measured by time, particularly given new technological delivery systems. However, the commenter felt that it would be inappropriate to eliminate the 12-hour rule at this time because matters of educational quantity/quality need further study. One commenter, representing several consumer law advocacy organizations, opposed the elimination of the 12-hour rule, suggesting that it currently provides a quantitative method to measure the quality of an academic program. The commenter also stated that the proposed change would encourage some institutions to reduce program content without a commensurate reduction in tuition and other charges.

Discussion: We disagree with the commenter that the 12-hour rule provided any assurance that institutions would provide a minimum quantity of education to warrant support under the Title IV, HEA programs. Hours of regularly scheduled instruction are not the exclusive measure of the quantity of education provided in a postsecondary educational program. For example, in certain educational programs, research papers and projects may make up a considerable portion of that program, and the work associated with carrying out those papers and projects would not be considered as instructional hours under the 12-hour rule or the one-day rule. We believe that the one-day rule is adequate for programs offered in traditional terms and have no evidence to suggest that it is inadequate for programs offered in nonstandard terms and nonterms.

The 12-hour rule was established to measure educational quantity, not educational quality. It was established to implement the statutory requirement that an academic year for Title IV, HEA program purposes had to contain at least 30 weeks of instructional time, which in turn was enacted for the purpose of determining how much Title IV, HEA program funds a student could receive. As we noted in the preamble to the August 8, 2002 NPRM, we believe that there are adequate safeguards in place to ensure program integrity, such as the changes to the definition of a payment period made by this final rule, the clock-hour/credit-hour conversion regulations, and program monitoring by accrediting agencies. Finally, we are aware of no evidence that the proposed change would encourage some institutions to reduce program content.

Changes: None.

Comments: One commenter suggested that our statement in the preamble to the August 8, 2002 NPRM that the clock-hour/credit-hour conversion regulations provide adequate safeguards is questionable since those requirements do not apply to programs that are two years or longer in length and lead to a degree. The commenter stated the belief that the existence of what was perceived to be ''low-content degree programs'' offered by for-profit institutions demonstrates that the clock-hour/credit-hour conversion is not as valuable as we had stated.

Discussion: We disagree with the commenter because, based upon our experience with the clock/credit hour conversion controversy, the problems that needed to be addressed were found in short-term vocational programs, not in associate and higher degree programs. Moreover, we have no evidence that any institutions have reduced educational content in educational programs that lead to associate and higher degrees.

Changes: None.

Comments: A commenter representing accrediting agencies asked for clarification as to whether the change from the 12-hour rule to the one-day rule will impose any additional responsibilities on those agencies or on the process by which the Secretary recognizes accrediting agencies.

Discussion: No additional regulatory requirements are being placed on accrediting agencies as a result of this change.

Changes: None.

Comments: Two commenters requested specific clarification as to what exactly constituted a day of instruction. One of those commenters asked how much time during each day must actually be spent on instruction. The other commenter asked specifically how one day would be counted for a program offered on-line. That same commenter suggested that we make it clear that the one-day rule did not have to be met on a week-by-week basis, but could be met on average. That is, the requisite number of days must be met over the course of the program.

Discussion: We do not believe it is appropriate for the Department to limit institutional flexibility by establishing a rigid definition of how many hours of instructional time must be included in order for a day to be considered a day of instruction. We agree with the commenter who suggested that the measure should be whether the institution can demonstrate that the activities that make up a day of instruction are reasonable in both content and time. We also will rely upon the determination of the relevant accrediting agency in this regard.

We disagree with the commenter who suggested that the one-day rule did not

require one day each week but could be met by the program having an average of one day per week over the course of the program. The basis for the one-day rule is the requirement contained in section 481 of the HEA that states that an academic year must contain at least 30 weeks of instructional time. The one-day rule simply defines a week of instructional time as one that includes at least one day of instruction or examinations. The regulations make it clear that a week is a consecutive seven-day period. Therefore, a week in which there is not at least one day of instruction or examination cannot be counted as one of the 30 weeks of instructional time required by the statute. In order for a program to meet the 30 weeks of instructional time requirement, it must include at least 30 separate weeks in which at least one day of instruction or examination occurs.

Changes: None.

Payment Periods (Sections 668.4, 682.603, 685.301, and 690.75)

Comments: One commenter was uncertain whether the proposal to require a payment period to be made up of both the requisite number (usually half) of credit hours in an academic year or program, and the requisite number (usually half) of weeks in the academic year or program was to be applied to both credit-hour programs with terms and credit-hour programs without terms.

Discussion: The proposal applies only to credit-hour programs without terms.

Changes: None.

Comments: A number of commenters supported the Department's proposal that students who withdraw from an institution during a payment period and then return within 180 days to the same program remain in the same payment period. But one commenter wondered what would happen when the student returns, and thus the resumption of the payment period, was in a different award year. The commenter suggested that, if some of the funds for the payment period were to be paid from a different (new) award year, they should be a percentage of the aid that would have been scheduled for that payment period in the new award year, equal to the percentage of the original payment period amount that was not disbursed or returned from the initial period of attendance.

Discussion: A student who was originally enrolled in a payment period that began, and was scheduled to end, in one award year could return after the end of that award year (June 30). However, the intent of these regulations is that such a student is considered, upon his or her return, to be in the same payment period. Therefore, any Title IV program funds that will be disbursed to the student should be paid from the original award year regardless of whether the resumption of the payment period is in a new award year. Generally, the original payment for the payment period would have come from the earlier award year and any new disbursements would be from that same year. Of course, if the original payment period had been a crossover payment period (one that was originally scheduled to begin in one award year and end in the following award year) and the institution had paid (or planned to pay) the student from the second award year, then the resumption of the payment period and any required disbursements would remain in the second award year.

Finally, even if the student's absence and subsequent return causes more than six months of the recalculated payment period to fall into the second award year, we will still consider that the institution's original decision to place the payment period in the first award year remains valid based on the fact that, at the time of that original choice, less than six months of the payment period was scheduled to fall into the second award year.

Changes: None.

Comments: With regard to the student's withdrawal and subsequent return (within 180 days) to the same program, one commenter asked whether, if aid had not been disbursed during the original enrollment, credits earned for the entire payment period, both those enrolled in before the withdrawal and those enrolled in after the return, could be included in determining payment eligibility.

Discussion: The regulation addressing the situation in which a student withdraws from a program and then returns to that program within 180 days applies only to clock-hour programs and credit-hour programs without terms. For those programs, the regulations define a payment period in a way that generally requires the clock-hours or credit-hours in one payment period to be completed before the next payment period begins. Further, students in those payment periods are generally paid for one-half of the program or academic year, as appropriate, at a time. Thus, regardless of whether the student had already been paid for a certain number of clock- or credit-hours before the student's withdrawal, upon the student's subsequent return to the same program within 180 days, the institution would not be adding hours to the payment period, but would simply be keeping the student in the same payment period (consisting of the same number of clock- or credit-hours) he or she was in before withdrawing. Then, upon completion of the hours (and weeks for a credit-hour without terms program) in that payment period, the student would advance to the next payment period.

Changes: None.

Comments: A number of commenters asked how a Return of Title IV Funds calculation would be performed if a student withdrew from a program during a payment period and returned to that program within 180 days, and then withdrew a second time during that same payment period.

Discussion: When a student withdraws (the first time) without completing the payment period, a Return of Title IV Funds calculation is performed. If the student returns to the program within 180 days of his or her initial withdrawal, the student is put back into the same payment period he or she withdrew from, and any Title IV funds that the student or institution returned to the Title IV programs or to a lender for that payment period as a result of the earlier withdrawal are restored to the student. If the student then withdraws from the institution again during that same payment period, a new Return of Title IV Funds calculation, based on the second withdrawal date, would be performed using the full payment period and the full amount of Title IV aid for the payment period.

Changes: None.

Comments: One commenter raised general questions about the way payment periods are determined for programs that measure progress in credit hours but do not use terms. The commenter suggested that there should not be any rigid rules for such programs, but that the institution should have flexibility in determining the length and timing of a student's payment period based upon the program length and a student's enrollment pattern.

Discussion: The changes proposed in the August 8, 2002 NPRM and finalized in this document do not address the entire concept of payment periods, but instead only relate to two issues: (1) For nonterm credit hour programs, requiring a payment period to include, in addition to half the number of credits in the academic year, program, or remainder of the program, also half the number of weeks in that period, and (2) guidance on the treatment for a student who withdraws from a clock-hour or credit-hour nonterm program, and then returns to school.

Therefore, since a more comprehensive review of payment

periods was not included in either the negotiated rulemaking process that led to the August 8, 2002 NPRM or in the proposal presented in the NPRM, we do not believe that it would be appropriate to make additional changes to the payment period regulations at this time.

Changes: None.

Comments: One commenter asked whether an institution should remove costs for the period that the student was out of school in those cases where the student withdrew from an institution and returned within 180 days, and was worried that if that were done the student might not qualify for the original loan amount once he returned to the institution.

Discussion: The cost of attendance would be the costs associated with the original period before the student withdrew. Once the student has withdrawn and then returned to the same program within a 180-day period, the regulation states that the student remains in the same payment period. The cost of attendance for such a student returning to the same program within 180 days must reflect the original educational costs associated with the payment period from which the student withdrew.

Changes: None.

Comments: One commenter suggested that if a student withdraws but returns to the institution during the period in which the institution is required to return funds under the Return of Title IV Funds calculation, the institution would not have to return any funds or notify the lender of the enrollment change. In essence, the student would be retroactively granted a leave of absence.

Discussion: If a student returns to the institution before the Title IV funds are returned, the institution is not required to return the funds. However, § 668.22(j) requires an institution to return unearned funds for which it is responsible as soon as possible, but no later than 30 days after the date of the institution's determination that the student withdrew. Therefore, an institution is expected to begin the Return of Title IV Funds process immediately upon its determination that a student has withdrawn.

Changes: None.

Comments: One commenter stated that it was his understanding that students who withdraw and return after 180 days, or transfer to new programs within any timeframe, have their payment periods restarted, and that this meant that these students would not have to complete the credits that they were already paid for before they could receive additional student aid payments.

Discussion: The regulation addresses the determination of payment periods for students who have withdrawn and either returned to the same program after 180 days, or returned to another program within any timeframe. The regulation specifies that students who have withdrawn and either returned to the same program after 180 days, or returned to another program within any timeframe start a new payment period. However, a student's eligibility for additional Title IV funds may be subject to a variety of limitations associated with the aid the student received during the most recent period of attendance. For example, in the Federal Pell Grant Program, a student may never receive more than the student's scheduled annual award. In the FFEL Program, there are limitations imposed by annual loan limits, the existence of crossover loan periods, and overlapping award years.

Changes: None.

Comments: A couple of commenters asked for further clarification of the payment period provisions as they relate to the Return of Title IV Funds provisions and various Title IV program provisions.

Discussion: We will provide additional clarification on the applicability of these changes through appropriate Department publications after publication of these final regulations.

Changes: None.

Program Participation Agreement (Section 668.14)

Comments: The vast majority of commenters supported the proposal that came out of the negotiated rulemaking sessions to establish safe harbors that institutions could use to avoid the statutory prohibition against making incentive payments to recruiters and other covered personnel.

Discussion: None.

Changes: None.

Comments: Some commenters opposed any change to the current regulations dealing with incentive compensation. They believed that the proposed regulations were not authorized under section 487(a)(20) of the HEA, were ambiguous, and were burdensome to institutions.

Discussion: We disagree with the commenters. With regard to the first point, we believe that the regulations lawfully implement section 487(a)(20) of the HEA. As indicated in the preamble to the proposed regulations, the Congress recognized that if given a strictly literal interpretation, section 487(a)(20) of the HEA could be interpreted to cover almost every compensation arrangement involving a student's ultimate admission to a postsecondary institution. As a result, when enacting section 487(a)(20) of the HEA in 1992, the conference report resolving the different House and Senate versions of the Higher Education Amendments of 1992 indicated that the statutory words ''directly'' and ''indirectly'' in section 487(a)(20) of the HEA did not imply that institutions could not base salaries or salary increases on merit. Thus, Congress recognized that the scope of section 487(a)(20) of the HEA had limits, even though that section precluded incentive payments based directly or indirectly on success in securing enrollments.

Consistent with this clarification of legislative intent, we based the proposed safe harbors on a ''purposive reading'' of section 487(a)(20) of the HEA. This purposive reading is based upon our view that Congress enacted this provision with the purpose of preventing an institution from providing incentives to its staff to enroll unqualified students.

In viewing the scope of section 487(a)(20) of the HEA through this purposive reading, we determined that various payment arrangements constituted legitimate business practices that did not support the enrollment of unqualified students and therefore did not fall within the scope of section 487(a)(20) of the HEA. Making these determinations is within the scope of the Secretary's authority of interpreting the statutory provisions he is charged with administering.

With regard to the commenters' other two points, we agree with the vast majority of commenters that, rather than being ambiguous, the safe harbors clarify the current law for most institutions by setting forth specific payment arrangements that an institution may carry out that have been determined not to violate the incentive compensation prohibition in section 487(a)(20) of the HEA. Moreover, no burden is placed upon an institution that uses a payment arrangement set forth in one of the safe harbors.

Changes: None.

Comments: The commenters who felt that the regulations were not authorized under section 487(a)(20) of the HEA also felt that any change to the current regulations would allow unscrupulous institutions to engage in the kinds of improper recruiting activities that gave rise to section 487(a)(20) of the HEA. They also felt that there was no demonstrated need for any change to the current regulations covering the

incentive compensation prohibition, and that any change should be made through legislation during the next HEA reauthorization.

Discussion: We believe that the primary purpose of the regulatory safe harbors is to provide guidance to institutions so they may adopt compensation arrangements that do not run afoul of the incentive compensation prohibition contained in section 487(a)(20) of the HEA. The safe harbors are based on comments we received from institutions during the FED UP initiative that requested that we provide clearer and more detailed guidance regarding this topic, suggestions by negotiators, and numerous questions we have received from institutions during the last eight years. We believe that institutions need this guidance now, and therefore it is neither necessary nor desirable to wait to make changes legislatively during the next HEA reauthorization.

Finally, we do not agree with the commenters that the safe harbors will allow unscrupulous institutions to engage in the kinds of improper recruiting activities that took place during the 1980s and early 1990s. As the commenters noted, during that period, institutions would recruit ability-to-benefit students who were not qualified to enroll in their institutions and keep the Title IV, HEA program funds those students received. That result is no longer possible today.

The incentive compensation prohibition is only one of the remedies that Congress has enacted to preclude such results. First, most of those unscrupulous institutions were terminated from participating in the Title IV, HEA programs because of their high cohort default rates. Second, there is a strengthened ability-to-benefit process that walls off institutions from the process and has higher standards of judging a student's ability-to-benefit. Third, if an institution enrolls unqualified students who then drop out, the institution may only keep Title IV, HEA program funds that the student has earned and must return unearned funds under the Return of Title IV Funds rules set forth in § 668.22. Fourth, under the default rate termination provisions, the institution would put its continuing eligibility to participate in the Title IV loan programs in jeopardy if their unqualified students fail to repay their loans. Finally, an institution could have its eligibility terminated if it misrepresents its programs to students.

Changes: None.

Comments: A commenter asked about the interrelationship between the various safe harbors.

Discussion: The 12 safe harbors are divided into two categories. The first category relates to whether a particular compensation payment is an incentive payment. The first safe harbor addresses this category by describing the conditions under which an institution may pay compensation without that compensation being considered an incentive payment.

The second category relates to the conditions under which an institution may make an incentive payment to an individual or entity that could be construed as based upon securing enrollments. The remaining 11 safe harbors address this category by describing the conditions under which such a payment may be made. These 11 safe harbors reflect our view that the individuals and activities described in a safe harbor are not covered by the statutory prohibition.

With regard to the latter 11 safe harbors, if an incentive payment arrangement falls within any one safe harbor, that payment arrangement is not covered by the statutory prohibition.

Changes: None.

Comments: Several commenters suggested that the Secretary include additional safe harbors in the final regulations and provided examples of safe harbors that they would like to see added.

Discussion: We proposed 12 safe harbors based upon the suggestions of the negotiators and questions we received regarding the incentive compensation prohibition. We intended that these safe harbors be clear and uncomplicated. As a result, we believe that institutions can use these safe harbors as a workable framework to determine if their payment arrangements violate the incentive compensation prohibition.

Changes: None.

Comments: A commenter suggested that we discuss the penalties that apply if an institution violates the incentive compensation prohibition.

Discussion: We believe that a discussion of the penalties for violating the incentive compensation prohibition are outside the scope of this exercise in developing final regulations for the provision.

Changes: None.

Comments: A commenter indicated that the safe harbors should specifically indicate that an institution could pay an incentive payment to a person or entity that was in the safe harbor.

Discussion: The last 11 safe harbors describe situations under which an institution can make an incentive payment to an individual or entity based upon success in securing enrollments. Therefore, it is not necessary to include that statement in each safe harbor. For this very reason, as noted below, we will eliminate the restriction in the last sentence in the ''clerical pre-enrollment'' safe harbor, § 668.14(b)(22)(ii)(F).

Changes: See discussion under Pre-Enrollment Activities.

Adjustments to Employee Compensation (Section 668.14(b)(22)(ii)(A))

Comments: Many commenters approved of our determination set forth in the first safe harbor that fixed compensation could include up to two adjustments in a twelve-month period as long as no adjustment is based solely on success in securing enrollments. Some commenters believed that two adjustments were too many; that two adjustments during a 12-month period was a loophole that institutions could use to bundle their bonuses and pay them as a salary adjustment.

Discussion: We believe that defining fixed compensation to include up to two pay adjustments during a 12-month period is not inconsistent with standard business practice, particularly as this safe harbor includes pay adjustments to an individual for any reason, including promotions.

Changes: None.

Comments: Almost all commenters approved our determination that one cost of living increase that is paid to all or substantially all employees would not count as one of the two allowable adjustments. One commenter asked the effect of an employer policy that withheld cost-of-living increases to poorly performing employees. Another pointed out that employers treat full-time employees differently from part-time employees, and suggested that cost of living increases that are paid to all or substantially all full-time employees not count as an adjustment in the safe harbor.

Discussion: We believe that if an employer has a written policy that indicates that cost of living increases are denied to poorly performing employees, that policy would not disqualify cost of living increases from being treated in the manner described in this safe harbor unless such a written policy has the effect of no longer applying the cost of living increase to ''all or substantially all'' employees, and other relevant factors reveal the increase to be tied to student recruitment and not within any of the prescribed safe harbors.

We agree with the commenters that employers often treat full-time employees differently from part-time employees, and therefore agree with the

commenters' suggestion that cost-of-living increases that are given to all or substantially all of an institution's full-time employees would not be considered a compensation adjustment.

Changes: Section 668.14(b)(22)(ii)(A) is changed to reflect that cost of living increases that are given to all or substantially all of an institution's full-time employees will not be considered a compensation adjustment.

Comments: Many commenters noted that salary adjustments could not be based solely on the number of students recruited, admitted, enrolled, or awarded financial aid, and asked whether the term ''solely'' was being used in its dictionary definition. If it was not, the commenters suggested a definition.

Discussion: In this safe harbor, the word ''solely'' is being used in its dictionary definition.

Changes: None.

Comments: Commenters raised a series of questions concerning various aspects of fixed compensation, including how overtime should be treated, how employee benefits should be treated, and the effect under this safe harbor if some of an institution's employees are unionized and others are not.

Discussion: With regard to overtime and benefits, if the basic compensation of an employee would not be an incentive payment, neither would overtime pay required under the Federal Labor Standards Act. Generally, the fact that some of an institution's employees are unionized and others are not should have no bearing on this safe harbor.

Changes: None.

Comments: One commenter asked about activities that recruiters could perform that would not be considered recruitment.

Discussion: There are a myriad of non-recruitment activities that a recruiter may engage in on a day-to-day basis, but we do not believe that it is practical nor necessary to provide an exhaustive list for purposes of this discussion.

Changes: None.

Enrollment in Programs That Are Not Eligible for Title IV, HEA Assistance (Section 668.14(b)(22)(ii)(B))

Comments: Some commenters objected to this safe harbor, because they believed that the Secretary had no authority to establish it because section 487(a)(20) of the HEA does not cover incentive payments to enroll students in educational programs that are not eligible programs under the Title IV, HEA programs. Another commenter objected to the safe harbor because it would encourage institutions to promote private loans.

Discussion: We disagree with the commenters. The safe harbor is authorized, as well as appropriate, because it informs institutions of the scope of the coverage of the incentive compensation prohibition of section 487(a)(20) of the HEA. Moreover, we believe that this safe harbor will have no bearing on whether institutions promote private loan programs to students attending ineligible programs.

Changes: None.

Contracts With Employers (Section 668.14(b)(22)(ii)(C))

Comments: Most commenters supported this safe harbor. The commenters recognized that the underlying rationale for the safe harbor was that an employer should have a significant stake in the education being offered its employees under a contract with an institution that uses a recruiter who receives an incentive payment. However, several commenters objected to the conditions that employers under this safe harbor had to satisfy. In particular, they objected to the conditions that an employer had to pay at least 50 percent of the tuition and fees charged its employees, and that recruiters have no contact with the employees. Some commenters recommended that these conditions be eliminated; that the employer/employee relationship itself provided a sufficient stake in the education being offered. Some commenters indicated that the percentage of tuition and fees that an employer had to pay should be a smaller percentage, while others indicated that the employer's stake in the education being offered could be demonstrated by other criteria. One commenter noted that literally no one could satisfy this safe harbor because a recruiter had to contact an employee in order to negotiate the contract. Another commenter recommended that Title IV, HEA program funds could not be used to pay the portion of the tuition and fees not paid by the employer.

Discussion: This safe harbor represents that, in general, business-to-business marketing of employer-provided education is not covered by the incentive compensation prohibition. However, not all business-to-business transactions are paid in the same manner, such as the straightforward payment by a company to an institution to educate its employees. This safe harbor deals with an iteration of that scheme; the payment of employees' tuition and fee charges by the employer under a contract arranged by an institution's recruiter who is paid an incentive.

In this safe harbor, the Secretary believes that the 50 percent requirement is a simple, straightforward standard to assure that an employer has a significant financial stake in the outcome of the education provided to its employees. This standard was supported by a majority of the negotiators. Therefore, we disagree with the commenters who suggested that this safe harbor be changed to allow an employer to pay less than 50 percent of its employees' tuition and fee charges.

With regard to the alternatives suggested by commenters, we believe that they are too complicated for a safe harbor. With regard to recruiter contact with employees, the contact that is prohibited does not include the contact necessary to obtain the contract.

Changes: None.

Profit-Sharing or Bonus Payments (Section 668.14(b)(22)(ii)(D))

Comments: Most commenters supported this safe harbor. However, one commenter objected to it because the commenter considered that the safe harbor could be manipulated. Several commenters pointed out that the safe harbor allowed a profit sharing plan to be limited to employees in an ''organizational level'' at an institution rather than the institution as a whole, and asked whether an organizational level in a multi-school institution could be one of the institutions. Other commenters suggested that the definition of ''profit'' be defined as ''total profit resulting when total costs are subtracted from total revenue at the institution.'' One commenter noted that while the regulatory safe harbor required that profit sharing or bonus payments be provided to all or substantially all of an institution's full-time employees, the preamble indicated that such payments had to be substantially the same amount, or based upon the same percentage of salary. The commenter recommended that the preamble requirement be eliminated as unnecessary. Moreover, if this condition is to be retained, the commenter proposed that percentage increases, like dollar increases, should also be substantially the same to all covered employees.

Discussion: We do not agree with the commenter who indicated that this safe harbor could be manipulated to provide incentive payments to recruiters under the guise of profit sharing because the payments must be made to all or substantially all of the full-time employees at one or more organizational level at the institution. In response to

comments relating to organizational level, we believe an ''organizational level'' at a multi-school institution would be one of the institutions.

We do not believe that it is necessary to define the term ''profit'' in this safe harbor as it is a commonly used business term that needs no explanation.

With regard to the last comment, we agree that a safe harbor should be in the regulation itself rather than in the preamble. Contrary to the commenter's suggestion, we believe that the safe harbor for bonuses and profit sharing should require that the payments to employees be substantially the same amount or the same percentage of salary. We do not, however, see the need to allow percentage increases to be substantially the same. We believe that this safe harbor already provides significant flexibility particularly since institutions can provide different percentages of compensation based on employees' organizational levels.

Changes: Section 668.14(b)(22)(ii)(D) is changed to reflect that the safe harbor only applies if the profit sharing or bonus payment is substantially the same amount or the same percentage of salary or wages.

Compensation Based Upon Completion of Program (Section 668.14(b)(22)(ii)(E))

Comments: Most commenters supported this safe harbor. However, several objected to it on the grounds that completion of an educational program is not a valid measure when the quality of an institution's programs is poor. One commenter, quoting from our preamble statement of April 24, 1994, when the current regulation was published, objected to the use of retention as a safe harbor, and also objected to the one-year retention period as too short.

Discussion: As previously indicated, we believe that the purpose of the incentive compensation prohibition is to prevent institutions from enrolling unqualified students. We note that other legislative and regulatory requirements are designed to weed out institutions with poor quality programs. We agree with most of the commenters that a student who successfully completes an educational program in which he or she was enrolled means, for this purpose, that the student was qualified to attend the institution.

With regard to retention, we believe that the successful completion of 24 semester or trimester credit hours, 36 quarter credit hours, or 900 clock hours of instruction also means that the student was qualified to enroll at the institution. Moreover, as a general matter, retention and completion of programs by students is a positive result that should be encouraged.

Changes: None.

Comments: Several commenters requested that the measure of whether a student completes one year of a program should be time rather than credits earned. One commenter asked whether all the required credits or hours had to be earned at the institution, or could they include transfer credits, life experience credit, or credits earned through tests. Another commenter asked whether the student had to earn one academic year of credit within the institution's satisfactory progress standard, and another asked whether the 30 weeks of instructional time element of the definition of an ''academic year'' was included in this safe harbor. A commenter indicated that the safe harbor should indicate that retention for one year is a minimum requirement and institutions are free to establish longer periods. Finally, one commenter asked whether a recruiter could get paid a bonus for each year the student successfully completes, so that the recruiter can theoretically receive four years of bonuses for a student enrolled in a four-year program.

Discussion: We believe that the appropriate method of measuring whether a student completes one academic year is by determining that the student has earned one academic year of credit rather than by not dropping out during a 12-month period. Therefore, we do not agree with the commenters' suggestions to substitute time for credits earned. To answer the questions raised by the other commenters: All the credits have to be earned at the institution as a result of taking courses at that institution; we have not applied the 30 weeks of instructional time element of the definition of an ''academic year'' to this safe harbor. Thus, this safe harbor applies when a student earns, for example, 24 semester credits no matter how short or long a time that takes.

We agree with the commenter that the one-year retention condition requirement is a minimum. Finally, if an institution so chooses, it may pay a recruiter a bonus for each academic year a student completes and not be in violation.

Changes: Section 668.14(b)(22)(ii)(E) is changed to reflect that the one academic year's worth of credit or hours must be earned at the institution.

Pre-Enrollment Activities (Section 668.14(b)(22)(ii)(F))

Comments: Most commenters supported this safe harbor. Some commenters objected to the requirement that the pre-enrollment activity had to be clerical in nature, with some noting that the clerical requirement was not in the proposed safe harbor itself, but was in the preamble discussion of the safe harbor. Some commenters concluded that the safe harbor described an individual rather than an activity, and based upon that interpretation, the commenters were concerned that recruiters could not be paid a bonus based upon their performance of pre-enrollment activities.

Some commenters requested that the list of pre-enrollment activities be expanded, and other commenters objected to the characterization that soliciting students for interviews is a recruitment activity rather than a pre-enrollment activity. Other commenters asked whether institutions could purchase leads to potential students for a flat fee from a third party under this safe harbor.

Discussion: We believe that one of the most important criterion for inclusion in this safe harbor is the clerical nature of the pre-enrollment activities that are being performed. Limiting pre-enrollment activities to rote clerical activities helps to draw the line between recruiting and pre-enrollment activity. Therefore, we will incorporate this requirement into the regulations.

We disagree with the characterization that this safe harbor describes an individual rather than an activity. However, by the very job description, a recruiter's job is to recruit. Therefore, as a practical matter, it would be very difficult for an institution to document that it was paying a bonus based upon enrollments to a recruiter solely for clerical pre-enrollment activities.

We are not going to expand the list of acceptable clerical pre-enrollment activities because no list will be all-inclusive, and we believe that institutions can determine whether activities qualify as clerical pre-enrollment activities based upon the current examples. Contrary to the commenter's conclusion, we believe that soliciting students for interviews is a core recruiting activity. Finally, although we believe that buying leads from third parties for a flat fee is not a clerical pre-enrollment activity under this safe harbor, we believe that the activity is not covered under the incentive compensation prohibition. Buying leads from third parties for a flat fee is not providing a commission, bonus, or other incentive payment based directly or indirectly on success in securing enrollments.

Changes: Section 668.14(b)(22)(ii)(F) is changed to add the requirement that pre-enrollment activities must be clerical in nature, and, for the reasons

stated earlier in connection with the general comments, we are deleting the requirement that compensation is not based upon the number of people actually enrolled.

Managerial and Supervisory Employees (Section 668.14(b)(22)(ii)(G))

Comments: One commenter objected to this safe harbor because the commenter believed that managers of recruiters and other covered persons should not be covered by the incentive compensation prohibition, and therefore should be included in this safe harbor. Other commenters objected to the preamble discussion of this safe harbor, where we indicated that an individual's occasional direct contact with students in the recruiting process would not turn that individual into a recruiter, because it would not necessarily be easy to determine whether an individual's involvement was occasional.

Discussion: As indicated in the preamble to the proposed regulations, we believe that direct supervisors of recruiters and other covered persons should be excluded from this safe harbor because their actions have a direct and immediate effect on the recruiters and other covered persons.

Changes: None.

Token Gifts (Section 668.14(b)(22)(ii)(H))

Comments: One commenter appreciated the increase in the cost of token gifts allowed under this safe harbor, indicating that it would eliminate concerns at many institutions.

Discussion: None.

Changes: None.

Profit Distributions (Section 668.14(b)(22)(ii)(I))

Comments: One commenter objected to this safe harbor because some institutions could treat revenue as profits.

Discussion: We disagree with the commenter because institutions participating in the Title IV, HEA programs must submit compliance audits and financial statement audits, and such audits would uncover this practice.

Changes: None.

Internet-Based Activities (Section 668.14(b)(22)(ii)(J))

Comments: Almost all commenters supported this safe harbor. One commenter agreed that the Internet is a communications medium much like the U.S. mail and direct mail solicitations. The commenter noted, however, that compensation arrangements between institutions and direct mail servicers are typically not based upon enrollments, and therefore suggested that the Internet safe harbor exclude compensation arrangements that are based upon enrollments.

Discussion: We disagree with the commenter. We believe that the use of the Internet is outside the scope of the incentive compensation prohibition, and, as indicated earlier, the point of the last 11 safe harbors is that they describe situations that would not violate the incentive compensation prohibition to make incentive payments to recruiters and other covered individuals based on enrollments. However, to highlight that the Internet is frequently used to refer prospective students to institutions, we are including that activity in the safe harbor.

Changes: Section 668.14(b)(22)(ii)(J) is changed to add referring prospective students to the institution as a described safe harbor.

Payments to Third Parties for Non-Recruitment Activities (Section 668.14(b)(22)(ii)(K))

Comments: One commenter requested that we clarify that recruiting activities do not include advertising or marketing.

Discussion: We agree with the commenter that if an institution pays a third party for marketing and advertising, those contracted services are not considered recruiting.

Changes: None.

Payments to Third Parties for Recruitment Activities (Section 668.14(b)(22)(ii)(L))

Comments: Several commenters specifically indicated their support for this safe harbor. Several others objected to it because they believed that it violated the spirit of the incentive compensation prohibition as well as the literal language of that provision.

Discussion: With regard to the reasons given by the commenters who objected to the safe harbor, as we stated in the preamble to the August 8, 2002 NPRM, we believe that Congress did not intend to limit an institution's ability to contract with outside entities for recruitment, admissions, enrollment, or financial aid services if the outside entity adheres to the same limitations that apply to institutions. Payments made by an institution to a third party would not violate the incentive payment restrictions as long as the individuals performing any activities related to recruitment, admissions, enrollment, or financial aid were compensated in a way that would otherwise be permissible under the standards in this section for covered employees of the institution.

Changes: None.

Institutions Required To Take Attendance (Section 668.22)

Comments: One commenter did not believe that an institution that is required to take attendance by an outside entity for a limited time for census purposes should automatically qualify as an institution that is required to take attendance for purposes of the Return of Title IV Funds calculation. The commenter indicated that census records may not be appropriate for determining a student's withdrawal date. As such, the commenter suggested that the length of a limited period of census taking does not matter. Rather, if the institution's policy does not result in a student being withdrawn as a result of the census data, the institution should not be considered one that is required to take attendance for the census period.

The commenter asked for clarification regarding the procedures that must be followed after the end of the period of required attendance taking.

Discussion: Census taking was merely an example of a reason why an institution might be required to take attendance by an outside entity for a limited period of time. As stated in the preamble to the August 8, 2002 NPRM, if the outside entity determines that the institution is required to take attendance for any period, for any purpose, including census purposes, then the institution is considered to be one that is required to take attendance for that period of time. We would like to emphasize that the change to the regulations related to determining whether an institution is one that is required to take attendance, specifically revises § 668.22(b)(3)(i) to state that it is such an institution only if the outside entity has determined that the institution is required to take attendance. Thus, if an outside entity that imposes census taking requirements does not consider its requirements to require an institution to take attendance continuously for the limited period of time, the institution would be considered an institution that is not required to take attendance for that period for Title IV purposes. The exception that the preamble addressed was that even if the outside entity considers a one-day census activity to be required attendance taking, we would not consider the institution to be one that is required to take attendance.

Unless an institution demonstrates that a withdrawn student who is not in attendance at the end of a limited period of required attendance taking attended after the limited period, the student's

withdrawal date would be determined according to the requirements for an institution that is required to take attendance. That is, the student's withdrawal date would be the last date of academic attendance as determined by the institution from its attendance records. If the institution demonstrates that the student attended past the end of the limited period, the student's withdrawal date is determined in accordance with the requirements for an institution that is not required to take attendance. So, for a student who has attended past the limited period and unofficially withdrew, the student's withdrawal date is the midpoint of the payment period or period of enrollment. Consistent with the policy for documenting a student's last date of attendance at an academically-related activity, an institution is not required to take attendance to demonstrate a student's attendance past the end of the limited period of attendance taking.

Changes: None.

Leaves of Absence (Section 668.22)

Comments: One commenter requested that we repeat the discussion in the August 8, 2002 NPRM on allowing multiple leaves of absence as long as the sum of the leaves does not exceed 180 days within any 12-month period and the requirement that an institution must require the student to submit a written reason for his or her request for an approved leave of absence.

Discussion: The commenter is correct that the proposed change does mean that an institution can approve more than one leave of absence for a student as long as the total of all leaves for that student does not exceed 180 days in a 12-month period. The commenter is also correct that the new regulations require the student to submit a written reason for the request for the leave of absence. We refer the reader to the more extensive discussion on these matters that was included in the August 8, 2002 NPRM beginning on page 51726.

Changes: None.

Comments: One commenter agreed with our position that a student should be able to return to an institution from an approved leave of absence and repeat coursework as long as there are no additional institutional charges.

Discussion: We clarified in the NPRM that a student may resume his or her academic program at a point earlier than the point where the academic program was suspended temporarily through an approved leave of absence. Under this guidance, both the student and the institution enjoy greater flexibility to deal with student academic needs. However, since the regulations provide that an institution may not impose additional charges when the approved leave of absence ends and the student resumes his or her program of study, a student who returns for the purpose of repeating prior coursework may not be assessed additional charges by the institution.

Changes: None.

Comments: One commenter noted that, especially for nonterm programs, there are a variety of reasons (most frequently scheduling problems) that prevent students from simply restarting their coursework at the same place they stopped. Particularly if the nonterm program offers its course in a series of modules, a returning student might choose to re-enter into a different course in a different module within the same program. The commenter suggested that students in nonterm programs be exempt from the requirement that, after returning from an approved leave of absence, they must return to the same point in the coursework that they were at the time the leave of absence began.

Discussion: Currently, § 668.22(d)(1)(viii) requires that when a student returns from a leave of absence, the student must be permitted to complete the coursework he or she began prior to the leave of absence. This is because the concept of an approved leave of absence is that the payment period in which the student was originally enrolled in has been temporarily suspended due to the leave of absence. Upon the student's return, the student simply resumes or continues the same payment period and coursework and is not eligible for additional Title IV program assistance until the payment period has been completed.

For term-based programs, where the payment period is the term, a student returning from a leave of absence must complete the term in order to complete the payment period and be eligible to receive a second or subsequent disbursement. In addition, as noted earlier, upon return from a leave of absence the student cannot be assessed any additional charges. Therefore, we think it very unlikely that a student enrolled in a term-based program could ever participate in the leave of absence process included as part of the Return of Title IV Funds requirements.

However, for nonterm-based programs, the regulations in § 668.4, as finalized by this document, provide that the payment period is the period of time it takes a student to complete both half the number of credits and half the number of weeks of the academic year, program or remainder of the program, as appropriate. For clock-hour programs, the payment period is the period of time it takes a student to complete half the number of clock hours in the program. Therefore, whether the student returns to the point in the same course as when the leave of absence began, or the student starts in a new course within the program (without additional institutional charges), once half the required credits are earned and half the number of weeks are completed or, for a clock-hour program, half the number of clock hours are completed, the student has completed the payment period for which the student was previously paid Title IV funds. If otherwise eligible, the student may receive a second or subsequent disbursement of Title IV program funds. Thus, we agree with the commenter that flexibility in this area could be provided to students and institutions when the program is offered on a nonterm basis.

Changes: Section 668.22(d)(1)(vii) is revised to provide that for a clock-hour program or a nonterm credit-hour program, the student need not complete the exact same coursework he or she began prior to the leave.

Comments: One commenter suggested that we modify the proposed rule to allow an institution to offer the student a full tuition credit towards the course the student chooses to re-enter as a mechanism to comply with the requirement that the institution not assess the student any additional charges upon return from an approved leave of absence.

Discussion: As we understand the commenter's suggestion, we do not see a need to modify the regulations. We believe that the commenter's proposal would meet the requirement that a student returning from an approved leave of absence not be assessed any additional institutional charges for completing the payment period.

Changes: None.

Expiration of Ability To Benefit Tests (Sections 668.32 and 668.151)

Comments: While there was general support for the removal of the 12-month limitation on the acceptability of an ability to benefit (ATB) passing score, one commenter expressed concern about the exception that ''home-schooled'' students are not required to have passed the GED or an ATB test before becoming eligible for Title IV, HEA program assistance.

Discussion: We appreciate the support for the elimination of the 12-month limitation of ATB passing scores. Section 484(d)(3) of the HEA provides that, as an alternative to a high school diploma, a student who has completed a secondary school education in a home

school setting that is treated as a home school or private school under State law meets the applicable standard to be eligible for Title IV, HEA program assistance without the need for such a student to have passed the GED or an ATB test.

Changes: None.

Overpayments (Sections 668.35, 673.5, and 690.79)

Comments: One commenter indicated that the *de minimis* standard of less than $25 for student original overpayment amounts is too low and should be increased to at least $100. Further, the commenter stated that excluding from the application of the *de minimis* standard situations in which the amount owed by the student was the result of an original overpayment amount that was paid down to less than $25, or was the result of the application of the $300 campus-based overaward threshold, makes the regulation too complicated for efficient program administration.

Discussion: The less than $25 *de minimis* standard used in the regulations is based upon an amount that is cost effective for the Department to collect. We are able to successfully pursue collections of $25 or higher with Internal Revenue Service (IRS) offsets, as well as with other methods. As to the second comment, the regulations exclude two instances in which the *de minimis* amount provisions do not apply. In the case where the original overpayment amount was $25 or more, but has been reduced to less than $25, the student is still responsible for fully paying that remaining balance. Without this exclusion, students would be encouraged not to pay the last $24.99 of their overpayment. In the other case, a student is responsible for paying the balance of the overpayment, even if it is less than $25, when the overpayment is a result of applying the $300 campus-based overaward threshold to an FSEOG or Federal Perkins Loan overaward. Without this second exclusion, we would be creating a new campus-based overaward threshold of $324.99. There is no basis in the statute for changing the campus-based overaward threshold beyond $300.

Changes: None.

Comments: One commenter recommended that, in addition to applying the less than $25 *de minimis* amount to original overpayments owed by a student, the regulations provide the same treatment to an institution when it is liable for an overpayment. That is, the commenter suggested that an institution not be required to return an original overpayment that is less than $25. The commenter believed that the requirement for an institution to return small amounts is administratively burdensome to the institution and is not cost effective.

Discussion: The purpose of having the less than $25 *de minimis* amount for student original overpayments is to allow needy students to continue to be eligible for Title IV aid when their overpayment obligation is a small amount. The overpayment amounts that an institution owes do not impact a student's eligibility. However, the regulatory change that we are making for student original overpayment amounts that are less than $25 provides for a consistent application across the Title IV programs, reduces the burden on needy students, and reduces the burden for institutions in the recording and collection of a small student debt.

Changes: None.

Comments: One commenter suggested that the language in the regulations requiring the institution to provide written notice of an FSEOG or Federal Pell Grant overpayment to the student be clarified. The commenter suggested that the regulations state that an institution is not required to send the written notice if the institution pays the overpayment on the student's behalf from its own funds, because there is no reason for the student to register a formal objection to an overpayment determination with the institution.

Discussion: The written notice requirement for overpayments does not apply unless the student owes an overpayment that is outstanding. If the institution already paid the overpayment on the student's behalf from its own funds, the institution would not have to send the written notice to the student because there is no overpayment to collect.

Changes: None.

Rehabilitation of Defaulted Loans (Sections 668.35, 674.39, 682.405, and 685.211)

Comments: One commenter objected to the addition of language in § 668.35(b) that allows a Perkins Loan borrower against whom a judgment has been obtained to regain eligibility for further Title IV student aid by making satisfactory repayment arrangements. The commenter noted that seeking a judgment against a defaulted Perkins Loan borrower is a last resort that involves considerable time and money and that a judgment is pursued only after a Perkins institution has exhausted all other means of collecting the defaulted loan. The commenter stated that extending further Title IV student financial assistance to such a borrower is against the taxpayers' best interests and that the only option that should be offered to a defaulted borrower against whom a judgment has been obtained is to pay the judgment amount in full.

Discussion: The proposal to allow a borrower who is subject to a judgment to regain eligibility for Title IV program assistance reflects the concerns expressed by the negotiators that, under the original proposal presented to the negotiators, borrowers subject to a judgment would not only be excluded from the benefits of rehabilitation, but would also be unable to regain eligibility for Title IV aid. The negotiators felt that denying access to additional student financial assistance to a borrower who makes an agreement with the loan holder to repay the loan was excessively harsh and had the potential to effectively prohibit the borrower from furthering his or her education, securing employment, and being better able to repay student loan obligations.

The new regulations in § 668.35(b) provide institutions and guarantors with significant flexibility to recover judgment debts by allowing the loan holder to determine the conditions that the judgment debtor must satisfy to regain eligibility for additional Title IV aid. For example, if, in a particular case, payment in full is the only repayment arrangement that is satisfactory to the holder, then a borrower who is subject to a judgment must pay the loan in full. Alternatively, should the holder agree to repayment arrangements with the judgment debtor, the holder is free to determine the number and amount of payments necessary to restore eligibility for further Title IV aid, as long as those arrangements include the borrower making at least six consecutive monthly payments.

Changes: None.

Comments: Some commenters noted that proposed language in § 682.405(b)(1), which defines ''voluntary'' payments for the purpose of loan rehabilitation, excluded payments made ''after a judgment has been entered on a loan.'' (The commenters incorrectly believed that this proposed change was the basis for excluding judgment borrowers from rehabilitation.) The commenters further noted that the proposed regulations in § 668.35(b) provided that a borrower who is subject to a judgment may reestablish Title IV eligibility if the borrower pays the debt in full or makes at least six payments under arrangements satisfactory to the judgment holder, but that the proposed regulation did not require that such payments be ''voluntary.'' Lastly, the

commenters noted that the FFEL Program definition of ''satisfactory repayment arrangements'' in § 682.200(b) defines the term ''voluntary payments'' differently than it is defined in § 682.405(b)(1) of the FFEL Program regulations. While the commenters supported the proposed language in § 668.35(b) to provide a mechanism for judgment borrowers to regain Title IV eligibility, the commenters believed the interplay between this provision and the provisions within the FFEL Program regulations requiring differing ''voluntary'' payments is confusing and that clarification was needed.

Several commenters representing institutions that participate in the Perkins Loan Program also noted that proposed § 668.35(b) is inconsistent with § 674.9(j) of the Perkins Loan Program regulations, in that the Perkins regulations require a defaulted Perkins Loan borrower subject to a judgment to make ''voluntary'' payments to reestablish eligibility for a Federal Perkins Loan. (Sections 674.9(j)(1) and (2) define ''voluntary'' payments as ''payments made directly by the borrower, including payments made over and above payments made pursuant to a judgment * * * and do not include payments obtained pursuant to a judgment.'') In contrast, the commenters noted that proposed § 668.35(b) did not require that payments to reestablish Title IV eligibility be voluntary.

The commenters suggested that we revise the FFEL regulations defining ''satisfactory repayment arrangement'' to clarify that a borrower against whom a judgment has been obtained can reestablish Title IV eligibility under § 668.35(b). With regard to the Perkins Loan program, the commenters suggested that we either revise proposed § 668.35(b) to reference the Perkins Loan program definition of ''satisfactory repayment arrangement'' or remove the reference to ''voluntary'' payments in § 674.9 for the purpose of regaining eligibility for a Perkins Loan.

Discussion: We disagree with the commenters' assumption that the basis for excluding borrowers subject to a judgment from loan rehabilitation is that payments on a judgment are not considered ''voluntary.'' The preamble of the August 6, 2002 NPRM, beginning at 67 FR 51036, has a full discussion of the reasons we proposed to exclude borrowers subject to a judgment from the opportunity for loan rehabilitation. We agree with the commenters, however, that the interplay of provisions defining ''voluntary'' in the Perkins Loan and the FFEL program regulations and their relationship with proposed § 668.35(b) is confusing.

We believe that the best resolution is to modify proposed § 668.35(b) to add the word ''voluntary,'' with a definition, to the description of the monthly payments that a borrower who is subject to a judgment must make before regaining eligibility for additional Title IV aid. We believe that the definition of ''voluntary payments,'' in the definition of ''satisfactory repayment arrangement'' in § 682.200(b) of the FFEL Program regulations is the most appropriate definition to use. Accordingly, we will define ''voluntary'' in § 668.35(b) as ''payments made directly by the borrower, not including payments obtained by Federal offset, garnishment, or income or asset execution.'' We would emphasize that a payment on a judgment is considered a ''voluntary'' payment under this definition if the borrower who is subject to the judgment makes a payment directly to the judgment holder and that there is no requirement that the payment be over and above the payment required on the judgment.

We also believe that the definition of ''voluntary'' in § 674.9(j)(1) and (2) and in the Direct Loan Program definition of ''satisfactory repayment arrangement'' in § 685.102(b) should be changed to reflect the definition of ''voluntary'' in § 682.200(b).

Changes: We have added the requirement that payments made pursuant to § 668.35(b) must be voluntary payments, along with a definition of ''voluntary.'' We have also amended the definition of ''voluntary'' in §§ 674.9(j) and 685.102(b) to reflect the definition of ''voluntary'' in current § 682.200(b).

Comments: Several commenters requested that we revise the rules governing a guaranty agency's basic program agreement with the Secretary in § 682.401(b)(4), as they relate to reinstatement of borrower eligibility, to add a reference to proposed language in § 668.35(b) that allows a borrower who is subject to a judgment to reestablish eligibility for Title IV, HEA program assistance. The commenters believed that since loan rehabilitation would no longer be an option for a borrower with a loan on which a judgment has been obtained, a clarifying change was needed to exempt these borrowers from the FFEL Program rules governing reinstatement of borrower eligibility.

Discussion: We agree that the addition of a reference in § 682.401(b)(4), stating that reinstatement of Title IV eligibility for a borrower with a defaulted loan on which a judgment has been obtained is governed by § 668.35(b), would add clarity.

Changes: We have made the suggested change to § 682.401(b)(4).

Comments: Several commenters supported the proposed regulations that excluded from rehabilitation defaulted Title IV loans on which a judgment has been obtained.

Discussion: None.

Changes: None.

Comments: One commenter stated that rehabilitation of loans subject to a judgment has served as a beneficial and successful tool to encourage borrowers to repay their loans and objected to the proposed changes that excluded from rehabilitation defaulted loans on which a judgment has been obtained. The commenter stated that many borrowers default at an early age without realizing the serious and long-lasting consequences of their failure to repay their loan and that eliminating the option of rehabilitation denies borrowers subject to a judgment the ability to improve their credit history.

Discussion: The negotiators reached consensus that the effort and expense associated with rehabilitating loans subject to a judgment outweighed the value of rehabilitation of judgment debts as a collection tool. However, as we pointed out in the August 6, 2002, NPRM, while the new regulations exclude a loan on which a judgment has been obtained from rehabilitation, a loan holder may, at its option, enter into an agreement with such a borrower to offer some of the benefits of rehabilitation while maximizing recovery of the debt. Moreover, we also proposed new language in § 668.35(b) to ensure that a borrower subject to a judgment may reestablish eligibility for further Title IV, HEA program assistance.

Changes: None.

Comments: Several commenters requested that we revise § 682.405(b)(1) to specify that the definition of the term voluntary in that section applies only to loan rehabilitation. The commenters felt that we introduced ambiguity with regard to the meaning of voluntary payments by placing language in the August 6, 2002 NPRM preamble describing proposed changes to § 682.405(b)(1) in the same paragraph as language describing reinstatement of Title IV eligibility. The commenters also suggested revising this paragraph to exclude payments obtained by state offset from the definition of voluntary payments for the purpose of loan rehabilitation.

Discussion: Although we regret any confusion that resulted from the placement of preamble language

describing proposed changes to § 682.405(b)(1) in the same paragraph as language describing reinstatement of Title IV eligibility, we do not see the need for a clarification that the term voluntary, as defined in § 682.405(b)(1), applies only to that section. The proposed language, by its placement within § 682.405, makes it clear that the definition of voluntary applies only to that section. We also disagree with the suggestion to revise this paragraph to add that payments made by state offset are excluded from the definition of voluntary payments for the purposes of loan rehabilitation because making such a change is more than a technical change to the regulations and was not subject to negotiated rulemaking.

Changes: None.

Comments: One commenter felt strongly that the regulations should specifically state that judgment holders may enter into an agreement with the judgment debtor that would allow the holder to provide many of the same benefits offered under loan rehabilitation programs. The commenter asked if the proposed addition of language in § 668.35(b), which allows a judgment borrower the opportunity to reestablish Title IV eligibility by making repayment arrangements that are satisfactory to the holder of the debt, gives the holder of a judgment the authority to enter into agreements with judgment borrowers that would provide borrowers with some of the benefits of rehabilitation.

Discussion: In many cases, the terms of a court judgment make the entire obligation due and payable in full immediately, and any payment arrangements that arise between the parties to satisfy the judgment is solely by agreement between the debtor and the judgment holder. We do not see the need to specify in regulation the authority already held by a judgment holder to enter into such agreements with a judgment debtor.

The new regulations in § 668.35(b) simply extend to a borrower who is subject to a judgment the opportunity to reestablish eligibility for Title IV student financial assistance. As stated earlier, the negotiators were concerned that borrowers who were subject to a judgment would no longer be entitled to rehabilitate their loans and would be left without any recourse if the borrower wished to return to school and needed additional financial aid. We note that a borrower who is subject to a judgment will reestablish Title IV eligibility as part of an agreement between the debtor and judgment holder, if the holder chooses to enter into such an agreement. However, the authority to enter into such an agreement stems from the nature of the judgment debt, not from this regulatory provision.

Changes: None.

Comments: Several commenters asked us to clarify what types of benefits a holder can provide to a borrower with a Title IV loan that is subject to a judgment pursuant to an agreement outside of the holder's loan rehabilitation program. The commenters were concerned that loan holders would not have the authority to offer removal of the borrower's negative credit history under such an agreement under the Fair Credit Reporting Act and loan program credit bureau reporting regulations. Several commenters wanted us to address the status of a loan on which a judgment has been obtained, both from the standpoint of the borrower and the judgment holder, once the borrower has reached an agreement with the judgment holder. One commenter asked us to clarify how long a borrower has to repay the loan and what interest rate would apply in cases when the borrower signs a new note under an arrangement between the borrower and the judgment holder.

Discussion: The holder of a Title IV loan that is subject to a judgment has the option, but is not required, to enter into an agreement with the borrower in which the holder agrees to offer some benefits. We expect any agreement between a borrower subject to a judgment and the judgment holder to require the debtor to make at least six consecutive, voluntary monthly payments, the minimum standard contained in § 668.35(b) for a judgment borrower to reestablish Title IV eligibility. A judgment holder is also free to require other, more stringent repayment arrangements it considers appropriate. The benefits the judgment holder may offer the borrower as part of an agreement to resolve a judgment include the return of Title IV eligibility and removal of a borrower's negative credit history. Alternatively, the holder may offer to vacate the judgment and allow the borrower to sign a new promissory note after the borrower complies with the conditions of the agreement. However, it is up to the holder of the judgment to consider any legal and practical restrictions on its ability to offer the borrower certain benefits, such as credit report changes.

In accordance with general legal principles and our longstanding policy, a judgment debt on a Title IV loan is considered a Title IV loan obligation. An agreement between a loan holder and a borrower to resolve a judgment does not change the character of the debt. Accordingly, if the holder vacates the judgment as part of such an agreement, the borrower's rights and responsibilities would be those of a defaulted Title IV borrower and would include the opportunity to enter into a formal regulatory rehabilitation agreement with the loan holder. The holder would be subject to the requirements and benefits associated with holding a defaulted Title IV loan. The interest rate and repayment options would be those available under the original promissory note.

Changes: None.

Comments: One commenter stated that the regulations addressing rehabilitation of loans, although now revised to exclude loans reduced to judgment, still may imply that the Secretary considers defaulted borrowers to be able to seek rehabilitation even after the Secretary has referred a loan to the Department of Justice for collection litigation. The commenter considered this implication unfounded as a matter of law, contrary to the interests of the loan programs and the Federal government, and urged the Secretary to clarify the proposed regulations to specify that neither the statute nor the regulations allow borrowers to rehabilitate loans that have been referred to the Department of Justice for litigation.

Discussion: We believe that the HEA and the Federal Claims Collection Standards adequately address this concern and that a regulatory change is unnecessary. A rehabilitation agreement is a form of repayment arrangement; after a Federal agency has referred a debt owed the agency to the Department of Justice for litigation, the Federal Claims Collection Standards provide that the Department of Justice has ''exclusive jurisdiction'' over the debt, and the agency is no longer authorized to determine repayment terms for that debt (31 CFR 904.1(b)). Moreover, sections 432(a)(2) and 468(3) of the HEA state explicitly that the Secretary's broad power to enforce Title IV HEA loans remains subject to the full authority of the Attorney General to conduct litigation to collect those loans. The HEA both directs the institution, the guarantor, or the Secretary to offer the borrower in default an opportunity for rehabilitation of the loan, and directs that the Secretary's authority to arrange repayment terms ends where responsibility for enforcement of the debt passes to the Department of Justice. The Secretary therefore interprets the HEA itself to limit the defaulted borrower's ability to seek rehabilitation of a Title IV loan only to the period during which the loan is held by the Secretary. The option to rehabilitate a

defaulted loan therefore lapses once the debt is referred to the Department of Justice.

Changes: None.

Comments: Two commenters recommended that borrowers subject to a judgment, who have begun the rehabilitation process but not completed the payment stream before final regulations are effective, be permitted to complete the rehabilitation process.

Discussion: If a holder has agreed to allow a judgment borrower to attempt rehabilitation of his or her loan prior to the effective date of these final regulations, we expect the loan holder to honor such an agreement. However, if the judgment borrower misses any of the required payments, the holder is not required to allow the borrower another attempt at rehabilitation.

Changes: None.

Comments: One commenter asked if the holder of an institutional loan subject to a judgment has the option to enter into an agreement with the borrower and offer to remove the borrower's negative credit history under the proposed regulations.

Discussion: The terms and conditions of non-Federal loans are not subject to the regulations that apply to the Title IV loan programs.

Changes: None.

Late Disbursements (Section 668.164)

Comments: Several commenters objected to the proposal that an institution would be required to obtain the Secretary's approval in order to make late disbursements more than 120 days after the student was no longer eligible. Most of these commenters believed that we should continue the current practice of allowing guaranty agencies to approve late disbursements of FFEL Program funds. Two commenters stated that deciding to make a late disbursement was similar to professional judgment and argued that institutions should be permitted to make these disbursements without obtaining our approval.

Discussion: While we appreciate the willingness of guaranty agencies to approve requests for late disbursements that are not made within the 120-day timeframe, we continue to believe that we should review and approve such disbursement requests. These rules (and previous late disbursement rules) provide an exception to the general rule that a student must be enrolled and eligible to receive Title IV student aid. If a disbursement is not made while a student is enrolled and eligible, an institution now has, regardless of the reason and without any approval, 120 days to make that disbursement. Beyond that, from both a policy and operations perspective, we need to be aware of the frequency and circumstances under which this exception is used. In addition, we believe it is more efficient, and more equitable to students and institutions, to direct all late disbursement requests requiring approval (those after the 120-day timeframe) to one party for review, particularly for requests that deal with funds from more than one Title IV program. To facilitate the process, before the effective date for these regulations, the Department plans to establish a process by which institutions will submit their request. In its request, an institution will provide the name of the student (or parent in the case of a PLUS loan), the type and amount of Title IV aid to be disbursed, and a description of the circumstances that resulted in the disbursement not being made, including why the disbursement was not made and was not the fault of the student or parent. After we review the request, we will promptly inform the institution of our decision or if necessary, request additional information. If the request is approved, the institution can, consistent with the requirements of the funding source (*i.e.,* FFEL lender or guaranty agency) make the late disbursement. We expect the institution to maintain documentation of its request and the Department's response to that request.

Changes: None.

Comments: One commenter did not agree with the proposal that an institution would be required to offer a late disbursement to a student who had completed a payment period or period of enrollment. The commenter contended that in many such cases the student would not owe the institution any money or would not be likely to have other remaining costs, thereby eliminating the need for the late disbursement. For this reason, the commenter was concerned that requiring an institution to make a late disbursement of a loan would needlessly increase a student's debt. Instead, the commenter suggested that an institution should have sole discretion in determining whether a late disbursement was necessary.

Discussion: As we explained in the August 8, 2002 NPRM, because the student earned the funds for the period completed, it is up to the student, not the institution, to decide whether he or she needs the funds. Consequently, an institution must offer the late disbursement to the student and must make that disbursement if the student accepts the offer. If an institution believes a late disbursement is not needed or is concerned that a late disbursement of a loan may increase the risk of default, we encourage the institution to advise the student about how the disbursement may affect his or her eligibility for additional Title IV aid and caution the student about loan debt. An institution may do this in the offer it makes to the student.

Changes: None.

Comments: Many commenters supported the proposal eliminating the requirement that, for a student to qualify for late disbursement, an institution must have a valid SAR/ISIR for that student on or before the date the student became ineligible.

Discussion: We appreciate the support for a proposal that makes it easier for a student to qualify for a late disbursement and easier for an institution to document that the student qualified. However, as we noted in the NPRM, an institution must still have a valid SAR/ISIR to make a late disbursement of a Federal Pell Grant. In this regard, two changes are necessary.

Changes: Two conforming changes are necessary. First, we have made a conforming change to 668.22(a)(4)(ii)(B) to increase from 90 to 120 days the amount of time within which an institution must disburse a post-withdrawal disbursement. Second, we have made a conforming change to § 690.61(b) to exempt a student, who now otherwise qualifies for a late disbursement, from the requirement that the student submit a valid SAR/ISIR to the institution while the student is enrolled (the student now qualifies, in part, when the Department processes a SAR/ISIR with a valid EFC). As a result of this conforming change, the deadline date for receiving a valid SAR/ISIR in § 690.61(b)(2) no longer applies to a late disbursement of a Federal Pell Grant. Rather, the deadline date provisions for receiving a valid SAR/ISIR for the purpose of making a late disbursement of a Federal Pell Grant are now included as part of § 668.164(g)(4).

Notices and Authorizations (Section 668.165)

Comments: Many commenters supported the proposed change that would eliminate the requirement that an institution confirm receipt by a student of a notice sent electronically that Title IV loan funds were credited to a student's account.

Discussion: We are appreciative of the commenters' support.

Changes: None.

Timely Return of Funds (Sections 668.171 and 668.173)

Comments: Two commenters opposed the proposal under which an institution would have to return unearned Title IV program funds no later than 30 days after the institution determines that a student withdrew. The commenters stated that the process of determining which students unofficially withdrew, and the subsequent calculation of the amount of unearned funds, often takes longer than the 30-day period allowed for returning the funds.

Discussion: We did not propose any changes to the 30-day timeframe for returning unearned Title IV program funds, as currently provided in § 668.22. The proposed changes focused solely on establishing clear requirements for returning unearned Title IV funds within the existing 30-day timeframe and the consequences if that timeframe is not met. Consequently, we decline to accept the commenters' proposal.

Changes: None.

Comments: A few commenters objected to the 45-day proposal for returning unearned funds by check, arguing it would be unreasonable to hold an institution responsible for the time it takes the Secretary or an FFEL Program lender to cash a check. One of these commenters believed that we should not impose any requirements along these lines, unless there is a deliberate pattern of delaying the return of unearned funds.

Discussion: The Department or an FFEL lender (or its agent) will usually receive a check mailed by an institution within three to five days. Within the next day or two, that check is endorsed by the bank used by the Department or lender, resulting in a typical timeframe of four to seven days. Even if this process takes twice as long, an institution would still satisfy the requirements that unearned funds were returned in a timely manner (an institution must issue the check no later than 30 days after it determines the student withdrew, and the check must have been endorsed by the bank used by the Department or lender no later than 45 days after that date). Moreover, the regulations provide that if an institution can show that something unusual happened that delayed the delivery or receipt of a particular check, we will not hold the institution responsible.

Changes: None.

Comments: One commenter stated that the date on the back of the check is not necessarily the date it was received by an FFEL lender. To clarify the rule, the commenter suggested that we define the clearance date as the date the check clears the lender's or Department's bank account.

Discussion: In proposing this provision, we intended to describe the first date that appears on a cancelled check. In this regard, the Federal Reserve banking regulations under 12 CFR part 229, appendix D, require a depository bank (in this case, the bank used by the Department or FFEL lender) to evidence that it received a check by endorsing that check. Under those regulations, the bank's endorsement must include the routing number, the name of the bank, and the endorsement date. We agree to revise the regulations to clarify that the endorsement date is the date used to determine whether an institution returned unearned funds by check in a timely manner.

Changes: Section 668.173(b)(4)(ii) is revised to provide that if a check is used to return unearned funds, it must be endorsed by the bank used by the Department or FFEL Program lender no later than 45 days after the institution's determination that a student withdrew.

Comments: One commenter suggested another method of returning unearned funds. In cases where an institution needs Title IV program funds to make disbursements to additional eligible students, the institution should be permitted to use unearned funds of withdrawn students to make those disbursements instead of depositing or transferring those funds into the institution's Federal account.

Discussion: An institution that maintains a separate Federal bank account must deposit to that account, or transfer from its operating account to its Federal account, the amount of unearned program funds, as determined under § 668.22. The date the institution makes that deposit or transfer is the date used to determine whether the institution returned the funds within the 30-day timeframe permitted in the regulations. After that, the institution can use the unearned funds to make disbursements to other eligible students, provided those funds were originally received from the Department or from an FFEL lender under a process that allows the institution to use the unearned funds for this purpose.

However, unless the Department requires an institution to use a separate account, the institution may use its operating account for Title IV purposes. In this case, the institution must designate that account as its Federal bank account, as required under § 668.163(a), and have an auditable system of records showing that the funds have been allocated properly and returned in a timely manner. Absent a clear audit trail, the Department can require the institution to begin maintaining Title IV funds in a separate bank account.

Moreover, the institution has a fiduciary responsibility to segregate Federal funds from all other funds and to ensure that Federal funds are used only for the benefit of eligible students. Absent a separate Federal bank account, the institution must ensure that its accounting records clearly reflect that it segregates Federal funds. Under no circumstances may the institution use Federal funds for any other purpose, such as paying operating expenses, collateralizing or otherwise securing a loan, or earning interest or generating revenue in a manner that risks the loss of Federal funds or subjects Federal funds to liens or other attachments (such as would be the case with certain overnight investment arrangements or sweeps). Clearly, carrying out these fiduciary duties limits the ways the institution can otherwise manage cash in its operating account, simply because that account contains Federal funds.

In any event, we consider an institution that maintains (co-mingles) Federal Title IV, HEA program funds and general operating funds in the same bank account to satisfy the requirement under § 668.173(b)(1) that it return unearned funds on a timely basis if (1) the institution maintains subsidiary ledgers of each type of funds co-mingled in that account that clearly show how and when those funds were used and reconciled to its general ledger, (2) the subsidiary ledgers for each Federal program provide a detailed audit trail on a student-by-student basis that reconciles to the amount of Federal Title IV, HEA program funds received and disbursed by the institution, and (3) the institution updates the relevant subsidiary ledger accounts in its general ledger no later than 30 days after it determines that the student withdrew. More specifically, the return of an unearned funds transaction should be recorded as a debit to the Federal program fund subsidiary ledger account and credit to the institution's operating fund subsidiary ledger account. The date of the return is the date this transaction is posted to the institution's general ledger.

Changes: None.

Comments: One commenter felt that the letter of credit trigger should be changed from a finding that an institution has not returned unearned funds for ''10 percent or more'' of the sampled students, to a finding that an institution has not returned unearned funds for ''more than 10 percent'' of the sampled students. The commenter noted that a ''more than 10 percent''

trigger would be consistent with the Department's Program Review Guide and the Department's School Site Review Guide for Guaranty Agencies, which use a trigger of ''greater than 10 percent'' as an indication of a possible significant problem.

Discussion: We agree that the triggers should be consistent.

Changes: Section 668.173(d)(3)(iv) has been changed to require a letter of credit upon a finding that an institution has not returned unearned funds for more than 10 percent of the sampled students.

Federal Perkins Loan—Master Promissory Note (Sections 674.2 and 674.16)

Comments: Many commenters supported the proposal to adopt a Master Promissory Note (MPN) in the Federal Perkins Loan Program. These commenters believe that the MPN will simplify the loan process by eliminating the need for institutions to prepare, and students to sign, a promissory note each award year. They also stated that uniformity across the Title IV loan program regulations, where possible, is beneficial for institutions and borrowers.

One commenter representing several institutions participating in the Perkins Loan Program expressed concern about setting conditions under which an MPN would automatically expire. The commenter stated that there is no apparent reason for establishing arbitrary timeframes by which an MPN will automatically expire since participating institutions do not need to coordinate with a third party. The commenter believed that these timeframes would diminish the streamlining benefits of the MPN in the Perkins Loan Program and create additional burden on institutions because they would be required to ensure that funds are not advanced against an expired MPN.

Discussion: We appreciate the overwhelming support for an MPN in the Perkins Loan Program and agree with those commenters that consistency across the Title IV loan programs is beneficial to both institutions and borrowers. We disagree with the commenter who objected to the time limits on the use of an MPN. Because a Perkins Loan borrower will be signing the MPN only once, we believe it is necessary to have time limits on the use of the MPN to achieve an appropriate balance between consumer protection and simplification of the loan process. Further, we are not aware of any public or private loan program that has open-ended promissory notes. In addition, the expiration date provisions are consistent with the expiration date provisions for FFEL and Direct Loan MPNs, and ensure that borrowers across all three Title IV loan programs are treated consistently. We do not believe that these time limits diminish the benefit of an MPN or cause any additional workload for institutions.

Changes: None.

Federal Perkins Loan—Write-Offs (Sections 674.9 and 674.47)

Comments: Several commenters supported the proposed regulations in § 674.47(g) and (h) to allow institutions to write off accounts of less than $25, or less than $50, if the borrower has been billed for at least two years. These commenters also supported the provisions that would make it clear that a borrower whose balance has been written off is relieved of all repayment obligations. One commenter representing several Perkins Loan institutions recommended modifying the proposed language under § 674.47(h)(1)(ii) that would permit institutions to write off an account with a balance of less than $50 if the borrower has been billed for this balance for at least two years. The commenter recommended that the language be modified so that institutions would not be required, given the minimal amount owed, to keep accounts with balances of less than $50 open for two years before being able to write off these accounts. The commenter pointed out that institutions that outsource the servicing of their loans could pay nearly 50 percent of the value of the loan in servicing costs alone over that two-year period.

Discussion: We appreciate the commenters' support for the increased write-off authority. However, we disagree with the commenter who recommended modifying the proposed language in § 674.47(h) so that institutions would not be required to bill the borrower for two years before writing off accounts with balances of less than $50. We believe that the proposed language ensures program integrity and financing. The proposed language balances the need to maintain program integrity by attempting to make the institution's Perkins revolving fund whole with the need to provide institutions greater flexibility in servicing their Perkins loan portfolio. The failure to collect on these funds could affect the future level of the Perkins Loan Fund and the availability of loans for future borrowers. Institutions that outsource the servicing of their loans could possibly reduce servicing costs associated with these loans by recalling these accounts and performing the required collection action on their own. As stated in the preamble to the August 6, 2002 NPRM, we also believe that the changes approved by the negotiating committee will reduce costs and administrative burden on Perkins Loan institutions.

Changes: None.

Retention of Promissory Notes (Sections 674.19, 682.402, and 682.414)

Comments: Some commenters indicated that it would be simpler to state in § 682.414(a)(5)(ii) that an electronically signed promissory note must be stored ''electronically and it must be retrievable in a coherent format'' rather than using a cross-reference to 34 CFR 668.24(d)(3)(i) through (iv).

Discussion: We agree that it would be simpler if FFEL Program requirements were stated directly in the FFEL regulations to the extent practicable. Additionally, after reviewing the provisions in § 668.24(d)(3)(i)–(iv), we do not believe that they clearly address the maintenance of electronically signed documents.

Changes: We have revised § 682.414(a)(5)(ii) to replace the cross-reference with the language recommended by the commenters. For consistency, a comparable change also has been made in the Federal Perkins Loan regulations at 34 CFR 674.19(e)(4)(ii).

Initial and Exit Counseling (Sections 674.42, 682.604, and 685.304)

Comments: One commenter representing several institutions participating in the Perkins Loan Program noted that the proposed regulations in § 674.42(b) did not use the term ''institution'' consistently throughout the section. Instead, both the terms ''institution'' and ''school'' were used in the section.

Discussion: We appreciate the commenter pointing out that the term ''institution'' was not used consistently in § 674.42(b) and agree that the section should be revised accordingly.

Changes: We have revised § 674.42(b) by changing references to ''school'' to ''institution'' or ''the institution'' as appropriate.

Comments: One commenter representing financial aid administrators noted that the proposed language in §§ 682.605(f)(2)(v) and 685.304(a)(3)(iv) did not offer the option of basing the sample monthly repayment amounts that must be provided to FFEL and Direct Loan borrowers as part of initial counseling on the average indebtedness of borrowers with FFEL or Direct Loan

program loans for attendance in the borrower's program of study at the institution. The commenter believed that since this option is available under the corresponding exit counseling provisions it should also be available under the initial counseling provisions. The commenter noted that some institutions that have graduate programs or short-term programs may want to exercise the option of providing sample monthly repayment amounts based on a borrower's program of study and that adding the option would not impose an additional regulatory requirement on institutions because it would not be mandatory.

Discussion: We agree with the commenter that it is important to offer in initial counseling the option of basing sample monthly repayment amounts on the average indebtedness of borrowers with FFEL or Direct Loan program loans for attendance in the borrower's program of study at the institution. The final regulations reflect that this option is available to institutions and to parties that provide initial counseling for institutions.

In reviewing the preamble to the August 6, 2002 NPRM and the proposed regulations, we discovered that our preamble discussion of the new requirement that sample monthly repayment amounts be provided to borrowers as part of initial counseling was inaccurate. Specifically, the preamble to the August 6, 2002 NPRM stated that this was a new exit counseling requirement under the FFEL Program. However, the proposed regulations reflected a new initial counseling requirement under the FFEL Program. We would like to take this opportunity to accurately explain the change.

The proposed regulations did not include any changes to the current exit counseling provisions in the Perkins, FFEL, and Direct Loan programs that require borrowers to be informed of average anticipated monthly repayment amounts. As part of exit counseling, Perkins, FFEL, and Direct Loan borrowers must be informed of the average anticipated monthly repayment amount based either on the borrower's indebtedness or on the average indebtedness of other borrowers who have obtained Perkins, FFEL, or Direct Loan program loans for attendance at the borrower's institution or in the borrower's program of study at the institution.

The proposed regulations did add to the FFEL Program's initial counseling regulations a provision requiring that sample monthly repayment amounts be provided to borrowers. The proposed regulations also modified an already existing repayment-related provision in the Direct Loan Program initial counseling regulations to mirror the new FFEL Program provision. As a result, the new initial counseling regulations require that FFEL and Direct Loan borrowers be informed of sample monthly repayment amounts. In both programs, the sample monthly repayment amounts may be based either on a range of student levels of indebtedness or on the average indebtedness of other borrowers.

Changes: We have changed §§ 682.604(f)(2)(v) and 685.304(a)(3)(iv) to reflect that sample monthly repayment amounts may be based on the average indebtedness of borrowers with FFEL or Direct Loan program loans for attendance in the borrower's program of study at the institution.

Comments: One commenter representing an institution expressed opposition to the provision in the proposed FFEL and Direct Loan program exit counseling regulations that requires a borrower to provide, as part of exit counseling updated personal information, as well as information about the borrower's expected permanent address, the address of the borrower's next of kin, and the name and address of the borrower's expected employer. The commenter stated that the regulations should not place on an institution (or a party that provides exit counseling for an institution) the burden of requiring a borrower to provide this information. Specifically, the commenter noted that some of the information may not be known to a borrower at the time exit counseling occurs and would make it difficult for an institution to enforce this requirement. The commenter requested that we revise the proposed regulations to state that exit counseling must ''request'' rather than ''require'' that a borrower provide the specified information.

Discussion: The exit counseling provision to which the commenter referred has been longstanding in the Perkins, FFEL, and Direct Loan programs and is based on section 485(b)(2) of the HEA. We are not aware of any problems in this area and decline to accept the commenter's suggested change to the regulatory language. However, we would like to assure the commenter that neither the statute nor the regulations requires a borrower to provide information that is not known to the borrower at the time exit counseling occurs.

Changes: None.

Comments: None.

Discussion: In reviewing the new requirement that exit counseling provide Perkins, FFEL, and Direct Loan borrowers with information about the availability of the Department's National Student Loan Data System (NSLDS), we realized that there may be questions about the information that is expected to be provided to borrowers. As agreed during negotiated rulemaking, it is important for borrowers to be informed that they may access NSLDS to review information about all of their Title IV loans. To achieve this goal, borrowers must be informed of the existence of NSLDS and of the fact that information about their Title IV loans is stored in NSLDS. We do not want to be prescriptive in this area. However, we believe it would be helpful to provide borrowers with the address for the NSLDS Web site and the toll-free phone number that borrowers may call if they do not have Internet access. The address for the NSLDS Web site is *http://www.nslds.ed.gov/*. The toll-free phone number that borrowers may call is 1–800–4–FED–AID.

Changes: None.

Perkins Loan—Credit Bureau Reporting (Section 674.45)

Comments: One commenter representing several Perkins Loan institutions agreed with the goal of clarifying when a borrower's default status is to be reported to a national credit bureau, but believed that the proposed change does not achieve that result. The commenter recommended modifying the proposed language in § 674.45(a)(1) to clarify that an institution must report the account as in default, ''if the institution has not already done so'' since such reporting typically occurs in advance of the collection procedures being initiated. The commenter further recommended removing the words ''before beginning collection procedures'' from § 674.43(f) to provide additional clarification.

Discussion: We do not agree with the commenter's suggested changes to the proposed language because we believe that such a change would give the false impression that reporting default status information to a national credit bureau for the first time is appropriate when done before beginning collection procedures. Institutions are required by the HEA to report to credit bureaus beginning when the loan is disbursed and to report information concerning the repayment and collection of any loan as soon as that loan is more than 30 days past due.

Changes: None.

Perkins Loan—Litigation (Section 674.46)

Comments: Several commenters supported the proposal to increase from $200 to $500 the amount that the Perkins Loan institution must use to determine if it must litigate. However, a few commenters pointed out that it was not cost effective to litigate accounts of $500 or less and recommended that the minimum dollar amount be increased to $1000. One commenter urged the Secretary to remove the two-year timeframe for reviewing accounts for litigation and eliminate the minimum dollar threshold because the institution is in the best position to make the assessment as to whether it is cost effective to litigate. This commenter pointed out that due to the institutional investment in the Perkins Loan Program and the inherent interest in recovering these funds, the Secretary should take every opportunity to eliminate unnecessary regulations that result in greater expense but do not yield greater debt recovery. The commenter felt that the proposed regulations requiring a two-year review and increasing the minimum threshold amount to $500 was a step in the right direction, but was not enough.

Discussion: We appreciate the support from most of the commenters. However, we do not accept the recommendations for changes made by some of the commenters. The preamble language contained in the NPRM accurately describes the basis on which a consensus was reached on this issue by the negotiators. As indicated in the preamble language, the decision to increase the litigation threshold amount from $200 to $500 was based upon average Perkins loan balance data and our view that the majority of these accounts should remain subject to litigation. In addition, we continue to believe that requiring a review once every two years ensures that these overdue accounts will remain subject to litigation. Failure to litigate on these overdue accounts in a relatively timely manner could result in the reduction of an institution's revolving fund, thereby decreasing the number of loans awarded to needy students.

Changes: None.

Federal Work-Study at For-Profit Institutions (Sections 675.2 and 675.21)

Comments: One commenter requested clarification on one of the revisions made to the definition of ''student services.'' One of the examples added to the definition of student services was assisting instructors in curriculum-related activities. The commenter recommended that the language in the regulation or the preamble clarify that this means that a student may be employed under the FWS Program as a teaching assistant.

Discussion: The amended definition of ''student services'' added more examples of acceptable jobs in which a proprietary institution may employ students on campus to work for the institution itself. The example of assisting instructors in curriculum-related activities was added to highlight that an FWS student is considered to be providing a student service when he or she is assisting an instructor in the lab or in other work that is related to the instructor's official academic duties at the proprietary institution. This change does allow a student to serve as a teaching assistant. However, an FWS student may not be hired to be an instructor at a proprietary institution, while remaining a FWS student.

Changes: None.

Comments: One commenter requested clarification on whether services provided to the institution's former students meets the definition of student services. The commenter stated that FWS students should be able to be employed in areas such as job placement and default management services in which the services are available to former students as well as to current students.

Discussion: Student services are those services that provide a benefit, either directly or indirectly, to students. Students are persons enrolled or accepted for enrollment at the institution. An FWS student whose job is to provide services only to the institution's former students would not be considered to be providing a student service because the service is not for currently enrolled students. However, if a student's FWS job involved providing services to both current students and to former students, the job would be considered one that provides student services. As an example, an FWS student is employed in the job placement office providing assistance in finding potential employers and helping prepare resumes for current students as well as for alumni of the institution. Because the FWS student is providing these services to current students, the fact that he or she is also helping alumni does not mean that the FWS student is not providing a student service. On the other hand, if an institution has a default management counselor job in which the employee assists only former students of the institution, the requirement that the job be one that provides student services would not be met because the service is not being provided to currently enrolled students.

Changes: None.

FFEL and Direct Loan—Loan Limits (Sections 682.204 and 685.203)

Comments: One commenter stated that he did not understand what types of abuses the new loan limit regulations are intended to address. However, the commenter felt strongly that if a program requires a student to complete two years of prerequisite coursework in order to be admitted, then the student should be considered a third-year student upon admission to that program.

Discussion: As we explained in the preamble to the proposed regulations, the new regulations clarify that an institution may not link separate, stand-alone programs to allow students to qualify for higher annual loan limits than they would otherwise be eligible to receive based on the length of the program. As an example, we noted that an institution may not allow students in one-year program ''B'' to borrow at the second-year loan level based on the fact that they were required to have previously completed one-year program ''A'' as a prerequisite for admission to program ''B''. Since program ''B'' is only one academic year in length, students enrolled in that program are restricted to first-year annual loan limits.

We remind the commenter that the new regulations do not affect the existing provisions in §§ 682.204 and 685.203, which allow undergraduate borrowers who enroll in programs that require prior completion of an associate or baccalaureate degree to borrow at the higher annual loan limits for third-year undergraduates. In addition, as we noted in the preamble to the proposed regulations, the new regulations do not restrict an institution from determining a student's grade level based on the number of hours earned at another institution that are applicable to the student's program at the new institution.

Changes: None.

Comments: One commenter requested that the loan limit regulations be revised to clearly state that second-year annual loan limits apply when prorating a loan for a student who is enrolled in the final period of study of a program that is more than one academic year in length, but less than two academic years in length. The commenter further recommended that the final regulations clarify the role of the Secretary's ''Eligibility and Certification Approval Report'' (ECAR) in determining whether a program is longer than one academic year in length for annual loan limit

purposes. The commenter noted that there has been some confusion as to whether first- or second-year annual loan limits apply for the final portion of programs that are longer than one academic year, but shorter than two academic years, because the section of the ECAR that identifies the highest educational program offered by an institution categorizes these programs as ''one year'' programs. The commenter believed that second-year annual loan limits should apply after a student has completed the first academic year of such a program, regardless of how the program is classified on the ECAR.

Discussion: The commenter is correct in understanding that a student who has completed the first academic year of a program that is more than one academic year in length, but less than two academic years in length, may receive a prorated loan at the second-year level for the final portion of the program. As noted below, the current regulations clearly support the understanding of the commenter. The proposed changes do not affect these provisions.

The current annual loan limit regulations in the FFEL and Direct Loan programs provide for second-year annual loan limits in the situation described by the commenter. Sections 682.204(a)(2)(ii), 682.204(d)(2)(ii), 685.203(a)(2)(ii), and 685.203(c)(2)(ii)(B) specify a prorated annual loan limit at the second-year undergraduate level for students who have completed the first year of study of a program and are in a remaining portion of the program that is less than one academic year in length. While the ECAR contains the information that forms the basis of an institution's approval to participate in the Title IV, HEA programs, including the highest level of program offered, annual loan limits are not strictly determined by the ECAR, but rather on the actual length of the academic program.

Changes: None.

FFEL—Unemployment Deferment (Sections 682.210 and by reference 685.204)

Comments: Some commenters recommended that the unemployment deferment regulations be revised in § 682.210(h)(3)(iv) to state that a borrower is not required to ''certify'' his or her search for full-time employment. The commenters noted that § 682.210(h)(2) uses the term ''certify'' rather than ''describe'' and believed these two regulatory provisions should use the same terminology.

Discussion: We agree that a borrower requesting a period of initial deferment is not required to describe his or her search for full-time employment at the time the deferment is granted. After examining the regulations, however, we have determined that the effect of recent regulatory changes and the proposed changes to this section of the regulations has caused the entire first sentence of § 682.210(h)(3)(iv), in which the commenter requested the change, to be duplicative and unnecessary.

Changes: We have deleted the first sentence of proposed § 682.210(h)(3)(iv) from these final regulations.

Comments: One commenter believed that it is no longer appropriate to require a ''written certification'' in § 682.210(h)(4) because § 682.210(h)(2) permits an alternative equivalent as approved by the Secretary. The commenter recommended that the word ''written'' be deleted from § 682.210(h)(4).

Discussion: The commenter's rationale for the deletion appears to be based on the presumption that the alternative equivalent form of borrower certification approved by the Secretary would not be in writing, therefore the requirement for a written certification in § 682.210(h)(4) should be modified accordingly. However, the regulatory provision permits both requirements to exist simultaneously independent of each other; a written certification and another that applies to an equivalent form of borrower certification approved by the Secretary. Even if the Secretary were to approve an equivalent that would not need to be in writing, that does not mean that the other requirement for a written certification needs to be undone. We believe it is clearer to amend § 682.210(h)(4) to reflect an alternate approved form of certification.

Changes: We have amended § 682.210(h)(4) to include reference to an approved equivalent.

FFEL and Direct Loan—Consolidation Loan Benefits (Sections 682.402, 685.212, and 685.220)

Comments: One commenter representing a guaranty agency recommended that the new provisions in §§ 682.402, 685.212, and 685.220 related to discharges of consolidation loans apply only to consolidation loans made on or after July 1, 2003. The commenter believed that they should not apply to consolidation loans made before July 1, 2003, since it would be very difficult for program participants to identify previous underlying loans that might qualify for discharge under the new regulations.

The commenter also asked how a lender would file a claim when only one of the borrowers of a joint consolidation loan qualifies for a loan discharge under the new provisions. The commenter suggested that such claims should be handled in a manner similar to the procedures for unpaid refund discharge claims.

Finally, the commenter asked how a guaranty agency would assign a portion of a joint consolidation loan to the Secretary—and who would hold the promissory note—when a preliminary determination has been made that one of the borrowers is totally and permanently disabled. The commenter recommended that the entire joint consolidation loan be assigned to the Secretary, instead of ''splitting'' the loan and assigning only the potentially dischargeable portion.

Discussion: As we explained in the preamble to the August 6, 2002 NPRM, we suggested the changes related to consolidation loan discharges because we believed that borrowers should be permitted to receive discharges that they would have qualified for if they had not consolidated their loans. We did not intend to provide the new benefits only to borrowers who receive consolidation loans in the future. Moreover, there was never any suggestion made during the negotiated rulemaking that discharge eligibility should be limited based on the date the consolidation loan was made, or the date the discharge condition was met. Accordingly, a consolidation loan borrower may qualify for a discharge under the new provisions regardless of when the consolidation loan was made or when the discharge condition was met, provided that the borrower still has an outstanding balance on the consolidation loan at the time of the borrower's discharge request. However, a borrower who would have qualified for a discharge of a consolidation loan under the new regulations may not apply for a discharge of a loan that has already been paid in full.

We would also like to note that we do not plan to attempt, nor do we expect guaranty agencies to attempt, to identify borrowers who were not eligible to receive loan discharges in the past, but who might qualify under the new regulations. However, we will work with interested parties to determine how to make information about the new consolidation loan benefits available to the public.

With regard to filing claims when only one of the borrowers of a joint consolidation loan qualifies for loan discharge under the new provisions, the procedures would be the same as the procedures for filing claims when a joint consolidation loan is partially discharged under current regulations

due to school closure, false certification, or unpaid refund.

The assignment of joint consolidation loans to the Secretary when one of the borrowers may qualify for a total and permanent disability discharge involves operational issues that are not regulated. We will work with lenders, servicers and guaranty agencies to address the issues raised by the commenter.

Changes: None.

Comments: None.

Discussion: We have determined that the language in the proposed regulations on loan discharge for consolidation loans did not clearly reflect our intentions. In the case of a discharge of a consolidation loan based on the death of the student for whom the parent had obtained a PLUS loan that was included in the consolidation loan, or the death or total and permanent disability of one of the borrowers of a joint consolidation loan, the borrower or the borrower's estate should receive the same discharge benefit that they would have received if the loan(s) had not been consolidated. Current loan discharge regulations in both the FFEL and Direct Loan programs provide that any payments received after the date of a borrower's (or dependent student's) death or after the date that a borrower became totally and permanently disabled are returned to the borrower or the borrower's estate. In the case of a consolidation loan, loan holders should return payments to the borrower or the borrower's estate only if there is no remaining balance on the consolidation loan after the discharge. Otherwise, payments received after the date the discharge condition was met should be reapplied to reduce the remaining outstanding balance of the consolidation loan. Payments received after the date the discharge condition was met should be reflected in the discharge amount, regardless of how that amount is determined. However, the proposed regulatory language might have suggested that the amount discharged is limited to the applicable portion of the current outstanding balance of the loan, and does not include a refund or reapplication of payments received after the date that the borrower met the eligibility requirements for the discharge.

Changes: We have revised §§ 682.402(a)(2), 685.212(a)(3), 685.220(l)(3)(i), and 685.220(l)(3)(ii) to reflect that the amount discharged is an amount equal to the applicable portion of the outstanding balance of the consolidation loan as of the date that the borrower met the eligibility requirements for the discharge.

Comments: Several commenters recommended that we add language to § 682.402(a)(2) clarifying that in the case of a joint consolidation loan that is partially discharged due to the death or total and permanent disability of one of the borrowers, neither that borrower nor that borrower's estate is any longer jointly and severally liable for repayment of the remaining portion of the consolidation loan. One commenter proposed the addition of similar language, but also recommended that the information in § 682.402(a)(2) related to the discharge amount be removed from that paragraph and placed in § 682.402(h), which covers the payment of discharge claims by a guaranty agency. That commenter recommended that § 682.402(a)(2) be revised to include only general discharge information.

Discussion: In the case of discharges involving the death of one of the borrowers of a joint consolidation loan, the suggested additional language is unnecessary. A borrower's joint and several liability for repayment of the balance of the joint consolidation loan ends upon the borrower's death, and an existing provision in § 682.402(b)(4) prohibits lenders from attempting to collect on a loan from the borrower's estate or from any endorser after making a determination that the borrower has died. The same policy applies in the Direct Loan Program.

The commenters are not correct in assuming that a total and permanent disability discharge of a portion of a joint consolidation loan eliminates joint and several liability for the remaining balance of the loan for either of the borrowers. In the case of a partial discharge of a joint consolidation loan for a reason other than the death of one of the borrowers, both borrowers remain jointly and severally liable for the remaining balance of the loan. For example, under current regulations, a joint consolidation loan may be partially discharged if one of the borrowers meets the eligibility requirements for discharge based on school closure, false certification, or an unpaid refund. However, both borrowers on the joint consolidation loan are still jointly and severally liable for the amount of the loan that remains after the discharge has been granted. Under the new regulations, this will also be true if a joint consolidation loan is partially discharged based on the total and permanent disability of one of the borrowers. That is, each borrower will remain jointly and severally liable for repayment of the remaining portion of the consolidation loan.

With regard to the suggestion that information on the discharge amount be moved from § 682.402(a)(2) to § 682.402(h), we understand the rationale for the commenter's recommendation. However, we believe that this information is presented more clearly and concisely in § 682.402(a)(2).

Changes: None.

Comments: Several commenters suggested that we restore language that was deleted from redesignated § 682.402(a)(3) in the proposed regulations. Specifically, they proposed that the words ''or a Consolidation loan was obtained by a married couple,'' be restored after the word ''co-makers''. The commenters believed that the deleted language ensures that when only one of the borrowers of a co-made PLUS loan or joint consolidation loan meets the requirements for loan discharge based on death, total and permanent disability, or bankruptcy, the other borrower remains obligated to repay the portion of the loan that is not discharged.

One commenter made a similar recommendation for revising redesignated § 682.402(a)(3) to specifically state that if one of the borrowers of a co-made PLUS loan or one of the borrowers of a joint consolidation loan dies or becomes totally and permanently disabled, the other borrower remains obligated to repay the remaining balance of the loan. The commenter further noted that the proposed regulations did not address bankruptcy situations, and recommended additional language for redesignated § 682.402(a)(3) specifying that if the loan obligation of one of the borrowers of a co-made PLUS loan or joint consolidation loan is stayed by a bankruptcy filing or discharged in bankruptcy, but the other borrower's obligation is not stayed or discharged, the other borrower remains obligated to repay the remaining balance of the loan.

Discussion: The commenters suggest that the new loan discharge provisions apply to both joint consolidation loans and PLUS loans obtained jointly by two parents as co-makers. That is incorrect. The proposed regulations that resulted from the negotiated rulemaking sessions apply only to joint consolidation loans, not to co-made PLUS loans.

Restoring the language that was deleted from redesignated § 682.402(a)(3) would not have the effect of ensuring that the other borrower is responsible for repaying the remaining portion of a partially discharged joint consolidation loan, as suggested by the commenters. In the current regulations, § 682.402(a)(2) (redesignated § 682.402(a)(3)) prohibits partial discharges of both joint consolidation loans and PLUS loans obtained by two parents as co-makers if one of the two

borrowers dies or becomes totally and permanently disabled, has collection of his or her loan obligation stayed by a bankruptcy filing, or has that obligation discharged in bankruptcy, but the other borrower does not qualify for any type of discharge. In such cases, current regulations provide that the other borrower is responsible for repaying the entire loan. The new regulations provide for the partial discharge of a joint consolidation loan—but not a PLUS loan obtained by two parents as co-makers—if one of the borrowers dies or becomes totally and permanently disabled. To allow for this new provision, it was necessary to remove the reference to joint consolidation loans from redesignated § 682.402(a)(3). If the language of the current regulations were restored, there would be a conflict with the new provisions related to discharges of joint consolidation loans.

We do not believe that it is necessary to explicitly state in the regulations that when a joint consolidation loan is partially discharged as a result of the death of one of the borrowers, the other borrower remains responsible for repaying the outstanding balance of the loan. We also do not believe that it is necessary to state in the regulations that, as explained elsewhere in this preamble, each borrower of a joint consolidation loan remains jointly and severally liable for repayment of the remaining balance of the loan if the loan is partially discharged based on the total and permanent disability of one of the borrowers.

The new provisions related to the discharge of joint consolidation loans do not specifically address the discharge of joint consolidation loans due to bankruptcy, since our regulations do not determine whether one or both of the borrowers of a joint consolidation loan is relieved of any repayment obligation as the result of a bankruptcy filing. Such determinations are made by a bankruptcy court in accordance with the Bankruptcy Code.

Changes: None.

Comments: Several commenters recommended that, based on the new regulations which allow partial discharges of joint consolidation loans based on the death or total and permanent disability of one of the borrowers, we make a conforming change to § 682.402(k)(2)(iii) by eliminating language that provides, in the case of claims for reimbursement on joint consolidation loans, for the Secretary to reimburse a guaranty agency only if each of the co-makers of the loan has died or become totally and permanently disabled. Some commenters also suggested additional technical changes to this paragraph to reflect the fact that under the current total and permanent disability discharge regulations, a guaranty agency does not make the determination that a borrower is totally and permanently disabled.

Discussion: We agree that most of the changes suggested by the commenters are appropriate. However, the commenters' proposed conforming change to § 682.402(k)(2)(iii) would retain current language specifying that in the case of a bankruptcy claim, both co-makers of a joint consolidation loan must file a petition for relief in bankruptcy in order for a guaranty agency to be reimbursed. As explained elsewhere in this preamble, the new provisions for the discharge of joint consolidation loan do not address bankruptcy, since our regulations do not determine whether a borrower who has filed for bankruptcy is relieved of the obligation to repay a loan. For the same reason, we do not believe that it is appropriate for § 682.402(k)(2)(iii) to specify that both co-makers of a joint consolidation loan must file for bankruptcy.

Changes: We have revised § 682.402(k)(2)(iii) by removing language that provides for reimbursement by the Secretary only if each of the co-makers of a joint consolidation loan has died or become totally and permanently disabled. We have also removed the reference to determination of a borrower's total and permanent disability by the guaranty agency.

Comments: One commenter objected to the proposed changes related to consolidation loan discharges in §§ 685.212(a)(3) and 685.220(l)(3) on the basis that comparable provisions were not proposed for the FFEL Program. The commenter believed that the proposed changes would give an unfair advantage to Direct Loan borrowers, and felt that the new consolidation loan discharge benefits should be made available to FFEL Program borrowers as well.

Discussion: We disagree with the commenter. The August 6, 2002 NPRM included proposed changes in §§ 682.402(a)(2) and 682.402(b)(6) of the FFEL Program regulations that provide the same benefits as the proposed changes in § 685.212(a)(3) and 685.220(l)(3) of the Direct Loan Program regulations.

Changes: None.

Direct Loans—Expiration of Master Promissory Note (Section 685.102)

Comments: None.

Discussion: In reviewing the proposed regulations, we realized that the Direct Loan MPN expiration date provision based on a borrower providing written notice that no further loans may be made under an MPN was not stated correctly. Instead of referring to a written notice that no further loans may be ''made,'' the proposed regulations referred to a written notice that no further loans may be ''disbursed.'' To be technically correct, the regulations need to refer to a written notice that no further loans may be made.

Changes: We have revised § 685.102(b)(3)(i) in the definition of Master Promissory Note (MPN) to refer to a written notice that no further loans may be made.

GEAR UP Program (Section 694.10)

Comments: One commenter requested clarification on whether GEAR UP funds may be used to replace a student's expected family contribution (EFC).

Discussion: Section 404E(c) of the HEA provides that a GEAR UP scholarship ''* * * shall not be considered for purpose of awarding Federal grant assistance under this title, except that in no case shall the total amount of student financial assistance awarded to a student under this title exceed such student's total cost of attendance.'' Thus, a GEAR UP scholarship can be awarded without considering the student's EFC as long as the total Title IV aid, including the GEAR UP scholarship, does not exceed the student's cost of attendance. Also, when awarding other Title IV grants, a GEAR UP scholarship is not to be considered. The combination of these two provisions means, in effect, that a GEAR UP scholarship may be used to replace EFC for Title IV grants, including FSEOG. However, when awarding FWS, Federal Perkins Loans, and subsidized FFEL or Direct Loans to a student who is receiving a GEAR UP scholarship, GEAR UP funds may not be used to replace the EFC.

Changes: None.

Executive Order 12866

We have reviewed these final regulations in accordance with Executive Order 12866. Under the terms of the order we have assessed the potential costs and benefits of this regulatory action.

The potential costs associated with the final regulations are those resulting from statutory requirements and those we have determined to be necessary for administering these programs effectively and efficiently.

In assessing the potential costs and benefits—both quantitative and qualitative—of these final regulations, we have determined that the benefits of the regulations justify the costs.

We have also determined that this regulatory action does not unduly interfere with State, local, and tribal governments in the exercise of their governmental functions.

Summary of Potential Costs and Benefits

We summarized the potential costs and benefits of these final regulations in the preamble to the August 6, 2002, NPRM (67 FR 51046) and in the preamble to the August 8, 2002, NPRM (67 FR 51733).

Paperwork Reduction Act of 1995

We received no comments on the Paperwork Reduction Act portion of the rule. The Paperwork Reduction Act of 1995 does not require you to respond to a collection of information unless it displays a valid OMB control number. OMB has approved the information collection request and assigned the following numbers to the collections of information in these final regulations:

Section 600.21	1845–0012
Section 600.31	1845–0012
Section 668.22	1845–0022
Section 668.165	1845–0038
Section 668.173	1845–0022
Section 668.183	1845–0022
Section 668.193	1845–0022
Section 673.5	1845–0019
Section 674.16	1845–0019
Section 674.19	1845–0019
Section 674.33	1845–0019
Section 674.34	1845–0019
Section 674.39	1845–0023
Section 674.42	1845–0023
Section 674.43	1845–0023
Section 674.45	1845–0023
Section 674.47	1845–0023
Section 674.50	1845–0019
Section 682.200	1845–0020
Section 682.209	1845–0020
Section 682.210	1845–0020
Section 682.211	1845–0020
Section 682.402	1845–0020
Section 682.405	1845–0020
Section 682.414	1845–0020
Section 682.604	1845–0020
Section 685.212	1845–0021
Section 685.220	1845–0021
Section 685.304	1845–0021

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 Numbers: 84.007 Federal Supplemental Educational Opportunity Grant Program; 84.032 Federal Family Education Loan Program; 84.033 Federal Work-Study Program; 84.038 Federal Perkins Loan Program; 84.063 Federal Pell Grant Program; and 84.268 William D. Ford Federal Direct Loan Program)

List of Subjects

34 CFR Parts 600 and 668

Administrative practice and procedure, Colleges and universities, Consumer protection, Education, Grant programs-education, Loan programs—education, Reporting and recordkeeping requirements, Student aid, Vocational education.

34 CFR Parts 673 and 675

Administrative practice and procedure, Colleges and universities, Consumer protection, Education, Employment, Grant programs—education, Loan programs—education, Reporting and recordkeeping requirements, Student aid, Vocational education.

34 CFR Parts 674, 682, and 685

Administrative Practice and Procedure, Colleges and universities, Education, Loans program—education, Reporting and recordkeeping requirements, Student aid, Vocational education.

34 CFR Part 690

Grant programs—education, Reporting and recordkeeping requirements, Student aid.

34 CFR Part 694

Colleges and universities, Elementary and secondary education, Grant programs—education, Reporting and recordkeeping requirements, Student aid.

Dated: October 23, 2002.

Rod Paige,

Secretary of Education.

For the reasons discussed in the preamble, the Secretary amends parts 600, 668, 673, 674, 675, 682, 685, 690, and 694 of title 34 of the Code of Federal Regulations as follows:

PART 600—INSTITUTIONAL ELIGIBILITY UNDER THE HIGHER EDUCATION ACT OF 1965, AS AMENDED

1. The authority citation for part 600 is revised to read as follows:

Authority: 20 U.S.C. 1001, 1002, 1003, 1088, 1091, 1094, 1099b, and 1099c, unless otherwise noted.

§ 600.8 [Amended]

2. Section 600.8 is amended by adding ''proprietary institution of higher education or a postsecondary vocational'' after ''eligible''.

3. Section 600.21 is amended:

A. By revising paragraph (f);

B. By revising the Office of Management and Budget control number.

The revisions read as follows:

§ 600.21 Updating application information.

* * * * *

(f) *Definition.* A family member includes a person's—

(1) Parent or stepparent, sibling or step-sibling, spouse, child or stepchild, or grandchild or step-grandchild;

(2) Spouse's parent or stepparent, sibling or step-sibling, child or stepchild, or grandchild or step-grandchild;

(3) Child's spouse; and

(4) Sibling's spouse.

(Approved by the Office of Management and Budget under control number 1845–0012)

4. Section 600.31 is amended:

A. By revising paragraph (e);

B. By revising the Office of Management and Budget control number.

The revisions read as follows:

§ 600.31 Change in ownership resulting in a change in control for private nonprofit, private for-profit and public institutions.

* * * * *

(e) *Excluded transactions.* A change in ownership and control reported under § 600.21 and otherwise subject to this section does not include a transfer of ownership and control of all or part of an owner's equity or partnership interest in an institution, the

institution's parent corporation, or other legal entity that has signed the institution's Program Participation Agreement—

(1) From an owner to a ''family member'' of that owner as defined in § 600.21(f); or

(2) Upon the retirement or death of the owner, to a person with an ownership interest in the institution who has been involved in management of the institution for at least two years preceding the transfer and who has established and retained the ownership interest for at least two years prior to the transfer.

(Approved by the Office of Management and Budget under control number 1845–0012)

PART 668—STUDENT ASSISTANCE GENERAL PROVISIONS

5. The authority citation for part 668 continues to read as follows:

Authority: 20 U.S.C. 1001, 1002, 1003, 1085, 1091, 1091b, 1092, 1094, 1099c, and 1099c–1, unless otherwise noted.

§ 668.2 [Amended]

6. Section 668.2(b) is amended by removing the definition of ''Academic year''.

7. Section 668.3 is revised to read as follows:

§ 668.3 Academic year.

(a) *General.* Except as provided in paragraph (c) of this section, an academic year is a period that begins on the first day of classes and ends on the last day of classes or examinations during which—

(1) An institution provides a minimum of 30 weeks of instructional time; and

(2) For an undergraduate educational program, a full-time student is expected to complete at least—

(i) Twenty-four semester or trimester credit hours or 36 quarter credit hours for a program measured in credit hours; or

(ii) 900 clock hours for a program measured in clock hours.

(b) *Definitions.* For purposes of paragraph (a) of this section—

(1) A week is a consecutive seven-day period;

(2) A week of instructional time is any week in which at least one day of regularly scheduled instruction or examinations occurs or, after the last scheduled day of classes for a term or payment period, at least one day of study for final examinations occurs; and

(3) Instructional time does not include any vacation periods, homework, or periods of orientation or counseling.

(c) *Reduction in the length of an academic year.*

(1) Upon the written request of an institution, the Secretary may approve, for good cause, an academic year of 26 through 29 weeks of instructional time for educational programs offered by the institution if the institution offers a two-year program leading to an associate degree or a four-year program leading to a baccalaureate degree.

(2) An institution's written request must—

(i) Identify each educational program for which the institution requests a reduction, and the requested number of weeks of instructional time for that program;

(ii) Demonstrate good cause for the requested reductions; and

(iii) Include any other information that the Secretary may require to determine whether to grant the request.

(3)(i) The Secretary approves the request of an eligible institution for a reduction in the length of its academic year if the institution has demonstrated good cause for granting the request and the institution's accrediting agency and State licensing agency have approved the request.

(ii) If the Secretary approves the request, the approval terminates when the institution's program participation agreement expires. The institution may request an extension of that approval as part of the recertification process.

(Approved by the Office of Management and Budget under control number 1845–0022)

(Authority: 20 U.S.C. 1088)

8. Section 668.4 is revised to read as follows:

§ 668.4 Payment period.

(a) *Payment periods for an eligible program that measures progress in credit hours and has academic terms.* For a student enrolled in an eligible program that measures progress in credit hours and has academic terms, the payment period is the academic term.

(b) *Payment periods for an eligible program that measures progress in credit hours and does not have academic terms.* (1) For a student enrolled in an eligible program that is one academic year or less in length—

(i) The first payment period is the period of time in which the student completes half the number of credit hours in the program and half the number of weeks in the program; and

(ii) The second payment period is the period of time in which the student completes the program.

(2) For a student enrolled in an eligible program that is more than one academic year in length—

(i) For the first academic year and any subsequent full academic year—

(A) The first payment period is the period of time in which the student completes half the number of credit hours in the academic year and half the number of weeks in the academic year; and

(B) The second payment period is the period of time in which the student completes the academic year.

(ii) For any remaining portion of an eligible program that is more than one-half an academic year but less than a full academic year in length—

(A) The first payment period is the period of time in which the student completes half the number of credit hours in the remaining portion of the program and half the number of weeks remaining in the program; and

(B) The second payment period is the period of time in which the student completes the remainder of the program.

(iii) For any remaining portion of an eligible program that is not more than half an academic year, the payment period is the remainder of the program.

(3) For purposes of paragraphs (b)(1) and (b)(2) of this section, if an institution is unable to determine when a student has completed half of the credit hours in a program, academic year, or remainder of a program; the student is considered to begin the second payment period of the program, academic year, or remainder of a program at the later of—

(i) The date, as determined by the institution, on which the student has completed half of the academic coursework in the program, academic year, or remainder of the program; or

(ii) The calendar midpoint between the first and last scheduled days of class of the program, academic year, or remainder of the program.

(c) *Payment periods for an eligible program that measures progress in clock hours.* (1) For a student enrolled in an eligible program that is one academic year or less in length—

(i) The first payment period is the period of time in which the student completes half the number of clock hours in the program; and

(ii) The second payment period is the period of time in which the student completes the program.

(2) For a student enrolled in an eligible program that is more than one academic year in length—

(i) For the first academic year and any subsequent full academic year—

(A) The first payment period is the period of time in which the student completes half the number of clock hours in the academic year; and

(B) The second payment period is the period of time in which the student completes the academic year.

(ii) For any remaining portion of an eligible program that is more than one-half an academic year but less than a full academic year in length—

(A) The first payment period is the period of time in which the student completes half the number of clock hours in the remaining portion of the program; and

(B) The second payment period is the period of time in which the student completes the remainder of the program.

(iii) For any remaining portion of an eligible program that is not more than one half of an academic year, the payment period is the remainder of the program.

(d) *Number of payment periods.* Notwithstanding paragraphs (b) and (c) of this section, an institution may choose to have more than two payment periods. If an institution so chooses, the regulations in paragraphs (b) and (c) of this section are modified to reflect the increased number of payment periods. For example, if an institution chooses to have three payment periods in an academic year in a program that measures progress in credit hours but does not have academic terms, each payment period must correspond to one-third of the academic year measured in both credit hours and weeks of instruction.

(e) *Re-entry within 180 days.* If a student withdraws from a program described in paragraph (b) or (c) of this section during a payment period and then reenters the same program within 180 days, the student remains in that same payment period when he or she returns and, subject to conditions established by the Secretary or by the FFEL lender or guaranty agency, is eligible to receive any title IV, HEA program funds for which he or she was eligible prior to withdrawal, including funds that were returned by the institution or student under the provisions of § 668.22.

(f) *Re-entry after 180 days or transfer.* (1) Subject to the conditions of paragraph (f)(2) of this section, an institution calculates new payment periods for the remainder of a student's program based on paragraphs (b) through (d) of this section, for a student who withdraws from a program described in paragraph (b) or (c) of this section, and—

(i) Reenters that program after 180 days,

(ii) Transfers into another program at the same institution within any time period, or

(iii) Transfers into a program at another institution within any time period.

(2) For a student described in paragraph (f)(1) of this section—

(i) For the purpose of calculating payment periods only, the length of the program is the number of credit hours and the number of weeks, or the number of clock hours, that the student has remaining in the program he or she enters or reenters; and

(ii) If the remaining hours, and weeks if applicable, constitute one-half of an academic year or less, the remaining hours constitute one payment period.

(Authority: 20 U.S.C. 1070 *et seq.*)

9. Section 668.8 is amended by:

A. Revising paragraph (b)(3).

B. Removing paragraph (b)(4).

The revision reads as follows:

§ 668.8 Eligible program.

* * * * *

(b) * * *

(3)(i) The Secretary considers that an institution provides one week of instructional time in an academic program during any week the institution provides at least one day of regularly scheduled instruction or examinations, or, after the last scheduled day of classes for a term or a payment period, at least one day of study for final examinations.

(ii) Instructional time does not include any vacation periods, homework, or periods of orientation or counseling.

* * * * *

10. Section 668.14(b)(22) is revised to read as follows:

§ 668.14 Program participation agreement.

* * * * *

(b) * * *

(22)(i) It will not provide any commission, bonus, or other incentive payment based directly or indirectly upon success in securing enrollments or financial aid to any person or entity engaged in any student recruiting or admission activities or in making decisions regarding the awarding of title IV, HEA program funds, except that this limitation does not apply to the recruitment of foreign students residing in foreign countries who are not eligible to receive title IV, HEA program funds.

(ii) Activities and arrangements that an institution may carry out without violating the provisions of paragraph (b)(22)(i) of this section include, but are not limited to:

(A) The payment of fixed compensation, such as a fixed annual salary or a fixed hourly wage, as long as that compensation is not adjusted up or down more than twice during any twelve month period, and any adjustment is not based solely on the number of students recruited, admitted, enrolled, or awarded financial aid. For this purpose, an increase in fixed compensation resulting from a cost of living increase that is paid to all or substantially all full-time employees is not considered an adjustment.

(B) Compensation to recruiters based upon their recruitment of students who enroll only in programs that are not eligible for title IV, HEA program funds.

(C) Compensation to recruiters who arrange contracts between the institution and an employer under which the employer's employees enroll in the institution, and the employer pays, directly or by reimbursement, 50 percent or more of the tuition and fees charged to its employees; provided that the compensation is not based upon the number of employees who enroll in the institution, or the revenue they generate, and the recruiters have no contact with the employees.

(D) Compensation paid as part of a profit-sharing or bonus plan, as long as those payments are substantially the same amount or the same percentage of salary or wages, and made to all or substantially all of the institution's full-time professional and administrative staff. Such payments can be limited to all, or substantially all of the full-time employees at one or more organizational level at the institution, except that an organizational level may not consist predominantly of recruiters, admissions staff, or financial aid staff.

(E) Compensation that is based upon students successfully completing their educational programs, or one academic year of their educational programs, whichever is shorter. For this purpose, successful completion of an academic year means that the student has earned at least 24 semester or trimester credit hours or 36 quarter credit hours, or has successfully completed at least 900 clock hours of instruction at the institution.

(F) Compensation paid to employees who perform clerical ''pre-enrollment'' activities, such as answering telephone calls, referring inquiries, or distributing institutional materials.

(G) Compensation to managerial or supervisory employees who do not directly manage or supervise employees who are directly involved in recruiting or admissions activities, or the awarding of title IV, HEA program funds.

(H) The awarding of token gifts to the institution's students or alumni, provided that the gifts are not in the form of money, no more than one gift is provided annually to an individual, and

the cost of the gift is not more than $100.

(I) Profit distributions proportionately based upon an individual's ownership interest in the institution.

(J) Compensation paid for Internet-based recruitment and admission activities that provide information about the institution to prospective students, refer prospective students to the institution, or permit prospective students to apply for admission on-line.

(K) Payments to third parties, including tuition sharing arrangements, that deliver various services to the institution, provided that none of the services involve recruiting or admission activities, or the awarding of title IV, HEA program funds.

(L) Payments to third parties, including tuition sharing arrangements, that deliver various services to the institution, even if one of the services involves recruiting or admission activities or the awarding of title IV, HEA program funds, provided that the individuals performing the recruitment or admission activities, or the awarding of title IV, HEA program funds, are not compensated in a manner that would be impermissible under paragraph (b)(22) of this section.

* * * * *

11. Section 668.22 is amended by:

A. In paragraph (a)(3), removing ''§ 668.164(g)(2)'' and adding, in its place, ''§ 668.164(g)''.

B. In paragraph (a)(4)(ii)(B), removing ''90'' and adding, in its place, ''120''.

C. Revising paragraph (b)(3)(i).

D. Revising paragraph (d)(1)(vi).

E. Removing paragraph (d)(1)(vii).

F. Redesignating paragraphs (d)(1)(viii) and (d)(1)(ix) as paragraphs (d)(1)(vii) and (d)(1)(viii), respectively, and revising the newly designated paragraph (d)(1)(vii).

G. Removing paragraph (d)(2).

H. Redesignating paragraphs (d)(3) and (d)(4) as paragraphs (d)(2) and (d)(3), respectively.

I. Removing ''on'' and adding, in its place, ''at'' in newly redesignated paragraph (d)(2).

J. Removing ''are'' and adding, in its place, ''is'' in newly redesignated paragraph (d)(3)(i).

K. Adding '', that includes the reason for the request,'' after ''request'' in the first sentence in newly redesignated paragraph (d)(3)(iii)(B).

L. Adding ''The timeframe for returning funds is further described in § 668.173(b).'' at the end of paragraph (j)(1).

The revisions and additions read as follows:

§ 668.22 Treatment of title IV funds when a student withdraws.

* * * * *

(b) * * *

(3)(i) An institution is required to take attendance if an outside entity (such as the institution's accrediting agency or a State agency) has a requirement, as determined by the entity, that the institution take attendance.

* * * * *

(d) * * *

(1) * * *

(vi) The number of days in the approved leave of absence, when added to the number of days in all other approved leaves of absence, does not exceed 180 days in any 12-month period;

(vii) Except for a clock hour or nonterm credit hour program, upon the student's return from the leave of absence, the student is permitted to complete the coursework he or she began prior to the leave of absence; and

* * * * *

§ 668.32 [Amended]

12. Section 668.32(e)(2) is amended by removing ''within 12 months before the date the student initially receives title IV, HEA program assistance,''.

13. Section 668.35 is amended:

A. In paragraph (a)(2), by adding new introductory text.

B. By redesignating paragraphs (b), (c), (d), (e), and (f) as paragraphs (d), (e), (f), (g), and (h) respectively.

C. By adding new paragraphs (b) and (c).

D. By revising newly redesignated paragraph (e).

The revision and additions read as follows:

§ 668.35 Student debts under the HEA and to the U.S.

(a) * * *

(2) Except as limited by paragraph (c) of this section—

* * * * *

(b) A student who is subject to a judgment for failure to repay a loan made under a title IV, HEA loan program may nevertheless be eligible to receive title IV, HEA program assistance if the student—

(1) Repays the debt in full; or

(2) Except as limited by paragraph (c) of this section—

(i) Makes repayment arrangements that are satisfactory to the holder of the debt; and

(ii) Makes at least six consecutive, voluntary monthly payments under those arrangements. Voluntary payments are those payments made directly by the borrower, and do not include payments obtained by Federal offset, garnishment, or income or asset execution.

(c) A student who reestablishes eligibility under either paragraph (a)(2) of this section or paragraph (b)(2) of this section may not reestablish eligibility again under either of those paragraphs.

* * * * *

(e) A student who receives an overpayment under the Federal Perkins Loan Program, or under a title IV, HEA grant program may nevertheless be eligible to receive title IV, HEA program assistance if—

(1) The student pays the overpayment in full;

(2) The student makes arrangements satisfactory to the holder of the overpayment debt to pay the overpayment; or

(3) The overpayment amount is less than $25 and is neither a remaining balance nor a result of the application of the overaward threshold in 34 CFR 673.5(d).

* * * * *

§ 668.151 [Amended]

14. Section 668.151(a)(2) is amended by adding the words ''it received from an approved test publisher or assessment center'' after ''an approved test''.

15. Section 668.164(g) is revised to read as follows:

§ 668.164 Disbursing funds.

* * * * *

(g) *Late disbursements.* (1) *Ineligible student.* For purposes of this paragraph, an otherwise eligible student becomes ineligible to receive title IV, HEA program funds on the date that—

(i) For a loan under the FFEL and Direct Loan programs, the student is no longer enrolled at the institution as at least a half-time student for the period of enrollment for which the loan was intended; or

(ii) For an award under the Federal Pell Grant, FSEOG, and Federal Perkins Loan programs, the student is no longer enrolled at the institution for the award year.

(2) *Conditions for a late disbursement.* Except as limited under paragraph (g)(4) of this section, a student who becomes ineligible (or the student's parent in the case of a PLUS loan) qualifies for a late disbursement if, before the date the student became ineligible—

(i) Except in the case of a PLUS loan, the Secretary processed a SAR or ISIR with an official expected family contribution; and

(ii) (A) For a loan under the FFEL or Direct Loan programs, the institution certified or originated the loan; or

(B) For an award under the Federal Perkins Loan or FSEOG programs, the institution made that award to the student.

(3) *Making a late disbursement.* Provided that the conditions described in paragraph (g)(2) of this section are satisfied—

(i) If the student withdrew from the institution during a payment period or period of enrollment, the institution must make any post-withdrawal disbursement required under § 668.22(a)(3) in accordance with the provisions of § 668.22(a)(4);

(ii) If the student successfully completed the payment period or period of enrollment, the institution must provide the student (or parent) the opportunity to receive the amount of title IV, HEA program funds that the student (or parent) was eligible to receive while the student was enrolled at the institution. For a late disbursement in this circumstance, the institution may credit the student's account to pay for current and allowable charges as described in paragraph (d) of this section, but must pay or offer any remaining amount to the student or parent; or

(iii) If the student did not withdraw but ceased to be enrolled as at least a half-time student, the institution may make the late disbursement of a loan under the FFEL or Direct Loan programs to pay for educational costs that the institution determines the student incurred for the period in which the student was eligible.

(4) *Limitations.* (i) Generally, an institution may not make a late disbursement later than 120 days after the date of the institution's determination that the student withdrew, as provided under § 668.22, or, for a student who did not withdraw, 120 days after the date the student otherwise became ineligible. On an exception basis, and with the approval of the Secretary, an institution may make a late disbursement after the applicable 120-day period, if the reason the late disbursement was not made within the 120-day period was not the fault of the student.

(ii) An institution may not make a second or subsequent late disbursement of a loan under the FFEL or Direct Loan programs unless the student successfully completed the period of enrollment for which the loan was intended.

(iii) An institution may not make a late disbursement of a loan under the FFEL or Direct Loan programs if the student was a first-year, first-time borrower unless the student completed the first 30 days of his or her program of study. This limitation does not apply if the institution is exempt from the 30-day delayed disbursement requirements under § 682.604(c)(5)(i), (ii), or (iii) or § 685.303(b)(4)(i)(A), (B), or (C) of this chapter.

(iv) An institution may not make a late disbursement of a Federal Pell Grant unless it received a valid SAR or a valid ISIR for the student by the deadline date established by the Secretary in a notice published in the **Federal Register**.

16. Section 668.165 is amended:

A. By revising paragraph (a)(3);

B. By revising the Office of Management and Budget control number.

The revisions read as follows:

§ 668.165 Notices and authorizations.

(a) * * *

(3) The institution must send the notice described in paragraph (a)(2) of this section in writing no earlier than 30 days before, and no later than 30 days after, crediting the student's account at the institution.

* * * * *

(Approved by the Office of Management and Budget under control number 1845–0038)

§ 668.171 [Amended]

17. Section 668.171(b) is amended by:

A. Removing ''refunds'' and adding, in its place, ''returns of unearned title IV HEA program funds'' in paragraph (b)(2).

B. Removing ''and the payment of post-withdrawal disbursements under § 668.22'' in paragraph (b)(4)(i).

18. Section 668.173 is amended by:

A. Revising paragraphs (a) through (c).

B. Redesignating paragraph (d) as paragraph (f).

C. Adding new paragraphs (d) and (e).

D. Adding an Office of Management and Budget control number.

The revisions and additions read as follows:

§ 668.173 Refund reserve standards.

(a) *General.* The Secretary considers that an institution has sufficient cash reserves, as required under § 668.171(b)(2), if the institution—

(1) Satisfies the requirements for a public institution under § 668.171(c)(1);

(2) Is located in a State that has a tuition recovery fund approved by the Secretary and the institution contributes to that fund; or

(3) Returns, in a timely manner as described in paragraph (b) of this section, unearned title IV, HEA program funds that it is responsible for returning under the provisions of § 668.22 for a student that withdrew from the institution.

(b) *Timely return of title IV, HEA program funds.* In accordance with procedures established by the Secretary or FFEL Program lender, an institution returns unearned title IV, HEA funds timely if—

(1) The institution deposits or transfers the funds into the bank account it maintains under § 668.163 no later than 30 days after the date it determines that the student withdrew;

(2) The institution initiates an electronic funds transfer (EFT) no later than 30 days after the date it determines that the student withdrew;

(3) The institution initiates an electronic transaction, no later than 30 days after the date it determines that the student withdrew, that informs an FFEL lender to adjust the borrower's loan account for the amount returned; or

(4) The institution issues a check no later than 30 days after the date it determines that the student withdrew. However, the Secretary considers that the institution did not satisfy this requirement if—

(i) The institution's records show that the check was issued more than 30 days after the date the institution determined that the student withdrew; or

(ii) The date on the cancelled check shows that the bank used by the Secretary or FFEL Program lender endorsed that check more than 45 days after the date the institution determined that the student withdrew.

(c) *Compliance thresholds.* (1) An institution does not comply with the reserve standard under § 668.173(a)(3) if, in a compliance audit conducted under § 668.23, an audit conducted by the Office of the Inspector General, or a program review conducted by the Department or guaranty agency, the auditor or reviewer finds—

(i) In the sample of student records audited or reviewed that the institution did not return unearned title IV, HEA program funds within the timeframes described in paragraph (b) of this section for 5% or more of the students in the sample. (For purposes of determining this percentage, the sample includes only students for whom the institution was required to return unearned funds during its most recently completed fiscal year.); or

(ii) A material weakness or reportable condition in the institution's report on internal controls relating to the return of unearned title IV, HEA program funds.

(2) The Secretary does not consider an institution to be out of compliance with the reserve standard under § 668.173(a)(3) if the institution is cited in any audit or review report because it did not return unearned funds in a timely manner for one or two students,

or for less than 5% of the students in the sample referred to in paragraph (c)(1)(i) of this section.

(d) *Letter of credit.* (1) Except as provided under paragraph (e)(1) of this section, an institution that can satisfy the reserve standard only under paragraph (a)(3) of this section, must submit an irrevocable letter of credit acceptable and payable to the Secretary if a finding in an audit or review shows that the institution exceeded the compliance thresholds in paragraph (c) of this section for either of its two most recently completed fiscal years.

(2) The amount of the letter of credit required under paragraph (d)(1) of this section is 25 percent of the total amount of unearned title IV, HEA program funds that the institution was required to return under § 668.22 during the institution's most recently completed fiscal year.

(3) An institution that is subject to paragraph (d)(1) of this section must submit to the Secretary a letter of credit no later than 30 days after the earlier of the date that—

(i) The institution is required to submit its compliance audit;

(ii) The Office of the Inspector General issues a final audit report;

(iii) The designated department official issues a final program review determination;

(iv) The Department issues a preliminary program review report or draft audit report, or a guaranty agency issues a preliminary report showing that the institution did not return unearned funds for more than 10% of the sampled students; or

(v) The Secretary sends a written notice to the institution requesting the letter of credit that explains why the institution has failed to return unearned funds in a timely manner.

(e) *Exceptions.* With regard to the letter of credit described in paragraph (d) of this section—

(1) An institution does not have to submit the letter of credit if the amount calculated under paragraph (d)(2) of this section is less than $5,000 and the institution can demonstrate that it has cash reserves of at least $5,000 available at all times.

(2) An institution may delay submitting the letter of credit and request the Secretary to reconsider a finding made in its most recent audit or review report that it failed to return unearned title IV, HEA program funds in a timely manner if—

(i)(A) The institution submits documents showing that the unearned title IV, HEA program funds were not returned in a timely manner solely because of exceptional circumstances beyond the institution's control and that the institution would not have exceeded the compliance thresholds under paragraph (c)(1) of this section had it not been for these exceptional circumstances; or

(B) The institution submits documents showing that it did not fail to make timely refunds as provided under paragraphs (b) and (c) of this section; and

(ii) The institution's request, along with the documents described in paragraph (e)(2)(i) of this section, is submitted to the Secretary no later than the date it would otherwise be required to submit a letter of credit under paragraph (d)(3).

(3) If the Secretary denies the institution's request under paragraph (e)(2) of this section, the Secretary notifies the institution of the date it must submit the letter of credit.

* * * * *

(Approved by the Office of Management and Budget under control number 1845–0022)

19. Section 668.174(c)(4) is revised to read as follows:

§ 668.174 Past performance.

* * * * *

(c) * * *

(4) ''Family member'' is defined in § 600.21(f) of this chapter.

§ 668.183 [Amended]

20. Section 668.183(c)(1) is amended as follows:

A. In paragraph (c)(1)(ii), by adding ''or'' after the semi-colon.

B. By removing paragraph (c)(1)(iii).

C. By redesignating paragraph (c)(1)(iv) as paragraph (c)(1)(iii).

§ 668.193 [Amended]

21. Section 668.193 is amended:

A. In paragraph (d)(1), by removing the last sentence.

B. By removing paragraph (f)(3).

PART 673—GENERAL PROVISIONS FOR THE FEDERAL PERKINS LOAN PROGRAM, FEDERAL WORK-STUDY PROGRAM, AND FEDERAL SUPPLEMENTAL EDUCATIONAL OPPORTUNITY GRANT PROGRAM

22. The authority citation for part 673 continues to read as follows:

Authority: 20 U.S.C. 421–429, 1070b–1070b–3, and 1087aa–1087ii; 42 U.S.C. 2751–2756b, unless otherwise noted.

23. Section 673.5(f) is revised to read as follows:

§ 673.5 Overaward.

* * * * *

(f) *Liability for and recovery of Federal Perkins loans and FSEOG overpayments.* (1) Except as provided in paragraphs (f)(2) and (f)(3) of this section, a student is liable for any Federal Perkins loan or FSEOG overpayment made to him or her. An FSEOG overpayment for purposes of this paragraph does not include the non-Federal share of an FSEOG award if an institution meets its FSEOG matching share by the individual recipient method or the aggregate method.

(2) The institution is liable for a Federal Perkins loan or FSEOG overpayment if the overpayment occurred because the institution failed to follow the procedures in this part or 34 CFR parts 668, 674, or 676. The institution shall restore an amount equal to the overpayment and any administrative cost allowance claimed on that amount to its loan fund for a Federal Perkins loan overpayment or to its FSEOG account for an FSEOG overpayment.

(3) A student is not liable for, and the institution is not required to attempt recovery of, a Federal Perkins loan or FSEOG overpayment, nor is the institution required to refer an FSEOG overpayment to the Secretary, if the overpayment—

(i) Is less than $25; and

(ii) Is neither a remaining balance nor a result of the application of the overaward threshold in paragraph (d) of this section.

(4)(i) Except as provided in paragraph (f)(3) of this section, if an institution makes a Federal Perkins loan or FSEOG overpayment for which it is not liable, it shall promptly send a written notice to the student requesting repayment of the overpayment amount. The notice must state that failure to make that repayment, or to make arrangements satisfactory to the holder of the overpayment debt to pay the overpayment, makes the student ineligible for further title IV, HEA program funds until final resolution of the overpayment.

(ii) If a student objects to the institution's Federal Perkins loan or FSEOG overpayment determination on the grounds that it is erroneous, the institution shall consider any information provided by the student and determine whether the objection is warranted.

(5) Except as provided in paragraph (f)(3) of this section, if a student fails to repay an FSEOG overpayment or make arrangements satisfactory to the holder of the overpayment debt to repay the FSEOG overpayment after the institution has taken the action required by paragraph (f)(4) of this section, the institution must refer the FSEOG overpayment to the Secretary for

collection purposes in accordance with procedures required by the Secretary. After referring the FSEOG overpayment to the Secretary under this section, the institution need make no further effort to recover the overpayment.

PART 674—FEDERAL PERKINS LOAN PROGRAM

24. The authority citation for part 674 continues to read as follows:

Authority: 20 U.S.C. 1087aa–1087hh and 20 U.S.C. 421–429, unless otherwise noted.

25. Section 674.2(b) is amended:

A. By revising the definition of ''Making of a loan''.

B. By adding, in alphabetical order, a new definition of ''Master Promissory Note (MPN)''.

The revision and addition read as follows:

§ 674.2 Definitions.

* * * * *

(b) * * *

Making of a loan: When the institution makes the first disbursement of a loan to a student for an award year.

Master Promissory Note (MPN): A promissory note under which the borrower may receive loans for a single award year or multiple award years.

* * * * *

26. Section 674.9 is amended:

A. By removing paragraph (g).

B. By redesignating paragraphs (h), (i), (j), (k) and (l) as paragraphs (g), (h), (i), (j) and (k), respectively.

C. In newly redesignated paragraph (g)(3), by removing ''(h)(1) and (h)(2)'' and adding, in its place, ''(g)(1) and (g)(2)''; and by removing the period at the end of the last sentence and adding, in its place, a ''; and''.

D. By revising newly redesignated paragraph (j).

The revision reads as follows:

§ 674.9 Student eligibility.

* * * * *

(j) In the case of a borrower who is in default on a Federal Perkins Loan, NDSL or Defense loan, satisfies one of the conditions contained in § 674.5(c)(3)(i) or (ii) except that—

(1) For purposes of this section, voluntary payments made by the borrower under paragraph (i) of this section are those payments made directly by the borrower; and

(2) Voluntary payments do not include payments obtained by Federal offset, garnishment, or income or asset execution.

* * * * *

27. Section 674.16 is amended:

A. By revising paragraph (d)(2).

B. By adding a new paragraph (d)(3).

The revision and addition read as follows:

§ 674.16 Making and disbursing loans.

* * * * *

(d) * * *

(2) The institution shall ensure that each loan is supported by a legally enforceable promissory note as proof of the borrower's indebtedness.

(3) If the institution uses a Master Promissory Note (MPN), the institution's ability to make additional loans based on that MPN will automatically expire upon the earliest of—

(i) The date the institution receives written notification from the borrower requesting that the MPN no longer be used as the basis for additional loans;

(ii) Twelve months after the date the borrower signed the MPN if no disbursements are made by the institution under that MPN; or

(iii) Ten years from the date the borrower signed the MPN or the date the institution receives the MPN, except that a remaining portion of a loan may be disbursed after this date.

* * * * *

§ 674.17 [Amended]

28. Section 674.17 is amended:

A. In paragraph (a), by removing in the introductory text ''one or more of''.

B. By removing paragraph (a)(2).

C. By redesignating paragraph (a)(3) as paragraph (a)(2).

D. In newly redesignated paragraph (a)(2), by removing ''transfer'' and adding, in its place, ''assignment''; and by removing ''Department of Education'' and adding, in its place, ''United States''.

E. In paragraph (b), by removing ''transfers'' and adding, in its place, ''assigns''.

F. By removing paragraphs (c), (d), and (e).

29. Section 674.19(e)(4) is revised to read as follows:

§ 674.19 Fiscal procedures and records.

* * * * *

(e) * * *

(4) *Manner of retention of promissory notes and repayment schedules.* An institution shall keep the original promissory notes and repayment schedules until the loans are satisfied. If required to release original documents in order to enforce the loan, the institution must retain certified true copies of those documents.

(i) An institution shall keep the original paper promissory note or original paper Master Promissory Note (MPN) and repayment schedules in a locked, fireproof container.

(ii) If a promissory note was signed electronically, the institution must store it electronically and the promissory note must be retrievable in a coherent format.

(iii) After the loan obligation is satisfied, the institution shall return the original or a true and exact copy of the note marked ''paid in full'' to the borrower, or otherwise notify the borrower in writing that the loan is paid in full, and retain a copy for the prescribed period.

(iv) An institution shall maintain separately its records pertaining to cancellations of Defense, NDSL, and Federal Perkins Loans.

(v) Only authorized personnel may have access to the loan documents.

30. Section 674.33(b) is amended:

A. By revising the introductory text following the heading in paragraph (b)(2).

B. By revising the text following the heading of paragraph (b)(3).

The revisions read as follows:

§ 674.33 Repayment.

* * * * *

(b) * * *

(2) * * * If a borrower has received loans from more than one institution and has notified the institution that he or she wants the minimum monthly payment determination to be based on payments due to other institutions, the following rules apply:

* * * * *

(3) * * * If the borrower has notified the institution that he or she wants the minimum monthly payment determination to be based on payments due to other institutions, and if the total monthly repayment is less than $30 and the monthly repayment on a Defense loan is less than $15 a month, the amount attributed to the Defense loan may not exceed $15 a month.

* * * * *

31. Section 674.34 is amended:

A. In paragraph (e)(4), by removing ''(e)(9)'' and adding, in its place, ''(e)(10)''.

B. In paragraph (e)(5), by adding ''as determined under paragraph (e)(10) of this section'' after the first occurrence of ''burden''.

C. By revising paragraph (e)(10).

The revision reads as follows:

§ 674.34 Deferment of repayment—Federal Perkins loans, NDSLs and Defense loans.

* * * * *

(e) * * *

(10) In determining a borrower's Federal education debt burden under paragraphs (e)(4) and (e)(5) of this section, the institution shall—

(i) If the Federal postsecondary education loan is scheduled to be repaid

in 10 years or less, use the actual monthly payment amount (or a proportional share if the payments are due less frequently than monthly); or

(ii) If the Federal postsecondary education loan is scheduled to be repaid in more than 10 years, use a monthly payment amount (or a proportional share if the payments are due less frequently than monthly) that would have been due on the loan if the loan had been scheduled to be repaid in 10 years.

* * * * *

§ 674.39 [Amended]

32. Section 674.39(a) is amended:

A. In the first sentence of the introductory text in paragraph (a), by adding ‘‘, except for loans for which a judgment has been secured’’ after ‘‘part’’.

B. In paragraph (a)(2), by removing ‘‘; and’’ and adding, in its place, a period.

C. By removing paragraph (a)(3).

33. Section 674.42 is amended:

A. By revising paragraph (a)(10).

B. By adding a new paragraph (a)(11).

C. By revising paragraph (b)(1) and the introductory text in paragraph (b)(2).

D. In paragraph (b)(2)(i), by removing ‘‘that school’’ and adding, in its place, ‘‘the institution’’.

E. By revising paragraph (b)(2)(iii).

F. In paragraph (b)(2)(v), by removing ‘‘in forceful terms’’.

G. In paragraph (b)(2)(vi), by removing ‘‘school’’ and adding, in its place, ‘‘institution’’.

H. In paragraph (b)(2)(vii), by removing ‘‘with’’ and adding, in its place, ‘‘for’’.

I. In paragraph (b)(2)(viii), by removing ‘‘corrections to the institution’s records’’ and adding, in its place, ‘‘current information’’; and by removing ‘‘and’’ following the semi-colon.

J. In paragraph (b)(2)(ix), by removing ‘‘with’’ and adding, in its place, ‘‘for’’; and by removing the period and adding, in its place, ‘‘; and’’.

K. By adding a new paragraph (b)(2)(x).

L. By removing paragraph (b)(3).

M. By redesignating paragraphs (b)(4) and (b)(5) as paragraphs (b)(3) and (b)(4), respectively.

N. By revising newly redesignated paragraph (b)(3).

O. In newly redesignated paragraph (b)(4), by removing ‘‘school’s’’ and adding, in its place, ‘‘institution’s’’.

The revisions and additions read as follows:

§ 674.42 Contact with the borrower.

(a) * * *

(10) The contact information of a party who, upon request of the borrower, will provide the borrower with a copy of his or her signed promissory note.

(11) An explanation that if a borrower is required to make minimum monthly repayments, and the borrower has received loans from more than one institution, the borrower must notify the institution if he or she wants the minimum monthly payment determination to be based on payments due to other institutions.

(b) * * * (1) An institution must ensure that exit counseling is conducted with each borrower either in person, by audiovisual presentation, or by interactive electronic means. The institution must ensure that exit counseling is conducted shortly before the borrower ceases at least half-time study at the institution. As an alternative, in the case of a student enrolled in a correspondence program or a study-abroad program that the institution approves for credit, the borrower may be provided with written counseling material by mail within 30 days after the borrower completes the program. If a borrower withdraws from the institution without the institution’s prior knowledge or fails to complete an exit counseling session as required, the institution must ensure that exit counseling is provided through either interactive electronic means or by mailing counseling materials to the borrower at the borrower’s last known address within 30 days after learning that the borrower has withdrawn from the institution or failed to complete exit counseling as required.

(2) The exit counseling must—

* * * * *

(iii) Suggest to the borrower debt-management strategies that would facilitate repayment;

* * * * *

(x) Inform the borrower of the availability of title IV loan information in the National Student Loan Data System (NSLDS).

(3) If exit counseling is conducted through interactive electronic means, the institution must take reasonable steps to ensure that each student borrower receives the counseling materials, and participates in and completes the exit counseling.

* * * * *

§ 674.43 [Amended]

34. Section 674.43(b)(2) is amended in the introductory text by removing ‘‘shall’’ and adding, in its place, ‘‘may’’.

§ 674.45 [Amended]

35. Section 674.45(a)(1) is amended by removing ‘‘defaulted account’’ and adding, in its place, ‘‘account as being in default’’.

§ 674.46 [Amended]

36. Section 674.46(a) is amended as follows:

A. In the introductory text of paragraph (a)(1), by removing ‘‘annually’’ and adding, in its place, ‘‘once every two years’’.

B. In paragraph (a)(1)(i), by removing ‘‘$200’’ and adding, in its place, ‘‘$500’’.

37. Section 674.47 is amended:

A. By removing paragraph (g)(1).

B. By redesignating paragraphs (g)(2), (g)(2)(i), and (g)(2)(ii) as paragraph (g) introductory text, paragraph (g)(1), and paragraph (g)(2) respectively.

C. In newly redesignated paragraph (g)(1), by removing the last ‘‘the’’ and adding, in its place, ‘‘this’’.

D. In the paragraph (h) heading, by removing ‘‘of less than $5’’.

E. By revising paragraph (h)(1).

F. By adding a new paragraph (h)(3).

The revision and addition read as follows:

§ 674.47 Costs chargeable to the Fund.

* * * * *

(h) * * *

(1) Notwithstanding any other provision of this subpart, an institution may write off an account, including outstanding principal, accrued interest, collection costs, and late charges, with a balance of—

(i) Less than $25; or

(ii) Less than $50 if, for a period of at least 2 years, the borrower has been billed for this balance in accordance with § 674.43(a).

* * * * *

(3) When the institution writes off an account, the borrower is relieved of all repayment obligations.

§ 674.50 [Amended]

38. Section 674.50 is amended:

A. In paragraph (e)(2)(ii), by adding ‘‘or’’ after the semicolon.

B. In paragraph (e)(3), by deleting ‘‘; or’’ at the end of the paragraph and adding, in its place, a period.

C. By removing paragraph (e)(4).

D. In paragraph (g)(2), by adding ‘‘Secretary may require the’’ after ‘‘The’’; and by removing ‘‘shall’’ and adding, in its place, ‘‘to’’.

PART 675—FEDERAL WORK-STUDY PROGRAMS

39. The authority citation for part 675 continues to read as follows:

Authority: 42 U.S.C. 2751–2756b, unless otherwise noted.

40. Section 675.2(b) is amended by revising the definition of ''Student services'' to read as follows:

§ 675.2 Definitions.

* * * * *

(b) * * *

Student services: Services that are offered to students that may include, but are not limited to, financial aid, library, peer guidance counseling, job placement, assisting an instructor with curriculum-related activities, security, and social, health, and tutorial services. Student services do not have to be direct or involve personal interaction with students. For purposes of this definition, facility maintenance, cleaning, purchasing, and public relations are never considered student services.

* * * * *

41. Section 675.21(b)(2)(i) is revised to read as follows:

§ 675.21 Institutional employment.

* * * * *

(b) * * *

(2) * * *

(i) Involve the provision of student services as defined in § 675.2(b) that are directly related to the work-study student's training or education;

* * * * *

PART 682—FEDERAL FAMILY EDUCATION LOAN (FFEL) PROGRAM

42. The authority citation for part 682 continues to read as follows:

Authority: 20 U.S.C. 1071 to 1087–2, unless otherwise noted.

43. Section 682.200(b) is amended:

A. By adding a sentence at the end of paragraph (2)(ii) of the definition of ''Lender'' to read as follows: ''For purposes of this paragraph, loans held in trust by a trustee lender are not considered part of the trustee lender's consumer credit function.''

B. In the definition of ''Master promissory note (MPN)'', by changing ''Master promissory note (MPN)'' to ''Master Promissory Note (MPN)''.

44. Section 682.204 is amended:

A. By adding new paragraphs (a)(8), (a)(9), (d)(7), and (d)(8).

B. In paragraph (l) by removing ''34 CFR 668.2'' and adding, in its place, ''34 CFR 668.3''.

The additions read as follows:

§ 682.204 Maximum loan amounts.

(a) * * *

(8) Except as provided in paragraph (a)(4) of this section, an undergraduate student who is enrolled in a program that is one academic year or less in length may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(1) of this section.

(9) Except as provided in paragraph (a)(4) of this section—

(i) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has not successfully completed the first year of that program may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(1) of this section.

(ii) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has successfully completed the first year of that program, but has not successfully completed the second year of the program, may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(2) of this section.

* * * * *

(d) * * *

(7) Except as provided in paragraph (d)(4) of this section, an undergraduate student who is enrolled in a program that is one academic year or less in length may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (d)(1) of this section.

(8) Except as provided in paragraph (d)(4) of this section—

(i) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has not successfully completed the first year of that program may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (d)(1) of this section.

(ii) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has successfully completed the first year of that program, but has not successfully completed the second year of the program, may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (d)(2) of this section.

* * * * *

45. Section 682.209(a) is amended by:

A. Removing the number ''45'' each time it appears in paragraphs (a)(3)(ii)(A), (a)(3)(ii)(B), and (a)(3)(ii)(C) and adding, in its place, the number ''60''.

B. Adding a new paragraph (a)(3)(iii).

C. Revising the last sentence in paragraph (a)(8)(iv).

The revisions and addition read as follows:

§ 682.209 Repayment of a loan.

(a) * * *

(3) * * *

(iii) When determining the date that the student was no longer enrolled on at least a half-time basis, the lender must use a new date it receives from a school, unless the lender has already disclosed repayment terms to the borrower and the new date is within the same month and year as the most recent date reported to the lender.

* * * * *

(8) * * *

(iv) * * * Subject to paragraph (a)(8)(iii) of this section, a borrower who makes such a request may notify the lender at any time to extend the repayment period to a minimum of 5 years.

* * * * *

46. Section 682.210 is amended by revising paragraphs (h)(2), (h)(3)(iv), (h)(4), (s)(6)(vii), and (s)(6)(ix) to read as follows:

§ 682.210 Deferment.

* * * * *

(h) * * *

(2) A borrower also qualifies for an unemployment deferment by providing to the lender a written certification, or an equivalent as approved by the Secretary, that—

(i) The borrower has registered with a public or private employment agency, if one is available to the borrower within a 50-mile radius of the borrower's current address; and

(ii) For all requests beyond the initial request, the borrower has made at least six diligent attempts during the preceding 6-month period to secure full-time employment.

(3) * * *

(iv) The initial period of unemployment deferment may be granted for a period of unemployment beginning up to 6 months before the date the lender receives the borrower's request, and may be granted for up to 6 months after that date.

(4) A lender may not grant an unemployment deferment beyond the date that is 6 months after the date the borrower provides evidence of the borrower's eligibility for unemployment insurance benefits under paragraph (h)(1) of this section or the date the borrower provides the written certification, or an approved equivalent, under paragraph (h)(2) of this section.

* * * * *

(s) * * *

(6) * * *

(vii) In determining a borrower's Federal education debt burden for purposes of an economic hardship deferment under paragraphs (s)(6)(iv) and (v) of this section, the lender shall—

(A) If the Federal postsecondary education loan is scheduled to be repaid in 10 years or less, use the actual monthly payment amount (or a proportional share if the payments are due less frequently than monthly);

(B) If the Federal postsecondary education loan is scheduled to be repaid in more than 10 years, use a monthly payment amount (or a proportional share if the payments are due less frequently than monthly) that would have been due on the loan if the loan had been scheduled to be repaid in 10 years; and

(C) Require the borrower to provide evidence that would enable the lender to determine the amount of the monthly payments that would have been owed by the borrower during the deferment period.

* * * * *

(ix) To qualify for a subsequent period of deferment that begins less than one year after the end of a period of deferment under paragraphs (s)(6)(iii) through (v) of this section, the lender must require the borrower to submit evidence showing the amount of the borrower's monthly income or a copy of the borrower's most recently filed Federal income tax return.

* * * * *

47. Section 682.211 is amended by:

A. Revising paragraphs (b), (c), and (e).

B. Amending the introductory text of paragraph (f) by adding the words ''or would be due'' after the word ''overdue''.

C. Amending paragraph (f)(2) by removing the reference to paragraph ''(f)(10)'' and adding, in its place, ''(f)(11)''.

D. Revising paragraph (f)(11).

E. Redesignating paragraph (h)(3) as paragraph (h)(4).

F. Adding a new paragraph (h)(3).

The revisions and addition read as follows:

§ 682.211 Forbearance.

* * * * *

(b) A lender may grant forbearance if—

(1) The lender and the borrower or endorser agree to the terms of the forbearance and, unless the agreement was in writing, the lender sends, within 30 days, a notice to the borrower or endorser confirming the terms of the forbearance; or

(2) In the case of forbearance of interest during a period of deferment, if the lender informs the borrower at the time the deferment is granted that interest payments are to be forborne.

(c) A lender may grant forbearance for a period of up to one year at a time if both the borrower or endorser and an authorized official of the lender agree to the terms of the forbearance. If the lender and the borrower or endorser agree to the terms orally, the lender must notify the borrower or endorser of the terms within 30 days of that agreement.

* * * * *

(e) Except in the case of forbearance of interest payments during a deferment period, if a forbearance involves the postponement of all payments, the lender must contact the borrower or endorser at least once every six months during the period of forbearance to inform the borrower or endorser of—

(1) The outstanding obligation to repay;

(2) The amount of the unpaid principal balance and any unpaid interest that has accrued on the loan;

(3) The fact that interest will accrue on the loan for the full term of the forbearance; and

(4) The borrower's or endorser's option to discontinue the forbearance at any time.

(f) * * *

(11) For a period not to exceed 3 months when the lender determines that a borrower's ability to make payments has been adversely affected by a natural disaster, a local or national emergency as declared by the appropriate government agency, or a military mobilization.

* * * * *

(h) * * *

(3) *Written agreement.* The terms of the forbearance must be agreed to in writing—

(i) By the lender and the borrower for a forbearance under paragraphs (h)(1) or (h)(2)(ii)(A) of this section; or

(ii) By the lender and the borrower or endorser for a forbearance under paragraph (h)(2)(i) of this section.

* * * * *

§ 682.401 [Amended]

48. Section 682.401 is amended by adding a sentence after the heading of paragraph (b)(4) to read as follows: ''Except as provided in § 668.35(b) for a borrower with a defaulted loan on which a judgment has been obtained, reinstatement of Title IV eligibility for a borrower with a defaulted loan must be in accordance with this paragraph (b)(4).''

49. Section 682.402 is amended by:

A. Redesignating paragraphs (a)(2) through (a)(4) as paragraphs (a)(3) through (a)(5), respectively.

B. Adding a new paragraph (a)(2).

C. Amending newly redesignated paragraph (a)(3) by removing the words ''or a Consolidation loan was obtained by a married couple,''.

D. Amending newly redesignated paragraph (a)(5)(iii) by removing the reference to paragraph ''(a)(4)(i) or (ii)'' and adding, in its place, ''(a)(5)(i) or (ii)''.

E. Adding a new paragraph (b)(6).

F. Revising paragraph (f)(4).

G. Revising paragraph (g)(1)(i).

H. Revising paragraph (h)(1)(i).

I. Revising paragraph (h)(3)(iii).

J. Revising paragraph (k)(2)(iii).

The revisions and additions read as follows:

§ 682.402 Death, disability, closed school, false certification, unpaid refunds, and bankruptcy payments.

(a) * * *

(2) If a Consolidation loan was obtained jointly by a married couple, the amount of the Consolidation loan that is discharged if one of the borrowers dies or becomes totally and permanently disabled is equal to the portion of the outstanding balance of the Consolidation loan, as of the date the borrower died or became totally and permanently disabled, attributable to any of that borrower's loans that would have been eligible for discharge.

* * * * *

(b) * * *

(6) In the case of a Federal Consolidation Loan that includes a Federal PLUS or Direct PLUS loan borrowed for a dependent who has died, the obligation of the borrower or any endorser to make any further payments on the portion of the outstanding balance of the Consolidation Loan attributable to the Federal PLUS or Direct PLUS loan is discharged as of the date of the dependent's death.

* * * * *

(f) * * *

(4) *Proof of claim.* (i) Except as provided in paragraph (f)(4)(ii) of this section, the holder of the loan shall file a proof of claim with the bankruptcy court within—

(A) 30 days after the holder receives a notice of first meeting of creditors unless, in the case of a proceeding under chapter 7, the notice states that the borrower has no assets; or

(B) 30 days after the holder receives a notice from the court stating that a chapter 7 no-asset case has been converted to an asset case.

(ii) A guaranty agency that is a state guaranty agency, and on that basis may assert immunity from suit in bankruptcy court, and that does not assign any loans affected by a bankruptcy filing to another guaranty agency—

(A) Is not required to file a proof of claim on a loan already held by the guaranty agency; and

(B) May direct lenders not to file proofs of claim on loans guaranteed by that agency.

* * * * *

(g) * * *

(1) * * *

(i) The original or a true and exact copy of the promissory note.

* * * * *

(h) * * *

(1) * * *

(i) The guaranty agency shall review a death, disability, bankruptcy, closed school, or false certification claim promptly and shall pay the lender on an approved claim the amount of loss in accordance with paragraphs (h)(2) and (h)(3) of this section—

(A) Not later than 45 days after the claim was filed by the lender for death and bankruptcy claims; and

(B) Not later than 90 days after the claim was filed by the lender for disability, closed school, or false certification claims.

* * * * *

(3) * * *

(iii) During the period required by the guaranty agency to approve the claim and to authorize payment or to return the claim to the lender for additional documentation not to exceed—

(A) 45 days for death or bankruptcy claims; or

(B) 90 days for disability, closed school, or false certification claims.

* * * * *

(k) * * *

(2) * * *

(iii) In the case of a Consolidation loan, the borrower (or one of the co-makers) has died, is determined to be totally and permanently disabled under § 682.402(c), or has filed the petition for relief in bankruptcy within the maximum repayment period described in § 682.209(h)(2), exclusive of periods of deferment or periods of forbearance granted by the lender that extended the maximum repayment period;

* * * * *

50. Section 682.405 is amended by:

A. Adding the words ‘‘, except for loans for which a judgment has been obtained,’’ after ‘‘defaulted loans’’ in paragraph (a)(1).

B. Removing paragraph (a)(4).

C. Revising the fifth sentence in paragraph (b)(1).

The revision reads as follows:

§ 682.405 Loan rehabilitation agreement.

* * * * *

(b) * * *

(1) * * * Voluntary payments are those made directly by the borrower, and do not include payments obtained by Federal offset, garnishment, income or asset execution, or after a judgment has been entered on a loan. * * *

* * * * *

51. Section 682.414 is amended by revising paragraph (a)(5)(ii) to read as follows:

§ 682.414 Records, reports, and inspection requirements for guaranty agency programs.

(a) * * *

(5) * * *

(ii) If a promissory note was signed electronically, the guaranty agency or lender must store it electronically and it must be retrievable in a coherent format.

* * * * *

§ 682.603 [Amended]

52. Sections 682.603(f)(1)(ii)(B) and (f)(2)(i) are amended by removing ‘‘34 CFR 668.2’’ and adding, in its place, ‘‘34 CFR 668.3’’.

53. Section 682.604 is amended by:

A. Revising paragraph (f)(1).

B. Revising the introductory text of paragraph (f)(2).

C. Revising paragraph (f)(2)(iii).

D. In paragraph (f)(2)(iv), removing the period and adding, in its place, ‘‘; and’’.

E. Adding a new paragraph (f)(2)(v).

F. Revising paragraph (f)(3).

G. Revising paragraph (g)(1).

H. Revising paragraph (g)(2).

I. Revising paragraph (g)(3).

The revisions and addition read as follows:

§ 682.604 Processing the borrower's loan proceeds and counseling borrowers.

* * * * *

(f) * * *

(1) A school must ensure that initial counseling is conducted with each Stafford loan borrower either in person, by audiovisual presentation, or by interactive electronic means prior to its release of the first disbursement, unless the student borrower has received a prior Federal Stafford, Federal SLS, or Direct subsidized or unsubsidized loan. A school must ensure that an individual with expertise in the title IV programs is reasonably available shortly after the counseling to answer the student borrower's questions regarding those programs. As an alternative, in the case of a student borrower enrolled in a correspondence program or a student borrower enrolled in a study-abroad program that the home institution approves for credit, the counseling may be provided through written materials, prior to releasing those loan proceeds.

(2) The initial counseling must—

* * * * *

(iii) Describe the likely consequences of default, including adverse credit reports, Federal offset, and litigation;

* * * * *

(v) Inform the student borrower of sample monthly repayment amounts based on a range of student levels of indebtedness or on the average indebtedness of Stafford loan borrowers at the same school or in the same program of study at the same school.

(3) If initial counseling is conducted through interactive electronic means, the school must take reasonable steps to ensure that each student borrower receives the counseling materials, and participates in and completes the initial counseling.

* * * * *

(g) * * *

(1) A school must ensure that exit counseling is conducted with each Stafford loan borrower either in person, by audiovisual presentation, or by interactive electronic means. In each case, the school must ensure that this counseling is conducted shortly before the student borrower ceases at least half-time study at the school, and that an individual with expertise in the title IV programs is reasonably available shortly after the counseling to answer the student borrower's questions. As an alternative, in the case of a student borrower enrolled in a correspondence program or a study-abroad program that the home institution approves for credit, written counseling materials may be provided by mail within 30 days after the student borrower completes the program. If a student borrower withdraws from school without the school's prior knowledge or fails to complete an exit counseling session as required, the school must ensure that exit counseling is provided through either interactive electronic means or by mailing written counseling materials to the student borrower at the student borrower's last known address within 30 days after learning that the student borrower has withdrawn from school or failed to complete the exit counseling as required.

(2) The exit counseling must—

(i) Inform the student borrower of the average anticipated monthly repayment amount based on the student borrower's indebtedness or on the average indebtedness of student borrowers who have obtained Stafford or SLS loans for attendance at the same school or in the same program of study at the same school;

(ii) Review for the student borrower available repayment options, including standard, graduated, extended, and

income-sensitive repayment plans and loan consolidation;

(iii) Suggest to the student borrower debt-management strategies that would facilitate repayment;

(iv) Include the matters described in paragraph (f)(2) of this section;

(v) Review for the student borrower the conditions under which the student borrower may defer or forbear repayment or obtain a full or partial discharge of a loan;

(vi) Require the student borrower to provide current information concerning name, address, social security number, references, and driver's license number and State of issuance, as well as the student borrower's expected permanent address, the address of the student borrower's next of kin, and the name and address of the student borrower's expected employer (if known). The school must ensure that this information is provided to the guaranty agency or agencies listed in the student borrower's records within 60 days after the student borrower provides the information;

(vii) Review for the student borrower information on the availability of the Student Loan Ombudsman's office; and

(viii) Inform the student borrower of the availability of title IV loan information in the National Student Loan Data System (NSLDS).

(3) If exit counseling is conducted by electronic interactive means, the school must take reasonable steps to ensure that each student borrower receives the counseling materials, and participates in and completes the counseling.

* * * * *

PART 685—WILLIAM D. FORD FEDERAL DIRECT LOAN PROGRAM

54. The authority citation for part 685 continues to read as follows:

Authority: 20 U.S.C. 1087a *et seq.*, unless otherwise noted.

55. Section 685.102(b) is amended:

A. By revising the definition of ''Master promissory note (MPN)''.

B. In the second sentence of paragraph (3) in the definition of ''Satisfactory repayment arrangement'', by removing '', regardless of whether there is a judgment against the borrower,''; and by removing ''income tax'' and adding, in its place, ''Federal''.

The revision reads as follows:

§ 685.102 Definitions.

* * * * *

(b) * * *

Master Promissory Note (MPN): (1) A promissory note under which the borrower may receive loans for a single academic year or multiple academic years.

(2) For MPNs processed by the Secretary before July 1, 2003, loans may no longer be made under an MPN after the earliest of—

(i) The date the Secretary or the school receives the borrower's written notice that no further loans may be disbursed;

(ii) One year after the date of the borrower's first anticipated disbursement if no disbursement is made during that twelve-month period; or

(iii) Ten years after the date of the first anticipated disbursement, except that a remaining portion of a loan may be disbursed after this date.

(3) For MPNs processed by the Secretary on or after July 1, 2003, loans may no longer be made under an MPN after the earliest of—

(i) The date the Secretary or the school receives the borrower's written notice that no further loans may be made;

(ii) One year after the date the borrower signed the MPN or the date the Secretary receives the MPN, if no disbursements are made under that MPN; or

(iii) Ten years after the date the borrower signed the MPN or the date the Secretary receives the MPN, except that a remaining portion of a loan may be disbursed after this date.

* * * * *

56. Section 685.203 is amended:

A. By adding new paragraphs (a)(8) and (a)(9).

B. By adding new paragraphs (c)(2)(viii) and (c)(2)(ix).

C. By adding in paragraph (h) '', as defined in 34 CFR 668.3'' after ''year''.

The additions read as follows:

§ 685.203 Loan limits.

(a) * * *

(8) Except as provided in paragraph (a)(4) of this section, an undergraduate student who is enrolled in a program that is one academic year or less in length may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(1) of this section.

(9) Except as provided in paragraph (a)(4) of this section—

(i) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has not successfully completed the first year of that program may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(1) of this section.

(ii) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has successfully completed the first year of that program, but has not successfully completed the second year of the program, may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (a)(2) of this section.

* * * * *

(c) * * *

(2) * * *

(viii) Except as provided in paragraph (c)(2)(iv) of this section, an undergraduate student who is enrolled in a program that is one academic year or less in length may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (c)(2)(i) of this section.

(ix) Except as provided in paragraph (c)(2)(iv) of this section—

(A) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has not successfully completed the first year of that program may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (c)(2)(i) of this section.

(B) An undergraduate student who is enrolled in a program that is more than one academic year in length and who has successfully completed the first year of that program, but has not successfully completed the second year of the program, may not borrow an amount for any academic year of study that exceeds the amounts in paragraph (c)(2)(ii) of this section.

* * * * *

57. Section 685.211(f) is revised to read as follows:

§ 685.211 Miscellaneous repayment provisions.

* * * * *

(f) *Rehabilitation of defaulted loans.* (1) A defaulted Direct Loan, except for a loan on which a judgment has been obtained, is rehabilitated if the borrower makes 12 consecutive, on-time, reasonable, and affordable monthly payments. The amount of such a payment is determined on the basis of the borrower's total financial circumstances. If a defaulted loan is rehabilitated, the Secretary instructs any credit bureau to which the default was reported to remove the default from the borrower's credit history.

(2) A defaulted Direct Loan on which a judgment has been obtained may not be rehabilitated.

58. Section 685.212 is amended by adding a new paragraph (a)(3) to read as follows:

§ 685.212 Discharge of a loan obligation.

(a) * * *

(3) In the case of a Direct PLUS Consolidation Loan that repaid a Direct PLUS Loan or a Federal PLUS Loan obtained on behalf of a student who dies, the Secretary discharges an amount equal to the portion of the outstanding balance of the consolidation loan, as of the date of the student's death, attributable to that Direct PLUS Loan or Federal PLUS Loan.

* * * * *

59. Section 685.220(l)(3) is revised to read as follows:

§ 685.220 Consolidation.

* * * * *

(l) * * *

(3) *Discharge.* (i) If a borrower dies and the Secretary receives the documentation described in § 685.212(a), the Secretary discharges an amount equal to the portion of the outstanding balance of the consolidation loan, as of the date of the borrower's death, attributable to any of that borrower's loans that were repaid by the consolidation loan.

(ii) If a borrower meets the requirements for total and permanent disability discharge under § 685.212(b), the Secretary discharges an amount equal to the portion of the outstanding balance of the consolidation loan, as of the date the borrower became totally and permanently disabled, attributable to any of that borrower's loans that were repaid by the consolidation loan.

(iii) If a borrower meets the requirements for discharge under § 685.212(d), (e), or (f) on a loan that was consolidated into a joint Direct Consolidation Loan, the Secretary discharges the portion of the consolidation loan equal to the amount of the loan that would be eligible for discharge under the provisions of § 685.212(d), (e), or (f) as applicable, and that was repaid by the consolidation loan.

(iv) If a borrower meets the requirements for loan forgiveness under § 685.212(h) on a loan that was consolidated into a joint Direct Consolidation Loan, the Secretary repays the portion of the outstanding balance of the consolidation loan attributable to the loan that would be eligible for forgiveness under the provisions of § 685.212(h), and that was repaid by the consolidation loan.

§ 685.301 [Amended]

60. Sections 685.301(a)(9)(i)(B)(*2*) and (a)(9)(ii)(A) are amended by removing ''34 CFR 668.2'' and adding, in its place, ''34 CFR 668.3''.

61. Section 685.304 is amended:

A. By revising paragraphs (a)(1), (a)(2), (a)(3), and (a)(5).

B. In paragraph (b)(1), by removing ''conduct'' and adding, in its place, ''ensure that''; by adding ''is conducted'' after ''counseling''; and by adding ''Loan'' after ''Subsidized''.

C. In paragraph (b)(2), by adding, in the first sentence, ''exit'' after ''The''; by removing, in the second sentence, ''knowledge of'' and adding, in its place, ''expertise in''; by removing, in the last sentence, ''the school may provide''; and by adding, in the last sentence, ''may be provided'' after the second occurrence of ''borrower''.

D. In paragraph (b)(3), by removing ''school must provide''; and by adding ''must be provided'' after the second occurrence of ''counseling''.

E. By revising paragraph (b)(4).

F. By revising paragraph (b)(5).

G. By redesignating paragraph (b)(6) as paragraph (b)(7).

H. By adding a new paragraph (b)(6).

The revisions and addition read as follows:

§ 685.304 Counseling borrowers.

(a) * * * (1) Except as provided in paragraph (a)(4) of this section, a school must ensure that initial counseling is conducted with each Direct Subsidized Loan or Direct Unsubsidized Loan student borrower prior to making the first disbursement of the proceeds of a loan to a student borrower unless the student borrower has received a prior Direct Subsidized, Direct Unsubsidized, Federal Stafford, or Federal SLS Loan.

(2) The initial counseling must be in person, by audiovisual presentation, or by interactive electronic means. In each case, the school must ensure that an individual with expertise in the title IV programs is reasonably available shortly after the counseling to answer the student borrower's questions. As an alternative, in the case of a student borrower enrolled in a correspondence program or a study-abroad program approved for credit at the home institution, the student borrower may be provided with written counseling materials before the loan proceeds are disbursed.

(3) The initial counseling must—

(i) Explain the use of a Master Promissory Note (MPN);

(ii) Emphasize to the borrower the seriousness and importance of the repayment obligation the student borrower is assuming;

(iii) Describe the likely consequences of default, including adverse credit reports, garnishment of wages, Federal offset, and litigation;

(iv) Inform the student borrower of sample monthly repayment amounts based on a range of student levels of indebtedness or on the average indebtedness of Direct Subsidized Loan and Direct Unsubsidized Loan borrowers at the same school or in the same program of study at the same school; and

(v) Emphasize that the student borrower is obligated to repay the full amount of the loan even if the student borrower does not complete the program, is unable to obtain employment upon completion, or is otherwise dissatisfied with or does not receive the educational or other services that the student borrower purchased from the school.

* * * * *

(5) If initial counseling is conducted through interactive electronic means, a school must take reasonable steps to ensure that each student borrower receives the counseling materials, and participates in and completes the initial counseling.

* * * * *

(b) * * *

(4) The exit counseling must—

(i) Inform the student borrower of the average anticipated monthly repayment amount based on the student borrower's indebtedness or on the average indebtedness of Direct Subsidized Loan and Direct Unsubsidized Loan borrowers at the same school or in the same program of study at the same school;

(ii) Review for the student borrower available repayment options including the standard repayment, extended repayment, graduated repayment, and income contingent repayment plans, and loan consolidation;

(iii) Suggest to the student borrower debt-management strategies that would facilitate repayment;

(iv) Explain to the student borrower how to contact the party servicing the student borrower's Direct Loans;

(v) Meet the requirements described in paragraphs (a)(3)(i), (ii), (iii), and (v) of this section;

(vi) Review for the student borrower the conditions under which the student borrower may defer or forbear repayment or obtain a full or partial discharge of a loan;

(vii) Review for the student borrower information on the availability of the Department's Student Loan Ombudsman's office;

(viii) Inform the student borrower of the availability of title IV loan information in the National Student Loan Data System (NSLDS); and

(ix) Require the student borrower to provide current information concerning name, address, social security number, references, and driver's license number and State of issuance, as well as the

student borrower's expected permanent address, the address of the student borrower's next of kin, and the name and address of the student borrower's expected employer (if known).

(5) The school must ensure that the information required in paragraph (b)(4)(ix) of this section is provided to the Secretary within 60 days after the student borrower provides the information.

(6) If exit counseling is conducted through interactive electronic means, a school must take reasonable steps to ensure that each student borrower receives the counseling materials, and participates in and completes the exit counseling.

* * * * *

PART 690—FEDERAL PELL GRANT PROGRAM

62. The authority citation for part 690 continues to read as follows:

Authority: 20 U.S.C. 1070a, unless otherwise noted.

§ 690.61 [Amended]

63. In paragraph (b) by removing ''34 CFR 668.60,'' and adding, in its place, ''the verification provisions of § 668.60 and the late disbursement provisions of § 668.164(g) of this chapter,''.

64. Section 690.75(a) is revised to read as follows:

§ 690.75 Determination of eligibility for payment.

(a) For each payment period, an institution may pay a Federal Pell Grant to an eligible student only after it determines that the student—

(1) Qualifies as an eligible student under 34 CFR Part 668, Subpart C;

(2) Is enrolled in an eligible program as an undergraduate student; and

(3) If enrolled in a credit hour program without terms or a clock hour program, has completed the payment period as defined in § 668.4 for which he or she has been paid a Federal Pell Grant.

* * * * *

65. Section 690.79 is revised to read as follows:

§ 690.79 Liability for and recovery of Federal Pell Grant overpayments.

(a)(1) Except as provided in paragraphs (a)(2) and (a)(3) of this section, a student is liable for any Federal Pell Grant overpayment made to him or her.

(2) The institution is liable for a Federal Pell Grant overpayment if the overpayment occurred because the institution failed to follow the procedures set forth in this part or 34 CFR Part 668. The institution must restore an amount equal to the overpayment to its Federal Pell Grant account.

(3) A student is not liable for, and the institution is not required to attempt recovery of or refer to the Secretary, a Federal Pell Grant overpayment if the amount of the overpayment is less than $25 and is not a remaining balance.

(b)(1) Except as provided in paragraph (a)(3) of this section, if an institution makes a Federal Pell Grant overpayment for which it is not liable, it must promptly send a written notice to the student requesting repayment of the overpayment amount. The notice must state that failure to make that repayment, or to make arrangements satisfactory to the holder of the overpayment debt to repay the overpayment, makes the student ineligible for further title IV, HEA program funds until final resolution of the Federal Pell Grant overpayment.

(2) If a student objects to the institution's Federal Pell Grant overpayment determination on the grounds that it is erroneous, the institution must consider any information provided by the student and determine whether the objection is warranted.

(c) Except as provided in paragraph (a)(3) of this section, if the student fails to repay a Federal Pell Grant overpayment or make arrangements satisfactory to the holder of the overpayment debt to repay the Federal Pell Grant overpayment, after the institution has taken the action required by paragraph (b) of this section, the institution must refer the overpayment to the Secretary for collection purposes in accordance with procedures required by the Secretary. After referring the Federal Pell Grant overpayment to the Secretary under this section, the institution need make no further efforts to recover the overpayment.

(Authority: 20 U.S.C. 1070a)

PART 694—GAINING EARLY AWARENESS AND READINESS FOR UNDERGRADUATE PROGRAMS (GEAR UP)

66. The authority citation for part 694 continues to read as follows:

Authority: 20 U.S.C. 1070a–21 to 1070a–28.

67. Section 694.10(e) is revised to read as follows:

§ 694.10 What are the requirements for awards under the program's scholarship component under section 404E of the HEA?

* * * * *

(e) *Other grant assistance.* A GEAR UP scholarship may not be considered in the determination of a student's eligibility for other grant assistance provided under title IV of the HEA.

[FR Doc. 02–27627 Filed 10–31–02; 8:45 am]

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Federal Register

Friday,
November 1, 2002

Part IV

The President

Proclamation 7615—National Family Caregivers Month, 2002

Federal Register
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Friday, November 1, 2002

Presidential Documents

Title 3—

The President

Proclamation 7615 of October 29, 2002

National Family Caregivers Month, 2002

By the President of the United States of America

A Proclamation

One of our most important responsibilities as citizens is to give back to our communities. Individuals who care for loved ones in their homes demonstrate the compassionate spirit of America. During National Family Caregivers Month, we honor these individuals who bring hope and comfort to their fellow citizens in need.

America's family caregivers are vital to the strength of our communities. Through specialized care for family members with disabilities or those who are aging or chronically ill, millions of caregivers help their loved ones live in a comforting environment. As the size of our elderly population continues to grow, home care increasingly represents an important, dignified, and compassionate alternative for countless individuals.

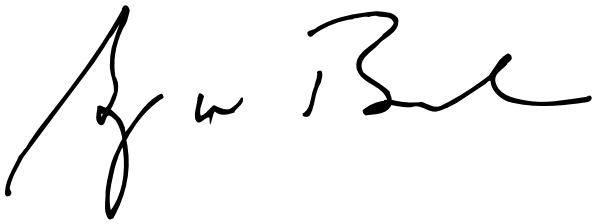
To support and train families at all stages of caregiving, the Administration on Aging provides community-based assistance through the ''National Family Caregiver Support Program.'' This network of community service providers, faith-based organizations, tribal organizations, State and local agencies on aging, and hundreds of thousands of volunteers informs caregivers that they are not alone, and that help is always available through counseling, support groups, training, respite care, and supplemental services.

As we work to build a culture of service, responsibility, and compassion, caregivers continue to bring our families and communities together. Through their efforts to assist loved ones in need, family caregivers demonstrate the true spirit of our Nation.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2002 as National Family Caregivers Month. I encourage all Americans to pause to honor the family members, friends, and neighbors who shoulder caregiving responsibilities.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-ninth day of October, in the year of our Lord two thousand two, and of the

Independence of the United States of America the two hundred and twenty-seventh.



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REMINDERS

The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

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The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.access.gpo.gov/nara/nara005.html*. Some laws may not yet be available.

H.R. 2486/P.L. 107–253

Inland Flood Forecasting and Warning System Act of 2002 (Oct. 29, 2002; 116 Stat. 1731; 2 pages)

H.R. 5647/P.L. 107–254

To authorize the duration of the base contract of the Navy-Marine Corps Intranet contract to be more than five years but not more than seven years. (Oct. 29, 2002; 116 Stat. 1733; 1 page)

H.J. Res. 113/P.L. 107–255

Recognizing the contributions of Patsy Takemoto Mink. (Oct. 29, 2002; 116 Stat. 1734; 1 page)

S. 1227/P.L. 107–256

Niagara Falls National Heritage Area Study Act (Oct. 29, 2002; 116 Stat. 1735; 2 pages)

S. 1270/P.L. 107–257

To designate the United States courthouse to be constructed at 8th Avenue and Mill Street in Eugene, Oregon, as the ''Wayne Lyman Morse United States Courthouse''. (Oct. 29, 2002; 116 Stat. 1737; 1 page)

S. 1339/P.L. 107–258

Persian Gulf War POW/MIA Accountability Act of 2002 (Oct. 29, 2002; 116 Stat. 1738; 3 pages)

S. 1646/P.L. 107–259

To identify certain routes in the States of Texas, Oklahoma, Colorado, and New Mexico as part of the Ports-to-Plains Corridor, a high priority corridor on the National Highway System. (Oct. 29, 2002; 116 Stat. 1741; 2 pages)

S. 2558/P.L. 107–260

Benign Brain Tumor Cancer Registries Amendment Act (Oct. 29, 2002; 116 Stat. 1743; 2 pages)

H.R. 669/P.L. 107–261

To designate the facility of the United States Postal Service located at 127 Social Street in Woonsocket, Rhode Island, as the ''Alphonse F. Auclair Post Office Building''. (Oct. 30, 2002; 116 Stat. 1745; 1 page)

H.R. 670/P.L. 107–262

To designate the facility of the United States Postal Service located at 7 Commercial Street in Newport, Rhode Island, as the ''Bruce F. Cotta Post Office Building''. (Oct. 30, 2002; 116 Stat. 1746; 1 page)

H.R. 3034/P.L. 107–263

To redesignate the facility of the United States Postal Service located at 89 River Street in Hoboken, New Jersey, as the ''Frank Sinatra Post Office Building''. (Oct. 30, 2002; 116 Stat. 1747; 1 page)

H.R. 3738/P.L. 107–2

4 To designate the facility of the United States Postal Service located at 1299 North 7th Street in Philadelphia, Pennsylvania, as the ''Herbert Arlene Post Office Building''. (Oct. 30, 2002; 116 Stat. 1748; 1 page)

H.R. 3739/P.L. 107–265

To designate the facility of the United States Postal Service located at 6150 North Broad Street in Philadelphia, Pennsylvania, as the ''Rev. Leon Sullivan Post Office Building''. (Oct. 30, 2002; 116 Stat. 1749; 1 page)

H.R. 3740/P.L. 107–266

To designate the facility of the United States Postal Service located at 925 Dickinson Street in Philadelphia, Pennsylvania, as the ''William A. Cibotti Post Office Building''. (Oct. 30, 2002; 116 Stat. 1750; 1 page)

H.R. 4102/P.L. 107–267

To designate the facility of the United States Postal Service located at 120 North Maine Street in Fallon, Nevada, as the ''Rollan D. Melton Post Office Building''. (Oct. 30, 2002; 116 Stat. 1751; 1 page)

H.R. 4717/P.L. 107–268

To designate the facility of the United States Postal Service located at 1199 Pasadena Boulevard in Pasadena, Texas, as the ''Jim Fonteno Post Office Building''. (Oct. 30, 2002; 116 Stat. 1752; 1 page)

H.R. 4755/P.L. 107–269

To designate the facility of the United States Postal Service located at 204 South Broad Street in Lancaster, Ohio, as the ''Clarence Miller Post Office Building''. (Oct. 30, 2002; 116 Stat. 1753; 1 page)

H.R. 4794/P.L. 107–270

To designate the facility of the United States Postal Service located at 1895 Avenida Del Oro in Oceanside, California, as the ''Ronald C. Packard Post Office Building''. (Oct. 30, 2002; 116 Stat. 1754; 1 page)

H.R. 4797/P.L. 107–271

To redesignate the facility of the United States Postal Service located at 265 South Western Avenue, Los Angeles, California, as the ''Nat King Cole Post Office''. (Oct. 30, 2002; 116 Stat. 1755; 2 pages)

H.R. 4851/P.L. 107–272

To redesignate the facility of the United States Postal Service located at 6910 South Yorktown Avenue in Tulsa, Oklahoma, as the ''Robert Wayne Jenkins Station''. (Oct. 30, 2002; 116 Stat. 1757; 1 page)

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When a date falls on a weekend or holiday, the next Federal business day is used. (See 1 CFR 18.17)

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Nov 26	Dec 11	Dec 26	Jan 10	Jan 27	Feb 24
Nov 27	Dec 12	Dec 27	Jan 13	Jan 27	Feb 25
Nov 29	Dec 16	Dec 30	Jan 13	Jan 28	Feb 27