8–12–03 Tuesday
Vol. 68 No. 155 Aug. 12, 2003

Pages 47835–48248

Federal Register

The **FEDERAL REGISTER** (ISSN 0097–6326) is published daily, Monday through Friday, except official holidays, by the Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408, under the Federal Register Act (44 U.S.C. Ch. 15) and the regulations of the Administrative Committee of the Federal Register (1 CFR Ch. I). The Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 is the exclusive distributor of the official edition. Periodicals postage is paid at Washington, DC.

The **FEDERAL REGISTER** provides a uniform system for making available to the public regulations and legal notices issued by Federal agencies. These include Presidential proclamations and Executive Orders, Federal agency documents having general applicability and legal effect, documents required to be published by act of Congress, and other Federal agency documents of public interest.

Documents are on file for public inspection in the Office of the Federal Register the day before they are published, unless the issuing agency requests earlier filing. For a list of documents currently on file for public inspection, see *http://www.nara.gov/fedreg.*

The seal of the National Archives and Records Administration authenticates the Federal Register as the official serial publication established under the Federal Register Act. Under 44 U.S.C. 1507, the contents of the **Federal Register** shall be judicially noticed.

The **Federal Register** is published in paper and on 24x microfiche. It is also available online at no charge as one of the databases on GPO Access, a service of the U.S. Government Printing Office.

The online edition of the **Federal Register** *www.access.gpo.gov/nara,* available through GPO Access, is issued under the authority of the Administrative Committee of the Federal Register as the official legal equivalent of the paper and microfiche editions (44 U.S.C. 4101 and 1 CFR 5.10). It is updated by 6 a.m. each day the **Federal Register** is published and includes both text and graphics from Volume 59, Number 1 (January 2, 1994) forward.

For more information about GPO Access, contact the GPO Access User Support Team, call toll free 1-888-293-6498; DC area 202-512-1530; fax at 202-512-1262; or via email at *gpoaccess@gpo.gov.* The Support Team is available between 7:00 a.m. and 5:30 p.m. Eastern Time, Monday–Friday, except official holidays.

The annual subscription price for the **Federal Register** paper edition is $699, or $764 for a combined **Federal Register, Federal Register** Index and List of CFR Sections Affected (LSA) subscription; the microfiche edition of the **Federal Register** including the **Federal Register** Index and LSA is $264. Six month subscriptions are available for one-half the annual rate. The charge for individual copies in paper form is $10.00 for each issue, or $10.00 for each group of pages as actually bound; or $2.00 for each issue in microfiche form. All prices include regular domestic postage and handling. International customers please add 40% for foreign handling. Remit check or money order, made payable to the Superintendent of Documents, or charge to your GPO Deposit Account, VISA, MasterCard, American Express, or Discover. Mail to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954; or call toll free 1-866-512-1800, DC area 202-512-1800; or go to the U.S. Government Online Bookstore site, *bookstore@gpo.gov.*

There are no restrictions on the republication of material appearing in the **Federal Register.**

How To Cite This Publication: Use the volume number and the page number. Example: 68 FR 12345.

Postmaster: Send address changes to the Superintendent of Documents, Federal Register, U.S. Government Printing Office, Washington DC 20402, along with the entire mailing label from the last issue received.

SUBSCRIPTIONS AND COPIES

PUBLIC

Subscriptions:

Paper or fiche	**202–512–1800**
Assistance with public subscriptions	**202–512–1806**
General online information	**202–512–1530; 1–888–293–6498**

Single copies/back copies:

Paper or fiche	**202–512–1800**
Assistance with public single copies	**1–866–512–1800 (Toll-Free)**

FEDERAL AGENCIES

Subscriptions:

Paper or fiche	**202–741–6005**
Assistance with Federal agency subscriptions	**202–741–6005**

What's NEW!

Federal Register Table of Contents via e-mail

Subscribe to FEDREGTOC, to receive the **Federal Register** Table of Contents in your e-mail every day.

If you get the HTML version, you can click directly to any document in the issue.

To subscribe, go to **http://listserv.access.gpo.gov** and select:

Online mailing list archives
FEDREGTOC-L
Join or leave the list

Then follow the instructions.

What's NEW!

Special Values on Selected Volumes of the 2002 **Code of Federal Regulations**

Selected volumes of the 2002 Code of Federal Regulations are now available for sale by the Government Printing Office at special prices.

Go to: **http://bookstore.gpo.gov/values/cfr.html**

Contents

Federal Register

Vol. 68, No. 155

Tuesday, August 12, 2003

Separate Parts In This Issue

Reader Aids

Consult the Reader Aids section at the end of this issue for phone numbers, online resources, finding aids, reminders, and notice of recently enacted public laws.

To subscribe to the Federal Register Table of Contents LISTSERV electronic mailing list, go to http://listserv.access.gpo.gov and select Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings); then follow the instructions.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

5 CFR
Proposed Rules:
532.....47877

9 CFR
94.....47835

14 CFR
39.....47842
71 (3 documents) 47844, 47846

20 CFR
Proposed Rules:
404.....47877

24 CFR
Proposed Rules:
3282.....47881

28 CFR
549.....47847

30 CFR
Proposed Rules:
72.....47886

33 CFR
117 (2 documents) 47850, 47851
165 (2 documents) 47852, 47854

40 CFR
81.....47964
Proposed Rules:
194.....47887

42 CFR
Proposed Rules:
410.....47966
419.....47966

47 CFR
25.....47856

49 CFR
390.....47860
398.....47860
Proposed Rules:
380.....47890
391.....47890

50 CFR
679.....47875
Proposed Rules:
635.....47904

Rules and Regulations

Federal Register
Vol. 68, No. 155
Tuesday, August 12, 2003

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 94

[Docket No. 01–074–2]

Classical Swine Fever Status of Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: We are amending the regulations by adding the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa to the lists of regions considered free of classical swine fever. We have conducted a series of risk evaluations and have determined that these four States have met our requirements for being recognized as free of this disease. This action will allow the importation into the United States of pork, pork products, live swine, and swine semen from these regions. We are also adding certification requirements for the importation of live swine, pork, and pork products from Baja California, Baja California Sur, Chihuahua, and Sinaloa. The certification would identify the regions of export and origin as Baja California, Baja California Sur, Chihuahua, or Sinaloa or some other region that we recognize as free of classical swine fever and would also prevent the commingling of animals and products from these States with animals and products from classical-swine-fever-affected regions prior to export.

EFFECTIVE DATE: August 27, 2003.

FOR FURTHER INFORMATION CONTACT: Dr. Hatim Gubara, Senior Staff Veterinarian, Regionalization Evaluation Services Staff, VS, APHIS, 4700 River Road Unit 38, Riverdale, MD 20737–1231; (301) 734–4356.

SUPPLEMENTARY INFORMATION:

Background

The Animal and Plant Health Inspection Service (APHIS) of the United States Department of Agriculture regulates the importation of animals and animal products into the United States to guard against the introduction of animal diseases not currently present or prevalent in this country. The regulations pertaining to the importation of animals and animal products are set forth in the Code of Federal Regulations (CFR), title 9, chapter I, subchapter D (9 CFR parts 91 through 99).

Until several years ago, the regulations in parts 91 through 99 (referred to below as the regulations) governed the importation of animals and animal products according to the recognized disease status of the exporting country. In general, if a disease occurred anywhere within a country's borders, the entire country was considered to be affected with the disease, and importations of animals and animal products from anywhere in the country were regulated accordingly. However, international trade agreements entered into by the United States—specifically, the North American Free Trade Agreement and the World Trade Organization Agreement on Sanitary and Phytosanitary Measures—require APHIS to recognize regions, rather than only countries, for the purpose of regulating the importation of animals and animal products into the United States.

Consequently, on October 28, 1997, we published in the **Federal Register** a final rule (62 FR 56000–56026, Docket No. 94–106–9, effective November 28, 1997) and a policy statement (62 FR 56027–56033, Docket No. 94–106–8) that established procedures for recognizing regions (referred to below as ''regionalization'') for the purpose of regulating the importation of animals and animal products. With the establishment of those procedures, APHIS may consider requests to allow the importation of a particular type of animal or animal product from a foreign region, as well as requests to recognize all or part of a country or countries as a region. The regulations define the term *region,* in part, as ''any defined geographic land area identifiable by geological, political, or surveyed boundaries.''

In accordance with these regionalization procedures, on May 13, 2002, we published in the **Federal Register** (67 FR 31987–31992, Docket No. 01–074–1) a proposal to amend the regulations in §§ 94.9 and 94.10 by adding the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa to the lists of regions considered free of classical swine fever (CSF), thus allowing the importation into the United States of pork, pork products, live swine, and swine semen from these regions. We also proposed to remove references to those four States in § 94.15(b) because we believed that the provisions of that paragraph, which, among other things, govern the transiting through the United States of pork and pork products not otherwise eligible for entry into the United States under part 94, would no longer apply to those States once they were recognized as CSF-free.

We solicited comments concerning our proposal for 60 days ending July 12, 2002. We received six comments by that date. They were from U.S. and Mexican swine producers, a swine producers' association, importers, and a representative of the Mexican Government. Five of the commenters wrote in favor of the proposed rule.

The remaining commenter raised a number of issues, which we will discuss in the paragraphs that follow. Areas of concern discussed by the commenter included APHIS' risk assessment methodology; the conditions under which live swine and swine semen could be imported from the four Mexican States; the possibility that imports of those two commodities, in particular, could transmit not only CSF to U.S. herds but other diseases as well; the adequacy of surveillance programs in the four Mexican States; and the possibility that Chihuahua might export to the United States pork and pork products derived from swine imported into the State from CSF-affected regions.

The commenter cited several concerns regarding the methodology APHIS used in conducting its risk evaluations of Baja California, Baja California Sur, Chihuahua, and Sinaloa. Noting that an earlier rule allowing pork imports from the States of Yucatan and Sonora had been based on a qualitative ''risk assessment,'' the commenter questioned

why ''risk evaluations'' of the four Mexican States preceded the current rulemaking process. The commenter requested explanations of the differences between the two and of how APHIS decides which type of analysis to do, and also questioned whether a ''full risk assessment'' had been completed for Baja California, Baja California Sur, Chihuahua, and Sinaloa. The commenter also pointed out that a proposal to recognize several European Union (EU) countries, as well as parts of Italy and Germany, as CSF-free (see 64 FR 34155–34168, Docket No. 98–090–1, published June 25, 1999) followed an APHIS risk analysis that included quantitative risk assessments for live swine, semen, and pork. Because live swine and swine semen imports may pose a greater risk of CSF transmission than pork imports, the commenter asserted, APHIS should conduct separate risk assessments for live swine and semen and then apply appropriate risk-mitigation strategies. Finally, the commenter also expressed some concern about the age of the data collected during the site visits APHIS conducted as part of the risk evaluations of the four Mexican States, pointing out that the most recent site visit took place in February 1997.

In conducting our risk evaluations of the four Mexican States, we used our standardized approach, which complies with § 92.2 of the regulations. It is unclear what the commenter means by a ''full risk assessment.'' The risk evaluation is equivalent, whether it is called a risk assessment or a risk evaluation. Historically, we have not conducted separate risk assessments for live swine and swine semen in similar rulemakings and have conducted quantitative as well as qualitative analyses primarily for rules designated as ''significant'' by the Office of Management and Budget. The EU proposal, unlike the one involving the four Mexican States, was a ''significant'' rule and was much larger in scope, involving various countries within the EU and regions within EU countries. For our proposed rule regarding Baja California, Baja California Sur, Chihuahua, and Sinaloa, we used our standard risk assessment methods and found the risk of CSF transmission to the United States via imports from the four Mexican States to be low. Because there have been no CSF outbreaks in any of the four States since our February 1997 site visit and APHIS had no information that risk levels had changed, APHIS did not view additional site visits as necessary.

The commenter requested additional information about the conditions under which live swine would be imported, since, heretofore, they have not been imported into the United States from Mexico, and about the types, locations, biosecurity policies, etc., of the semen centers that would have the potential to ship semen for use in U.S. swine herds.

Though this final rule allows imports of live swine and swine semen from the four Mexican States, we do not intend to issue import permits for live swine and swine semen from Mexico until we have resolved several issues related to the presence of blue eye disease in Mexico (those issues are discussed in greater detail later in this document). We are confident, however, that once the blue eye disease issue is settled, the regulations will provide for the safe importation into the United States of live swine and swine semen from Baja California, Baja California Sur, Chihuahua, and Sinaloa.

The importation of live swine is subject to the conditions set out in §§ 93.500 to 93.521. These conditions include, among other things, requirements for import permits, health certification, inspection and cleaning of conveyances used to transport swine, inspection of swine at the port of entry, and quarantine methods and facilities. Section 93.507, which pertains to port-of-entry inspection, provides that only those swine found to be free of communicable diseases and not to have been exposed to communicable diseases in the 60 days prior to their importation are eligible for entry. Section 93.510 requires that all imported swine be quarantined for a period of not less than 15 days, dating from the arrival of the swine at the port of entry. For the most part, the regulations in part 93 provide effective prevention against transmission of CSF to the U.S. swine population by means of imports of live swine. After reviewing our regulations in light of the issues raised by the commenter, however, we did determine that we needed to provide more protection against the possible commingling of live swine from the four CSF-free States with swine from other regions before the eligible swine are exported to the United States. This additional protection will take the form of a certification requirement, which we will discuss later in this document.

The importation of swine semen is subject to the conditions in §§ 98.30 to 98.36. These conditions include requirements for the inspection, unloading, cleaning, and disinfection of aircraft, other means of conveyance, and shipping containers used to move animal semen into the United States; import permits; and health certificates and other documents. Part 98 also offers protection against the commingling of animal semen from disease-free and disease-affected regions. Section 98.31(b) states that animal semen may not be imported into the United States from any region other than that in which it was collected. All shipping containers carrying animal semen for importation into the United States must be sealed with an official seal of the national veterinary service of the region of origin. Also, under part 98, import permits for semen may be denied because of, among other things, communicable disease conditions in the region of origin or in a region through which the shipment has been or will be transported. Taken together, these and other provisions in part 98 will make the prospect of CSF transmission to U.S. swine herds via the importation of swine semen from Baja California, Baja California Sur, Chihuahua, and Sinaloa very unlikely. Our review of part 98 in light of the issues raised by the commenter led us to conclude that we did not need to make any changes in the regulations pertaining to semen.

Another concern expressed by the commenter was that allowing the importation of live swine and swine semen from the four Mexican States could increase the risk of infection of U.S. swine herds with diseases such as pseudorabies, vesicular stomatitis, and blue eye disease.

The inspection, permitting, certification, and quarantine provisions in part 93 allow APHIS to screen imported live swine for pseudorabies and to take effective measures, which include refusal of entry, to prevent its spread. APHIS does not regard imports of live swine from Mexico as a source of risk for transmission of vesicular stomatitis and does not require testing of other species from Mexico for that disease. Blue eye disease does provide greater cause for concern. Although several laboratory tests have been developed for the detection of that disease, none has been validated or is commercially available in the United States. Moreover, APHIS does not have current and complete information on the geographic distribution of blue eye disease in Mexico. In the absence of specific clinical signs, a reliable laboratory test, and complete epidemiologic information, specific mitigation measures for blue eye disease of swine are difficult to design. Under § 93.504(a)(3), however, APHIS may deny permits for the importation of live swine and swine specimens if such imports would pose a disease risk. We intend to rely on this authority to support our decision to not issue any permits for the importation of live swine

and swine semen from the four Mexican States until the issue of blue eye disease can be addressed more comprehensively. With that goal in mind, APHIS intends to collect information and conduct an assessment of the risk of introducing blue eye disease in live swine and swine semen imported from Mexico.

The commenter also questioned why the import conditions we proposed to apply to pork and pork products from the four Mexican States differed from those specified in an earlier final rule pertaining to imports of pork and pork products from the Mexican States of Sonora and Yucatan that was published in the **Federal Register** on January 11, 2000 (65 FR 1529–1537, Docket No. 97–079–2).

Risk evaluations carried out during the 1990s led APHIS to promulgate the January 2000 final rule referred to by the commenter after concluding that pork and pork products could safely be imported into the United States from Yucatan and Sonora under conditions designed to prevent the commingling of such products prior to exportation with pork and pork products from surrounding regions with lower CSF status. Unlike this final rule, however, the January 2000 final rule did not recognize Yucatan and Sonora as free of CSF. Generally, import requirements tend to be more stringent for disease-affected regions than for those we recognize as disease-free, so it is to be expected that the requirements imposed on imports from Yucatan and Sonora would be more rigorous than those imposed on imports from Baja California, Baja California Sur, Chihuahua, and Sinaloa. On September 30, 2002, however, we published in the **Federal Register** (67 FR 61293–61300, Docket No. 02–002–1) a proposal to add Yucatan and Sonora, along with the Mexican States of Campeche and Quintana Roo, to the lists in §§ 94.9 and 94.10 of CSF-free regions. Should that proposed rule be finalized, pork and pork products imported from those States will be subject to the same requirements as pork and pork products from Baja California, Baja California Sur, Chihuahua, and Sinaloa.

The commenter also expressed concerns regarding surveillance activities in the four Mexican States. The commenter raised questions regarding the prevention of backyard swine from entering the commercial slaughtering process, the existence of feral swine populations in the four States and the prevalence of CSF among those populations, the States' plans for coping with future CSF outbreaks, the ability of APHIS to trace infected swine back to particular farms or slaughterhouses, and the procedures APHIS would use to notify U.S. importers in the event of an outbreak of CSF in any of the four States.

We believe that if a region from which swine are being imported is free of CSF, then there is no reason to prevent backyard swine from that region from being slaughtered and imported. We only view feral swine as a cause for concern if such animals are transmitting disease to swine being raised for slaughter. As noted in the risk assessment documents, in accordance with Mexico's National Eradication Program, the four Mexican States all have active disease surveillance programs, strict border controls for animal movement, and emergency response systems or teams available in the event of CSF outbreaks. The certificate of origin required under § 93.505 would enable APHIS to trace infected animals back to specific slaughterhouses or farms. In the event of an outbreak in any of the four States, APHIS would notify U.S. importers by imposing an immediate ban and enforcing it by publishing an interim rule.

The commenter also raised some issues with regard to individual States. The commenter requested more details regarding the process by which backyard herds are randomly selected for CSF surveillance in Baja California. Regarding Baja California Sur, the commenter requested information on the number of backyard herds tested for CSF and the sources of the four CSF outbreaks that have occurred in the State since it was declared free of the disease by Mexico in 1991. With regard to Sinaloa, the commenter requested information regarding the source of the 1998 outbreak of CSF in neighboring Durango.

In Baja California, as in the other three Mexican States covered by this rule, the size of backyard animal samples is established through the determination of the presence or absence of CSF by the Cannon and Roe formula (1982), with a confidence interval of 99 percent and an expected prevalence in backyard premises of 0.15 percent. The number of municipalities in the State and the number of backyard farms in each municipality are determined by the Secretariat for Agriculture, Livestock, Rural Development, Fisheries, and Food Safety (SAGARPA). Premises are randomly selected for sampling by the assigned veterinarian according to the number of samples assigned to each municipality. Based on a swine census conducted in the State in 1998 and 1999, it was determined that samples would be taken from 172 and 241 backyard premises for those years, respectively, and would consist of 10 percent of the animals randomly selected from the total on each farm.

A description of the methodology used in sampling backyard herds in Baja California Sur is provided in the risk evaluation report for that State. APHIS did not collect data on the sources of the CSF outbreaks in Baja California Sur because the last of them occurred in 1995, and the State has remained CSF-free since then.

APHIS did not see a need to collect information on the source of the 1998 CSF outbreak in Durango because Durango was not among the Mexican States that were the subject of the proposed rule and we have not proposed to make any changes to the regulations regarding Durango's CSF status. Durango, which was declared free of CSF by the Mexican Government subsequent to the 1998 outbreak and is separated from Sinaloa by the Sierra Madre Occidental Mountains, is not seen as a likely source for the introduction of CSF into Sinaloa. In addition, animals or pork from Durango would be excluded by the certification requirements in this rule.

Noting the paucity of commercial swine in Chihuahua relative to backyard swine and the fact that Chihuahua is a net exporter of pork, the commenter suggested that most of the slaughter volume in the State must come from swine raised in other regions, possibly including regions affected with CSF. The commenter requested information on the origin of the swine that are slaughtered in Chihuahua and on restrictions on interstate movement of swine into the State.

APHIS has requested data from Chihuahua on the specific origin of any swine entering the State for slaughter and is awaiting a response. In any event, APHIS does not consider the importation of pork or pork products from Chihuahua under the certification requirements of this final rule to constitute a risk for spreading CSF. Also, as noted in the risk evaluation document for Chihuahua and in the proposed rule, some safeguards already exist to prevent Chihuahua from exporting contaminated pork or pork products to the United States. Movement of live swine from Mexican States with a lower CSF status into Chihuahua is prohibited, so even though it does appear that much of the pork Chihuahua exports comes from imported swine, the swine are likely to have come from CSF-free regions. Moreover, the swine are slaughtered at

Tipo Inspección Federal (TIF) plants that comply with international sanitary requirements and have official veterinary sanitary officers and supervision and certification by the countries to which they export.

Still, APHIS shares the commenter's broader concerns about products imported into the United States from certain regions designated as free of CSF. Historically, the CSF-free designation has been justified not only by the absence of the disease in a particular country but also by the strong border controls existing at national boundaries. These border controls were thought to provide effective mitigation against the risks presented by the possibility of pork, pork products, live swine, or swine semen being imported into CSF-free countries for subsequent export to the United States. The advent of regionalization has allowed APHIS to designate regions within countries, as well as entire countries, as free of CSF. While regionalization has allowed APHIS to exercise more flexibility in its regulatory process and has helped to facilitate trade, it has caused APHIS to reconsider the issue of border controls in some cases. Border controls between higher- and lower-risk regions within a country or within a larger community, such as the EU, may not always be equivalent to border controls between nations. The possibility that pork or pork products intended for export to the United States from some CSF-free regions could be derived from swine that originated in CSF-affected regions or could be commingled with pork or pork products from affected regions prior to export to the United States appears to be greater than it did in the past. Such imports could present a risk of introducing CSF into this country. Commingling is also a concern with live swine intended for export to the United States from certain CSF-free regions.

Some sections of the regulations in part 94 do contain provisions aimed at reducing the potential risks posed by the importation of animal products from disease-free regions when circumstances exist that indicate there may be the possibility that those products may be commingled with animal products from disease-affected regions. For example, § 94.11 places certain restrictions on meat and other animal products imported from certain regions that are designated in § 94.1 as free of rinderpest and foot-and-mouth disease (FMD) but that (1) supplement their meat supplies by the importation of fresh meat of ruminants or swine from regions affected by rinderpest or FMD, (2) share a common land border with such regions, or (3) import ruminants or swine from such regions under conditions less restrictive than would be acceptable for importation into the United States. Section 94.13 has similar provisions for pork and pork products imported from certain regions that are designated in § 94.12(a) as being free of swine vesicular disease but that have risk factors like those of the FMD-free countries listed in § 94.11. The requirements currently in effect for the importation of pork and pork products from Yucatan and Sonora in § 94.20 include requirements for slaughtering, processing, and certification that are intended to address the risk of commingling.

Notwithstanding the requirements in § 94.20, the regulations in part 94 lack specific provisions for imports from CSF-free regions that are analogous to those of §§ 94.11 and 94.13. To mitigate the risks associated with importing live swine, pork, and pork products from the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa—States that are subject to risk factors similar to those associated with the regions listed in §§ 94.11 and 94.13—we are adding a certification requirement to this final rule. This certification requirement will help to ensure that live swine and pork and pork products from these four Mexican States will not be commingled with swine and products from CSF-affected regions in the region of origin, the region of export, or in transit prior to exportation, and that pork and pork products derived from swine originating in affected regions will not be exported to the United States from the four Mexican States.

Specifically, we are adding a new § 94.24, which specifies the contents of a certification that will have to accompany live swine, pork, or pork products imported into the United States from the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa. The new section has three components. The introductory text enumerates the risk factors that necessitate applying the certification requirement to the four States. Paragraph (a) specifies the certification requirements for live swine, and paragraph (b), for pork and pork products.

Paralleling §§ 94.11 and 94.13, the introductory text of new § 94.24 notes that although Baja California, Baja California Sur, Chihuahua, and Sinaloa are declared to be free of CSF in §§ 94.9 and 94.10, they supplement their pork supplies with fresh (chilled or frozen) pork imported from regions designated in §§ 94.9 and 94.10 as being affected by CSF, share a common land border with such affected regions, or import swine from such affected regions under conditions less restrictive than would be acceptable for importation into the United States. Thus, there exists a possibility that live swine, pork, or pork products from these CSF-free regions may be commingled with live swine, pork, or pork products from regions where CSF is considered to exist, resulting in a risk of introducing the disease into the United States. Therefore, live swine, pork, or pork products and shipstores, airplane meals, and baggage containing pork or pork products, other than those regulated under 9 CFR part 95 (which regulates, among other things, such swine products as hides and bristles) or part 96 (which regulates, among other things, swine casings) must meet the requirements of new § 94.24 in addition to other applicable requirements in the regulations. For imported live swine, other applicable requirements include those in §§ 93.500 to 93.521, which, as noted earlier, cover, among other things, import permits, health certification, inspection and cleaning of conveyances that transport swine, inspection of swine at the port of entry, and quarantine methods and facilities. Other applicable requirements that govern the importation of pork and pork products are specified in the regulations of the Food Safety Inspection Service (FSIS) of the U.S. Department of Agriculture. Of particular relevance in this case are the foreign country eligibility requirements for products imported into the United States in 9 CFR 327.2 and the foreign meat inspection certificate requirements in § 327.4.

Paragraph (a) of new § 94.24 states that the swine must be accompanied by a certification issued by a full-time salaried veterinary officer of the Government of Mexico. Upon arrival of the swine in the United States, the certification must be presented to an authorized inspector at the port of arrival. The certification must identify both the exporting region and the region of origin as a region designated in §§ 94.9 and 94.10 as free of CSF.

Paragraph (a)(1) specifies that the certification must state that the swine have not lived in a region designated in §§ 94.9 and 94.10 as affected with CSF. This provision, along with the certification in paragraph (a) that the region of origin and exporting regions are both CSF-free, will help to ensure that swine exported from Baja California, Baja California Sur, Chihuahua, and Sinaloa to the United States will in fact have come from one of those States and will not have been

kept on premises in any region where CSF exists.

Paragraph (a)(2) specifies that the certification must state that the swine have never been commingled with swine that have been in a region that is designated in §§ 94.9 and 94.10 as affected with CSF. This provision will help to ensure that the swine will not be commingled while in Baja California, Baja California Sur, Chihuahua, or Sinaloa with swine imported into those States from other regions that may be affected with CSF.

Paragraph (a)(3) specifies that the certification must state that the swine have not transited through a region designated in §§ 94.9 and 94.10 as affected with CSF unless moved directly through the region to their destination in a sealed means of conveyance with the seal intact upon arrival at the point of destination. This provision will help to ensure that swine intended for export to the United States from the four Mexican States are not exposed to CSF while in transit prior to being exported.

Paragraph (a)(4) specifies that the certification must state that the conveyances or materials used in transporting the swine, if previously used for transporting swine, have been cleaned and disinfected in accordance with the requirements of § 93.502. This provision will help ensure that swine from Baja California, Baja California Sur, Chihuahua, or Sinaloa will not be exposed to CSF as a result of being transported in a contaminated conveyance.

Paragraph (b) states that pork or pork products intended for export to the United States must, like live swine, be accompanied by a certification issued by a full-time salaried veterinary officer of the Government of Mexico. Upon arrival of the pork or pork products in the United States, the certification must be presented to an authorized inspector at the port of arrival. The certification must identify both the exporting region and the region of origin of the pork or pork products as a region designated in §§ 94.9 and 94.10 as free of CSF at the time the pork or pork products were in the region. This provision will help to ensure that no pork or pork products exported from the four States to the United States will have originated in or been in a CSF-affected region.

Paragraph (b)(1) specifies that the certification must state that the pork or pork products were derived from swine that were born and raised in a region designated in §§ 94.9 and 94.10 as free of CSF and were slaughtered in such a region at a federally inspected slaughter plant that is under the direct supervision of a full-time salaried veterinarian of the Government of Mexico and that is eligible to have its products imported into the United States under the Federal Meat Inspection Act (21 U.S.C. 601 *et seq.*) and the FSIS regulations in 9 CFR 327.2. This provision will help ensure that the pork or pork products will only be derived from swine that are free of CSF and that slaughtering will take place in establishments and under conditions that meet FSIS standards.

Paragraph (b)(2) specifies that the certification must state that the pork or pork products have never been commingled with pork or pork products that have been in a region that is designated in §§ 94.9 and 94.10 as affected with CSF. This provision will help to ensure that the pork or pork products are not placed at risk of contamination in their region of origin via contact with pork or pork products that originated in a CSF-affected region.

Paragraph (b)(3) specifies that the certification must state that the pork or pork products have not transited through a region designated in §§ 94.9 and 94.10 as affected with CSF unless moved directly through the region to their destination in a sealed means of conveyance with the seal intact upon arrival at the point of destination. This provision will help to ensure that pork or pork products from the four Mexican States will remain safe from contamination by being kept in sealed containers while transiting through CSF-affected regions prior to importation into the United States.

Finally, paragraph (b)(4) specifies that the certification must state that if processed, the pork or pork product was processed in a region designated in §§ 94.9 and 94.10 as CSF-free in a federally inspected processing plant that is under the direct supervision of a full-time salaried veterinary official of the Government of Mexico. This provision will help to ensure that contamination will not occur during processing because the pork or pork products will be processed under appropriate supervision in establishments that are eligible to export pork and pork products to the United States.

Miscellaneous

As we noted earlier in this document, in our May 2002 proposed rule, we had proposed to remove references to Baja California, Baja California Sur, Chihuahua, and Sinaloa that were contained in § 94.15(b) of the regulations because we believed that the provisions of that paragraph, which, among other things, govern the transiting through the United States of pork and pork products not otherwise eligible for entry into the United States under part 94, would no longer apply to those States once we recognized them as CSF-free. Some of the pork and pork products produced in those States for export, however, may be produced in plants that are not FSIS-approved. Such pork and pork products, while ineligible for importation into the United States under the conditions of this final rule, are allowed to transit through the United States under current § 94.15(b). In order to allow such products to continue to transit the United States, we have decided not to finalize our proposed changes to § 94.15(b).

The May 2002 proposed rule also discussed our intention to substitute the term ''classical swine fever,'' which has become standard usage among veterinary practitioners, for ''hog cholera'' wherever the latter term appeared in 9 CFR parts 71, 93, 94, 98, and 130. Because these editorial changes were included in another final rule pertaining to the CSF status of various regions in the EU, published in the **Federal Register** on April 7, 2003 (68 FR 16922–16941, Docket No. 98–090–5), we will not be finalizing that aspect of the proposed rule in this final rule.

Therefore, for the reasons given in the proposed rule and in this document, we are adopting the proposed rule as a final rule, with the changes discussed in this document.

Effective Date

This is a substantive rule that relieves restrictions and, pursuant to the provisions of 5 U.S.C. 553, may be made effective less than 30 days after publication in the **Federal Register**. This rule adds the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa to the lists of regions considered free of CSF and allows pork, pork products, live swine, and swine semen to be imported into the United States from those regions, subject to certain conditions. We have determined that approximately 2 weeks are needed to ensure that APHIS personnel at ports of entry receive official notice of this change in the regulations. Therefore, the Administrator of the Animal and Plant Health Inspection Service has determined that this rule should be effective 15 days after publication in the **Federal Register**.

Executive Order 12866 and Regulatory Flexibility Act

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

and, therefore, has not been reviewed by the Office of Management and Budget.

Based on the assumption that these four States will not drastically increase their levels of pork production over that of the last few years, the amount of pork, pork products, live swine, and swine semen that may potentially be imported into the United States from Baja California, Baja California Sur, Chihuahua, and Sinaloa is likely to be negligible. In 2000, the State of Sinaloa produced 1.1 percent of Mexico's live swine and 1.1 percent of its pork (FAS, USDA, GAIN Report, 2001), and Chihuahua produced 0.7 percent of Mexico's live swine and 0.5 percent of Mexico's pork (tables 1 and 2). The States of Baja California and Baja California Sur, which are not self-sufficient in pork production, produced smaller percentages. In 2001, these four States together produced less than 2 percent of Mexico's total number of live swine (table 1) and slaughtered swine (table 2). Between 1999 and 2001, Mexico exported around 5 percent of its annual production of pork (table 3), which amounted to 50,667 metric tons on average. Mexico has not exported any live swine since 1997 (table 4).

TABLE 1.—LIVE SWINE IN MEXICAN STATES, 2001

State	Swine in commercial farms	Swine in backyard operations	Total
Baja California	15,251 (in 10 farms)	6,951 (in 548 farms)	22,202 (0.09%)
Baja California Sur	1,200 (in 2 farms)	20,550 (in unknown number of farms)	21,750 (0.09%)
Chihuahua	2,626 (in 5 farms)	169,183 (in 45,714 farms)	171,809 (0.67%)
Sinaloa	92,070 (in 25 farms)	192,544 (in 33,475 farms)	284,614 (1.11%)
Mexico	25,736,000 (swine crop + beginning stocks) in both commercial and backyard operations		

Source: Risk Assessments of Importing Pork into the United States From the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa; Risk Analysis Systems, PPD, APHIS, USDA.

TABLE 2.—NUMBER OF SWINE SLAUGHTERED IN MEXICAN SLAUGHTERHOUSES

[Percentage of Mexico's Total in Parentheses]

State	1999	2000 *
Baja California	16,399 (0.15%)	7,660 (0.13%)
Baja California Sur	9,044 (0.08%)	4,612 (0.08%)
Chihuahua	60,634 (0.55%)	31,117 (0.54%)
Sinaloa	132,298 (1.19%)	63,639 (1.11%)
Mexico	11,110,978	5,729,229

Source: Confederacion Nacional Ganadera with data from SAGARPA. Sum of TIF and municipal slaughterhouses. *As of June 30, 2000.

TABLE 3.—MEXICAN PORK (METRIC TONS)

Calendar Year	1999	2000	2001
Production	994,000	1,035,000	1,065,000
Imports	143,000	276,000	300,000
Total supply	1,137,000	1,311,000	1,365,000
Exports	33,000	59,000	60,000
Domestic consumption	1,104,000	1,252,000	1,305,000
Total demand	1,137,000	1,311,000	1,365,000

Source: USDA, FAS, GAIN Report #MX2015, Mexico, Livestock & Products, Semiannual Report 2002; source for stocks is the FAOSTAT database.

TABLE 4.—MEXICAN EXPORTS OF SWINE, LIVE PURE-BREEDING—010310

	1995	1996	1997	1998	1999	2000
Quantity	8	29	22	0	0	0
Value	$5,000	$439,000	$170,000			

Source: FAS Global Agricultural Trade System using data from the UN Statistical Office.
Data: Harmonized Tariff Schedule (HS 6 Digit).

The Regulatory Flexibility Act requires that agencies specifically consider the economic effects of their rules on small entities. The domestic entities most likely to be affected by our declaring the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa free of CSF are pork producers and importers.

According to the 1997 Agricultural Census, there were about 102,106 hog and pig farms in the United States in that year, of which 93 percent received $750,000 or less in annual revenues. Agricultural operations with $750,000 or less in annual receipts are considered small entities, according to the Small Business Administration's size criteria.

We do not anticipate that any U.S. entities (*i.e.*, importers of swine and pork and pork products, and swine and pork producers), small or otherwise, will experience any negative economic effects as a result of this rule. This is because the amount of pork, pork products, live swine, and swine semen likely to be imported into the United States from Chihuahua and Sinaloa is

negligible. We expect that the amount of these articles likely to be imported from Baja California and Baja California Sur will either be less than that from the other two States or none at all.

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.

Executive Order 12988

This final rule has been reviewed under Executive Order 12988, Civil Justice Reform. This rule: (1) Preempts all State and local laws and regulations that are inconsistent with this rule; (2) has no retroactive effect; and (3) does not require administrative proceedings before parties may file suit in court challenging this rule.

Paperwork Reduction Act

This final rule contains an information collection requirement that was not included in the proposed rule. Specifically, this final rule requires 50 burden hours for a certification that will have to be completed by Federal animal health authorities in Mexico to ensure that, prior to importation into the United States, live swine, pork, and pork products from Baja California, Baja California Sur, Chihuahua, and Sinaloa are not commingled with live swine, pork, and pork products from CSF-affected regions. In accordance with section 3507(j) of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), we submitted this information collection requirement for approval to the Office of Management and Budget (OMB). OMB has approved the information collection for a period of 6 months under control number 0579–0230. We plan, in the near future, to request continuation of that approval for 3 years.

Government Paperwork Elimination Act Compliance

The Animal and Plant Health Inspection Service is committed to compliance with the Government Paperwork Elimination Act (GPEA), which requires Government agencies in general to provide the public the option of submitting information or transacting business electronically to the maximum extent possible. For information pertinent to GPEA compliance related to this rule, please contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

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.

■ Accordingly, we are amending 9 CFR part 94 as follows:

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

■ 1. The authority citation for part 94 continues to read as follows:

Authority: 7 U.S.C. 450, 7701–7772, and 8301–8317; 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.

§ 94.9 [Amended]

■ 2. In § 94.9, paragraph (a) is amended by adding the words ''the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa;'' after the words ''Isle of Man;''.

§ 94.10 [Amended]

■ 3. In § 94.10, paragraph (a) is amended by adding the words ''the Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa;'' after the words ''Isle of Man;''

■ 4. A new § 94.24 is added to read as follows:

§ 94.24 Restrictions on the importation of live swine, pork, or pork products from Baja California, Baja California Sur, Chihuahua, and Sinaloa.

The Mexican States of Baja California, Baja California Sur, Chihuahua, and Sinaloa, which are declared to be free of classical swine fever (CSF) in §§ 94.9 and 94.10, supplement their pork supplies with fresh (chilled or frozen) pork imported from regions designated in §§ 94.9 and 94.10 as being affected by CSF, share a common land border with CSF-affected regions, or import live swine from CSF-affected regions under conditions less restrictive than would be acceptable for importation into the United States. Thus, there exists a possibility that live swine, pork, or pork products from the CSF-free regions listed in this section may be commingled with live swine, pork, or pork products from CSF-affected regions, resulting in a risk of CSF introduction into the United States. Therefore, live swine, pork, or pork products and shipstores, airplane meals, and baggage containing pork or pork products, other than those articles regulated under part 95 or part 96 of this chapter, originating in the CSF-free regions listed in this section shall not be brought into the United States unless the following requirements are met in addition to other applicable requirements of parts 93 and 327 of this title:

(a) *Live swine.* The swine must be accompanied by a certification issued by a full-time salaried veterinary officer of the Government of Mexico. Upon arrival of the swine in the United States, the certification must be presented to an authorized inspector at the port of arrival. The certification must identify both the exporting region and the region of origin as a region designated in §§ 94.9 and 94.10 as free of classical swine fever at the time the swine were in the region and must state that:

(1) The swine have not lived in a region designated in §§ 94.9 and 94.10 as affected with classical swine fever.

(2) The swine have never been commingled with swine that have been in a region that is designated in §§ 94.9 and 94.10 as affected with classical swine fever;

(3) The swine have not transited through a region designated in §§ 94.9 and 94.10 as affected with classical swine fever unless moved directly through the region to their destination in a sealed means of conveyance with the seal intact upon arrival at the point of destination; and

(4) The conveyances or materials used in transporting the swine, if previously used for transporting swine, have been cleaned and disinfected in accordance with the requirements of § 93.502 of this subchapter.

(b) *Pork or pork products.* The pork or pork products must be accompanied by a certification issued by a full-time salaried veterinary officer of the Government of Mexico. Upon arrival of the pork or pork products in the United States, the certification must be presented to an authorized inspector at the port of arrival. The certification must identify both the exporting region and the region of origin of the pork or pork products as a region designated in §§ 94.9 and 94.10 as free of classical swine fever at the time the pork or pork products were in the region and must state that:

(1) The pork or pork products were derived from swine that were born and raised in a region designated in §§ 94.9 and 94.10 as free of classical swine fever and were slaughtered in such a region at a federally inspected slaughter plant that is under the direct supervision of a full-time salaried veterinarian of the Government of Mexico and that is eligible to have its products imported into the United States under the Federal Meat Inspection Act (21 U.S.C. 601 *et*

seq.) and the regulations in § 327.2 of this title;

(2) The pork or pork products have never been commingled with pork or pork products that have been in a region that is designated in §§ 94.9 and 94.10 as affected with classical swine fever;

(3) The pork or pork products have not transited through a region designated in §§ 94.9 and 94.10 as affected with classical swine fever unless moved directly through the region to their destination in a sealed means of conveyance with the seal intact upon arrival at the point of destination; and

(4) If processed, the pork or pork products were processed in a region designated in §§ 94.9 and 94.10 as free of classical swine fever in a federally inspected processing plant that is under the direct supervision of a full-time salaried veterinary official of the Government of Mexico.

(Approved by the Office of Management and Budget under control number 0579–0230)

Done in Washington, DC, this 7th day of August, 2003.

Peter Fernandez,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 03–20488 Filed 8–11–03; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2003–NM–141–AD; Amendment 39–13262; AD 2003–16–09]

RIN 2120–AA64

Airworthiness Directives; Learjet Model 45 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that is applicable to certain Learjet Model 45 airplanes. This action incorporates a reduced life-limit replacement interval for certain shear pins in the trunnion assemblies of the main landing gears (MLG) into the airworthiness limitations section of the Instructions for Continued Airworthiness, and requires replacement of those certain shear pins with new, improved shear pins. This action is necessary to prevent failure of the shear pins in the trunnion assemblies of the MLGs, which could result in the collapse of a MLG, and consequent reduced controllability of the airplane during takeoff or landing. This action is intended to address the identified unsafe condition.

DATES: Effective August 27, 2003.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of August 27, 2003.

Comments for inclusion in the Rules Docket must be received on or before October 14, 2003.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 2003–NM–141–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays. Comments may be submitted via fax to (425) 227–1232. Comments may also be sent via the Internet using the following address: *9-anm-iarcomment@faa.gov*. Comments sent via the Internet must contain ''Docket No. 2003–NM–141–AD'' in the subject line and need not be submitted in triplicate. Comments sent via fax or the Internet as attached electronic files must be formatted in Microsoft Word 97 or 2000 or ASCII text.

The service information referenced in this AD may be obtained from Learjet, Inc., One Learjet Way, Wichita, Kansas 67209–2942. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; at the FAA, Wichita Aircraft Certification Office, 1801 Airport Road, Room 100, Mid-Continent Airport, Wichita, Kansas; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Greg Davied, Aerospace Engineer, Airframe and Propulsion Branch, ACE–118W, FAA, Wichita Aircraft Certification Office, 1801 Airport Road, Room 100, Mid-Continent Airport, Wichita, Kansas 67209; telephone (316) 946–4128; fax (316) 946–4107.

SUPPLEMENTARY INFORMATION: The airplane manufacturer notified the FAA that results of fatigue testing conducted on the main landing gears (MLG) of Learjet Model 45 airplanes indicate that certain shear pins in the trunnion assemblies of the MLGs do not meet their expected life limit of 20,000 total landings. The shear pins in the trunnion assemblies are made of a material that allows hydrogen to penetrate the surface of the material, causing the material to become brittle. Under impact or dynamic loading such as landing, the brittle material could fracture or shatter causing the shear pin(s) to fail before reaching the expected life limit. This type of hydrogen penetration usually occurs during the manufacturing process.

The results of fatigue testing also indicate that the shear pin bushings in the trunnion fitting housings had migrated outward from the fitting, which further weakened the shear pins and contributed to their premature failure.

This condition, if not corrected, could result in the collapse of a MLG, and consequent reduced controllability of the airplane during takeoff or landing.

Explanation of Relevant Service Information

The FAA has reviewed and approved Bombardier Service Bulletin 45–57–6, dated June 9, 2003, which describes procedures for replacing certain shear pins in the trunnion assemblies of the MLGs with new, improved shear pins. This replacement also includes reidentifying the trunnion assemblies. The new, improved shear pins have a maximum life limit of 1,800 total landings.

In addition, we have reviewed Revision 32 of Chapter 4–11–00, dated June 13, 2003, of the Learjet 45 Maintenance Manual. Page 2 of Chapter 4–11–00 specifies a maximum life limit of 1,800 landings for the shear pins in the trunnion assemblies of the MLGs.

Accomplishment of the actions specified in the service bulletin and Learjet 45 Maintenance Manual is intended to adequately address the identified unsafe condition.

Explanation of the Requirements of the Rule

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, this AD incorporates a reduced replacement interval for certain shear pins in the trunnion assemblies of the MLGs into the airworthiness limitations section of the Instructions for Continued Airworthiness, and requires replacement of those certain shear pins with new, improved shear pins. The actions are required to be accomplished in accordance with the service bulletin and Learjet 45 Maintenance Manual described previously, except as discussed below.

Differences Between This AD and the Service Bulletin

Operators should note that this AD is applicable to Learjet Model 45 airplanes, serial numbers (S/N) 45–005 through 45–208 inclusive, 45–210 through 45–222 inclusive, 45–224, 45–225, 45–227, and 45–229 through 45–231 inclusive. The effectivity of Bombardier Service Bulletin 45–57–6 lists Model 45 airplanes, S/N 45–005 through 45–222 inclusive, 45–224, 45–225, and 45–229 through 45–232 inclusive. Since that service bulletin was issued, the manufacturer has determined that the affected airplanes listed in that service bulletin are incorrect and has advised us that it will revise Service Bulletin 45–57–6 to apply to the correct airplanes subject to the unsafe condition described previously. We agree with the manufacturer's determination and have made this AD applicable to those correctly identified airplanes.

Operators should also note that, although the Accomplishment Instructions of the service bulletin describe procedures for reporting compliance with the service bulletin to the airplane manufacturer, this AD does not include such a requirement.

Changes to 14 CFR Part 39/Effect on the AD

On July 10, 2002, the FAA issued a new version of 14 CFR part 39 (67 FR 47997, July 22, 2002), which governs the FAA's airworthiness directives system. The regulation now includes material that relates to altered products, special flight permits, and alternative methods of compliance (AMOCs). Because we have now included this material in part 39, only the office authorized to approve AMOCs is identified in each individual AD. However, Note 1 of this AD has been included to address material that relates to altered products.

Determination of Rule's Effective Date

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 shall 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.

Submit comments using the following format:

- Organize comments issue-by-issue. For example, discuss a request to change the compliance time and a request to change the service bulletin reference as two separate issues.
- For each issue, state what specific change to the AD is being requested.
- Include justification (*e.g.*, reasons or data) for each request.

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 rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket Number 2003–NM–141–AD.'' The postcard will be date stamped and returned to the commenter.

Regulatory Impact

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

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and that it 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:

2003–16–09 Learjet: Amendment 39–13262. Docket 2003–NM–141–AD.

Applicability: Model 45 airplanes, serial numbers 45–005 through 45–208 inclusive, 45–210 through 45–222 inclusive, 45–224, 45–225, 45–227, and 45–229 through 45–231 inclusive; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent failure of the shear pins in the trunnion assemblies of the main landing gears (MLG), which could result in the collapse of a MLG, and consequent reduced controllability of the airplane during takeoff or landing; accomplish the following:

Note 1: This AD requires revisions to certain operator maintenance documents to include new replacements. Compliance with these replacements is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by these replacements, the operator may not be able to accomplish the replacements described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance in accordance with paragraph (e) of this AD. The request should include a description of changes to the required replacements that will ensure the continued damage tolerance of the affected structure. The FAA has provided guidance for this determination in Advisory Circular (AC) 25–1529.

Revision to the Airworthiness Limitations Section of the Instructions for Continuing Airworthiness

(a) Within 14 days after the effective date of this AD, revise the airworthiness limitations (AWL) section of the Instructions for Continued Airworthiness by inserting the instructions for Inspection Reference Numbers (IRN) J3220041, J3220042, and J3220043 (shear pins); as specified on page 2 of Chapter 4–11–00, Revision 32, dated June 13, 2003, of the Learjet 45 Maintenance Manual; into the AWL section. Thereafter, except as provided in paragraph (e) of this AD, no alternative replacement interval may be approved for the shear pins in the trunnion assemblies of the MLGs.

Shear Pin Replacement

(b) Prior to the accumulation of 1,800 total landings on the shear pins, or within 100 landings after the effective date of this AD, whichever occurs later: Replace the shear pins, having part number (P/N) 4532103015–001V1088, 4532103015–003, 4532103025–001V1088, or 4532103026–001V1088 located in the trunnion assemblies of the MLGs with new, improved shear pins (including reidentifying the trunnion assemblies); per the Accomplishment Instructions of Bombardier Service Bulletin 45–57–6, dated June 9, 2003.

Parts Installation

(c) As of the effective date of this AD, no person may install on any airplane, a shear pin having P/N 4532103015–001V1088, 4532103015–003, 4532103025–001V1088, or 4532103026–001V1088 in the trunnion assemblies of the MLGs.

Information Submission

(d) Although the service bulletin referenced in this AD specifies to submit information to the airplane manufacturer, this AD does not include such a requirement.

Alternative Methods of Compliance

(e) In accordance with 14 CFR 39.19, the Manager, Wichita Aircraft Certification Office (ACO), FAA, is authorized to approve alternative methods of compliance for this AD.

Incorporation by Reference

(f) Unless otherwise specified by this AD, the actions shall be done per Bombardier Service Bulletin 45–57–6, dated June 9, 2003. 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 Learjet, Inc., One Learjet Way, Wichita, Kansas 67209–2942. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; at the FAA, Wichita Aircraft Certification Office, 1801 Airport Road, Room 100, Mid-Continent Airport, Wichita, Kansas; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Effective Date

(g) This amendment becomes effective on August 27, 2003.

Issued in Renton, Washington, on August 4, 2003.

Ali Bahrami,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 03–20238 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–01–ANM–16; Airspace Docket No. 02–AMM–16]

Establishment of Class E Airspace at Richfield Municipal Airport, Richfield, UT

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; correction.

SUMMARY: This action corrects an error in the longitude of the east boundary description of the newly established Class E airspace at Richfield Municipal Airport, Richfield, UT, that was published on May 7, 2003 (68 FR 24341), Airspace Docket 01–ANM–16

EFFECTIVE DATE: 0901 UTC, October 4, 2003.

FOR FURTHER INFORMATION CONTACT: Ed Haeseker, ANM–520.7; telephone (425) 227–2527; Federal Aviation Administration, Docket No. 01–ANM–16, 1601 Lind Avenue SW., Renton, Washington 98055–4056.

SUPPLEMENTARY INFORMATION:

History: Airspace Docket 01–ANM–16 published on May 7, 2003 (68 FR 24341), established Class E Airspace at Richfield Municipal Airport, Richfield, UT effective date of May 7, 2003. An error was discovered in the published description for the East side Class E Airspace boundary of the Richfield Municipal Airport, Richfield, UT. This action corrects that error.

■ Accordingly, 14 CFR part 71 is corrected by making the following correcting amendments:

PART 71—[AMENDED]

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

■ 1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Corrected]

■ 2. The geographic coordinates for the East side of the Class E Airspace boundary of the Richfield Municipal Airport, Richfield, UT, as published in the **Federal Register** on May 7, 2003 (68 FR 24341), (Airspace Docket 01–ANM–16); page 24342, column 1, are corrected as follows:

* * * * *

ANM UT E5 Richfield, UT [Amended]

[Lat. N38°44′11″, long. W112°05′56″;]

That airspace extending upward from 700 feet above the surface of the earth within 7.5 mile radius of the Richfield Municipal Airport; and that airspace extending upward from 1,200 feet, above the surface of the earth bounded by a line beginning at lat. N39°24′30″, long. W112°27′41″, to lat. N39°16′00″, long. W112°00′00″, to lat. N39°42′00″, long. W110°54′00″, to lat. N39°27′00″, long. W110°46′00″, to lat. N39°03′00″, long. W111°30′00″, to lat. N38°31′15″, long. W110°36′00″, to lat. N38°20′00″, long. W110°48′00″, to lat. N38°40′00″, long W111°47′00″, to lat. N38°16′40″, long. W112°36′40″, to lat. N38°29′00″, long. W112°53′00″, to lat. N39°11′30″, long. W112°34′00″; thence to the point of origin; excluding that airspace within Federal Airways and the Price, UT, Huntington, UT, Milford, UT, and Delta, UT Class E airspace.

* * * * *

Issued in Seattle, Washington, July 28, 2003.

John L. Pipes,

Acting Manager, Air traffic Division, Northwest Mountain Region.

[FR Doc. 03–20408 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2003–15719; Airspace Docket No. 03–ACE–61]

Modification of Class E Airspace; Seward, NE

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; request for comments.

SUMMARY: An examination of controlled airspace for Seward, NE revealed discrepancies in the Seward Municipal Airport airport reference point and in the location of the Seward nondirectional radio beacon (NDB), both used in the legal description for the Seward, NE Class E airspace area. This action corrects the discrepancies by modifying the Seward, NE Class E airspace and by incorporating the current Seward Municipal Airport airport reference point and the current

location of the Seward NDB in the Class E airspace legal description.

EFFECTIVE DATE: This direct final rule is effective on 0901 UTC, December 25, 2003. Comments for inclusion in the Rules Docket must be received on or before September 25, 2003.

ADDRESSES: Send comments on this rule 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–2003–15719/Airspace Docket No. 03–ACE–61, at the beginning of your comments. You may also submit comments on the Internet at *http://www.dms.dot.gov.* You may review the public docket containing the proposal, 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 Docket Office (telephone 1–800–647–5527) is on the plaza level of the Department of Transportation NASSIF Building at the above address.

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

SUPPLEMENTARY INFORMATION: This amendment to 14 CFR 71 modifies the Class E airspace area extending upward from 700 feet above the surface at Seward, NE. It incorporates the current airport reference point for Seward Municipal Airport and the current location of the Seward NDB. It brings the legal description of this airspace area into compliance with FAA Order 7400.2E, Procedures for Handling Airspace Matters. The area will be depicted on appropriate aeronautical charts. Class E 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 will be published subsequently in the Order.

The Direct Final Rule Procedure

The FAA anticipates that this regulation will not result in adverse or negative comment and, therefore, is issuing it as a direct final rule. Previous actions of this nature have not been controversial and have not resulted in adverse comments or objections. Unless a written adverse or negative comment, or a written notice of intent to submit an adverse or negative comment is received within the comment period, the regulation will become effective on the date specified above. After the close of the comment period, the FAA will publish a document in the **Federal Register** indicating that no adverse or negative comments were received and conforming the date on which the final rule will become effective. If the FAA does receive, within the comment period, an adverse or negative comment, or written notice of intent to submit such a comment, a document withdrawing the direct final rule will be published in the **Federal Register**, and a notice of proposed rulemaking may be published with a new comment period.

Comments Invited

Interested parties are invited to participate in this rulemaking by submitting such written data, views, or arguments, as they may advise. 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, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify both docket numbers and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. FAA–2003–15710/Airspace Docket No. 03–ACE–61.'' The postcard will be date/time stamped and returned to the commenter.

Agency Findings

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.

The FAA has determined that this regulation is noncontroversial and unlikely to result in adverse or negative comments. For the reasons discussed in the preamble, I certify that this regulation (1) is not a ''significant regulatory action;'' under Executive Order 12866; (2) is not a ''significant rule'' under Department of Transportation (DOT) Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, 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.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

■ Accordingly, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

■ 1. The authority citation for part 71 continues to read as follows:

Authority: U.S.C. 106(g), 40103, 40113, 40120; E.O. 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, dated August 30, 2002, and effective September 16, 2002, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth

* * * * *

ACE NE E5 Seward, NE

Seward Municipal Airport, NE
(Lat. 40°51′53″ N., long. 97°06′33″ W.)
Seward NDB
(Lat. 40°51′41″ N., long. 97°06′43″ W.)

The airspace extending upward from 700 feet above the surface within a 6.4-mile radius of Seward Municipal Airport and within 4 miles each side of the 166° bearing from the Seward NDB extending from the 6.4-mile radius to 14 miles southeast of the NDB and within 4 miles each side of the 359° bearing from the Seward NDB extending from the 6.4-mile radius to 13 miles north of the NDB.

* * * * *

Issued in Kansas City, MO, on July 28, 2003.

Herman J. Lyons, Jr.

Manager, Air Traffic Division, Central Region.

[FR Doc. 03–20407 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2003–15628; Airspace Docket No. 03–AWP–10]

Modification of Class E Airspace; Waimea-Kohala Airport, HI

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; request for comments.

SUMMARY: An Area Navigation (RNAV) Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) RNAV (GPS) Runway (RWY) 04/22 SIAP and a VHF Navigation Aid/Distance Measuring Equipment (VOR/DME) RWY 22/04 SIAP have been developed to serve Waimea-Kohala Airport, Kamuela, HI. This action expands Class E airspace extending upward from 700 feet or more above the surface at Waimea-Kohala Airport to contain aircraft executing these approaches. This action provides controlled airspace for Instrument Flight Rules (IFR) operations.

DATES: This direct final rule is effective on 0901 UTC, October 30, 2003. Comments for inclusion in the Rules Docket must be received on or before August 29, 2003.

ADDRESSES: Send comments on this rule 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–2003–15628/Airspace Docket No. 03–AWP–10, at the beginning of your comments. You may also submit comments on the Internet at *http://dms.dot.gov.* You may review the public docket containing the proposal, any comments received, and any final dispositions in person in the Docket Office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone 1–800–647–5527) is on the plaza level of the Department of Transportation NASSIF Building at the above address.

FOR FURTHER INFORMATION CONTACT: Debra Trindle, Air Traffic Division, Airspace Branch, AWP–520, Western-Pacific Region, Federal Aviation Administration, 15000 Aviation Boulevard, Lawndale, California 90261, telephone (310) 725–6613.

SUPPLEMENTARY INFORMATION: This amendment to 14 CFR part 71 modifies the Class E airspace at Waimea-Kohala, HI. An RNAV (GPS) RWY 22/04 SIAP and a VOR/DME RWY 22/04 SIAP have been developed to serve Waimea-Kohala Airport, HI. These SIAPs require additional controlled airspace to contain aircraft executing the new approach procedures. This action expands Class E airspace to support Instrument Flight Rules (IFR) operations to Waimea-Kohala Airport, Kamuela, HI. Class E 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 will be published subsequently in the Order.

The Direct Final Rule Procedure

The FAA anticipates that this regulation will not result in adverse or negative comment and therefore is issuing it as a direct final rule. Previous actions of this nature have not been controversial and have not resulted in adverse comments or objections. Unless a written adverse or negative comment, or a written notice of intent to submit an adverse or negative comment is received within the comment period, the regulation will become effective on the date specified above. After the close of the comment period, the FAA will publish a document in the **Federal Register** indicating that no adverse or negative comments were received and confirming the date on which the final rule will become effective. If the FAA does receive, within the comment period, an adverse or negative comment, or written notice of intent to submit such a comment, a document withdrawing the direct final rule will be published in the **Federal Register**, and a notice of proposed rulemaking may be published with a new comment period.

Comments Invited

Although this action is the form of a final rule and was not preceded by a notice of proposed rulemaking, comments are invited on this rule. Interested persons are invited to comment on this rule by submitting such written data, view, 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 or withdrawn in light of the comments received. Factual information that supports the commenter's ideas and suggestions is extremely helpful in evaluating the effectiveness of this action and determining whether additional rulemaking action is 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 action will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 03–AWP–10.'' The postcard will be date stamped and returned to the commenter.

Agency Findings

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.

The FAA has determined that this regulation is noncontroversial and unlikely to result in adverse or negative comments. For the reasons discussed in the preamble, this regulation only involves an established body of technical regulations that require frequent and routine amendments to keep operationally current. Therefore, this regulation—(1) Is not a ''significant regulatory action'' under Executive Order 12866; (20 is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) if promulgated, 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.

List of Subjects in CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

■ Accordingly, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120: E.O. 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 the Federal Aviation Administration Order 7400.9K, dated August 30, 2002, and effective September 16, 2002, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AWP HI E5 Waimea-Kohala, HI [Revised]

Waimea-Kohala Airport, HI
(Lat. 200°00′05″ N, long. 155°40′05″ W)
Kamuela VOR/DME
(Lat. 19°59′53″ N, long. 155°40′12″ W)

That airspace extending upward from 700 feet above the surface within a 6.4-mile radius of the Waimea-Kohala Airport and within 2 miles each side of the Kamuela VOR/DME 068° radial, extending from the 6.4-mile radius 12.6 miles northeast of the Kamuela VOR/DME and within 2 miles each side of the Kamuela VOR/DME 246° extending from the 6.4-mile radius to the 13.4 miles southwest of the Kamuela VOR/DME

* * * * *

Issued in Los Angeles, California, on July 23, 2003.

Stephen J. Lloyd,

Acting Manager, Air Traffic Division, Western-Pacific Region.

[FR Doc. 03–20406 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF JUSTICE

Bureau of Prisons

28 CFR Part 549

[BOP–1086–F]

RIN 1120–AA81

Over-The-Counter (OTC) Medications

AGENCY: Bureau of Prisons, Justice.

ACTION: Final rule.

SUMMARY: In this document, the Bureau of Prisons (Bureau) establishes procedures governing inmate access to Over-The-Counter (OTC) medications. Currently, the inmate population can only buy approved OTC medications through the commissary at their institutions. Our commissaries will continue to sell medications such as aspirin, acetaminophen, ibuprofen, chlorpheniramine, antacids, hemorrhoidal ointment, hydrocortisone cream, and a fiber supplement (*e.g.* Metamucil®), and other such medications used for symptomatic relief of common conditions. For inmates in inpatient status at our medical referral facilities, we will continue dispensing OTC medications at sick call. For all other inmates, we will continue dispensing OTC medications at sick call to inmates in the general population only if the inmate does not already have the OTC medication, and health services staff determine there is an immediate medical need which must be addressed before the inmate's regularly scheduled commissary visit, or that the inmate has no funds.

We intend that these procedures will help us allocate medical resources efficiently and cost-effectively, while remaining consistent with the Bureau's scope of services which meet inmates' medically mandatory and medically necessary needs.

EFFECTIVE DATE: September 11, 2003.

ADDRESSES: Rules Unit, Office of General Counsel, Bureau of Prisons, 320 First Street, NW., Washington, DC 20534.

FOR FURTHER INFORMATION CONTACT: Sarah Qureshi, Office of General Counsel, Bureau of Prisons, phone (202) 307–2105.

SUPPLEMENTARY INFORMATION: We amend our regulations on Over-The-Counter (OTC) medications (28 CFR part 549, subpart B). We published a proposed rule on this subject in the **Federal Register** on March 1, 1999 (64 FR 10094).

Summary of Public Comment

We received six comments. One generally supported the proposed rule, but five commenters objected.

Citing statutory authority requiring the Bureau to provide for the subsistence of persons charged to its custody, one commenter alleged that the proposed rule promoted the Bureau's economic interests over inmates' health needs and would further erode the quality of health care available to inmates.

This commenter argued that conditions in Bureau facilities leave inmates vulnerable to infection. The commenter further stated that Bureau health services staff do not act responsibly. For example, the commenter states that, at one institution, sick call appointments may be scheduled 3 to 5 work days after the initial request. The commenter suggests that this is intended to discourage inmates from coming to sick call and that requiring inmates to buy OTC medications would deter inmates from making sick call appointments. The commenter further charges that the Bureau would use profits from the sale of OTC medications to fund tort claim or law suit settlements.

Two additional commenters alleged that costs associated with the upkeep of inmates are the government's responsibility and should remain so. These commenters also objected to the pricing of OTC medications currently available in the institution's commissary. One commenter suggested that if the cost of OTC medications was passed on to the inmate, the inmate should be given a wider choice of medications. The other commenter alleged that staff were likely to abuse the administration of the proposed regulations and that staff improperly followed outdated procedures for addressing inmate complaints. The commenter also criticized the general quality of staff and the level of professional training available to staff.

Another commenter stated that having OTC medications available through the commissary does not justify discontinuing sick call distribution. This commenter states that access to the commissary at some institutions is limited to one scheduled visit per week, that the commissary closes quarterly for inventory, and that the medications are not affordable or are overpriced. This commenter suggested that the proposed procedures may encourage inmates to break other Bureau rules, namely the prohibition on sharing personal property with other inmates.

One commenter believes it is dangerous to permit mental health patients to purchase OTC medications which may adversely interact with prescribed medications. Another also objected to potential negative interactions between prescribed and OTC medications.

Another commenter raised administrative procedural objections to the proposed rule and various Bureau policies for providing inmate health care. This commenter stated that the proposed rule did not cite a need for the change nor expected results from application of the new regulation. The commenter argued that OTC medications can be used for illnesses, and consequently the Bureau is contradicting itself when it states that OTC medications are being used for cosmetic and general hygiene issues.

The commenter also disagreed with the Bureau's assertion that inmate health care conformed to community standards. The commenter criticized the actual provisioning of health care to inmates, citing as an example alleged misdiagnosis of a ''rash of illness over night among the prisoners'' at a Bureau institution.

Agency Response to Public Comment

Administrative Procedure. Procedures for providing for the health needs of inmates in federal facilities are in the Bureau's Health Services Manual. Because these procedures conform to the community standard of medical care (requiring us to meet inmates' medically mandatory and medically necessary needs), the procedures do not require separate rulemaking.

In instances where correctional management needs require adjustments to the procedures, we do go through rulemaking. For example, special provisions dealing with correctional management needs and chronic infectious disease are in 28 CFR part 549, subpart A.

The provisions for OTC medications are another example where we go through rulemaking because of our correctional management needs. We believe these regulations are necessary to allocate medical resources efficiently and cost-effectively.

The regulation should promote efficiency because Bureau health services staff will not need to see an inmate merely to dispense OTC medications. Health services staff can then devote more time to necessary medical care needs of inmates which they can only address through prescribed medications.

Also, limiting free distribution of OTC medications reduces government expenses. While requiring the inmate to purchase OTC medications may increase costs to the inmate, doing so will prepare inmates for post-incarceration life where individuals have the opportunity and responsibility to address their health care needs through sensible and prudent use of OTC medications.

Providing Health Care. By statute, we must provide for the safekeeping, care, and subsistence of the inmates in our custody. Title 18 of the United States Code, section 4042(a)(2) states that, with regard to inmates, we must ''provide for their proper government, discipline, treatment, care, rehabilitation, and reformation.''

We disagree with the comments that this rule will compromise our obligation to provide ''treatment'' and ''care'' to inmates or that inmates'' health is being used as the target of a money-making enterprise. This rule will, in fact, improve the quality of health care available to inmates: While continuing to meet inmates' medical needs by providing OTC medications in the commissary, we will free valuable medical staff time to more effectively meet inmates' medical needs.

In fact, only OTC medications that are approved by the Pharmacy and Therapeutics Committee (the Bureau's national formulary board) are available for sale in institution commissaries. Under this regulation, our commissaries will continue to sell OTCs such as aspirin, acetaminophen, ibuprofen, chlorpheniramine, antacids, hemorrhoidal ointment, hydrocortisone cream, and a fiber supplement (*e.g.* Metamucil®), and all other such medications that are available at the institution commissary.

It is consistent with community standards to expect inmates to responsibly, sensibly and prudently use OTC medications. While inmates can get various OTC medications through the institution commissary, some may choose to get these same medications for free through sick call.

The impact for the Bureau's medical resources is not limited merely to the cost of the free OTC medications dispensed at sick call, but also includes health services staff time, which could be more efficiently used during greater medical urgency. An inmate who needs to be evaluated by health care staff ought not to be deterred by the revised procedures. Instead of detracting from our quality of health care, this rule will allow us to use our health care resources where and when the inmates need them the most, thereby improving the quality of health care for inmates.

To clarify that we will still dispense OTC medications to those who do not have ready access to commissary purchases, we state in the rule that it applies to all inmates except those in inpatient status at Federal Medical Centers. Those in inpatient status who, necessarily, do not have commissary access, will receive OTC medications as needed. All other inmates, who have commissary access and are physically able to purchase OTC medications at the commissary will be required to do so by this rule.

Examples cited by some of the commenters of alleged excessive delay in scheduling sick call appointments may well be explained by the need for health services staff to spend time with inmates who attend sick call primarily to receive free OTC medications.

Commissary Sales. National policy established by the FDA and the Department of Health and Human Services specifies what medical items, including OTC medications, our commissaries may sell, and a national Pharmacy and Therapeutics Committee (a Bureau formulary committee composed of a group of accredited pharmacists) annually reviews and modifies the list of permissible OTC medications. The committee reviews medications to ensure that, before we sell or give them to inmates as ''OTC medications'', they are dispensed ''over the counter'' in the public community. In this way, we ensure that we conform to the community standard of medical care. The committee must give us permission before we may sell ''OTC medications'' to inmates in our commissaries.

We operate the commissary under generally accepted accounting principles. We use profits from commissary sales to provide benefits to inmates in general. We do not use profits to fund tort claim or law suit settlements.

Because of limitations imposed by the correctional setting, the institution commissary cannot offer the variety of items possibly available at local retailers. The commissary does not compete with local retailers, and we are not obligated to provide the lowest price on any particular item.

In any case, as noted above, profits from commissary sales are used for the general benefit of inmates. Even so, we conducted surveys comparing the prices of identical or similar items sold in retail convenience stores and supermarkets in the community surrounding the correctional institutions to assist in pricing policies.

One survey of 50 commissary items was conducted at the following locations: LSCI Allenwood, FPC Alderson, USP Leavenworth, FCI Dublin, FMC Fort Worth, and FCI Miami. We compared the prices of commissary items to identical or similar items in a local retail convenience store and a local supermarket at each location. In 70 percent of the comparisons, we found that the items surveyed were less expensive in the commissaries than in the local convenience stores and supermarkets.

While we limit access to the institution commissary, the proposed regulations allow for exceptions where health services staff determine that the inmate has an immediate medical need which must be addressed before the inmate's regularly scheduled commissary visit (*see* § 549.30(a)). The proposed regulations also allow for exceptions where the inmate does not have access to the commissary because

the inmate is in administrative detention or special housing.

Inmates Without Funds. The proposed regulations also allow for exceptions to be made for inmates without funds. In the final rule, we define an inmate without funds as one who has had an average daily trust fund account balance of less than $6.00 for the past 30 days. This definition is similar to that used in the Bureau's inmate telephone regulations (*see* § 540.105(b)) and in implementing instructions for payment of postage procedures (§ 540.21(d) and (e)). We believe this definition has proved to be both warranted and reasonable.

Interactions. Federal law and Bureau policy addresses issues on drug interactions between prescribed and OTC medications. These laws and our policy require verbal and/or written counseling information for all prescription drugs. When we prescribe such drugs, we give inmates information about potential drug-drug and drug-food interactions, including those with OTC medications.

Also, the regulations specify that Bureau medical centers (that is, the U.S. Medical Center for Federal Prisoners, other Federal Medical Centers, and psychiatric referral centers) will continue dispensing OTC medications through sick call, where inmates taking complex medication regimens, or inmates with cognitive impairments, would be at higher risk of inadvertent drug interactions with OTC medications.

Commissary procedures on the amount of items sold through the commissary serve to minimize the potential for misuse of purchased OTC medications.

Miscellaneous Issues. We believe that our discipline policy (*see* 28 CFR part 541, subpart B) will discourage inmates from violating Bureau regulations.

Concerns expressed over possible abuse of the administration of the proposed regulations, training available to staff, or over the general quality of staff are not relevant to the procedures of this specific proposed rule. Our administrative remedy program (*see* 28 CFR part 542) permits inmates to seek formal review of issues which relate to their confinement and is the appropriate channel to seek redress.

One commenter alleged that the administrative remedy program itself is outdated and improperly followed by staff. We disagree. Nevertheless, we will be revising the regulations for the administrative remedy program as part of the ''plain language'' initiative.

Members of the public may submit further comments concerning this rule by writing to the previously cited address. We will consider but not respond to these comments in the **Federal Register**.

Executive Order 12866

This regulation has been drafted and reviewed in accordance with Executive Order 12866, ''Regulatory Planning and Review'', section 1(b), Principles of Regulation. The Director of the Bureau of Prisons has determined that this rule is not a ''significant regulatory action'' under Executive Order 12866, section 3(f), and accordingly this rule has not been reviewed by the Office of Management and Budget.

Executive Order 13132

This regulation will not have substantial direct effects on the States, on the relationship between the national government and the States, or on distribution of power and responsibilities among the various levels of government. Under Executive Order 13132, this rule does not have sufficient federalism implications for which we would prepare a Federalism Assessment.

Regulatory Flexibility Act

The Director of the Bureau of Prisons, under the Regulatory Flexibility Act (5 U.S.C. 605(b)), reviewed this regulation. By approving it, the Director certifies that it will not have a significant economic impact upon a substantial number of small entities because: This rule is about the correctional management of offenders committed to the custody of the Attorney General or the Director of the Bureau of Prisons, and its economic impact is limited to the Bureau's appropriated funds.

Unfunded Mandates Reform Act of 1995

This rule will not cause State, local and tribal governments, or the private sector, to spend $100,000,000 or more in any one year, and it will not significantly or uniquely affect small governments. We do not need to take action under the Unfunded Mandates Reform Act of 1995.

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by § 804 of the Small Business Regulatory Enforcement Fairness Act of 1996. This rule 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.

Plain Language Instructions

We want to make Bureau documents easier to read and understand. If you can suggest how to improve the clarity of these regulations, call or write to Sarah Qureshi at the address or telephone number listed above.

List of Subjects in 28 CFR Part 549

Prisoners.

Harley G. Lappin,

Director, Bureau of Prisons.

■ Under the rulemaking authority vested in the Attorney General in 5 U.S.C. 552(a) and delegated to the Director, Bureau of Prisons, we amend 28 CFR part 549 as follows.

Subchapter C—Institutional Management

PART 549—MEDICAL SERVICES

■ 1. Revise the authority citation for 28 CFR part 549 to read as follows:

Authority: 5 U.S.C. 301; 18 U.S.C. 3621, 3622, 3624, 4001, 4005, 4042, 4045, 4081, 4082 (Repealed in part as to offenses committed on or after November 1, 1987), 4241–4247, 5006–5024 (Repealed October 12, 1984, as to offenses committed after that date), 5039; 28 U.S.C. 509, 510.

■ 2. Add a new Subpart B, consisting of §§ 549.30 and 549.31, to read as follows:

Subpart B—Over-The-Counter (OTC) Medications

Sec.

Subpart B—Over-The-Counter (OTC) Medications

§ 549.30 Purpose and scope.

This subpart establishes procedures governing inmate access to Over-The-Counter (OTC) medications for all inmates except those in inpatient status at Federal Medical Centers. Inmates may buy OTC medications which are available at the commissary. Inmates may also obtain OTC medications at sick call if the inmate does not already have the OTC medication and:

(a) Health services staff determine that the inmate has an immediate medical need which must be addressed before his or her regularly scheduled commissary visit; or

(b) The inmate is without funds.

§ 549.31 Inmates without funds.

(a) The Warden must establish procedures to provide up to two OTC medications per week for an inmate without funds. An inmate without funds

is an inmate who has had an average daily trust fund account balance of less than $6.00 for the past 30 days.

(b) An inmate without funds may obtain additional OTC medications at sick call if health services staff determine that he/she has an immediate medical need which must addressed before the inmate may again apply for OTC medications under this section.

(c) To prevent abuses of this section (*e.g.*, inmate shows a pattern of depleting his or her commissary funds before requesting OTC medications), the Warden may impose restrictions on the provisions of this section.

[FR Doc. 03–20491 Filed 8–11–03; 8:45 am]

BILLING CODE 4410–05–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD07–03–071]

RIN 1625–AA09

Drawbridge Operation Regulations; Atlantic Intracoastal Waterway, Mile 964.8 at Fort Pierce, St. Lucie County, FL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is temporarily changing the regulations governing the operation of the Fort Pierce North Bridge, mile 964.8, Fort Pierce, Florida. Under this temporary final rule, the bridge need open only a single-leaf every 20 minutes. Double-leaf openings will be available on certain dates with a two-hour advance notice to the bridge tender. This temporary rule is required to allow the bridge owner to safely complete repairs to the bridge.

DATES: This rule is effective from 6 a.m. on August 1, 2003 to 8 p.m. on January 9, 2004.

ADDRESSES: Documents indicated in this preamble as being available in the docket, are part of docket CGD07–03–071, and are available for inspection or copying at Commander (obr), Seventh Coast Guard District, 909 SE. 1st Avenue, Room 432, Miami, FL 33131, between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Michael Lieberum, Project Officer, Seventh Coast Guard District, Bridge Branch at (305) 415–6744.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NRPM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Publishing an NPRM is impracticable and contrary to the public interest, because it would delay immediate and required repairs to the bridge.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. The contractor, PCL, needs to immediately perform necessary repairs to the bridge. In order to do the repairs and ensure worker and public safety, this temporary final rule is required. This temporary rule requires scheduled bridge openings, which provide for the reasonable needs of navigation, and will allow the contractor the time needed to safely repair the bridge.

Background and Purpose

The Fort Pierce North Bridge, mile 964.8 at Fort Pierce, St. Lucie County, Florida, has a vertical clearance of 26 feet at mean high water and a horizontal clearance of 45 feet between the down span and the fender system. The existing operating regulations in 33 CFR 117.5 require the bridge to open on signal.

PCL Contractors notified the Coast Guard that work was needed on the bascule leaves of the Bridge beginning May 5, 2003, and continuing until January 9, 2004. The repair involves welding deck plates, painting, and rebalancing each leaf. In order to provide for worker and public safety, they requested a 20-minute single-leaf opening schedule. Additionally, since both leaves of the Bridge will be unable to open simultaneously, two-hours advance notice will be required to effect a double-leaf opening whenever necessary. However, from 6 a.m. on August 1, 2003, to 6 p.m. on August 10, 2003, the contractor will be performing counterweight girder modifications to the Bridge, and the Bridge will not be able to effect a double-leaf opening at any time during this period, but will open only a single-leaf. This temporary final rule will facilitate immediate and necessary repairs to the Bridge and address worker and public safety issues without significantly hindering navigation.

Discussion of Rule

From 6:01 p.m. August 1, 2003, to 8 p.m. January 9, 2004, this temporary rule requires the Bridge to open a single-leaf on a 20-minute schedule and provide double-leaf openings with two hours notice to the Bridge tender. This action is necessary to facilitate bridge repairs safely without significantly hindering navigation. During this time of year, the majority of vessels that require a double-leaf opening are traversing the open ocean, and not using the Intracoastal Waterway, due to favorable, seasonal weather.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security (DHS). The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation is unnecessary, because the rule will affect only a limited amount of marine traffic.

Small Entities

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

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities, because the regulations will affect only marine traffic that require double-leaf bridge openings. The impact will be limited to providing a two-hour advance notice to the bridge tender for a double-leaf opening. For a short period, vessels that require double-leaf openings will not be able to pass through at all; however, these types of vessels would most likely be traversing the open ocean and not using the Intracoastal Waterway, due to favorable, seasonal weather.

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 temporary final rule so that they can better evaluate its effects on them and participate in the

rulemaking. If this temporary rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in **FOR FURTHER INFORMATION CONTACT**.

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

Collection of Information

This temporary final 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 this rule 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 regulatory actions not specifically required by law. 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. Although this temporary rule would not result in such an expenditure, we do discuss the effects of this rule elsewhere in the preamble.

Taking of Private Property

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

Civil Justice Reform

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

Protection of Children

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

Indian Tribal Governments

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

Energy Effects

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

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (32)(e), of the Instruction, from further environmental documentation. Under figure 2–1, paragraph (32)(e), of the Instruction, an ''Environmental Analysis Check List'' and a ''Categorical Exclusion Determination'' are not required for this rule.

List of Subjects in 33 CFR Part 117

Bridges.

■ For the reasons discussed 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; Department of Homeland Security Delegation No. 0170.1; 33 CFR 1.05–1(g); Section 117.255 also issued under authority of Pub. L. 102–587, 106 Stat. 5039.

■ 2. From 6 a.m. on August 1, 2003, until 8 p.m. on January 9, 2004, § 117.261, a new paragraph (m) is added to read as follows:

§ 117.261 Atlantic Intracoastal Waterway from St. Marys River to Key Largo.

* * * * *

(m) The North Bridge, mile 964.8 at Fort Pierce, need open only a single-leaf on the hour, 20-minutes after the hour, and 40-minutes after the hour, except that, from 6:01 p.m., August 10, 2003, until 8 p.m., January 9, 2004, both leaves of the bridge will open if the bridge tender receives a two-hour advance notice requesting a double-leaf opening.

* * * * *

Dated: July 28, 2003.

H.E. Johnson, Jr.,

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

[FR Doc. 03–20506 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD08–03–031]

Drawbridge Operating Regulation; Illinois Waterway, Joliet, IL

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Eighth Coast Guard District has issued a temporary deviation from the regulation governing the operation of the Chicago, Rock Island and Pacific Railway Drawbridge, across the Illinois Waterway, mile 287.6 at Joliet, Illinois. This deviation allows the drawbridge to remain closed to navigation for six separate increments starting at 7 a.m, September 15, 2003, and ending at 7 p.m., September 26, 2003, Central Standard Time. The deviation is

necessary to facilitate maintenance work on the bridge that is essential to the continued safe operation of the drawbridge.

DATES: This temporary deviation is effective from 7 a.m., September 15, 2003, until 7 p.m., September 26, 2003.

ADDRESSES: Materials referred to in this rule are available for inspection or copying at the office of the Eighth Coast Guard District, Bridge Administration Branch, Commander (obr), Eighth Coast Guard District, 1222 Spruce Street, St. Louis, MO 63103–2832, between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The Bridge Administration Branch maintains the public docket for this temporary deviation.

FOR FUTHER INFORMATION CONTACT: Roger K. Wiebusch, Bridge Administrator, Commander (obr), Eighth Coast Guard District, 1222 Spruce Street, St. Louis, MO 63103–2832, (314) 539–3900, extension 2378.

SUPPLEMENTARY INFORMATION: The CSX Railway Company requested a temporary deviation on July 17, 2003 for the operation of the drawbridge to allow the bridge owner time for preventative maintenance. Presently, the draw opens on signal for passage of river traffic. This deviation allows the bridge to remain closed to navigation for six separate increments from 7 a.m. until 7 p.m., September 15, 2003; from 5 a.m. until 9 p.m., September 17, 2003; from 7 a.m., until 7 p.m., September 19, 2003; from 7 a.m. until 7 p.m., September 22, 2003, from 5 a.m., until 9 p.m., September 24, 2003; and from 7 a.m. until 7 p.m., September 26, 2003. Vessels not exceeding the vertical clearance of the drawbridge may pass under the drawbridge during repairs. There are no alternate routes for vessels transiting through mile 287.6 on the Illinois Waterway. The drawbridge will be incapable of opening for emergencies during the six increment repair periods.

The Chicago, Rock Island and Pacific Railway Drawbridge provides a vertical clearance of 9.5 feet above normal pool in the closed to navigation position. Navigation on the waterway consists primarily of commercial tows and recreational watercraft. In order to replace the counterweight cables the bridge must be kept inoperative and in the closed to navigation position. This deviation has been coordinated with waterway users. No objections were received.

In accordance with 33 CFR 117.35(c), this work will be performed with all due speed in order to return the bridge to normal operation as soon as possible. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: August 4, 2003.

Roger K. Wiebusch,

Bridge Administrator.

[FR Doc. 03–20507 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[COTP Tampa–03–080]

RIN 1625–AA00

Security Zones; Tampa Bay, FL

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard has established security zones in Tampa Bay, Florida, immediately adjacent to power facilities at Big Bend, and Weedon Island. These zones are needed to ensure public safety and security in the greater Tampa Bay area. Entry into these zones is prohibited unless authorized by the Captain of the Port, or their designated representative.

DATES: This rule is effective September 1, 2003.

ADDRESSES: Comments and material received from the public, as well as documents mentioned in this preamble as being available in the docket, are part of docket [COTP Tampa–03–080] and are available for inspection or copying at Marine Safety Office Tampa, 155 Columbia Drive, Tampa, Florida 33606–3598 between 7:30 a.m. and 3 p.m. Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: LT Heath Hartley, Coast Guard Marine Safety Office Tampa, at (813) 228–2189 extension 123.

SUPPLEMENTARY INFORMATION:

Regulatory History

On April 18, 2003, we published a notice of proposed rulemaking (NPRM) entitled ''Security Zones; Tampa Bay, Florida'' in the **Federal Register** (68 FR 19166). We did not receive any letters commenting on the proposed rule. No public hearing was requested, and none was held.

Background and Purpose

The terrorist attacks of September 11, 2001, killed thousands of people and heightened the need for development of various security measures throughout the seaports of the United States, particularly those vessels and facilities which are frequented by foreign nationals and are of interest to national security. Following these attacks by well-trained and clandestine terrorists, national security and intelligence officials have warned that future terrorists attacks are likely. The Captain of the Port of Tampa has determined that these security zones are necessary to protect the public, ports, and waterways of the United States from potential subversive acts.

These security zones are similar to the existing temporary security zones established for waters around power facilities in Tampa Bay that will soon expire. The following temporary final rule, temporary final rule correction, and notice of proposed rulemaking were published in the **Federal Register:**

Security Zones; Tampa Bay, Port of Tampa, Port of Saint Petersburg, Port Manatee, Rattlesnake, Old Port Tampa, Big Bend, Weedon Island, and Crystal River, FL. (68 FR 15328, March 25, 2003). This temporary final rule established 15 security zones including security zones at Weedon Island and Big Bend Power Facilities. These zones were extended through June 30, 2003.

Security Zones; Tampa Bay, Port of Tampa, Port of Saint Petersburg, Port Manatee, Rattlesnake, Old Port Tampa, Big Bend, Weedon Island, and Crystal River, FL; Correction. (68 FR 17291, April 9, 2003) This correction to the temporary final rule published in March 2003 in (68 FR 14328) changed the size of the security zone around the Big Bend Power facility and corrected erroneous descriptions of coordinates at both the Big Bend and Weedon Island Power facilities.

A notice proposing permanent security zones around Weedon Island and Big Bend Power facilities and soliciting comments on this proposal was published in the **Federal Register** (68 FR 19166, April 18, 2003). The comment period on the proposed rule concluded on June 17, 2003.

Discussion of Comments and Changes

No comments were received therefore no substantive changes have been made to the rule. We did, however, update the phone number for contacting the COTP.

Discussion of the Rule

The Coast Guard is establishing two permanent security zones in waters immediately adjacent to power facilities at Big Bend, and Weedon Island in Tampa Bay, Florida, to ensure public safety and security in the greater Tampa Bay area. Entry into or remaining within

these zones will be prohibited unless authorized by the Coast Guard Captain of the Port, Tampa, Florida or that officer's designated representative. Persons desiring to transit the security zone must contact the Captain of the Port at telephone number 813–228–2189/91 or on VHF channel 16 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 the COTP designated representative.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security. No significant changes have been made to the rule.

We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary. There is ample room for vessels to navigate around the security zones and the Captain of the Port may allow vessels to enter the zones, on a case-by-case basis with the express permission of the Captain of the Port of Tampa or their designated representative.

Small Entities

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

The majority of the zones are limited in size and leave ample room for vessels to navigate around the zones. The zones will not significantly impact commuter and passenger vessel traffic patterns, and vessels may be allowed to enter the zones, on a case-by-case basis, with the express permission of the Captain of the Port of Tampa or their designated representative. Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this final rule will not have a significant economic impact on a substantial number of small entities.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Public Law 104–121), we offered to assist small entities in understanding the rule so that they could better evaluate its effects on them and participate in the rulemaking.

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

Collection of Information

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

Federalism

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

Unfunded Mandates Reform Act

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

Taking of Private Property

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

Civil Justice Reform

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

Protection of Children

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

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it 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.

Energy Effects

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

Environment

We have analyzed this rule under Commandant Instruction M16475.lD, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2. of the Instruction. Therefore, of this rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction from further environmental documentation. Under figure 2–1, paragraph (34)(g), of the Instruction, an ''Environmental Analysis Check List'' and a ''Categorical Exclusion Determination'' are not required for this rule.

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 amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 is revised to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.764 to read as follows:

§ 165.764 Security Zones; Big Bend and Weedon Island Power Facilities, Tampa Bay, Florida.

(a) *Location.* The following areas, denoted by coordinates fixed using the North American Datum of 1983 (World Geodetic System 1984), are security zones:

(1) *Big Bend, Tampa Bay, Florida.* All waters of Tampa Bay, from surface to bottom, adjacent to the Big Bend Power Facility, and within an area bounded by a line connecting the following points: 27°47.85′ N, 082°25.02′ W then east and south along the shore and pile to 27°47.63′ N, 082°24.70′ W then north along the shore to 27° 48.02′ N, 082°24.70′ W then north and west along a straight line to 27°48.12′ N, 082°24.88′ W then south along the shore and pile to 27°47.85′ N, 082°25.02′ W, closing off entrance to the Big Bend Power Facility.

(2) *Weedon Island, Tampa Bay, Florida.* All waters of Tampa Bay, from surface to bottom, extending 50 yards from the shore, seawall and piers around the Power Facility at Weedon Island encompassed by a line connecting the following points: 27° 51.52′ N, 082° 35.82′ W then north and east along the shore to 27° 51.54′ N, 082° 35.78′ W then north to 27° 51.68′ N, 082° 35.78′ W then north to 27° 51.75′ N, 082° 35.78′ W closing off entrance to the canal then north to 27° 51.89′ N, 082° 35.82′ W then west along the shore to 27° 51.89′ N, 082° 36.10′ W then west to 27° 51.89′ N, 082° 36.14′ W closing off entrance to the canal.

(b) *Regulations.* (1) Entry into or remaining within these zones is prohibited unless authorized by the Coast Guard Captain of the Port, Tampa, Florida or their designated representative.

(2) Persons desiring to transit the area of the security zone may contact the Captain of the Port at telephone number 813–228–2189/91 or on VHF channel 16 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 their designated representative.

(c) *Authority.* In addition to 33 U.S.C. 1231 and 50 U.S.C. 191, the authority for this section includes 33 U.S.C. 1226.

Dated: July 23, 2003.

James M. Farley,

Captain, U.S. Coast Guard, Captain of the Port, Tampa, Florida.

[FR Doc. 03–20469 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[COTP Tampa-03–079]

RIN 1625–AA00

Security Zones; Tampa Bay, FL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing temporary security zones in Tampa Bay, at Big Bend, and Weedon Island, Florida. These zones are needed to ensure public safety and security in the greater Tampa Bay area. Entry into these zones is prohibited unless authorized by the Captain of the Port, or their designated representative.

DATES: This rule is effective from July 23, 2003, through August 31, 2003.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket [COTP Tampa-03–079] and are available for inspection or copying at Marine Safety Office Tampa, 155 Columbia Drive, Tampa, Florida 33606–3598 between 7:30 a.m. and 3 p.m. Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: LT Heath Hartley, Coast Guard Marine Safety Office Tampa, at (813) 228–2189 extension 123.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Publishing an NPRM and delaying the effective date of this rule would be contrary to the public interest since immediate action is needed to continue to protect the public, ports and waterways of the United States. The Coast Guard will issue a broadcast notice to mariners and place Coast Guard vessels in the vicinity of these zones to advise mariners of the restriction. We did issue an NPRM on April 18, 2003, concerning security zones in the vicinity of Big Bend and Weedon Island (68 FR 19166) and anticipate the final rule will become effective on September 1, 2003.

For the same reasons, under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. The Coast Guard will issue a broadcast notice to mariners to advise mariners of the restriction. The Coast Guard published a NPRM proposing a permanent rule for security zones in these same locations and requesting public comment. The comment period for the proposed permanent rule ended on June 17, 2003.

Background and Purpose

The terrorist attacks of September 11, 2001, killed thousands of people and heightened the need for development of various security measures throughout the seaports of the United States, particularly those vessels and facilities which are frequented by foreign nationals and are of interest to national security. Following these attacks by well-trained and clandestine terrorists, national security and intelligence officials have warned that future terrorists attacks are likely. The Captain of the Port of Tampa has determined that these security zones are necessary to protect the public, ports, and waterways of the United States from potential subversive acts.

These security zones are similar to the existing temporary security zones established for power facilities that will soon expire. A temporary final rule was published on March 23, 2003 (68 FR 14328), creating a temporary security zone around the Weedon Island and Big Bend Power Facilities. These zones expired at approximately 11:59 p.m. on June 30, 2003.

Discussion of Rule

This temporary rule establishes security zones in areas covered by a past temporary rule to ensure consistent security of facilities, and infrastructure throughout the Tampa Captain of the Port Zone. One security zone will encompass a portion of water adjacent to the Big Bend Power Plant in Tampa Bay, Florida. The zone encompasses all waters of Tampa Bay, from surface to bottom, shoreward of a line connecting the following points: 27°47.85′ N, 082°25.02′ W then east and south along the shore and pile to 27°47.63′ N, 082°24.70′ W then north along the shore to 27°48.02′ N, 082°24.70′ W then north

and west along a straight line to 27°48.12′ N, 082°24.88'W then south along the shore and pile to 27°47.85′ N, 082°25.02′ W, closing off entrance to the Big Bend Power Facility.

We are establishing another zone adjacent to the Weedon Island Power Plant in Tampa Bay, Florida. The zone encompasses all waters of Tampa Bay, from surface to bottom, extending 50 yards from the shore, seawall and piers around the Power Facility at Weedon Island shoreward of a line connecting the following points: 27°51.52′ N, 082°35.82′ W then north and east along the shore to 27°51.54′ N, 082°35.78′ W then north to 27°51.68′ N, 082°35.78′ W then north to 27°51.75′ N, 082°35.78′ W closing off entrance to the canal then north to 27°51.89′ N, 082°35.82′ W then west along the shore to 27°51.89′ N, 082°36.10′ W then west to 27°51.89′ N, 082°36.14′ W closing off entrance to the canal. No person or vessel may enter the zone without the permission of the Captain of the Port.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not ''significant'' under the regulatory policies and procedures of the Department of Homeland Security (DHS).

We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation is unnecessary because there is ample room for vessels to navigate around the security zones and the Captain of the Port may allow vessels to enter the zones, on a case-by-case basis with the express permission of the Captain of the Port of Tampa or their designated representative.

Small Entities

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

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities. The majority of the zones is limited in size and leave ample room for vessels to navigate around the zones. The zones will not significantly impact commuter and passenger vessel traffic patterns, and vessels may be allowed to enter the zones, on a case-by-case basis, with the express permission of the Captain of the Port of Tampa or their designated representative.

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 the rule so that they could better evaluate its effects on them and participate in the rulemaking. If the rule would effect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed under **FOR FURTHER INFORMATION CONTACT** for assistance in understanding this rule.

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

Collection of Information

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

Federalism

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

Unfunded Mandates Reform Act

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

Taking of Private Property

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

Civil Justice Reform

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

Protection of Children

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

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. We invite your comments on how this rule might impact tribal governments, even if that impact may not constitute a ''tribal implication'' under the Order.

Energy Effects

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

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

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2. of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction, from further environmental documentation. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES**. Under figure 2–1, paragraph (34)(g), of the Instruction, an ''Environmental Analysis Check List'' and a ''Categorical Exclusion Determination'' are not required for this rule.

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 amends 33 CFR Part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 is revised to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. From July 23, 2003, through August 31, 2003, add § 165.T07–079 to read as follows:

§ 165.T07–079 Security Zones; Tampa Bay, Florida.

(a) *Location.* The following areas, denoted by coordinates fixed using the North American Datum of 1983 (World Geodetic System 1984), are security zones:

(1) *Big Bend, Tampa Bay, Florida.* All waters of Tampa Bay, from surface to bottom, adjacent to the Big Bend Power Facility, and within an area bounded by a line connecting the following points: 27°47.85′ N, 082°25.02′ W then east and south along the shore and pile to 27°47.63′ N, 082°24.70′ W then north along the shore to 27°48.02′ N, 082°24.70′ W then north and west along a straight line to 27°48.12′ N, 082°24.88′ W then south along the shore and pile to 27°47.85′ N, 082°25.02′ W, closing off entrance to the Big Bend Power Facility.

(2) *Weedon Island, Tampa Bay, Florida.* All waters of Tampa Bay, from surface to bottom, extending 50 yards from the shore, seawall and piers around the Power Facility at Weedon Island encompassed by a line connecting the following points: 27°51.52′ N, 082°35.82′ W then north and east along the shore to 27°51.54′ N, 082°35.78′ W then north to 27°51.68′ N, 082°35.78′ W then north to 27°51.75′ N, 082°35.78′ W closing off entrance to the canal then north to 27°51.89′ N, 082°35.82′ W then west along the shore to 27°51.89′ N, 082°36.10′ W then west to 27°51.89′ N, 082°36.14′ W closing off entrance to the canal.

(b) *Regulations.* (1) In accordance with the general regulation in 33 CFR 165.33, entry into or remaining within these zones is prohibited unless authorized by the Coast Guard Captain of the Port, Tampa, Florida or their designated representative.

(2) Persons desiring to transit the area of the security zone may contact the Captain of the Port at telephone number 813–228–2189/91 or on VHF channel 16 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 their designated representative.

(c) *Authority.* In addition to 33 U.S.C. 1231 and 50 U.S.C. 191, the authority for this section includes 33 U.S.C. 1226.

Dated: July 23, 2003.

James M. Farley,

Captain, U.S. Coast Guard, Captain of the Port, Tampa, Florida.

[FR Doc. 03–20467 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 25

[IB Docket No. 01–185, FCC No. 03–162]

Flexibility for Delivery of Communications by Mobile Satellite Service Providers in the 2 GHz Band, the L-Band, and the 1.6/2.4 GHz Bands

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document is a summary of the Order on Reconsideration adopted by the Commission in this proceeding. The Commission reconsidered in part, its decision in this proceeding in which it allowed flexibility in the delivery of communications by Mobile Satellite Service (MSS) providers. On reconsideration, the Commission permitted authorized MSS systems to integrate ancillary terrestrial components (ATCs) into their MSS networks in three sets of ratio frequency bands. The Commission also clarified certain issues. The Commission took this action to address concerns raised by the wireless carriers.

DATES: Effective September 11, 2003.

FOR FURTHER INFORMATION: Breck Blalock, or James Ball, Policy Division, International Bureau, (202) 418–1460.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Order on Reconsideration* in IB Docket No. 01–185, FCC No. 03–162, adopted July 3, 2003 and released on July 3, 2003. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room CY–A257), 445 12th Street, SW., Washington, DC 20554. The document is also available for download over the Internet at *http://hraunfoss.fcc.gov/edocs_public/attachmatch/FCC-0-162A1.pdf.* The complete text may also be purchased from the Commission's copy contractor, Qualex International, in person at 445 12th Street, SW., Room CY–B402, Washington, DC 20554, via telephone at (202) 863–2893, via facsimile at (202) 863–2898, or via e-mail at *qualexint@aol.com.*

Summary of Order

On January 29, 2003, the Commission adopted a Report and Order, 68 FR 33640 (June 5, 2003), to permit flexibility in the delivery of communications by MSS providers that operate in three sets of radio frequency bands: the 2GHz MSS band, the L-band and the Big LEO bands. In the Report and Order, the Commission permitted MSS licensees to integrate ATCs into their MSS networks for the purpose of enhancing their ability to offer high-quality, affordable mobile services on land, in the air and over the oceans without using any additional spectrum resources beyond spectrum already allocated and authorized by the Commission for MSS in these bands.

Following release of the Report and Order, several wireless carriers made *ex parte* presentations stating that certain portions of the item required clarification. To resolve the concerns of the wireless carriers, the Commission on its own motion reconsidered the Report and Order in this proceeding.

In the Reconsideration Order, the Commission amended § 25.149 to clarify that the rule does not preclude an MSS operator from filing an ATC application prior to actually meeting all of the gating requirements. However, the Commission will not grant an ATC authorization prior to an MSS operator's demonstrating that it has, in fact, met the gating criteria. This rule change will serve the public interest by granting ATC applications only after the Commission is satisfied that each of the gating criteria has in fact been met, or will be met at the same time the application is granted.

The Commission adopted a new rule section that requires an MSS operator that is granted ATC authority to notify the Commission within 30 days once it begins providing ATC service. This notification must take the form of a letter formally filed with the Commission in the appropriate MSS license docket and shall contain a certification that the MCC ATC service is consistent with its ATC authority.

In the event that an MSS operator anticipates that its proposal will present complex or controversial issues that may warrant a longer deliberative process, the MSS operator may seek an initial finding from the Commission that its proposed service offerings are ''integrated'' as required by the Commission's Report and Order.

The Commission revised § 25.143 to eliminate the language that required MSS operators have a conditioned ATC authorization before engaging in preoperational construction and testing. Rather, the Commission will permit such construction and testing, at the operator's risk, at any time after an MSS provider has initiated physical construction on the MSS system satellites and notified us concerning the initiation of MSS system satellite construction and the MSS operator's intent to construct and test ATC facilities. The MSS operator must notify the Commission in the form of a letter formally filed with the Commission in the appropriate MSS license docket. The letter shall specify the frequencies on which the MSS licensee proposes to engage in pre-operational testing and shall specify the name, address, telephone number and other such information as may be necessary to contact a MSS licensee representative for the reporting and mitigation of any interference that may occur as a result of such pre-operational testing and build-out. Upon the filing of such a notification letter, the Commission will issue an informational public notice stating that such a notification letter has been filed. The Commission requires pre-operational construction and testing operations be in compliance with all appropriate technical rules including § 25.255 relating to procedures for resolving possible harmful interference. Also, MSS licensees engaging in pre-operational build-out and testing are required to comply with §§ 5.83, 5.85(c), 5.111 and 5.117.

Finally, the Commission modified § 25.117(f) to require that any initial application for the modification of a space station license to add an ancillary terrestrial component be placed on notice for public comment.

Procedural Matters

Supplemental Final Regulatory Flexibility Certification

The Regulatory Flexibility Act of 1980, as amended (RFA), requires that a regulatory flexibility analysis be prepared for notice-and-comment rule making proceedings, unless the agency certifies that ''the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.'' (The RFA, 5 U.S.C. 601–612, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, Title II, 110 Stat. 857 (1996).) The RFA generally defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act. *See* 5 U.S.C. 601(3) (incorporating by reference the definition of ''small-business concern'' in the Small Business Act, 15 U.S.C. 632). Pursuant to 5 U.S.C. 601(3), the statutory definition of a small business applies ''unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the **Federal Register**.'' A ''small business concern'' is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the U.S. Small Business Administration (SBA). *See* 15 U.S.C. 632. The SBA has developed a small business size standard for Satellite Telecommunications, which consists of all such companies having $12.5 million or less in annual revenue. *See* 13 CFR 121.201, NAICS code 517410.

Pursuant to the RFA, the Commission incorporated a Final Regulatory Flexibility Certification into the Report and Order. For the reasons described below, we now incorporate this supplemental final certification into the Order on Reconsideration and certify that the policies and rules adopted in the Order on Reconsideration will not have a significant economic impact on a substantial number of small entities.

The Order on Reconsideration will allow MSS operators to file applications prior to meeting the gating requirements. MSS operators that have been granted authorization will be required to notify the Commission within thirty days once the MSS operator begins providing ATC service. Finally, the rules will permit an MSS provider to construct and test, at the operator's risk, at any time after an MSS provider has initiated physical construction on the MSS system satellites and notified the Commission concerning the initiation of MSS system satellite construction and the MSS operator's intent to construct and test ATC facilities. The rule changes adopted in the Order on Reconsideration will have no significant economic impact on small entities because the MSS operators will not be required to make use of the additional capability. Under the rules adopted in the Order on Reconsideration, the Commission has permitted additional flexibility that will enhance the ability of MSS operators to offer American consumers high quality, affordable mobile services on land, in the air, and over the oceans without using spectrum resources beyond the spectrum already allocated and authorized for MSS use in these bands.

The Commission also finds that this Order on Reconsideration—which brings additional flexibility to existing MSS licensees—will not affect a substantial number of small entities. There are currently five 2 GHz MSS licensees, two Big LEO MSS licensees and three L-band MSS licensees authorized to provide service in the United States. Although at least one of the 2 GHz MSS system licensees and one of the Big LEO licensees are small businesses, small businesses often do not have the financial ability to become MSS system operators because of the high implementation costs associated with satellite systems and services. We expect that, by the time of MSS ATC system implementation, these current small businesses will no longer be considered small due to the capital requirements for launching and operating a proposed system.

Ordering Clauses

Pursuant to sections 4(i), 7, 302, 303(c), 303(e), 303(f) and 303(r) of the Communications Act of 1934, as amended, 47 U.S.C. sections 154(i), 157, 302, 303(c), 303(e), 303(f) and 303(r), this Order on Reconsideration *is adopted* and that part 25 of the rules *is amended,* as specified in the rule changes, effective September 11, 2003.

List of Subjects in 47 CFR Part 25

Radio, Satellites, Telecommunications.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

Rule Changes

PART 25—SATELLITE COMMUNICATIONS

■ 1. The authority citation for part 25 continues to read as follows:

Authority: 47 U.S.C. 701–744. Interprets or applies Sections 4, 301, 302, 303, 307, 309 and 322 of the Communications Act, as amended, 47 U.S.C. 154, 301, 302, 303, 307, 309 and 332, unless otherwise noted.

■ 2. Section 25.117 is amended by revising paragraph (f) to read as follows:

§ 25.117 Modification of station license.

* * * * *

(f) An application for modification of a space station license to add an ancillary terrestrial component to an eligible satellite network will be treated as a request for a minor modification if the particulars of operations provided by the applicant comply with the criteria specified in § 25.149. Notwithstanding the treatment of such an application as a minor modification, the Commission shall place any initial application for the modification of a space station license to add an ancillary terrestrial component on notice for public comment. Except as provided for in § 25.149(f), no application for authority to add an ancillary terrestrial component to an eligible satellite network shall be granted until the applicant has demonstrated actual compliance with the criteria specified in § 25.149(b).

■ 3. Section 25.136 is amended by revising paragraphs (f), (g), and (h) to read as follows:

§ 25.136 Licensing provisions for the L-Band mobile-satellite service.

* * * * *

(f) *Incorporation of ancillary terrestrial component base station into an L-band mobile-satellite service system.* Any licensee authorized to construct and launch an L-band mobile-satellite system may construct ancillary terrestrial component (ATC) base stations as defined in § 25.201 at its own risk and subject to the conditions specified in this subpart any time after commencing construction of the mobile-satellite service system.

(g) *Pre-operational build-out and testing.* An MSS licensee may, without further authority from the Commission and at its own risk engage in pre-operational build-out and, conduct equipment tests for the purpose of making such adjustments and measurements as may be necessary to assure compliance with the terms of the technical provisions of its MSS license, ATC operation requirements, the rules and regulations in this Part and the applicable engineering standards. Prior to engaging in such pre-operational build-out and testing, an MSS licensee must notify the Commission concerning the initiation of MSS system satellite construction and the MSS operator's intent to construct and test ATC facilities. This notification must take the form of a letter formally filed with the Commission in the appropriate MSS license docket. Such letter shall specify the frequencies on which the MSS licensee proposes to engage in pre-operational testing and shall specify the name, address, telephone number and other such information as may be necessary to contact a MSS licensee representative for the reporting and mitigation of any interference that may occur as a result of such pre-operational testing and build-out. MSS licensees engaging in pre-operational build-out and testing must also comply with §§ 5.83, 5.85(c), 5.111, and 5.117 of this chapter relating to experimental operations. An MSS licensee may not offer ATC service to the public for compensation during pre-operational testing. In order to operate any ATC base stations, such a licensee must meet all the requirements set forth in § 25.147 and must have been granted ATC authority.

(h) *Aircraft.* All portable or hand-held transceiver units (including transceiver units installed in other devices that are themselves portable or hand-held) having operating capabilities in the 1626.5–1660.5 MHz and 1525–1559 MHz bands shall bear the following statement in a conspicuous location on the device: ''This device may not be operated while on board aircraft. It must be turned off at all times while on board aircraft.''

■ 4. Section 25.143 is amended by revising paragraphs (i), (j), and (k) to read as follows:

§ 25.143 Licensing provisions for the 1.6/2.4 GHz mobile-satellite service and the 2 GHz mobile-satellite service.

* * * * *

(i) *Incorporation of ancillary terrestrial component base stations into a 1.6/2.4 GHz mobile-satellite service network or a 2 GHz mobile-satellite service network.* Any licensee authorized to construct and launch a 1.6/2.4 GHz or a 2 GHz mobile-satellite system may construct ancillary terrestrial component (ATC) base stations as defined in § 25.201 at its own risk and subject to the conditions specified in this subpart any time after commencing construction of the mobile-satellite service system.

(j) *Pre-operational build-out and testing.* An MSS licensee may, without further authority from the Commission and at its own risk, engage in pre-operational build-out and conduct equipment tests for the purpose of making such adjustments and measurements as may be necessary to assure compliance with the terms of the technical provisions of its MSS license, ATC operation requirements, the rules and regulations in this Part and the applicable engineering standards. Prior to engaging in such pre-operational build-out and testing, an MSS licensee must notify the Commission concerning the initiation of MSS system satellite construction and the MSS operator's intent to construct and test ATC facilities. This notification must take the form of a letter formally filed with the Commission in the appropriate MSS license docket. Such letter shall specify the frequencies on which the MSS licensee proposes to engage in pre-operational testing and shall specify the name, address, telephone number and other such information as may be necessary to contact a MSS licensee representative for the reporting and mitigation of any interference that may occur as a result of such pre-operational testing and build-out. MSS licensees engaging in pre-operational build-out and testing must also comply with §§ 5.83, 5.85(c), 5.111, and 5.117 of this chapter relating to experimental operations. An MSS licensee may not offer ATC service to the public for compensation during pre-operational testing. In order to operate any ATC base stations, such a licensee must meet all the requirements set forth in § 25.149 and must have been granted ATC authority.

(k) *Aircraft.* ATC mobile terminals must be operated in accordance with 25.136(a). All portable or hand-held transceiver units (including transceiver units installed in other devices that are themselves portable or hand-held)

having operating capabilities in the 2000–2020/2180–2200 MHz or 1610–1626.5 MHz/2483.5–2500 MHz bands shall bear the following statement in a conspicuous location on the device: ''This device may not be operated while on board aircraft. It must be turned off at all times while on board aircraft.''

* * * * *

■ 5. Section 25.149 is revised to read as follows:

§ 25.149 Application requirements for ancillary terrestrial components in the mobile-satellite service networks operating in the 1.5./1.6 GHz, 1.6/2.4 GHz and 2 GHz mobile-satellite service.

(a) Applicants for ancillary terrestrial component authority shall demonstrate that the applicant does or will comply with the following through certification or explanatory technical exhibit, as appropriate:

(1) ATC shall be deployed in the forward-band mode of operation whereby the ATC mobile terminals transmit in the MSS uplink bands and the ATC base stations transmit in the MSS downlink bands in portions of the 2000–2020 MHz/2180–2200 MHz bands (2 GHz band), the 1626.5–1660.5 MHz/1525–1559 MHz bands (L-band), and the 1610–1626.5 MHz/2483.5–2500 MHz bands (Big LEO band).

(2) ATC operations shall be limited to certain frequencies:

(i) In the 2000–2020 MHz/2180–2200 MHz bands (2 GHz MSS band), ATC operations are limited to the selected assignment of the 2 GHz MSS licensee that seeks ATC authority.

(ii) In the 1626.5–1660.5 MHz/1525–1559 MHz bands (L-band), ATC operations are limited to the frequency assignments authorized and internationally coordinated for the MSS system of the MSS licensee that seeks ATC authority.

(iii) In the 1610–1626.5 MHz/2483.5–2500 MHz bands (Big LEO band), ATC operations are limited to the 1610–1615.5 MHz, 1621.35–1626.5 MHz, and 2492.5–2498.0 MHz bands and to the specific frequencies authorized for use by the MSS licensee that seeks ATC authority.

(3) ATC operations shall not exceed the geographical coverage area of the mobile satellite service network of the applicant for ATC authority.

(4) ATC base stations shall comply with all applicable antenna and structural clearance requirements established in part 17 of this chapter.

(5) ATC base stations and mobile terminals shall comply with part 1 of this chapter, Subpart I—Procedures Implementing the National Environmental Policy Act of 1969, including the guidelines for human exposure to radio frequency electromagnetic fields as defined in §§ 1.1307(b) and 1.1310 of this chapter for PCS networks.

(6) ATC base station operations shall use less than all available MSS frequencies when using all available frequencies for ATC base station operations would exclude otherwise available signals from MSS space-stations.

(b) Applicants for an ancillary terrestrial component shall demonstrate that the applicant does or will comply with the following criteria through certification:

(1) *Geographic and temporal coverage.* (i) For the 2 GHz MSS band, an applicant must demonstrate that it can provide space-segment service covering all 50 states, Puerto Rico, and the U.S. Virgin Islands one-hundred percent of the time, consistent with the coverage requirements for 2 GHz MSS GSO operators.

(ii) For the L-band, an applicant must demonstrate that it can provide space-segment service covering all 50 states, Puerto Rico, and the U.S. Virgin Islands one-hundred percent of the time, unless it is not technically possible for the MSS operator to meet the coverage criteria from its orbital position.

(iii) For the Big LEO band, an applicant must demonstrate that it can provide space-segment service to all locations as far north as 70° North latitude and as far south as 55° South latitude for at least seventy-five percent of every 24-hour period, *i.e.*, that at least one satellite will be visible above the horizon at an elevation angle of at least 5° for at least 18 hours each day, and on a continuous basis throughout the fifty states, Puerto Rico and the U.S. Virgin Islands, *i.e.*, that at least one satellite will be visible above the horizon at an elevation angle of at least 5° at all times.

(2) *Replacement satellites.* (i) Operational NGSO MSS ATC systems shall maintain an in-orbit spare satellite.

(ii) Operational GSO MSS ATC systems shall maintain a spare satellite on the ground within one year of commencing operations and launch it into orbit during the next commercially reasonable launch window following a satellite failure.

(iii) All MSS ATC licensees must report any satellite failures, malfunctions or outages that may require satellite replacement within ten days of their occurrence.

(3) *Commercial availability.* Mobile-satellite service must be commercially available (*viz.*, offering services for a fee) in accordance with the coverage requirements that pertain to each band as a prerequisite to an MSS licensee's offering ATC service.

(4) *Integrated services.* MSS ATC licensees shall offer an integrated service of MSS and MSS ATC. Applicants for MSS ATC may establish an integrated service offering by affirmatively demonstrating that:

(i) The MSS ATC operator will use a dual-mode handset that can communicate with both the MSS network and the MSS ATC component to provide the proposed ATC service; or

(ii) Other evidence establishing that the MSS ATC operator will provide an integrated service offering to the public.

(5) *In-band operation.* (i) In the 2 GHz MSS band, MSS ATC is limited to an MSS licensee's selected assignment. MSS ATC operations on frequencies beyond the MSS licensee's selected assignment are prohibited.

(ii) In the Big LEO band, MSS ATC is limited to no more than 5.5 MHz of spectrum in each direction of operation. Licensees in these bands may implement ATC only on those channels on which MSS is authorized, consistent with the Big LEO band-sharing arrangement.

(iii) In the L-band, MSS ATC is limited to those frequency assignments available for MSS use in accordance with the Mexico City Memorandum of Understanding, its successor agreements or the result of other organized efforts of international coordination.

(c) *Equipment certification.* (1) Each ATC MET utilized for operation under this part and each transmitter marketed, as set forth in § 2.803 of this chapter, must be of a type that has been authorized by the Commission under its certification procedure for use under this part.

(2) Any manufacturer of radio transmitting equipment to be used in these services may request equipment authorization following the procedures set forth in subpart J of part 2 of this chapter. Equipment authorization for an individual transmitter may be requested by an applicant for a station authorization by following the procedures set forth in part 2 of this chapter.

(3) Licensees and manufacturers are subject to the radiofrequency radiation exposure requirements specified in §§ 1.1307(b), 2.1091 and 2.1093 of this chapter, as appropriate. MSS ATC base stations must comply with the requirements specified in § 1.1307(b) of this chapter for PCS base stations. MSS ATC mobile terminals must comply with the requirements specified for mobile and portable PCS transmitting devices in § 1.1307(b) of this chapter. MSS ATC mobile terminals must also

comply with the requirements in §§ 2.1091 and 2.1093 of this chapter for Satellite Communications Services devices. Applications for equipment authorization of mobile or portable devices operating under this section must contain a statement confirming compliance with these requirements for both fundamental emissions and unwanted emissions. Technical information showing the basis for this statement must be submitted to the Commission upon request.

(d) Applicants for an ancillary terrestrial component authority shall demonstrate that the applicant does or will comply with the provisions of §§ 1.924 and 25.203(e) through 25.203(g) and with §§ 25.252, 25.253, or 25.254, as appropriate, through certification or explanatory technical exhibit.

(e) Except as provided for in paragraph (f) of this section, no application for an ancillary terrestrial component shall be granted until the applicant has demonstrated actual compliance with the provisions of paragraph (b) of this section. Upon receipt of ATC authority, all ATC licensees must ensure continued compliance with this section and §§ 25.252, 25.253, or 25.254, as appropriate.

(f) Special provision for operational MSS systems. Applicants for MSS ATC authority with operational MSS systems that are in actual compliance with the requirements prescribed in paragraphs (b)(1), (b)(2), and (b)(3) of this section at the time of application may elect to satisfy the requirements of paragraphs (b)(4) and (b)(5) of this section prospectively by providing a substantial showing in its certification regarding how the applicant will comply with the requirements of paragraphs (b)(4) and (b)(5) of this section. Notwithstanding § 25.117(f) and paragraph (e) of this section, the Commission may grant an application for ATC authority based on such a prospective substantial showing if the Commission finds that operations consistent with the substantial showing will result in actual compliance with the requirements prescribed in paragraphs (b)(4) and (b)(5) of this section. An MSS ATC applicant that receives a grant of ATC authority pursuant to this paragraph (f) shall notify the Commission within 30 days once it begins providing ATC service. This notification must take the form of a letter formally filed with the Commission in the appropriate MSS license docket and shall contain a certification that the MSS ATC service is consistent with its ATC authority.

[FR Doc. 03–20325 Filed 8–11–03; 8:45 am]
BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 390 and 398

[Docket No. FMCSA–2000–7017]

RIN 2126–AA52

Safety Requirements for Operators of Small Passenger-Carrying Commercial Motor Vehicles Used In Interstate Commerce

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

ACTION: Final rule.

SUMMARY: FMCSA amends the Federal Motor Carrier Safety Regulations (FMCSRs) to require that motor carriers operating commercial motor vehicles (CMVs), designed or used to transport between 9 and 15 passengers (including the driver) in interstate commerce, must comply with the applicable safety regulations when they are directly compensated for such services and the vehicle is operated beyond a 75 air mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location. The agency has revised its proposed distance threshold to focus on the distance that the driver operates the vehicle, as opposed to the distance that the passengers are transported. These motor carriers, drivers, and vehicles are now, through this rule, subject to the same safety requirements as motor coach operators, except for the commercial driver's license, and controlled substances and alcohol testing regulations. This rule implements section 212 of the Motor Carrier Safety Improvement Act of 1999 (MCSIA).

DATES: This final rule is effective on September 11, 2003. *Compliance Date.* Affected motor carriers must be in compliance with this rule no later than November 10, 2003.

ADDRESSES:

Assistance for Small Entities: The Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121) requires the FMCSA to comply with small entity requests for information or advice about compliance with statutes and regulations within FMCSA's jurisdiction. Thus, if any small entity, organization, or governmental jurisdiction has a question regarding this document, please contact an FMCSA Division office in your State or an FMCSA Service Center for a given geographic area. For phone numbers and addresses, go to *http://www.fmcsa.dot.gov/aboutus/fieldoffs,* or call 1–800–832–5660, or Fax (202) 366–8842, FMCSA, Attn: Commercial Passenger Carrier Safety Division (MC–PSB), Washington, DC 20590.

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

FOR FURTHER INFORMATION CONTACT: Mr. Larry W. Minor, (202) 366–4009, Chief, Vehicle and Roadside Operations Division (MC–PSV); or Mr. Philip J. Hanley, (202) 366–9131, Commercial Passenger Carrier Safety Division (MC–PSB), Federal Motor Carrier Safety Administration, 400 Seventh Street, SW., Washington, DC 20590. Office hours are from 7:45 a.m. to 4:15 p.m., e.t., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Background

Congressional Mandate to Regulate Small Passenger-Carrying Commercial Motor Vehicles (CMVs)

Section 212 of the Motor Carrier Safety Improvement Act of 1999 (MCSIA), (Pub. L. 106–159, 113 Stat. 1748, December 9, 1999), requires that the FMCSA make its safety regulations applicable to: (1) Commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks.

Prior to enactment of the MCSIA, section 4008(a)(2) of the Transportation Equity Act for the 21st Century (TEA–21) Public Law 105–178, 112 Stat. 107, June 9, 1998) amended the passenger-vehicle component of the commercial motor vehicle (CMV) definition in 49 U.S.C. 31132(1). CMV is now defined statutorily to mean a self-propelled or towed vehicle used on the highways in interstate commerce to transport passengers or property, if the vehicle—

(A) has a gross vehicle weight rating or gross vehicle weight of at least 10,001 pounds, whichever is greater;

(B) is designed or used to transport more than 8 passengers (including the driver) for compensation;

(C) is designed or used to transport more than 15 passengers, including the driver, and is not used to transport passengers for compensation; or

(D) is used in transporting material found by the Secretary of Transportation to be hazardous under section 5103 of this title and transported in a quantity requiring placarding under regulations prescribed by the Secretary under section 5103.

Under section 4008(b) of the TEA–21, operators of the CMVs defined by section 31132(1)(B) would automatically become subject to the FMCSRs one year after the date of enactment of the TEA–21, if they were not already covered, ''except to the extent that the Secretary [of Transportation] determines, through a rulemaking, that it is appropriate to exempt such operators of commercial motor vehicles from the application of those regulations.'' Section 4008(b) of the TEA–21 is a mandate either to impose the FMCSRs on previously unregulated smaller-capacity passenger vehicles, or to exempt through notice and comment rulemaking some or all of the operators of such vehicles.

On September 3, 1999, the Federal Highway Administration (FHWA) published an interim final rule to adopt the new statutory definition of a CMV (64 FR 48510).[1] The agency revised its regulatory definition of CMV to be consistent with the statute, but exempted the operation of these small passenger-carrying vehicles from all of the FMCSRs pending the completion of a separate rulemaking in which the agency proposed requiring operators of such vehicles to file a motor carrier identification report, mark their CMVs with a USDOT identification number and certain other information, and maintain an accident register. The notice of proposed rulemaking (NPRM) for that rule was also published on September 3, 1999, at 64 FR 48518.

On January 11, 2001 (66 FR 2756), the FMCSA published a final rule that amended 49 CFR 390.5 to adopt the statutory definition of ''commercial motor vehicle'' published in the interim final rule on September 3, 1999. The final rule also revised § 390.3(f)(6) to require that all operators of CMVs designed or used to transport between 9 and 15 passengers for compensation (1) complete a motor carrier identification report (Form MCS–150) (49 CFR 390.19); (2) comply with certain provisions of the CMV marking regulation (49 CFR 390.21); and (3) maintain an accident register (49 CFR 390.15). These actions were intended to enable the agency to monitor the operational safety of all motor carriers operating small passenger-carrying vehicles for compensation. In addition, the three requirements were intended to help the agency compile information on the number of motor carriers operating small passenger-carrying vehicles for compensation, the location of their principal places of business, the number of vehicles operated, and the number of drivers employed.

On January 11, 2001 (66 FR 2767), FMCSA also published an NPRM for this proceeding. Section 212 of MCSIA required FMCSA to complete a rulemaking to determine whether motor carriers operating motor vehicles designed or used to transport between 9 and 15 passengers (including the driver) for compensation should be covered by the FMCSRs. Congress directed that, as a minimum, the regulations shall apply to (1) commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks.

This final rule makes the FMCSRs applicable to all motor carriers operating CMVs, designed or used to transport between 9 and 15 passengers (including the driver), in interstate commerce for ''direct compensation'' when the vehicle is operated beyond a 75 air mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location. This decision is based on: (1) The FMCSA's understanding of Congress's and the commercial passenger carrier industry's usage of the term ''camionetas''; (2) analysis of comments submitted in response to the agency's August 5, 1998 (63 FR 41766) advance notice of proposed rulemaking (ANPRM) concerning the definition of CMV; (3) analysis of comments submitted in response to the September 3, 1999 interim final rule and NPRM; (4) analysis of comments submitted in response to the January 11, 2001 NPRM; and (5) an analysis of accident data concerning commercial van transportation of passengers. The agency believes that this approach will be more effective than other alternatives for responding to congressional and public safety concerns about the use of small passenger-carrying CMVs in long-haul for-hire operations throughout the United States, including such operations for compensation by foreign-based motor carriers to and from the United States.

Covered Camioneta Operations

Furthermore, section 212 of the MCSIA requires the agency to make the safety regulations applicable to camioneta operations. The statute did not define the term camioneta, but Congress issued an explanatory statement (*see* 145 Cong. Rec. H12868, at H12873, November 18, 1999) that suggests camioneta operations are those that involve transporting passengers from Mexico to the United States and vice versa.

FMCSA does not have information concerning the number of motor carriers with CMV operations that fit the description of camioneta. The Texas Department of Public Safety, in comments to the September 3, 1999 interim final rule and NPRM published on the same day, described camioneta operations as those transporting passengers ''between major cities in Texas and the other southern States to and from our borders with Mexico.'' Based on analysis of the National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS), the agency believes the accident data suggest that, if there are fatal accidents involving these operators, the vast majority of vehicles appear to be registered in the United States. While they may travel between points in Mexico and the United States, the vehicles are not necessarily based in Mexico.

Rather than adopting a rule that specifically targets, in part, vehicles that actually cross the border, FMCSA continues to believe section 212 should be implemented by focusing on the distance traveled. The distance-based approach used in this final rule will capture CMV operators that transport passengers from the U.S.-Mexico border to major cities in Texas and other States. Carriers that actually cross the border will also be covered, but only in those instances where the driver operates the vehicle beyond a 75 air-mile radius from his or her normal work-reporting location. The distance the driver operates could be determined by enforcement personnel, by questioning the drivers about their employers, and by reviewing any available paperwork concerning the origin and the destination, regardless of which side of the U.S.-Mexico border the trip begins or ends.

Alternatives Considered

Several alternatives or options to implement section 212 of MCSIA were

[1] The MCSIA established the FMCSA in the Department of Transportation. On January 4, 2000, the Office of the Secretary published a final rule rescinding the authority previously delegated to the former Office of Motor Carrier Safety (OMCS) within FHWA (65 FR 220). This authority is now delegated to the FMCSA. Rulemaking, enforcement, and other activities of the former OMCS while part of the FHWA are now administered by the FMCSA.

considered. They included making the safety-related operational FMCSRs applicable to: (1) All motor carriers operating small passenger-carrying CMVs in interstate commerce for compensation (direct and indirect), irrespective of the distance traveled; (2) all motor carriers operating small passenger-carrying CMVs in interstate commerce that are *directly compensated,* irrespective of the distance traveled; and (3) only those motor carriers operating small passenger-carrying CMVs across the U.S.-Mexico border for compensation. FMCSA believes the alternative being implemented through this final rule will improve the safety performance of for-hire motor carriers that pose a serious safety risk to their customers and the traveling public, while avoiding to the greatest extent practicable, the imposition of Federal safety regulations on van operations that are local in nature and appear to pose a significantly lower level of safety risk.

Summary of Proposed Rulemaking

In the NPRM (66 FR 2767, January 11, 2001), the FMCSA requested public comment on making the safety regulations in parts 390, 391, 392, 393, 395 and 396, and the safety fitness rules in part 385, applicable to motor carriers operating CMVs designed or used to transport between 9 and 15 passengers (including the driver) in interstate commerce, when they are directly compensated for such services and the transportation of any passenger covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers). The agency made clear that the operators of these small passenger-carrying vehicles would be subject to the same safety requirements as motorcoach operations, with the exception of the commercial driver's license, and controlled substances and alcohol testing regulations.

Commenters

FMCSA received 29 comments in response to the NPRM. The commenters were: Academy Bus Co. (Academy); Advocates for Highway and Auto Safety (Advocates); AFL-CIO Transportation Trades Department (AFL-CIO); Amalgamated Transit Union (ATU); American Bus Association (ABA); the Association for Commuter Transportation (ACT); California Highway Patrol (CHP); Colorado Department of Public Safety (CDPS); the Commercial Vehicle Safety Alliance (CVSA); Farmworkers Justice Fund (FJF); Greyhound Lines, Inc. (Greyhound); League of United Latin American Citizens (LULAC); Pennsylvania Bus Association (PBA); Mr. Alan Jay Pomerance, a concerned citizen; National Association of State Directors of Pupil Transportation Services (State Directors); National Automobile Dealers Association (NADA); National Council of La Raza (NCLR); National Limousine Association (NLA); National School Transportation Association (NSTA); New Jersey Department of Transportation (NJDOT); Taxicab, Limousine & Paratransit Association (TLPA); Texas Bus Association (TBA); Texas Department of Public Safety (TXDPS); United Motorcoach Association (UMA); and four college students.

TXDPS, PBA, LULAC, NCLR and FJF fully supported the proposal as published. ABA, TBA, Greyhound, Academy, CHP, CDPS, CVSA, Advocates, ATU, NJDOT, AFL-CIO, NSTA, State Directors, Mr. Pomerance, and the four students were in favor of the FMCSA's rulemaking, although they generally believed that more remains to be done to protect public safety and help level the playing field. Advocates and UMA opposed the exclusion of small passenger-carrying vehicle operations within the proposed 75 air mile range. NLA, TLPA, NADA, and ACT, on the other hand, opposed making the safety regulations applicable to their members.

Discussion of Comments and FMCSA Responses

Direct Compensation Criterion

Eight commenters opposed the direct compensation criterion for determining the applicability of the safety requirements. Five commenters supported making safety-related operational regulations applicable to vehicles designed or used to transport between 9 and 15 passengers when the company holds itself out to the public as providers of transportation services, or when a company is primarily engaged in providing surface transportation. ABA suggested that the agency use the phrase ''primarily engaged in for-hire transportation.'' ABA points out that in applying requirements of the Americans with Disabilities Act for over-the-road buses, DOT used the terminology ''primarily engaged in transportation'' in 1998 regulations (63 FR 51670, 51692; September 1998).

Greyhound Stated

Greyhound's major concern is that by limiting applicability of the FMCSRs to smaller passenger-carrying commercial motor vehicles, the operators of which are ''directly compensated'' for their transportation services, FMCSA may be creating unnecessary confusion and an inappropriate loophole. We agree that only carriers that are ''compensated'' for transportation be regulated, it is the modifier, ''directly'' that causes the potential problem.

ATU Stated:

[W]e urge the agency to then adopt one of the alternative definitions provided by Greyhound Lines, Inc. in its comments to the proposed rule. Specifically, Greyhound suggests that the regulations be applied to transportation for compensation in smaller vehicles provided by entities that either ''hold themselves out to the public as providers of transportation services'' or ''are primarily engaged in providing surface transportation.'' We prefer the latter formulation, but either one would provide a clearer and more precise definition of the regulated class than the ''directly'' compensated test, which would allow organizations to avoid regulation by masking the transportation fee within a ''total package charge'' that includes other incidental services.

NJDOT, CHP, and CDPS generally contend that the proposed definition will lead to additional regulatory and enforcement problems.

Response: FMCSA agrees with commenters that the rule should focus first and foremost on motor carriers of passengers that offer their services to the general public. However, the agency disagrees with commenters' assertions that the term ''primarily engaged in providing surface transportation'' is a better criterion for determining the applicability of the FMCSRs to these motor carriers. The term ''primarily engaged in providing surface transportation'' requires that both the motor carrier and enforcement officials consider all of the motor carrier's business activities before determining whether the safety regulations apply. Each entity that operates small passenger-carrying vehicles for compensation in interstate commerce, regardless of the distance traveled, is considered a motor carrier, as defined in 49 CFR 390.5. Motor carriers and enforcement officials would have to determine whether the percentage of business that concerns the for-hire transportation of passengers is sufficient for the motor carrier to be primarily engaged in providing surface transportation. This may vary from season to season, or year to year. Generally, enforcement opportunities would be limited to carrier visits, unless enforcement officials conducting destination inspections or similar activities knew, or had reason to believe, that the entity responsible for the operation of the vehicle was primarily engaged in providing surface transportation of passengers.

By contrast, the approach FMCSA proposed and adopts makes the FMCSRs applicable for each interstate trip beyond a 75 air mile radius of the driver's normal work-reporting location, regardless of the percentage of the motor carrier's business involving the for-hire transportation of passengers. Motor carriers and enforcement officials need only determine the distance that the vehicle would be operated (in the case of the motor carrier planning a trip) or was operated (in the case of the enforcement official), and whether the vehicle was being operated for direct compensation. This could be accomplished by interviewing the driver and passengers to determine the nature of the trip. The inspector need not know about, and the motor carrier need not estimate, the percentages of the company's business operations involving for-hire passenger transportation in order to determine whether the FMCSRs are applicable to the trip in question.

We believe that our approach establishes a higher standard of safety for the operators of small passenger carrying vehicles than the approach recommended by the commenters. FMCSA's approach makes the rules applicable to every trip that meets the criterion, regardless of whether the entity is primarily engaged in transportation. Conversely, commenters would permit potentially unsafe operators to legally continue their long-haul van operations, provided they were not primarily engaged in the for-hire transportation of passengers. FMCSA believes that the approach adopted by this rule achieves a higher standard of safety.

Generally, only entities that assess a fee, monetary or otherwise, directly for the transportation of passengers would be subject to the safety regulations. The use of small passenger-carrying CMVs for compensation, by such operators as hotel/motel shuttle, rental car shuttle, and whitewater river rafter transporter services, using small passenger-carrying CMVs, would not be subject to the safety-related operational regulations, irrespective of the distance traveled. Since these businesses do not hold themselves out to the public as providers of transportation services and generally operate over short distances, FMCSA continues to believe that it is not necessary to impose safety-related operational regulations on them.

In response to Greyhound, the ATU, and other commenter assertions that the proposed rule would enable some motor carriers to avoid safety oversight by structuring their fees or fares as a total package charge, FMCSA does not believe the nature of most of these carrier operations is such that their identity as for-hire motor carriers of passengers can be effectively concealed. In such instances, carriers would have to devise a scheme wherein they would provide some other substantive service so that the transportation by motor vehicle of the passenger is incidental to some other function. Given that most passengers of these motor carriers expect to depart specific locations at specific times, and arrive at their destinations in a timely manner, it is unlikely the motor carriers this rule is intended to cover could maintain effective customer relationships by engaging in activities that would increase significantly the time required to complete a trip, or the fares customers must pay for the transportation service. In addition to differences in the nature of the transportation service, FMCSA believes the market forces of supply and demand and competitive pricing would discourage a commercial operator of a small passenger-carrying vehicle from employing this strategy to avoid regulation. Motor carriers that employ this strategy would place themselves at an economic disadvantage with other for-hire carriers that provide transportation services between the same locations.

75 Air-Mile Criterion

FMCSA proposed making the safety regulations applicable when the transportation of any passenger covers a distance greater than 75 air miles. Greyhound and the ABA supported the 75 air-mile standard. However, fifteen commenters opposed the standard.

The CVSA argued that commercial motor vehicles should be subject to the FMCSRs regardless of how far they travel. The State Directors stated a distance-based approach to applying the FMCSRs to commercial vans is neither reasonable nor feasible. The State Directors opined that the 37 percent of fatal van crashes at distances less than 75 miles is a substantial number and should not be ignored.

Response: FMCSA carefully analyzed accident data from the NHTSA Fatality Analysis Reporting System (FARS). Based on this analysis, FMCSA determined, to the greatest extent practicable, that vans most likely to pose a safety risk were those operating at a distance approximately 75 air miles or more from the driver's work-reporting location. The methodology for estimating this distance is explained below.

FMCSA reviewed the data fields in FARS to determine whether it would be possible to estimate the distance a large van may have traveled prior to being involved in the fatal accident, and if there was any way to identify those accidents most likely to have involved interstate transportation. The agency determined that FARS could provide potentially useful information to help identify the accidents most likely to have involved interstate transportation, based on a comparison of data fields for the State in which the vehicle crashed, the State in which the vehicle was registered, and the State of the driver's license.

FMCSA estimated the approximate distance between the geographic area of the driver's residential zip code and the county and State in which the crash took place. The distances were computed for almost all fatal accidents involving a large van transporting 9 or more people at the time of the accident for calendar years 1996, 1997, and 1998. The agency operated under the assumption that the most likely trips to be considered interstate in nature are ones in which the State of registration of the vehicle and State of issuance for the driver's license differ from the State where the vehicle crashed.

There were 161 fatal accidents between 1996 and 1998 (49 crashes in 1996, 54 crashes in 1997, and 58 crashes in 1998) in which the vehicle was transporting 9 or more passengers at the time of the crash. The FARS information for seven of the accidents lacked one or more of the data items needed for the analysis. Two of the accidents involved U.S. Government vehicles and were excluded from the analysis since they would not be covered by the rulemaking—the FMCSRs include an exception for transportation performed by the Federal government, a State, or any political subdivision of a State (49 CFR 390.3(f)). Five of the accidents involved Mexico-licensed drivers operating vehicles registered in the United States and one involved a Mexico-licensed driver operating a vehicle for which the database did not include registration information. It was not possible to complete the distance analysis for those accidents.

Of the remaining 146 fatal accidents in which the large van was transporting 9 or more people at the time of the crash, 45 of them (approximately 31 percent) appear to have been interstate trips with the crash taking place in a State other than the State where the driver was licensed, and at a distance greater than 100 statute miles from the driver's residence. The shortest distance among the likely interstate trips was just over 100 statute miles, while the longest was more than 2,100 statute miles (a trip

involving a driver licensed in California, a large van registered in Oregon, and a fatal crash in Louisiana).

Forty-seven of the 146 fatal accidents (approximately 32 percent) appear to have been intrastate trips with the fatal accident taking place in the State where the driver was licensed and where the vehicle was registered, and at a distance greater than 100 statute miles from the driver's residence. The shortest distance among the likely intrastate trips was just over 100 statute miles, while the longest was more than 550 statute miles (a trip involving a driver licensed in California, a large van registered in California, and a fatal crash in California).

Fifty-four of the accidents (37 percent) occurred within 100 statute miles of the driver's residence with only a small percentage (seven out of 54 crashes, approximately 13 percent) involving what appears to be an interstate trip.

Overall, approximately 63 percent of the fatal accidents involving large vans occurred between 100 and 2,200 statute miles from the driver's residence with the longest distances linked typically to the trips that were most likely interstate in nature.

It is not possible to determine the distance the driver may have traveled to get to the work-reporting location, or to determine whether the van was operated by an individual working from home. However, FMCSA has factored into the analysis a maximum distance of 25 statute miles between the driver's residence and a possible work-reporting location. The Federal Highway Administration (FHWA) ''Summary of Travel Trends 1995 Nationwide Personal Transportation Survey,'' FHWA–PL–00–006, December 1999, discussed in the NPRM, indicates that the average commute to work among the individuals participating in the survey was 11.63 miles. To decrease the likelihood of underestimating the average commuting distances of drivers of small passenger-carrying CMVs, the agency used an estimate of 25 miles, a little more than twice the average in the nationwide survey. When the estimated 25 statute miles for commuting to work is deducted from the estimates of the distance between the driver's residence and the crash location, the result is an estimate of 75 statute miles as the distance the driver may have traveled from the work reporting location to the crash site.

For simplicity, the agency used 75 air miles, which is equivalent to 86.3 statute miles, because the motor carrier industry and enforcement community have experience using air-miles, and the hours-of-service rules include an exemption from the records-of-duty status requirement for drivers operating within a 100 air-mile radius of their work-reporting location.

As discussed in the above analysis that was the basis for the NPRM, the agency continues to believe a mileage threshold of 75 air miles (86.3 statute miles or 138.9 kilometers) should be used for determining the applicability of the safety regulations to for-hire operations of small passenger-carrying vehicles operating in interstate commerce. The analysis indicates that approximately 63 percent of 146 fatal accidents, in which a large van was actually transporting 9 or more occupants at the time of the crash, involved drivers that apparently traveled more than 75 statute miles from their work-reporting location. While the agency certainly agrees with commenters' concerns that the remaining 37 percent of the fatal accidents should not be ignored, this rule would not affect most of those accidents, given that they appear to be primarily intrastate in nature. Section 212 of the MCSIA does not extend FMCSA's jurisdiction to regulate *intrastate* passenger-carrier operations. Accordingly, the final rule adopts a 75 air-mile threshold.

However, in this final rule, the agency is revising its proposed distance threshold to focus on the distance that the driver operates the vehicle, as opposed to the distance that the passengers are transported. The agency is aware of the potential complexities involved with the 75 air-mile standard proposed in the NPRM. In many cases, it would be difficult to determine the distance the passengers were transported in order to determine whether the safety-related operational regulations apply to the motor carrier. This is especially true when passengers are picked up or dropped off at multiple locations. To simplify compliance and enforcement, FMCSA will apply its safety regulations whenever a vehicle that is designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation is operated beyond a 75 air mile radius from the driver's normal work-reporting location. The agency believes that use of the driver's normal work reporting location provides an easier means for motor carriers and enforcement personnel to determine the applicability of the safety regulations, and will help to promote greater levels of compliance and ensure consistency in the enforcement of the rules.

State Adoption of Compatible Safety Regulations

FMCSA requested public comment on the feasibility of making the adoption and enforcement of compatible safety regulations applicable to small passenger-carrying CMVs operated in interstate commerce a condition of receiving Motor Carrier Safety Assistance Program (MCSAP) funds. The agency also requested comments on whether the variances from the FMCSRs allowed in State laws and regulations should be amended to require the adoption and enforcement of intrastate regulations applicable to the intrastate operation of these types of vehicles. Six commenters believed FMCSA should require the States to adopt compatible safety regulations concerning the operation of small passenger carrying commercial vehicles.

Response: Although FMCSA agrees with the commenters that States should have compatible regulations, the agency does not believe it is necessary to require that all States adopt intrastate requirements that are compatible with this final rule. The agency continues to believe that State agencies should be given flexibility in responding to unique safety issues or concerns involving the intrastate operation of small passenger-carrying vehicles.

The MCSAP is a Federal grant program that provides financial assistance to States to reduce the number and severity of accidents and hazardous materials incidents involving CMVs. The goal of the MCSAP is to reduce CMV-involved accidents, fatalities, and injuries through consistent, uniform, and effective CMV safety programs. The MCSAP sets forth the conditions for participation by States and local jurisdictions and promotes the adoption and uniform enforcement of safety rules, regulations, and standards compatible with the FMCSRs and Federal Hazardous Materials Regulations (HMRs) for both interstate and intrastate motor carriers and drivers. The MCSAP rules are codified in 49 CFR parts 350 and 355.

As a condition of participation in the MCSAP, States are required to adopt and enforce compatible regulations concerning the interstate operation of small passenger-carrying CMVs since FMCSA is adopting regulations applicable to these operations. The agency is not amending the variances under § 350.341, which means that the States are not required to adopt and enforce regulations concerning the intrastate operation of small passenger-carrying CMVs. However, FMCSA encourages the States to adopt and

enforce intrastate laws and regulations concerning the operation of these CMVs if their accident data warrants such action.

Based on the agency's analysis of the FARS data for 1996, 1997, and 1998, approximately 32 percent (51 out of 161) of all fatal crashes involving large vans transporting 9 or more passengers at the time of the accident during those three years occurred in just three States (California (24 fatal accidents), Texas (15 fatal accidents), and Florida (12 fatal accidents)). This suggests that it may not be necessary for each State to adopt and enforce intrastate regulations concerning small passenger-carrying CMVs. However, States such as California, Texas, and Florida should give strong consideration to adopting and enforcing intrastate regulations given the FARS data.

Commercial Driver's License, and Controlled Substances and Alcohol Testing Regulations

Seven commenters supported making the commercial driver's license (CDL), and controlled substances and alcohol testing regulations applicable to commercial van operations.

Response: While FMCSA understands commenter concerns, section 212 of the MCSIA did not expand the agency's statutory authority concerning the establishment and enforcement of the CDL and controlled substances and alcohol testing rules. Congress did not amend the statutory definition of ''commercial motor vehicle'' in chapter 313 of title 49, United States Code, which governs the applicability of the CDL and controlled substances and alcohol testing requirements. Therefore, FMCSA does not have the statutory authority to apply these requirements to commercial van operations. The passenger-carrying threshold that Congress provided under that statutory definition remains at 16 or more passengers, including the driver.

Applicability of Safety Fitness Procedures

The proposed rule requested comments on making the safety fitness procedures under part 385 applicable to motor carriers operating small passenger-carrying CMVs. The safety fitness procedures in 49 CFR part 385 provide guidance in assessing the safety management controls that motor carriers use to ensure compliance with the FMCSRs. Five commenters supported applicability of safety fitness procedures to such carriers. No commenter expressed specific opposition in relation to this proposal.

Response: FMCSA continues to believe that it is appropriate to make the safety fitness procedures applicable to motor carriers that operate vehicles designed or used to transport between 9 and 15 passengers, when the carrier is directly compensated for its transportation services, and the commercial vehicle is operated beyond a 75 air mile radius from the driver's normal work-reporting location. Motor carriers operating small passenger-carrying CMVs are now subject to compliance reviews and the same safety fitness procedures and standards used to evaluate other interstate motor carriers. Therefore, section 385.1, as amended on May 13, 2002 (67 FR 31978), by the interim final rule concerning new entrant motor carriers, made part 385 applicable to all motor carriers subject to the FMCSRs, except non-business private motor carriers of passengers. Carriers that operate small passenger-carrying vehicles, and that receive an ''Unsatisfactory'' safety rating will be prohibited from operating CMVs to transport passengers in interstate commerce. In addition, these motor carriers will be ineligible to contract or subcontract with any Federal agency for transportation of passengers in interstate commerce.

Discussion of the Final Rule

The FMCSA is revising the FMCSRs to require that motor carriers operating CMVs that are designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation in interstate commerce (including transportation between points in Canada or Mexico, and points in the United States) comply with the regulations contained in 49 CFR parts 390, 391, 392, 393, 395 and 396, and the safety fitness procedures in part 385, when the driver of the vehicle operates it beyond a 75 air mile radius (86.3 statute miles or 138.9 kilometers) from his/her normal work-reporting location. This means the motor carriers are required to ensure that each of their drivers meet all of the minimum qualifications for interstate CMV drivers, including physical qualifications prescribed in part 391, and maintain records to document compliance. The driver disqualification provisions of 49 CFR 391.15 are also applicable. Motor carriers and their drivers must also comply with the driving rules of part 392, and vehicles must meet all applicable requirements in part 393 concerning parts and accessories necessary for safe operation.

To avoid potential confusion, the exception under § 390.3(f)(6) has been revised to exempt the operation of CMVs designed or used to transport between 9 and 15 passengers, not for direct compensation, *provided the vehicle does not otherwise meet the definition of a commercial motor vehicle* (emphasis added). The agency believes that the proposed regulatory language could have been misunderstood to imply that vehicles designed or used to transport between 9 and 15 passengers, not for direct compensation, are exempt from the FMCSRs, even if the CMV meets the 10,001-pound weight threshold for applicability of the safety regulations, or is used to transport hazardous materials in a quantity requiring the use of placards.

Part 396 requires that each motor carrier must have a systematic inspection, repair, and maintenance program for the CMVs it operates, and must ensure that vehicles are in safe and proper operating condition at all times. They must also maintain records to document compliance with these rules.

In addition, motor carriers must ensure that each vehicle is inspected at least once every 12 months by a qualified inspector/mechanic and that any motor carrier employee responsible for the adequacy of any brake-related inspection, repair, or maintenance work meets certain minimum qualifications. They must also maintain records to document compliance with these rules.

Motor carriers must ensure that their drivers comply with the hours-of-service requirements of part 395, including reporting, recordkeeping, verifying, and responding to law enforcement requests. No driver of a passenger-carrying CMV may drive more than 10 hours following 8 consecutive hours off duty. No driver may operate a passenger-carrying CMV if the driver has been on duty more than 15 hours following 8 consecutive hours off duty (regardless of whether he or she drove). Furthermore, drivers of passenger-carrying CMVs must not drive after being on duty 60 hours in any seven consecutive days if the motor carrier does not operate CMVs every day of the week (60-hour rule), or after being on duty 70 hours in any eight consecutive days if the motor carrier operates CMVs every day of the week (70-hour rule). For drivers that operate passenger-carrying CMVs beyond a 100 air-mile radius of the normal work-reporting location, a record of duty status (log book) is required to document the number of hours on duty and the number of hours driving.

The hours of service rules include a 100 air-mile radius exemption from the log book requirement for drivers who operate passenger-carrying vehicles

within a 100 air-mile radius of their normal work reporting location, provided the driver: returns to the work reporting location and is released from work within 12 consecutive hours; has at least 8 consecutive hours off duty separating each 12 hours on duty; and does not exceed 10 hours maximum driving time following 8 consecutive hours off duty. As an alternative to the log book, motor carriers of passengers must maintain accurate time records showing the time the driver reports for duty each day, the total number of hours the driver is on duty each day, the time the driver is released from duty each day, and the total time for the preceding 7 days for drivers used for the first time or intermittently.

As discussed above, the agency is *not* (emphasis added) making the CDL and controlled substances and alcohol testing requirements applicable to operators of small passenger-carrying CMVs, because neither section 4008 of the TEA–21 nor section 212 of the MCSIA amended the statutory definition of CMV used for those regulations (49 U.S.C. 31301). Consequently, the passenger-carrying threshold for CDL, and controlled substances and alcohol testing requirements remains at 16 (including the driver).

Compliance Schedule

After the effective date of this rule, motor carriers will have 90 days (or 120 days from the **Federal Register** publication date) to comply with the safety regulations. The agency believes this is sufficient time for the affected motor carriers to establish and implement safety management controls to achieve compliance with the FMCSRs. Furthermore, the agency believes that NHTSA FARS data suggest that it is in the public interest to require compliance with the FMCSRs as soon as practicable.

Relationship Between Final Rules and Transportation of Migrant Workers

The FMCSA has determined that some of the motor carriers covered by this rulemaking may also be subject to the agency's rules for transporters of migrant workers in 49 CFR part 398. The agency prescribes certain requirements for motor carriers that transport migrant workers a total distance of more than 75 miles in interstate or foreign commerce. Section 398.1 defines a migrant worker as any individual proceeding to or returning from employment in agriculture as defined in section 3(f) of the Fair Labor Standards Act of 1938, as amended (29 U.S.C. 203(f)) or section 3121(g) of the Internal Revenue Code of 1986 (26 U.S.C. 3121(g)). The term ''carrier of migrant workers by motor vehicle'' means any person, with certain limited exceptions, who transports in interstate or foreign commerce at any one time three or more migrant workers to or from their employment by any motor vehicle other than a passenger automobile or station wagon.

Carriers of migrant workers that are directly compensated for their transportation services and that operate vehicles designed or used to transport between 9 and 15 passengers, in interstate commerce, are covered by this final rule if the driver operates beyond a 75 air-mile radius from their normal work reporting location. The final rule generally establishes more stringent safety requirements than those found in 49 CFR part 398. This is not the case, however, with § 398.6, which prohibits motor carriers from permitting or requiring drivers to operate vehicles for more than 10 hours in any 24-hour period, unless the driver is given eight hours rest immediately following the 10 hours driving time. This daily limit is more restrictive than the comparable provision for drivers of larger passenger-carrying CMVs (§ 395.5(a)(1)), which allows a driver to drive up to 16 hours out of 24 under certain circumstances.

Although compliance with part 395 would result in a less restrictive requirement in this instance, FMCSA does not believe this deviation is significant in terms of highway safety. The restriction in part 398 is based only on the amount of time the driver operates the vehicle that transports the migrant workers but does not take into account other activities that may affect the driver's fitness for duty and level of alertness. Part 395 includes rules to prohibit driving after being on-duty (both driving time and time spent performing other tasks) for more than 15 hours following at least eight consecutive hours off-duty. Part 395 also takes into account any compensated work, irrespective of whether the work was performed for the motor carrier. For example, if the driver has a part-time job, the time spent on the part-time job must be factored into the calculations to determine the available driving time. FMCSA believes that overall, part 395 is more stringent than part 398 and that compliance with all of the requirements of part 395 will improve safety.

FMCSA believes that it is appropriate to require more rigorous safety standards for carriers of migrant workers if their operations are conducted in a manner similar to intercity motorcoach businesses. Therefore, the agency is amending § 398.2, Applicability, of the transporters of migrant worker rules to make it clear to the affected motor carriers when they must comply with the same FMCSRs as intercity motorcoach operations.

Applicability of Safety Fitness Procedures to Operators of Small Passenger-Carrying CMVs

Part 385 of the FMCSRs establishes procedures to determine the safety fitness of motor carriers, assign safety ratings, take remedial action when required, and prohibit motor carriers receiving an ''Unsatisfactory'' safety rating from operating a CMV. As a result of this final rule, motor carriers operating small passenger-carrying CMVs are now covered by the same safety fitness procedures and standards used to evaluate other interstate motor carriers. This means that motor carriers affected by this rulemaking will be subject to compliance reviews and receive safety ratings. Those receiving an ''Unsatisfactory'' safety rating will be prohibited from operating CMVs to transport passengers in interstate commerce. In addition, these motor carriers will be ineligible to contract or subcontract with any Federal agency for transportation of passengers in interstate commerce. The agency is amending § 385.1, Purpose and scope, to reflect the new passenger-carrying threshold for the applicability of the FMCSRs and the safety fitness procedures.

Itemization of the Estimated Costs of Imposing Safety-Related Requirements

FMCSA has attempted to evaluate the potential costs of the final rule. The agency has considered currently available data concerning the number of affected motor carriers, CMVs, and drivers. The agency estimates that this rulemaking could affect up to 1,843 for-hire motor carriers of passengers with active operating authority who operate only CMVs with a seating capacity of 15 passengers or less.

Each of these motor carriers has on file with the FMCSA proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. This number does not include the following: (1) motor carriers that may have pending applications for operating authority; (2) passenger carriers shown as inactive because their authority was revoked for failure to maintain evidence of the required minimum levels of financial responsibility; (3) private motor carriers of passengers; or (4) carriers which also operate larger vehicles, as well as smaller vehicles. This number may also

overstate the population of affected carriers since some of the licensed carriers may be exclusively operating equipment carrying less than 9 passengers.

With regard to the number of drivers and vehicles that would be covered by the safety regulations, FMCSA does not have a definitive source for this information at this time because for-hire small passenger motor carriers were only recently required to complete the Form MCS–150, Motor Carrier Identification Report, which is used to gather information about motor carriers subject to the FMCSRs. However, the agency is now gathering data to better estimate the number of affected carriers, drivers, and vehicles.

In the absence of other sources of information, the agency believes certain estimates provided by the Taxicab, Limousine & Paratransit Association (TLPA) is useful in helping to estimate the number of drivers and vehicles that will be covered by this final rule. In comments submitted in response to the August 5, 1998, ANPRM (63 FR 41766) on the subject of safety requirements for the operators of small passenger-carrying CMVs, the TLPA estimated that there are 74,000 vans nationwide being operated for compensation. The TLPA estimated that van fleets average less than 10 vans. In addition, the TLPA estimated that if the agency made the FMCSRs applicable to the operation of small passenger-carrying vehicles, approximately 14,000 companies, 125,000 vehicles, and 165,000 drivers would be covered.

FMCSA believes most of the estimates provided by the TLPA appear to be representative of businesses that would not be covered by this rule, because this rulemaking applies to long-haul van operations, not for-hire operations that are local in nature. However, the agency will use the TLPA's previous estimate of the number of vehicles per fleet (10 vans) as a baseline estimate for the number of vehicles that would be covered. This means that approximately 18,430 small passenger-carrying vehicles (10 vans per fleet × 1,843 for-hire operations) would be covered under the FMCSRs.

The use of the estimates above is not intended to serve as a determination whether the passenger-carrying operations are small businesses. The estimates are used solely for the purpose of estimating the potential costs of this rulemaking action. TLPA's comments concerning the agency's estimate of the number of small businesses that could be affected by this rulemaking are addressed in the rulemaking analysis portion of this notice.

The agency estimates that the number of drivers affected will be a fraction of the 165,000 drivers in the TLPA estimate since the proposal is targeted at drivers in the long-haul segment of the small passenger carrier industry. The agency believes the total number of drivers will be approximately 22,000 (165,000 divided by 7.5) since the number of motor carriers currently operating as for-hire motor carriers of passengers with small passenger-carrying vehicles is approximately one-seventh of the TLPA's estimate of all for-hire motor carriers.

Earnings of Commercial Van Drivers, Mechanics, and Supervisors

In order to evaluate accurately the cost implications of the proposed rule, FMCSA reviewed earnings information from the ''Occupational Outlook Handbook,'' 2000–01 Edition, Bulletin 2520, published by the U.S. Department of Labor. We are using the earnings information to determine the costs of requiring motor carrier employees and individuals who perform services for motor carriers to complete certain records that would not otherwise be completed in the normal course of business, and to perform certain tasks associated with complying with the requirements.

The agency is using the earnings figures for taxi-drivers and chauffeurs because the drivers in question generally do not meet the qualifications requirements for intercity bus drivers. The median hourly earnings of taxi drivers and chauffeurs, excluding tips, were $7.48 in 1998. The middle 50 percent earned between $6.02 and $9.79 an hour. The lowest 10 percent earned less than $5.55 and the highest 10 percent earned more than $12.44 an hour. For the purpose of preparing cost estimates for imposing safety-related operational rules, the agency will use $12.44 an hour to decrease the likelihood of underestimating the impact of this rulemaking.

The ''Occupational Outlook Handbook'' shows the estimated median hourly earnings for automotive mechanics and service technicians, including commission, were $13.16 in 1998. The middle 50 percent earned between $10.02 and $17.14 an hour. The lowest 10 percent earned less than $7.44 and the highest 10 percent earned more than $21.25 an hour. For the purpose of preparing cost estimates for this rulemaking the agency is using $21.25 an hour.

FMCSA is using $22 an hour as the estimated earnings for supervisors and managers of transportation. The ''Occupational Outlook Handbook'' did not include a specific category for transportation supervisors so the agency is operating under the assumption that these supervisors are paid more than the individuals they supervise. The agency estimated that the supervisors are paid $ 0.75 an hour more than the service technicians, or $22.

Medical Examination and Certification

Drivers subject to the rule are required to obtain a medical examiner's certificate. FMCSA estimates that the average cost of a comprehensive medical examination is $300. This cost includes an estimate of the driver's out-of-pocket expenses or co-payment and an estimate of the amount the driver's health insurance company would pay the medical examiner. Since a medical examiner's certificate is usually valid for 24 months, the FMCSA estimates the prorated annual cost of CMV driver medical certifications to be approximately $3,300,000 [($300 per exam per driver) × (22,000 drivers) = $6,600,000 every two years] based on an estimated 22,000 drivers who would be subject to the rule.

Generally, it takes a medical examiner, such as a physician, doctor of osteopathy, physician assistant, advance practice nurse, or doctor of chiropractic, about 20 minutes to complete a medical examination form and one minute to fill out the medical certificate. Based on the $132,000 median annual earning of a general/family practice physician listed in the Department of Labor's ''Occupational Outlook Handbook'' and an estimated 2,080 hours of work per year, the earnings are equal to approximately $63 an hour. The estimated costs to the industry for having medical examiners complete the required paperwork would be $485,100 ($63 an hour × (21 minutes × 1 hour per 60 minutes) × 22,000 medical exams performed for drivers). This is the cost every two years. The cost each year would be $242,550.

Therefore, the total annual costs for the physical exam would be approximately $3,542,550.

Driver Qualification Files

FMCSA estimates that the operators of small passenger-carrying CMVs will have to create 22,000 driver qualifications files during the first year and create approximately 2,860 new files (13 percent of 22,000) each year thereafter as a result of driver turnover, retirement, etc. The estimate of driver turnover is the same used for previous information collection burden estimates for driver qualifications files. This means that motor carriers will be responsible for maintaining

approximately 19,140 existing files (22,000 − 2,860) every year after the first year this rule is in effect and creating 2,860 new files per year.

The creation of a single, complete driver qualification file involves an annual expenditure of approximately 25 minutes, which is the sum of 21 minutes of paperwork by a safety director, driver supervisor, or equivalent position, and 4 minutes of paperwork by a driver. For the first year, the cost would be $188,557 (0.35 hours per driver employed × 22,000 drivers × $22 an hour per supervisor) plus (0.07 hours per driver employed × 22,000 drivers × $12.44 an hour per driver), or $169,400 for the time supervisors spend on this task and $19,157 for drivers. For subsequent years the cost for creating new driver qualification files would be $24,512 (0.35 hours per driver employed × 2,860 drivers × $22 an hour per supervisor) plus (0.07 hours per driver employed × 2,860 driver × $12.44 an hour per driver), or $22,022 for the time supervisors spend on this task and $2,490 for drivers.

Each driver is required by § 391.27 to furnish their employing motor carrier with a list of traffic violations. FMCSA estimates that it takes a driver approximately 2 minutes to complete the list. Motor carriers are required to conduct an annual review of their drivers' records. The agency estimates that it takes approximately 5 minutes per driver to complete this task. The cost of complying with the list of traffic violations is $7,143 [19,140 drivers × (0.03 hours per driver) × ($12.44 an hour for a driver)]. The cost of complying with the annual review is $33,686 [(19,140 drivers) × (0.08 hours per driver) × ($22 an hour for a supervisor)]. The total cost per year for the annual list of violations and the review of the driving record is $40,829.

Therefore, the estimated cost for driver qualification files is $188,557 for the first year carriers are required to comply with the safety-related operational provisions of the FMCSRs, and $65,341 for each subsequent year ($24,512 for creating new qualification files, $7,143 for the list of traffic violations, and $33,686 for the driving record review).

Records of Duty Status

As indicated above, FMCSA believes the final rule will apply to 22,000 drivers. It is estimated that each driver would spend approximately 6.5 minutes per workday to complete a record of duty status and work 240 workdays a year. The information collection burden for completing the record of duty status would be approximately 571,999 hours [22,000 drivers × (6.5 minutes per day × 1 hour per 60 minutes) × (240 workdays)]. The estimated total cost burden related to completing the record of duty status is approximately $7,115,667 based on an estimated time burden of 571,999 hours at $12.44 an hour for drivers. This time and cost burden estimate takes into consideration two weeks of sick/vacation leave for these drivers.

FMCSA estimates that each motor carrier, affected by this rule, will need a supervisor responsible for reviewing its drivers' records of duty status and that the supervisor will spend approximately three minutes per day reviewing each driver's records to ensure compliance with the hours-of-service rules. The information collection burden for reviewing the record of duty status would be approximately 264,000 hours [22,000 drivers x (3 minutes per day per driver's log x 1 hour per 60 minutes) x (240 workdays)]. Using the earnings estimate presented above (*i.e.*, $22 per hour for supervisors), the annual cost would be $5,808,000.

Therefore, the total costs for requiring motor carriers to comply with part 395 would be $12,923,667.

Vehicle Inspection, Repair, and Maintenance

FMCSA estimates the various recordkeeping requirements in part 396 related to vehicle inspection, repair, and maintenance would involve an estimated total annual expenditure of 12 hours and 57 minutes per CMV (48 minutes for systematic inspection, repair, and maintenance; 724 minutes for driver vehicle inspection reports; and 5 minutes for periodic inspection). Evidence of an individual's qualifications to perform periodic vehicle inspections must be retained by the motor carrier. Evidence of an individual's qualifications to be a brake inspector must also be retained. The creation of these two types of qualification evidence involves an estimated one-time, non-recurring expenditure of 5 minutes by a safety director, driver supervisor, or equivalent position for each type of qualification.

The systematic inspection, repair, and maintenance records would be completed by a mechanic. The periodic inspection records would also be prepared by a mechanic. The estimated hourly earnings for a mechanic is $21.25 as indicated above. If the mechanic must spend approximately 53 minutes per year per vehicle, the cost per year per vehicle for recordkeeping would be approximately $18.77. If there are 18,430 vehicles that would be covered by the proposed rule, the total cost for systematic inspection, repair, and maintenance, and periodic inspection records would be $345,931.

Drivers must prepare vehicle inspection reports at the end of each workday. It is estimated that each driver would spend 724 minutes per year, or 12.06 hours per year completing the paperwork. Using the earnings estimate of $12.44 an hour, the cost for having drivers prepare vehicle inspection reports would be $150 per driver per year. Based on an estimate of 22,000 drivers, the cost per year for the industry would be $3,300,000.

Finally, looking at the cost for inspector qualifications, FMCSA believes the paperwork would be completed by a supervisor. Using the earnings estimate of $22 an hour, and an information collection burden of 10 minutes (five minutes for each certification of qualifications), the cost per carrier would be $3.66. The total non-recurring cost would be approximately $6,745.

Therefore, the estimated total cost burden related to the vehicle inspection, repair, and maintenance recordkeeping is approximately $3,652,676 per year.

Total Costs and Qualitative Estimate of Benefits

Costs

The sum of all estimated costs of requiring operators of small passenger-carrying CMVs to comply with parts 391, 395, and 396 is $23,850,000 for the first year and $20,184,234 each year thereafter. A summary of the first-year costs is presented below:

Summary of First-Year Costs to Comply with the FMCSRs
$7,085,100 for medical exams ($3,542,550 prorated annual estimate for subsequent years)
$188,557 for driver qualifications files ($65,341 subsequent years)
$12,923,667 for hours of service recordkeeping
$3,652,676 for inspection, repair, and maintenance
Total: $23,850,000

Benefits

FMCSA is not able to quantify the benefits at this time because the agency does not have detailed accident causation data. However, the agency believes that operational safety will be improved through compliance with the FMCSRs. Furthermore, section 212 of the MCSIA requires that the agency make its safety regulations applicable to: (1) Commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks.

The agency believes the benefits of this rulemaking outweigh the estimated costs. The benefit of preventing as few as 8 of the 58 fatal accidents in 1998 involving large vans transporting 9 or more passengers at the time of the crash would outweigh the estimated costs. This is especially the case when consideration is also given to the prevention of injury and property-damage only accidents that occur annually.

FMCSA has considered the accident information submitted by commenters. The agency also considered data from the NHTSA FARS. The data suggests that there may be serious safety management control problems with some commercial van operations that transport passengers for compensation in interstate commerce. Having the FMCSRs apply to these operations should help to reduce the incidence of crashes involving large vans thereby reducing to some extent the number of fatalities and injuries.

Rulemaking Analyses

Privacy Act Statement

Anyone is able to search the electronic form of all comments received into any of DOT's dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78) or you may visit *http://dms.dot.gov.*

Regulatory Planning and Review and DOT Regulatory Policies and Procedures

We have determined that this rulemaking action is a significant regulatory action under Executive Order 12866, Regulatory Planning and Review, and significant under Department of Transportation regulatory policies and procedures because of the substantial public interest concerning extending the FMCSRs to a larger population of for-hire motor carriers of passengers. This final rule requires that operators of vehicles designed or used to carry between 9 and 15 passengers (including the driver) for direct compensation, in interstate commerce comply with the following rules when the commercial vehicle is operated beyond a 75 air mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location: 49 CFR part 391, Qualifications of drivers; 49 CFR part 392, Driving of commercial motor vehicles; 49 CFR part 393, Parts and accessories necessary for safe operation; 49 CFR part 395, Hours of service of drivers; and 49 CFR part 396, Inspection, repair, and maintenance.

Executive Order 12866 requires that regulatory agencies assess both the costs and benefits of intended regulations and proposed regulations. Based upon the information above, the agency anticipates that the economic impact associated with this rulemaking action will be $23,850,000 for the first year, and $20,184,234 for each subsequent year. The benefit of preventing as few as 8 of the 58 fatal accidents in 1998 involving large vans transporting 9 or more passengers at the time of the crash would outweigh the estimated costs. The agency estimates that each fatality prevented would be equivalent to a benefit of $3 million, based on the Department of Transportation's guidance memorandum on ''Treatment of Value of Life and Injuries in Preparing Economic Evaluations.''

Preventing 8 single-fatality accidents per year would result in at least $24 million in benefits per year. Additional benefits would be achieved through reductions in injuries and property-damage only accidents involving small passenger-carrying CMVs.

For purposes of Executive Order 12866, this rulemaking does not impose an economic burden greater than $100 million on these motor carriers. Therefore, a full Regulatory Impact Statement is not necessary.

Regulatory Flexibility Act Analysis

In compliance with the Regulatory Flexibility Act (5 U.S.C. 601–612), FMCSA considered the effects of this regulatory action on small entities and determined that this final rule will not affect a substantial number of small entities that operate CMVs designed or used to transport between 9 and 15 passengers, for compensation, in interstate commerce. However, the agency believes the rule will have a significant impact on some of the small entities operating such vehicles.

FMCSA is requiring motor carriers that operate CMVs, designed or used to transport between 9 and 15 passengers, in interstate commerce, to be made subject to the safety-related operational FMCSRs when they are directly compensated for such services and the vehicle is operated beyond 75 air miles (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location. These motor carriers will be required to comply with 49 CFR parts 390, 391, 392, 393, 395, and 396. FMCSA estimates that this rule will affect 1,843 of the estimated 14,000 entities that operate CMVs designed or used to transport between 9 and 15 passengers for compensation, and that most, if not all, of these 14,000 businesses are small entities based on criteria established by the Small Business Administration (SBA).[2]

[2] The SBA's Office of Size Standards publishes a list of Small Business Size Standards matched to the North American Industry Classification System (NAICS). The U.S. Office of Management and Budget (OMB) classifies approximately 1,000 activities as industries under NAICS. For each industry, except those in public administration, SBA has established a size standard. Industries are described in detail in *North American Industry Classification System—United States, 1997*. It can be found in many libraries or purchased from the National Technical Information Service, by calling (800) 553–6847 or (703) 605–6000. Subsector 485 of the NAICS covers transit and ground passenger transportation. SBA has established $6,000,000 in annual receipts as the maximum size for a small business for all of the classifications under this subsector (*e.g.*, interurban and rural bus transportation, bus service, taxi service, limousine service, charter bus industry). Gross receipts are averaged over a firm's latest 3 completed fiscal years to determine its average annual receipts.

The estimate of 1,843 is based on the current number of for-hire motor carriers of passengers with active authority that operate only CMVs with a seating capacity of 15 passengers or less. Although the universe of for-hire motor carriers of passengers potentially subject to this rule consists of approximately 14,000 entities, we estimate that the final rule will apply to only the 1,843 carriers whose operations require interstate operating authority under the FMCSA's commercial regulations. Each of these motor carriers has on file with the FMCSA proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. This number may overstate the population of affected carriers since some of the licensed carriers may be exclusively operating equipment carrying less than 9 passengers. However, FMCSA's estimate does not include the following: (1) Motor carriers that may have pending applications for operating authority; (2) passenger carriers shown as inactive because their authority was revoked for failure to maintain evidence of the required minimum levels of financial responsibility; (3) private motor carriers of passengers; or (4) carriers which also operate larger vehicles, as well as smaller vehicles. Therefore, the agency believes its estimate of 1,843 motor carriers of passengers is a reasonable estimate of the number of entities that will be subject to this rule.

This final rule is the last in a series of rulemaking actions intended to improve the safety of operation of vehicles designed or used to transport between 9 and 15 passengers, for compensation, in interstate commerce. After reviewing the public comments received in response to previous rulemaking notices in this series, and completing an analysis of accident data, the agency continues to believe that it is appropriate to limit the applicability of the rule to those motor carriers that are most likely to have safety performance problems. Therefore, this rule involves 1,843 out of the 14,000 small entities that the agency is authorized to regulate under section 212 of MCSIA.

The rulemaking series mentioned above began with the August 5, 1998 (63 FR 41766) ANPRM in which the agency requested public comment from all interested parties concerning the potential impact of amending the definition of ''commercial motor vehicle'' to make the FMCSRs applicable to the operation of small passenger-carrying CMVs. The agency specifically asked for comments concerning the types and numbers of passenger carriers that would be covered by the safety regulations under the revised definition of CMV provided in section 4008(a) of TEA–21. At that time, we indicated that due to the preliminary nature of the ANPRM and the lack of information about the potential costs of the rulemaking, the agency could not evaluate the potential regulatory changes on small entities. The agency solicited comments, information, and data on these potential impacts on small entities.

On September 3, 1999, the agency published an interim final rule (64 FR 48510) and a NPRM (64 FR 48518) based on the comments received in response to the ANPRM. The agency used the interim final rule to adopt the statutory definition of CMV provided by TEA–21, and temporarily exempt the operation of small passenger-carrying vehicles from all of the FMCSRs pending completion of a companion rulemaking that would help the agency gather additional information about the entities operating vehicles designed or used to transport between 9 and 15 passengers. The exemption was necessary because the agency viewed section 4008(a) of TEA–21 as a mandate either to impose the FMCSRs on previously unregulated smaller capacity vehicles, or to exempt through a rulemaking proceeding some or all of the operators of such vehicles. The statute provided that operators of small passenger-carrying vehicles would automatically become subject to the FMCSRs unless the agency, through a rulemaking proceeding, determines that it is appropriate to exempt such operators from the safety regulations.

While none of the commenters responded to the request for information about potential impacts of the rulemaking on small entities, the TLPA estimated that if the agency made the FMCSRs applicable to the operation of small passenger-carrying vehicles, approximately 14,000 companies, 125,000 vehicles, and 165,000 drivers would be covered. The agency reviewed its database of for-hire interstate motor carriers of passengers to determine whether TLPA's estimate was reasonable. At that time, we indicated there were 1,636 for-hire motor carriers of passengers with active operating authority that had on file with the

''Receipts'' means the firm's gross or total income, plus cost of goods sold, as defined by or reported on the firm's Federal Income Tax return. Therefore, only those motor carriers of passengers that averaged $6,000,000 or less in annual receipts for the past 3 fiscal years would be considered small businesses for the purposes of the regulatory flexibility analysis.

agency proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. Recognizing that TLPA's estimate included a wide range of passenger-carrying operations that far exceeded the limited number of carriers with active operating authority, the agency stated that it could not confirm the accuracy of the number.

The September 3, 1999 NPRM proposed that each motor carrier operating small passenger-carrying vehicles submit a Motor Carrier Identification Report (FMCSA Form MCS–150), maintain an accident register, and mark their CMVs with the motor carrier identification number assigned by the agency (64 FR 48518). The agency stated that this would provide it with information about the number of passenger carriers, their business locations, and the number of drivers employed and vehicles operated. We believed that the proposal could affect a substantial number of small entities, but would not have a significant impact on them. The agency stated that if the TLPA's estimate of 14,000 interstate motor carriers operating CMVs designed or used to transport 9- to 15- passengers was accurate, and most or all of these businesses are classified as small businesses by SBA, the rulemaking would affect up to 14,000 small entities. The agency provided examples of the potential costs to mark each vehicle, in accordance with 49 CFR 390.21, with a worse case scenario of a one-time cost of $420 for a carrier with a fleet of 20 vehicles.

With the enactment of MCSIA, the agency was required to take a more aggressive regulatory approach and impose safety requirements on: (1) Commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks. Therefore, the agency was required to continue the series of rulemaking actions in the absence of definitive industry characteristic and safety performance data, including data concerning the potential impact on small businesses that would be made subject to the FMCSRs.

On January 11, 2001, FMCSA issued a final rule adopting the statutory definition of CMV as revised by section 4008 of TEA–21, and requiring motor carriers operating small passenger-carrying vehicles to submit the identification report, mark their vehicles, and maintain an accident register (66 FR 2756). On the same day, in response to section 212 of MCSIA, the agency issued an NPRM (66 FR 2767) proposing that motor carriers operating vehicles designed or used to transport between 9 and 15 passengers (including the driver) in interstate commerce comply with the safety regulations when they are directly compensated for such services, and the transportation of any of the passengers covers a distance greater than 75 air miles (86.3 statute miles).

FMCSA indicated that in order to avoid underestimating the potential impact of the rule on small entities, it estimated that 1,648 passenger carriers would be subject to the proposed requirements. This estimate was based on the number of for-hire motor carriers of passengers with active authority to operate CMVs with a seating capacity of 15 passengers or less. The agency argued that using the estimate of 1,648 carriers from the database of motor carriers of passengers provided a reasonable estimate of the number of entities that could be subject to the proposed rules. The agency estimated that the costs per carrier would be $6,200 for the first year the requirements are in effect, and $6,100 per year thereafter, if the costs are distributed evenly among the carriers.

FMCSA estimated that the costs per carrier associated with the NPRM would, on average, be 2.2 percent of their revenues based on data from the SBA's 1997 ''Employer Firms, Employment and Estimated Receipts by Employment Size of Firm'' tables. The agency reviewed revenues for motor carriers in the intercity and rural bus transportation segment of the industry. The SBA data indicated there are 145 firms in this category with less than 20 employees—the 20-employee threshold was chosen by FMCSA to be consistent with its estimate of the average number of drivers likely to be employed by the 1,648 for-hire passenger carriers. These 145 carriers had combined revenues of $41,793,000. The average revenues were considered by dividing the combined revenues by the total number of firms, or $288,227 in revenues per year for each carrier.

FMCSA made a preliminary determination that the proposed rule would not affect a substantial number of small entities because it would be applicable to only a fraction of the 14,000 entities operating 9- to 15-passenger vehicles for compensation. However, the agency recognized that the NPRM would have a significant impact on some of the small entities, especially in those cases where the profit margins are approximately 2.2 percent or less. The agency indicated that there is a possibility for failure of some small passenger-carrying CMV operations, especially those with profit margins of 2.2 percent or less. Because it was limiting the applicability of the rules to only a fraction of the universe of eligible small entities (thus minimizing the overall impact), and the estimated costs of the rule would be 2.2 percent of the revenues of the affected small entities, the agency did not believe that a more comprehensive analysis was needed to ensure compliance with the Regulatory Flexibility Act. This was particularly in view of the fact that the agency was statutorily required to regulate operators of 9- to 15-passenger vehicles and had exercised its discretion, as limited by MCSIA, to minimize the impact on small entities.

After publication of the January 11, 2001 NPRM, the agency increased its estimate of the potential costs of the rule for small entities based on: (1) A revision of the estimated information collection burden for driver records of duty status; (2) a correction of the estimate of the costs for medical examinations for drivers; and (3) consultation with SBA about the number of small businesses and their revenues.

First, the agency revised the estimated costs associated with the information collection burden for drivers' records of duty status, and submitted the revised estimate to OMB for approval. The agency estimated that the information collection burden for the records of duty status (required by 49 CFR part 395) for the operators of 9- to 15-passenger vehicles would be 137,250 hours, based on an estimated 18,300 drivers being subject to the requirements. Using the new estimates, approved by OMB [OMB Control No. 2126–0001] on information collection burden for the records of duty status, and applying the burden per driver and carrier to the entities that would operate small passenger-carrying CMVs, the agency now believes the additional burden would be 836,000 annual burden hours, for approximately 22,000 drivers. The result of the increased estimate of the annual burden hours for completing and retaining the records of duty status, and an increase in the number of drivers that would be subject to the hours of service rules, is an increase from $2,539 per carrier per year for such records to $7,012 per carrier per year.

FMCSA also revised its estimates of the costs for medical examinations of drivers. The agency's previous calculations included an error resulting in an estimate of $1,718 per carrier per year. A correction of the error, plus a revision of the estimate of the number

of drivers yields an estimate of $3,844 per carrier per year for medical examinations.

As indicated earlier, FMCSA estimates that the sum of all estimated costs of requiring operators of small passenger-carrying CMVs to comply with 49 CFR parts 391, 395, and 396 is approximately $23,850,000 for the first year and $20,184,234 per year thereafter. If the costs of the rulemaking are distributed evenly among these 1,843 motor carriers, the costs per carrier would be approximately $12,940 for the first year the requirements are in effect, and a little more than $10,952 per year thereafter.

A summary of the estimated first-year costs per motor carrier is presented below:

Summary of First-Year Costs Per Motor Carrier to Comply with the FMCSRs
$3,844 for medical exams
$102 for driver qualifications files ($35 subsequent years)
$7,012 for hours-of-service recordkeeping
$1,982 for inspection, repair, and maintenance
Total: $12,940

The actual costs each individual fleet would experience depend on the number of drivers employed and the number of small passenger-carrying CMVs operated. The above estimates are intended to serve as a baseline of 10 CMVs per fleet and about 11 drivers per business. Driver-related costs, such as driver qualifications and hours-of-service, for each business would decrease or increase as the number of drivers employed decreases below the baseline or increases above the baseline. The same holds true for vehicle-related costs.

In order to better determine the potential impact on small businesses, FMCSA met with representatives of SBA. As a result of that meeting, the FMCSA reviewed the U.S. Department of Commerce's 1997 Economic Census, Transportation and Warehousing (Publication No. EC 97T48S–LS, Issued August 2000) to better determine the revenues of businesses under the NAICS subsector 485, which covers transit and ground transportation, and more accurately assess the number of small entities based on SBA's $6,000,000 threshold for defining a small business in the passenger transportation industry.

For businesses covered by NAICS code 4852, interurban and rural bus transportation, the 1997 census data indicate there are 407 firms with combined revenues of $1,147,432,000. For the purposes of this analysis, the revenues for the businesses in this group were divided by the number of firms resulting in an estimate of $2,819,243 in revenues per year for each carrier [$1,147,432,000/407 firms = $2,819,243].

The agency also considered businesses covered by NAICS code 4853, taxi and limousine service. The 1997 census data indicate there are 6,418 firms with combined revenues of $3,154,521,000. For purposes of this analysis, the revenues for businesses in this group were also divided by the number of firms resulting in an estimate of $491,511 in revenues per year for each carrier [($3,154,521,000/6,418) = $491,511].

Based on the estimates above for the revenues per firm for interurban and rural bus transportation businesses, and revenues per firm for taxi and limousine service businesses, FMCSA believes that most, if not all, of the firms in these categories appear to be small businesses based on SBA's $6,000,000 threshold.

The costs per carrier associated with this rule would, on average, be approximately 0.45 percent of the revenues for interurban and rural bus services [($12,940 costs per carrier)/($2,819,243 revenues per carrier) x 100 = 0.45 percent], and 2.6 percent of the revenues for taxi and limousine services [($12,940 costs per carrier)/$491,511 revenues per carrier) x 100 = 2.6 percent].

For interurban and rural bus services with a profit margin greater than 0.45 percent, the new rule will decrease their profits but the businesses would maintain some level of profit. For bus services with profit margins of 0.45 percent or less, the rule could result in the failure of the business. Likewise, for taxi and limousine services with a profit margin greater than 2.6 percent, the rule would decrease their profits but the businesses would maintain some level of profit. For taxi and limousine businesses with profit margins of 2.6

percent or less, the rule could result in failure of the business.

FMCSA does not have data on the revenues or profit margins of the 1,843 motor carriers likely to be impacted by the rule or more precise information about their revenues. Also, the agency does not have sufficient data about these motor carriers to determine the distribution of drivers and vehicles, such as the number of carriers with 1 to 5 vehicles, the number of carriers with 6 to 10 vehicles, the number of carriers with 11 to 20 vehicles, and similar data for the number of drivers, to make more precise its estimates concerning revenues. However, the agency believes it is appropriate to consider all 1,843 motor carriers of passengers likely to be affected by this rulemaking to be small entities to avoid underestimating the impact this rule will have on them. The agency believes the estimates presented above are reasonable given the limited information available about this segment of the motor carrier industry. Therefore, the agency has made a determination that this rule would not affect a substantial number of small entities. However, it could have a significant impact on some of these 1,843 small entities, especially in those cases where the profit margins are approximately 2.6 percent or less.

FMCSA has considered the comments to the previous rulemaking documents concerning the regulation of small passenger-carrying CMVs, and believes this group of motor carriers provides an important service to its clients. These motor carriers provide services to individuals for whom motor coach services are not available, those who may not be able to afford to use motor coach operators, or individuals who choose, for whatever reason, not to use motor coach operators for their intercity travel. The agency believes the industry is very important to those who rely on it. There is a possibility for failure of some small passenger-carrying CMV operations, especially those with profit margins of 2.6 percent or less. However, the number of failures among the estimated 1,843 motor carriers operating small passenger-carrying CMVs is expected to be small. Therefore, the agency believes there could be a small degree of disruption in the services provided by small passenger-carrying CMV operations that are not capable of putting into place the safety management controls necessary to achieve compliance with 49 CFR parts 390, 391, 392, 393, 395, and 396.

FMCSA has considered other regulatory alternatives as described earlier, and determined that this action is necessary to fulfill section 212 of the MCSIA and respond to the safety problem indicated by the FARS and General Estimates System (GES) data. It is unlikely that a rule establishing less stringent requirements would have the same potential for improving the safety of operations of these CMVs.

Accordingly, FMCSA has considered the economic impacts of the requirements on small entities and certifies that this rule will not have a significant economic impact on a substantial number of small entities.

Intergovernmental Review

Catalog of Federal Domestic Assistance Program Number 20.217, Motor Carrier Safety. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities do not apply to this program.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct, sponsor, or require through regulations. FMCSA determined that the requirements in this final rule will impact four currently-approved information collections. FMCSA is requiring that motor carriers operating CMVs designed or used to transport 9- to 15- passengers be required to meet the recordkeeping requirements of 49 CFR parts 391, 395, and 396.

Medical Examination and Certification—OMB Control No. 2126–0006

Drivers operating CMVs designed or used to transport between 9 and 15 passengers will be required to meet the medical examination and certification requirements at 49 CFR part 391, subpart E. The information collection requirements related to that subpart have been approved by the OMB under provisions of the PRA and assigned the OMB Control No. 2126–0006, which is currently due to expire on October 31, 2003. FMCSA estimates it takes a medical examiner approximately 20 minutes to complete and document the medical examination and 1 minute to complete the medical certificate, and that it takes a motor carrier approximately 1 minute to make a copy of the medical certificate and file it. Therefore, the total time associated with this information collection, per driver, is 22 minutes. FMCSA estimates that approximately 22,000 drivers will be subject to the final rule. The estimated burden for the first year will be 8,067 burden hours [22,000 drivers × 22 minutes per driver, divided by 60 minutes in an hour]. Since the medical examiner's certificate is usually made valid for 24 months, the prorated annual burden will be approximately half that amount. Therefore, the annual burden hours will be 4,034. FMCSA submitted the amended medical qualification information collection to the OMB for review and approval.

Driver Qualification Files—OMB Approval No. 2126–0004

Motor carriers that employ drivers of CMVs designed or used to transport between 9 and 15 passengers will be required to maintain a complete driver qualification file for each driver in accordance with 49 CFR 391.51. The information collection requirements related to driver qualification files have been approved by the OMB under the provisions of the PRA and assigned the OMB Control No. 2126–0004, which is currently due to expire on August 31, 2004. The following components are involved in this information collection: driver's employment application (2 minutes for drivers), review of driver's employment application (1 minute for motor carriers), initial inquiry of driving record and investigation of employment (15 minutes for motor carriers), list or certification of violations (2 minutes for drivers), and annual review of driving record (5 minutes for motor carriers). The burden hour estimate associated with this information collection is 25 minutes per driver, which includes 21 minutes for motor carriers and 4 minutes for drivers. Therefore, FMCSA estimates that the addition of the 22,000 drivers who will be subject to this final rule will increase the burden hours of this information collection by 9,167 [22,000 drivers × 25 minutes, divided by 60 minutes in an hour]. FMCSA submitted the amended driver qualification information collection to OMB for review and approval.

Records of Duty Status—OMB Control No. 2126–0001

Drivers operating CMVs designed or used to transport between 9 and 15 passengers will be required to record their duty status in accordance with 49 CFR 395.8. The information collection requirements related to records of duty status have been approved by the OMB under the provisions of the PRA and assigned the OMB Control No. 2126–0001, which expires on March 31, 2005. FMCSA estimates the annual burden on each CMV driver to be approximately 26 hours [6 minutes and 30 seconds for each daily log × 240 workdays a year, divided by 60 minutes in an hour]. The

total burden for the 22,000 drivers affected by this rule will be 572,000 [22,000 drivers × 26 hours per year]. In addition, each motor carrier affected by this rule will have a supervisor responsible for reviewing its driver records of duty status and that the supervisor will spend approximately 12 hours per year reviewing these records to ensure compliance with the hours-of-service rules [3 minutes per day to review logs × 240 workdays]. The total burden for the supervisors of the 22,000 drivers affected by this rule will be 264,000 [22,000 drivers × 12 hours per year]. Therefore, the total additional burden for OMB Control No. 2126–0001 will be 836,000 annual burden hours [572,000 + 264,000]. FMCSA submitted the amended driver records of duty status information collection to OMB for review and approval.

Vehicle Inspection, Repair, and Maintenance—OMB Control No. 2126–0003

Motor carriers operating CMVs designed or used to transport between 9 and 15 passengers for direct compensation will be required to maintain records of inspection, repair, and maintenance for their CMVs in accordance with 49 CFR part 396. The information collection requirements related to inspection, repair, and maintenance have been approved by the OMB under the provisions of the PRA and assigned OMB Control No. 2126–0003, which expires on May 31, 2004. FMCSA estimates that it will take a total expenditure of 12 hours and 57 minutes (or 777 minutes) per year per CMV to complete the required recordkeeping related to vehicular inspection, repair, and maintenance (48 minutes per vehicle for systematic inspection, repair, and maintenance; 12 hours and 4 minutes per year per vehicle for driver vehicle inspection reports; and 5 minutes per year per vehicle for periodic inspection).

Evidence of an individual's qualifications to perform periodic vehicle inspections must be retained by the motor carrier. Evidence of an individual's qualifications to be a brake inspector must also be retained. The creation of these two types of qualification evidence involves an estimated one-time, non-recurring expenditure of 5 minutes by a safety director, driver supervisor, or equivalent position for each type of inspector. Based on an estimate of 1,843 motor carriers that will be subject to the rule and on the assumption that each motor carrier has at least (1) one employee who is a qualified periodic vehicle inspector and (2) one employee who is a qualified brake inspector, the estimated total time burden related to the inspector qualifications rules is approximately 307 annual burden hours [(5 minutes for each periodic vehicle inspector certification × 1,843 motor carriers) + (5 minutes for each brake inspector certification × 1,843 motor carriers) = 18,430 minutes, divided by 60 minutes in an hour = 307 hours].

FMCSA estimates that the total inspection, repair, and maintenance recordkeeping burden is approximately 238,976 burden hours per year [18,430 CMVs × 777 minutes (or 12 hours and 57 minutes) per year per CMV, divided by 60 minutes in an hour = 238,669, plus an additional 307 = 238,976]. FMCSA submitted the amended inspection, repair, and maintenance information to OMB for review and approval.

The total estimated additional burden hours imposed by this rule will be 1,088,177 [4,034 (associated with OMB Control No. 2126–0006) + 9,167 (associated with OMB Control No. 2126–0004) + 836,000 (associated with OMB Control No. 2126–0001) + 238,976 (associated with OMB Control No. 2126–0003)]. The following table displays this information:

OMB control No.	Currently-approved annual burden hours	Additional burden hours associated with this final rule
2126–0006	1,180,792	4,034
2126–0004	941,856	9,167
2126–0001	161,364,492	836,000
2126–0003	35,107,856	238,976
Total ...	198,594,996	1,088,177

In the NPRM stage, we requested comments regarding the information collection burden hour estimates. However, no comments were received during the NPRM comment period regarding the estimated information collection burdens.

National Environmental Policy Act

The agency has analyzed this rulemaking for purposes of the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*) and has determined that this action does not have any effect on the quality of the environment.

Energy Effects

We have analyzed this action 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 economically significant and is not likely to have a significant adverse effect on the supply, distribution, or use of energy.

Unfunded Mandates Reform Act of 1995

This final rule does not impose an unfunded mandate, as defined by the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532 *et seq.*), that will result in a $100 million or more expenditure (adjusted annually for inflation) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector.

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 action 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 safety that may disproportionately affect children.

Taking of Private Property

This final 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.

Federalism Assessment

We have analyzed this rule in accordance with the principles and criteria of Executive Order 13132, Federalism. We have determined that this action does not have a substantial direct effect on States or impose additional costs or burdens on the States. Nothing in this document limits the policymaking discretion of the States or directly preempts any State law or regulation. Therefore, we have determined that this final rule does not have federalism implications.

List of Subjects

49 CFR Part 390

Highway safety, Intermodal transportation, Motor carriers, Motor vehicle safety, Reporting and recordkeeping requirements.

49 CFR Part 398

Highway safety, Migrant labor, Motor carriers, Motor vehicle safety, Reporting and recordkeeping requirements.

■ For the reasons discussed in the preamble, the Federal Motor Carrier Safety Administration amends title 49,

Code of Federal Regulations, parts 385, 390, and 398 as follows:

PART 390—FEDERAL MOTOR CARRIER SAFETY REGULATIONS; GENERAL

■ 1. The authority citation for part 390 is revised to read as follows:

Authority: 49 U.S.C. 13301, 13902, 31132, 31133, 31136, 31502, and 31504; sec. 204, Pub. L. 104–88, 109 Stat. 803, 941 (49 U.S.C. 701 note); secs. 212 and 217, Pub. L. 106–159, 113 Stat. 1748, 1766, 1767; and 49 CFR 1.73.

■ 2. Amend § 390.3 by revising paragraph (f)(6) to read as follows:

§ 390.3 General applicability.

(f) * * *

(6)(i) The operation of commercial motor vehicles designed or used to transport between 9 and 15 passengers (including the driver), not for direct compensation, provided the vehicle does not otherwise meet the definition of a commercial motor vehicle, except that motor carriers operating such vehicles are required to comply with §§ 390.15, 390.19, and 390.21(a) and (b)(2).

(ii) The operation of commercial motor vehicles designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation, provided the vehicle is not being operated beyond a 75 air-mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location, and provided the vehicle does not otherwise meet the definition of a commercial motor vehicle, except that motor carriers operating such vehicles are required to comply with §§ 390.15, 390.19, and 390.21(a) and (b)(2).

■ 3. Amend § 390.5 by adding a definition for ''direct compensation,'' in alphabetical order to read as follows:

§ 390.5 Definitions.

* * * * *

Direct compensation means payment made to the motor carrier by the passengers or a person acting on behalf of the passengers for the transportation services provided, and not included in a total package charge or other assessment for highway transportation services.

* * * * *

PART 398—TRANSPORTATION OF MIGRANT WORKERS

■ 4. The authority citation for part 398 is revised to read as follows:

Authority: 49 U.S.C. 13301, 13902, 31132, 31133, 31136, 31502, and 31504; sec. 204, Pub. L. 104–88, 109 Stat. 803, 941 (49 U.S.C. 701 note); sec. 212, Pub. L. 106–159, 113 Stat. 1748, 1766; and 49 CFR 1.73.

■ 5. Revise § 398.2 to read as follows:

§ 398.2 Applicability.

(a) *General.* The regulations prescribed in this part are applicable to carriers of migrant workers by motor vehicle, as defined in § 398.1(b), but only in the case of transportation of any migrant worker for a total distance of more than 75 miles (120.7 kilometers) in interstate commerce, as defined in 49 CFR 390.5.

(b) *Exception.*

(1) The regulations prescribed in this part are not applicable to carriers of migrant workers by motor vehicle, as defined in § 398.1(b), when:

(i) The motor vehicle is designed or used to transport between 9 and 15 passengers (including the driver);

(ii) The motor carrier is directly compensated for the transportation service; and

(iii) The vehicle used to transport mirgrant workers is operated beyond a 75 air-mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location.

(2) Carriers of migrant workers by motor vehicle that operate vehicles, designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation, in interstate commerce, must comply with the applicable requirements of 49 CFR parts 385, 390, 391, 392, 393, 395, and 396, when the motor vehicle is operated beyond a 75 air-mile radius (86.3 statute miles or 138.9 kilometers) from the driver's normal work-reporting location.

* * * * *

Issued on: August 5, 2003.

Annette M. Sandberg.

Administrator.

[FR Doc. 03–20369 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 021212307–3037–02; I.D. 080103C]

Fisheries of the Exclusive Economic Zone Off Alaska; Non-Community Development Quota Pollock with Trawl Gear in the Chinook Salmon Savings Areas of the 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 prohibiting directed fishing for non-Community Development Quota (CDQ) pollock with trawl gear in the Chinook Salmon Savings Areas of the Bering Sea and Aleutian Islands management area (BSAI). This action is necessary to prevent exceeding the 2003 non-CDQ limit of chinook salmon caught by vessels using trawl gear while directed fishing for pollock in the BSAI.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), September 1, 2003, through 2400 hrs, A.l.t., December 31, 2003.

FOR FURTHER INFORMATION CONTACT: Mary Furuness, 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.

For 2003, the chinook salmon PSC limit for the pollock fishery was set at 33,000 fish (68 FR 9907, March 3, 2003). Of that limit, 7.5 percent is allocated to the groundfish CDQ program as prohibited species quota reserve. Consequently, the 2003 non-CDQ limit of chinook salmon caught by vessels using trawl gear while directed fishing for pollock in the BSAI, is 30,525 animals (§ 679.21(e)(1)(i) and (vii)).

In accordance with § 679.21(e)(7)(viii), the Administrator, Alaska Region, NMFS (Regional Administrator), has determined that the 2003 non-CDQ limit of chinook salmon caught by vessels using trawl gear while directed fishing for pollock in the BSAI has been reached. Consequently, the Regional Administrator is prohibiting directed fishing for non-CDQ pollock with trawl gear in the Chinook Salmon Savings Areas defined at Figure 8 to 50 CFR part 679.

Maximum retainable 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 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) as such requirement is contrary to the public interest. This requirement is contrary to the public interest as it would delay the closure of the fishery, lead to exceeding the 2003 non-CDQ limit of chinook salmon caught by vessels using trawl gear while directed fishing for pollock in the BSAI, and therefore reduce the public's ability to use and enjoy the fishery resource.

The Assistant Administrator for Fisheries, NOAA also finds good cause to waive the 30–day delay in the effective date of this action under 5 U.S.C. 553(d)(3). This finding is based upon the reasons provided above for waiver of prior notice and opportunity for public comment.

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: August 6, 2003.

Bruce C. Morehead,

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

[FR Doc. 03–20515 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 68, No. 155
Tuesday, August 12, 2003

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

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 532

RIN 3206–AJ79

Prevailing Rate Systems; Change in Federal Wage System Survey Job

AGENCY: Office of Personnel Management.

ACTION: Proposed rule with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing a proposed rule that would change a Federal Wage System appropriated fund optional survey job, Industrial Electronic Controls Repairer, so that its grade level and title would better reflect the level of work and occupational title that private industry typically uses. This change would enable the Department of Defense to collect more wage data when conducting local wage surveys to set pay levels for the Government's blue-collar workforce.

DATES: Comments must be received on or before September 11, 2003.

ADDRESSES: Send or deliver comments to Donald J. Winstead, Deputy Associate Director for Pay and Performance Policy, Strategic Human Resources Policy Division, Office of Personnel Management, Room 7H31, 1900 E Street, NW., Washington, DC 20415–8200; e-mail *payleave@opm.gov*; or FAX: (202) 606–4264.

FOR FURTHER INFORMATION CONTACT: Mark A. Allen, (202) 606–2848; e-mail *maallen@opm.gov*; or FAX: (202) 606–4264.

SUPPLEMENTARY INFORMATION: The Federal Prevailing Rate Advisory Committee (FPRAC), the national labor-management committee responsible for advising the Office of Personnel Management (OPM) on matters concerning the pay of Federal Wage System (FWS) employees, established a Survey Job Work Group (SJWG) to review the survey job descriptions the Department of Defense (DOD) uses during FWS local wage surveys to determine prevailing rates of pay for FWS employees. DOD contacts private sector employers annually in each of the 132 appropriated fund FWS wage areas to determine prevailing rates of pay.

The SJWG has recommended that OPM change the title of the optional survey job, ''Industrial Electronic Controls Repairer'' to ''Electronic Industrial Controls Mechanic,'' and the grade level of the survey job from WG–10 to WG–11. The change in job title is proposed so that it would conform to the title of the FWS job grading standards for the occupation, a title now also more commonly used in private industry. The change in grade would better reflect the grade level of the work that Federal employees are currently doing. When the job is surveyed in the future, it is anticipated that DOD would be able to collect more private sector wage data for the occupation. FPRAC agreed with the Work Group's recommendations.

Regulatory Flexibility Act

I certify that this regulation would not have a significant economic impact on a substantial number of small entities because it would affect only Federal agencies and employees.

List of Subjects in 5 CFR Part 532

Administrative practice and procedure, Claims, Freedom of information, Government employees, Reporting and recordkeeping requirements, Wages.

Office of Personnel Management.

Kay Coles James,

Director.

Accordingly, the Office of Personnel Management is proposing to amend 5 CFR part 532 as follows:

PART 532—PREVAILING RATE SYSTEMS

1. The authority citation for part 532 continues to read as follows:

Authority: 5 U.S.C. 5343, 5346; § 532.707 also issued under 5 U.S.C. 552.

§ 532.217 [Amended]

2. In § 532.217, paragraph (c) table is amended by removing the job title entry ''Industrial Electronic Controls Repairer'', and its corresponding job grade ''10'', and adding in its place ''Electronic Industrial Controls Mechanic'', grade ''11''.

[FR Doc. 03–20445 Filed 8–11–03; 8:45 am]
BILLING CODE 6325–39–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

RIN 0960–AF78

Entitlement and Termination Requirements for Stepchildren

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Social Security Administration (SSA) proposes to amend its regulations to incorporate the changes to the entitlement and termination requirements for stepchild's benefits introduced by the Contract with America Advancement Act of 1996. Under the changes, a stepchild is considered dependent upon a stepparent for Social Security benefit purposes only if he or she receives at least one-half support from the stepparent. The fact that a stepchild may be living with a stepparent is no longer a basis for a dependency determination. The changes also require benefit termination when the stepchild's natural parent and stepparent divorce (unless the stepchild has been adopted by the stepparent and can qualify for benefits as his or her adopted child). We propose to extend the termination requirement to include: A divorce that ends the marriage between a stepchild's *adoptive* parent and stepparent; and a *prospective annulment* that ends the marriage between a stepchild's natural or adoptive parent and stepparent. We also propose to include in the regulations our longstanding practice of terminating a stepchild's benefits when the marriage between the stepchild's parent and the stepparent is annulled from the beginning (*ab initio*). These rules would reflect enacted legislation and provide accurate and complete guidelines for determining entitlement to benefits.

DATES: In order for your comments to be considered, you must submit them on or before October 14, 2003.

ADDRESSES: You may give us your comments by using: our Internet site facility (*i.e., Social Security Online*) at *http://policy.ssa.gov/pnpublic.nsf/*

LawsRegs, e-mail to *regulations@ssa.gov;* telefax to (410) 966–2830; or by letter to the Commissioner of Social Security, P.O. Box 17703, Baltimore, Maryland 21235–7703. You may also deliver them to the Office of Regulations, Social Security Administration, Room 100 Altmeyer, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, between 8 a.m. and 4:30 p.m. on regular business days. Comments are posted on our Internet site, or you may inspect them on regular business days by making arrangements with the contact person shown in this preamble.

Electronic Version: The electronic file of this document is available on the date of publication in the **Federal Register** on the Internet site for the Government Printing Office: *http://www.gpoaccess.gov/fr/index.html.* It is also available on the Internet site for SSA (*i.e., Social Security Online*) at *http://policy.ssa.gov/pnpublic.nsf/LawsRegs.*

FOR FURTHER INFORMATION CONTACT: Sherry Pollack, Social Insurance Specialist, Office of Income Security Programs, Social Security Administration, #153 RRCC, 6401 Security Boulevard, Baltimore, MD 21235–6401, *regulations@ssa.gov,* (410) 965–7915 or TTY (410) 966–5609 for information about these proposed rules.

For information on eligibility or filing for benefits, call our national toll-free numbers, 1–800–772–1213 or TTY 1–800–325–0778 or visit our Internet Web site, *Social Security Online*, at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION:

Background

Section 104 of the Contract with America Advancement Act of 1996 (Pub. L. 104–121) changed the entitlement and termination requirements for stepchild's benefits under the Social Security Act (the Act).

Under prior law:

- The stepparent's divorce from the stepchild's parent did not terminate the stepchild's entitlement to child's benefits; and
- A stepchild was considered dependent upon the stepparent if the child was either living with or receiving at least one-half support from the stepparent at the applicable time under the statute.

Under the statutory changes:

- A stepchild's entitlement to child's benefits on a stepparent's record ends with the month the divorce between the child's natural parent and stepparent becomes final (unless the stepchild has been adopted by the stepparent and can qualify for benefits as his or her adopted child); and
- To be entitled to child's benefits based on a stepparent's record, a child is considered dependent upon the stepparent only if the stepparent was providing at least one-half of the child's support at the applicable time. ''Living with'' the stepparent is no longer a factor in determining stepchild dependency.

One-Half Support as the Sole Basis for a Stepchild's Dependency on a Stepparent

Under section 202(d)(1)(C) of the Act, a stepchild's dependency upon the stepparent at a statutorily specified time is a requirement for entitlement to benefits on the stepparent's Social Security earnings record. Prior to the Contract with America Advancement Act of 1996, under section 202(d)(4) of the Social Security Act, a stepchild was considered dependent upon a stepparent if the stepchild was either living with or receiving at least one-half of his or her support from the stepparent at the applicable time under the statute. Under the legislative amendment to section 202(d)(4) of the Act, in section 104(a) of the Contract with America Advancement Act, a stepchild is considered dependent upon a stepparent only if he or she receives at least one-half support from the stepparent. Living with a stepparent is no longer a basis for a dependency determination. Consequently, we propose to eliminate the reference to the ''living with'' standard from our regulation on stepchild dependency, § 404.363 of our regulations. Under section 104(a)(2) of the Contract with America Advancement Act of 1996, this policy applies to benefits of individuals who become entitled to such benefits for months after June 1996.

Extending the Stepchild Benefit Termination Requirement to a Divorce Between the Stepchild's Adoptive Parent and Stepparent

Section 104(b) of the Contract with America Advancement Act of 1996 amended section 202(d)(1) of the Act to provide for termination of a stepchild's benefits upon the divorce of the stepparent and the stepchild's *natural* parent. Section 104(b) did not, however, explicitly provide for the termination of a stepchild's benefits upon the divorce of the stepparent and the child's *adoptive* parent. We propose to apply the stepchild termination provision upon the divorce of the stepparent and the stepchild's *natural or adoptive parent.* We believe that there is a clear basis for this approach.

A marriage between the child's adoptive parent and the stepparent establishes a stepchild relationship for entitlement purposes. Under § 404.357, an individual can qualify as the insured's stepchild if the child's natural *or* adoptive parent married the insured. This established rule parallels other benefit eligibility provisions of the Act that routinely place natural and adoptive parenting on equal footing. *See, e.g.*, sections 202(d)(1), 202(d)(3), 202(d)(8), and 216(e) of the Act. Once a natural or adopted child establishes a right to Social Security benefits, benefit termination does not normally depend on the child's natural or adopted status. *See* section 202(d)(1) of the Act; *see* also § 404.352(b). A rule ending stepchild's benefits upon divorce only when a natural parent and stepparent divorce therefore represents a departure from policies in surrounding statutory benefit provisions.

Apart from using the term ''natural parent,'' the amendments to the Social Security Act's stepchild benefit provisions in the Contract with America Advancement Act of 1996 similarly reflect the above-described parallel treatment of natural and adopted children. Section 104(b)(2) of the Contract with America Advancement Act added section 202(d)(10) to the Social Security Act. Section 202(d)(10) states that for purposes of the new provision requiring termination of stepchild's benefits upon the parents' divorce, ''each stepparent shall notify the Commissioner of Social Security of any divorce upon such divorce becoming final'' * * * This provision by its terms affects ''each'' insured stepparent of a stepchild beneficiary. It requires stepparents to inform SSA of ''any divorce,'' and not simply divorces from a child's natural parent, thus indicating that any divorce by a stepparent is significant for stepchild benefit purposes.

Discussions of the changes to the stepchild benefit rules in the legislative history of the Contract with America Advancement Act of 1996 similarly reflect a preference for equal treatment of natural and adopted children. The relevant legislative history involves a connection between the dependency test applicable to stepchildren and the requirement for stepchild benefit termination upon parental divorce. The Contract with America Advancement Act of 1996 changed the dependency test in section 202(d)(4) of the Social Security Act by making receipt of at least one-half support the sole basis upon which a stepchild can be considered dependent upon his or her stepparent. It did not, however, change

the universe of stepchildren to whom the dependency test applies. Section 202(d)(4) of the Act applies to all children seeking entitlement to benefits as a stepchild. Our regulations set out at § 404.363 provide, with respect to the dependency requirement as it existed before the enactment of the Contract with America Advancement Act of 1996, that stepchild dependency requirements apply to a stepchild ''as defined in § 404.357 * * *'', *i.e.*, a child whose natural or adopting parent married the insured. The Contract with America Advancement Act of 1996 did not alter the effect of this language. Therefore, under the law as amended by that Act, and as previously, both a natural child and an adopted child of the stepparent's spouse must show that the stepparent provided at least one-half of the stepchild's support at the applicable time.

Reports by the House Ways and Means Committee on the 1996 legislation consistently discuss the above-described stepchild dependency rules in the same context as the new provision mandating benefit termination when the stepchild's parents divorce. For example, a Report on Legislative and Oversight Activity of the Committee on Ways and Means during the 104th Congress discusses the change in the dependency requirement, which is applicable to all stepchildren. It immediately thereafter states, without qualification, that ''[in] cases of a subsequent divorce * * * benefits to stepchildren terminate * * *'' H.R. Rep. 104–872 at 36, 104th Cong., 2nd Sess. 1997, 1996 WL 760037 (Leg. Hist.). The legislative history thereby supports the conclusion that both the dependency requirement and the termination provision apply to the same universe of beneficiaries, *i.e.*, all stepchildren. It suggests an intention to equate natural and adopted children, as under previous law. Significantly, apart from repeating the term ''natural parent'' as found in the statute, it suggests no basis for an uncharacteristic statutory rule terminating benefits of only the natural children of stepparents' spouses. Limiting the termination requirement to situations involving divorces of natural parents therefore is not only an unusual departure from previously existing law, but is incompatible with the logical structure of the relevant 1996 legislative changes as well.

We view section 104(b) of the Contract with America Advancement Act of 1996 in light of the overall changes to stepchild benefit provisions of that Act, the legislative history of that Act, and related portions of the Social Security Act. When so considered, apart from the use of the term ''natural parent,'' the legislation and its legislative history provide no indication of an intention to terminate benefits only of natural children of the spouses of stepparents upon a divorce. Under the most logical reading of the term ''natural parent'' in context, it merely distinguishes the other parent involved in a divorce from the stepparent, and that is how we interpret the term in issuing these regulations.

We, therefore, propose to add a new paragraph (b)(7) to § 404.352 of our regulations to apply this policy and would apply it from the effective date of the corresponding provision of the Contract with America Advancement Act of 1996, section 104(b)(1). Accordingly, under section 104(b)(3) of that Act, we propose to apply the policy to final divorces of stepparents from adoptive parents occurring after June 1996.

Extending the Stepchild Benefit Termination Provision to a Prospective Annulment of the Marriage Between the Stepparent and the Child's Parent

Under our proposed regulations, if a voidable marriage between the stepparent and the child's natural or adoptive parent is annulled prospectively, the stepchild's benefits end with the month in which the annulment becomes final. A voidable marriage is flawed at its inception and could be declared invalid at any time after inception. However, the marriage remains valid until a court declares it invalid. If the parties to a voidable marriage do not exercise their legal right to annul the marriage, the marriage is binding. When an annulment operates prospectively, rather than from the beginning (*ab initio*), the annulment is very similar to divorce, since the marriage ceases to exist from the point at which it is annulled. Moreover, if we did not terminate stepchild benefits upon a prospective annulment of the parent and stepparent's marriage, we would be treating cases involving legally flawed marriages ended by annulment more favorably than cases involving legally valid marriages ended by divorce. We, therefore, propose to include this policy in the new paragraph (b)(7) we would add to § 404.352 and to apply it from the effective date of the corresponding provision of the Contract with America Advancement Act of 1996, section 104(b)(1). Accordingly, under section 104(b)(3) of that Act, we propose to apply the policy to prospective annulments occurring after June 1996.

Termination of Stepchild's Benefits Upon Annulment Ab Initio of the Marriage Between the Stepparent and the Child's Parent

We also propose to include in new paragraph (b)(7) of § 404.352 our longstanding position that annulment of a voidable marriage from the beginning, or *ab initio*, terminates stepchild's benefits, and that such benefits end with the month before the month in which the annulment becomes final. There is support for this position and effective date in *Folsom* v. *Pearsall*, 245 F.2d 562 (9th Cir. 1957), which found that when mother's insurance benefits have been terminated due to a voidable remarriage which was later annulled *ab initio,* benefits could be reinstated beginning with the month of the annulment. In addition, under section 202 of the Act, when a benefit-terminating event (such as death or marriage) occurs, benefits generally end with the month before the terminating event. We have always followed this pattern regarding termination of stepchild's benefits in cases involving *ab initio* annulments of the parents' marriage. The provision of the Contract with America Advancement Act of 1996 ending a stepchild's benefits with the month in which the divorce becomes final is an exception to the general rule.

Correction of Cross-Reference in § 404.339(a)

Section 404.339 describes how a person becomes entitled to mother's or father's benefits. Section 404.339(a) currently requires that the person be the widow or widower of the insured and meet the conditions described in § 404.335(a)(1), which refers to a 9-month duration of marriage requirement for a widow or widower. This cross-reference is incorrect, since it does not include the alternatives to the 9-month duration of marriage requirement, which are contained in § 404.335(a)(2), (a)(3), and (a)(4). We therefore propose to correct the cross-reference to refer to § 404.335(a).

Reintroduction of ''Substantially All'' Definition for Dependent Grandchild or Stepgrandchild

Consistent with statutory requirements in section 202(d)(9)(A) of the Act, § 404.364 explains when a child applying for benefits as a grandchild or stepgrandchild is considered ''dependent'' on the insured for benefit purposes. Among the dependency requirements is the rule that a grandchild or stepgrandchild must have been both living with and receiving at least one-half support from the insured

for the one-year period before the insured became entitled to old-age or disability benefits or died. Under section 202(d)(9)(B) of the Act and § 404.364(b) of our regulations, if a grandchild or stepgrandchild was born during this one-year period, the living-with and support requirements must be met for ''substantially all'' of the period beginning on the child's date of birth. Section 404.364(b) refers to § 404.362(b)(1)(iii) for a definition of ''substantially all.'' However, § 404.362(b)(1)(iii) was inadvertently deleted from the regulations. We propose to reintroduce the definition of ''substantially all'' as subparagraph (c) of § 404.364, using the same language that was inadvertently deleted. Under the proposed language, the ''substantially all'' requirement is met if, at the applicable time, the insured was living with the child and providing at least one-half of the child's support; and any period during which the grandparent or stepgrandparent was *not* living with the child and providing at least one-half support did not exceed the lesser of 3 months or one-half of the period beginning with the month of the child's birth.

Revision of Headings

We propose to revise the headings of §§ 404.339, 404.363 and 404.364 to be in plain language format to comply with the provisions of Executive Order 12866, as amended by Executive Order 13258.

Clarity of These Proposed Rules

Executive Order 12866, as amended by Executive Order 13258, requires each agency to write all rules in plain language. In addition to your substantive comments on these proposed rules, we invite your comments on how to make these proposed rules easier to understand. For example:

- Have we organized the material to suit your needs?
- Are the requirements in the rules clearly stated?
- Do the rules contain technical language or jargon that isn't clear?
- Would a different format (grouping and order of sections, use of headings, paragraphing) make the rules easier to understand?
- Would more (but shorter) sections be better?
- What else could we do to make the rules easier to understand?

Regulatory Procedures

Executive Order 12866, as Amended by Executive Order 13258

We have consulted with the Office of Management and Budget (OMB) and determined that these proposed regulations do not meet the criteria for a significant regulatory action under Executive Order (E.O.) 12866, as amended by E.O. 13258. Thus, they were not subject to OMB review.

Regulatory Flexibility Act

We certify that these proposed rules would not have a significant economic impact on a substantial number of small entities because they affect only individuals. Thus, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

The proposed regulations impose no reporting or recordkeeping requirements requiring OMB clearance.

(Catalog of Federal Domestic Assistance Program Nos. 96.001 Social Security-Disability Insurance; 96.002 Social Security-Retirement Insurance; 96.004 Social Security-Survivors Insurance)

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors and Disability Insurance, Reporting and Recordkeeping Requirements, Social Security.

Dated: August 6, 2003.

Jo Anne B. Barnhart,

Commissioner of Social Security.

For the reasons stated in the preamble, we propose to amend Subpart D of part 404 of chapter III of title 20 of the Code of Federal Regulations as set forth below.

PART 404—FEDERAL OLD–AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

Subpart D—[Amended]

1. The authority citation for subpart D of part 404 continues to read as follows:

Authority: Secs. 202, 203(a) and (b), 205(a), 216, 223, 225, 228(a)–(e), and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403(a) and (b), 405(a), 416, 423, 425, 428(a)–(e), and 902(a)(5)).

2. Section 404.339 is amended by revising the heading and paragraph (a) to read as follows:

§ 404.339 How do I become entitled to mother's or father's benefits?

* * * * *

(a) You are the widow or widower of the insured and meet the conditions described in § 404.335(a);

* * * * *

3. Section 404.352 is amended by adding paragraph (b)(7) to read as follows:

§ 404.352 When does my entitlement to child's benefits begin and end?

* * * * *

* * * * *

(b) * * *

(7) With the month in which the divorce between your parent and the insured becomes final, if you are entitled to benefits as a stepchild and the marriage between your parent and the insured ends in divorce. If the marriage between your parent and the insured is annulled prospectively, your entitlement to benefits will end with the month in which the annulment becomes final. If the marriage between your parent and the insured is annulled from the beginning (*ab initio*), your entitlement to benefits will end with the month before the month in which the annulment becomes final.

* * * * *

4. Section 404.363 is revised to read as follows:

§ 404.363 When is a stepchild dependent?

If you are the insured's stepchild, as defined in § 404.357, you are considered dependent upon him or her if you were receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or,

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

5. Section 404.364 is revised to read as follows:

§ 404.364 When is a grandchild or stepgrandchild dependent?

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and,

(b) You were living with the insured in the United States and receiving at least one-half of your support from him for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month

in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. The term *substantially all* is defined in paragraph (c) of this section.

(c) The *substantially all* requirement will be met if, at one of the times in paragraph (b) of this section, the insured was living with you and providing at least one-half of your support, and any period during which he or she was not living with you and providing one-half of your support did not exceed the lesser of 3 months or one-half of the period beginning with the month of your birth.

[FR Doc. 03–20490 Filed 8–11–03; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 3282

[Docket No. FR–4867–C–03]

Manufactured Housing Consensus Committee—Rejection of Consumer Complaint Handling Proposal; Correction

AGENCY: Office of the General Counsel, HUD.

ACTION: Denial of proposed recommendation for revisions for regulations; correction.

SUMMARY: This document corrects an error in a denial of proposed recommendation for revisions for regulations, concerning how manufacturers are required to handle reports of problems with manufactured homes, that was published in incomplete form on July 25, 2003.

FOR FURTHER INFORMATION CONTACT: Nicholas Hluchyj, Regulations Division, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–0500, (202) 708–3055 (this is not a toll-free number). Persons with hearing or speech impairments access this number through TTY by calling the toll-free Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: On July 25, 2003 (68 FR 35850), HUD published a denial of a proposed recommendation by the Manufactured Housing Consensus Committee to revise regulations concerning how manufacturers are required to handle reports of problems with manufactured homes. That document was inadvertently published in incomplete form, and to correct that error, the text is being republished in its entirety for the convenience of the public as Attachment 1.

Dated: August 5, 2003.

Camille E. Acevedo,

Associate General Counsel for Legislation and Regulations.

Attachment 1—Department of Housing and Urban Development

24 CFR Part 3282

[Docket No. FR–4867–N–02]

Manufactured Housing Consensus Committee—Rejection of Consumer Complaint Handling Proposal

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioner, HUD.

ACTION: Denial of proposed recommendation for revisions for regulations.

SUMMARY: The Secretary has rejected a proposed recommendation by the Manufactured Housing Consensus Committee to revise regulations concerning how manufacturers are required to handle reports of problems with manufactured homes. The Secretary has determined that the proposal conflicts in several ways with the requirements of the National Manufactured Housing Construction and Safety Standards Act of 1974.

FOR FURTHER INFORMATION CONTACT: William W. Matchneer III, Administrator, Manufactured Housing Program, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–8000; telephone (202) 708–6401 (this is not a toll-free number). Hearing- or speech-impaired individuals may access this number via TTY by calling the toll-free Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: The Manufactured Housing Consensus Committee (MHCC) has transmitted to the Secretary a recommendation dated March 26, 2003 (MHCC proposal), that the Manufactured Home Procedural and Enforcement Regulations, 24 CFR part 3282, be amended by revising Subpart I, Consumer Complaint Handling and Remedial Actions (24 CFR 3282.401–416) (Subpart I).

Background

The MHCC was established by the National Manufactured Housing Construction and Safety Standards Act of 1974, 42 U.S.C. 5401–5426 (the Act) for the purpose of providing periodic recommendations to the Secretary to adopt, revise, and interpret the federal manufactured housing construction and safety standards and the procedural and enforcement regulations. 42 U.S.C. 5403(a)(3)(A). It may submit to the Secretary proposed procedural and enforcement regulations and recommendations for the revision of the regulations. 42 U.S.C. 5403(b)(1). To be promulgated by HUD, the regulations and revisions recommended by the MHCC must be consistent with the Act.

Within 120 days from the date on which the Secretary receives a proposed procedural or enforcement regulation from the MHCC, the Secretary must approve or reject the proposal. If the Secretary rejects the proposal, HUD must provide to the MHCC a written explanation of the reasons for rejection and publish in the **Federal Register** the rejected proposal and the reasons for the rejection. 42 U.S.C. 5403(b)(4).

Procedural Explanation

The Secretary recognizes and appreciates that the members of the MHCC are working hard to implement the role of the MHCC in the federal manufactured housing program. Although this proposal is inconsistent with the authority granted to the MHCC under the Act, HUD is publishing this proposal (Appendix A) and the Secretary's reasons for rejecting the proposal, as if the proposal were subject to the procedures in section 604(b).

Decision of the Secretary

The Secretary rejects the MHCC's proposal for the revision of regulations in Subpart I for the handling of reports of problems in manufactured housing for reasons that include the following:

The MHCC proposal is in direct conflict with parts of the Act. In section 615 of the Act (42 U.S.C. 5414), Congress placed responsibility for the correction and notification of defects in manufactured homes on manufacturers, and set guidelines for manufacturers to meet these responsibilities. Section 613 of the Act (42 U.S.C. 5412) imposes additional repair and repurchase requirements on manufacturers. Subpart I, which the MHCC proposal would amend, contains the regulations by which the Department has implemented the intent of Congress with respect to notification and correction requirements.

The MHCC proposal seeks to limit the statutory responsibilities of manufacturers while imposing similar duties on parties on whom Congress did not place these responsibilities, such as retailers, distributors, transporters, and landscapers. HUD does not have authority to shift statutory

responsibilities away from manufacturers. The MHCC has not established that HUD has authority to hold these newly identified parties responsible for correction and notification of defects in manufactured homes.

The MHCC proposal adds significantly to the administrative responsibilities of HUD and the states, by making HUD and the State Administrative Agencies (SAA's) the initial arbiters of responsibility on all complaints and information about problems in manufactured homes. The proposal does not take into account the self-policing responsibilities of the manufacturers set out in section 615 of the Act (42 U.S.C. 5414). The concern about additional administrative burdens also applies to the provisions that make SAA's responsible for assuring that all notifications are sent and all corrections are made. In addition, the MHCC proposal may define roles for HUD and the SAAs that require them to interfere in matters that are traditionally settled through private contracts. Further, HUD cannot permit voluntary undertakings by private parties to constitute governmental action for purposes of judicial review.

The MHCC proposal would, in effect, create a warranty for products found in the home, and would then limit the applicable time of the warranty. There is no authority in the Act to create a warranty. In fact, during consideration of the most recent amendments to the Act, Congrss heard testimony suggesting a statutory warranty, but declined to adopt this approach. Instead, the Act was amended in section 623 (42 U.S.C. 5422) to establish an additional protection for consumers through a dispute resolution program that covers problems reported in the first year after a manufactured home is installed.

The MHCC proposal does not adequately implement the provision in section 615(h) of the Act (43 U.S.C. 5414(h)), which requires manufacturers to submit a notification and correction plan to the Secretary for approval before the plan is implemented. Under the MHCC proposal, a party would be permitted to correct a home without first having a plan of correction approved.

The MHCC proposal seeks to establish time limits for a manufacturer's responsibilities under section 615 (42 U.S.C. 5414) that are not consistent with the Act. Section 615 contemplates enforcement authority over certain defects about which the consumer would not have knowledge unless notified or until his or her safety is compromised. While the Act places affirmative notification and correction requirements on manufacturers for defects as a protective measure even if an affected consumer has not yet complained, the MHCC proposal would limit a manufacturer's responsibility to act until after a consumer complains. Further, the MHCC proposal would limit the responsibility of manufacturers and retailers to those defects discovered within 5 years from the date of the first sale. An even shorter period of 2 years would be established for defects that could be attributed to other parties. Section 615 includes no such limits.

The MHCC proposal raises further questions relating to section 623 of the Act (42 U.S.C. 5422). Section 623 requires HUD to implement a dispute resolution program by December 2005, which would be used to resolve disputes among manufacturers, retailers, and installers about responsibility for the correction of defects reported in the first year after a manufactured home is installed. The MHCC proposal is not in agreement with the section 623 process because the proposal: adds potentially responsible parties (*e.g.*, landscapers, contractors, product suppliers); creates time limits that are inconsistent with section 623; and fails to provide for a forum in which the disputes are to be resolved.

Text of MHCC Proposal

The text of the rejected proposal as submitted by the MHCC is published as Appendix A.

Dated: July 17, 2003.

John C. Weicher,

Assistant Secretary for Housing-Federal Housing Commissioner.

Appendix A

Manufactured Housing Consensus Committee Proposal To Amend Manufactured Housing Home Procedural and Enforcement Regulations 24 CFR Part 3282

March 26, 2003.

§ 3282.7 Definitions.

(i) *Dealer*—See *Retailer.*

(j) *Defect* means a failure to comply, or the failure of a component used to comply with an applicable Federal Manufactured home safety and construction standard that renders the manufactured home or any part thereof not fit for the ordinary use for which it was intended, but does not result in an unreasonable risk of injury or death to occupants of the affected manufactured home. See related definitions of imminent safety hazard (definition q), non-compliance (definition x), and serious defect (definition ff).

(dd) *Retailer* means any person engaged in the sale, leasing, or distribution of new manufactured homes primarily to persons whom in good faith purchase or lease a manufactured home for purposes other than resale.

(ee) *Responsible Party* means any of the following: manufactured home manufacturers, retailers, distributors, contractors, product suppliers, product distributors, installers, transporters, developers, landscapers, and/or homeowners.

Subpart—Consumer Complaint Handling and Remedial Actions

§ 3282.401 Purpose and scope.

(a) The purpose of this subpart is to establish a system under which the protections of the Act are provided with a minimum of formality and delay, but in which the rights of all parties are protected.

(b) This subpart sets out the procedures to be followed by responsible parties, State Administrative Agencies, primary inspection agencies, and the Secretary to assure proper notification and/or correction with respect to manufactured homes as required by the Act. Notification and correction may be required to be provided with respect to manufactured homes that have been sold or otherwise released by the manufacturer to another party when the responsible party, an SAA or the Secretary determines that an imminent safety hazard, serious defect, or defect may exist in those manufactured homes as set out herein. For non-compliances, corrections shall be required to the single home it's reported in.

(c) This subpart sets out the rights of retailers under section 613 of the Act, 42 U.S.C. 5412, to obtain remedies from manufacturers in certain circumstances.

§ 3282.402 General principles.

(a) Nothing in this subpart or in these regulations shall limit the rights of the purchaser under any contract or applicable law.

(b) The liability of manufactured home manufacturers to provide remedial actions under this subpart is limited by the principle that manufacturers are not responsible for failures that occur in manufactured homes or parts thereof as the result of the actions of other responsible parties, normal wear and aging, gross and unforeseeable consumer abuse, or unforeseeable neglect of maintenance.

(c) Responsibility for remedial actions under this subpart may also be assessed to responsible parties to the extent that

they have contributed to or caused the failure.

(d) The extent of a responsible party's responsibility for providing notification and/or correction depends upon the seriousness of problems for which they may be responsible under this subpart.

(e) It is the policy of these regulations that all consumer complaints or other information indicating the possible existence of an imminent safety hazard, serious defect, defect, or non-compliance should be referred to the manufacturer and/or retailer and/or other responsible party of the potentially affected manufactured home as early as possible so that the manufacturer or other responsible party can begin to timely respond to the consumer and take any necessary remedial actions. If the responsible party receiving the notice believes the issue is the responsibility of another responsible party, the information may be forwarded to that party.

§ 3282.403 Limitations

This shall limit the requirements under this subpart for notification or correction to the time frames listed below;

(a) By a manufactured home manufacturer or retailer, to a period of five (5) years from the date of first sale and completion of set-up of the manufactured home to the first purchaser. Any home over five (5) years in age from the date of sale and delivery to the first purchaser is exempt from these regulations or requirements for notification or correction by a manufactured home manufacturer or retailer;

(b) By an installer, contractor, product supplier, product distributor, transporter, developer, or landscaper for work completed and/or product supplied, to a period of two (2) years from the date such work is completed or such product is supplied. Any home over two (2) years after the date of completion of such work is exempt from these regulations by an installer, contractor, product supplier, product distributor, transporter, developer, or landscaper.

(c) The homeowner has a continuing obligation for providing adequate upkeep and maintenance of their manufactured home.

(d) Manufacturers and/or other responsible parties are not liable for the notification and correction of work done by others.

§ 3282.404 Consumer complaint and information referral.

When a consumer complaint or other information indicating the likely existence of a non-compliance, defect, serious defect, or imminent safety hazard is received by a State Administrative Agency or the Secretary, the SAA or the Secretary shall forward the complaint or other information to the responsible party. The responsibility to assure proper investigation and assignment of responsible party belongs to the SAA in the state in which the home is located. The SAA or the Secretary may, when it appears from the complaint or other information that more than one manufactured home may be involved, simultaneously send a copy of the complaint or other information to the SAA of the state where the manufactured home was manufactured or to the Secretary if there is no such SAA. When it appears that an imminent safety hazard or serious defect may be involved, the SAA shall send a copy to the Secretary. The SAA in the state of production of the manufactured home shall assist the SAA in the state in possession of the manufactured home as needed. The SAA in the state of production shall be responsible to assure the manufacturer's records reflect the proper investigation, record keeping, corrective action, and responses of manufacturer actions.

§ 3282.405 Investigation, Determination, Repair and Notification by Responsible Parties.

(a) The manufacturer shall review its records to determine whether or not a defect, serious defect, or imminent safety hazard is indicated as set out in this subpart with respect to all manufactured homes produced by the manufacturer within five (5) years of the date of sale to the first purchaser, in which there likely exists an imminent safety hazard, serious defect, or defect.

(b) Whenever a responsible party receives from any source information that indicates the likely existence of a defect, serious defect, or imminent safety hazard in a manufactured home for which they are responsible for repair, the responsible party shall, as soon as possible, but not later than 20 days after receipt of the information, carry out any necessary investigations or inspections to determine and shall determine whether they are responsible for correction and/or notification. They shall report the results of the initial investigation to the SAA as required.

(c) Determinations and investigations must be completed within 20 days of the date of notification. These determinations may be initial determinations with more thorough investigation to follow. The original assessment and determination is required within the 20-day period and may be followed up as more information is gathered during the process of investigation. The responsible party shall maintain complete records of all such information and determinations in a form that will allow the Secretary or an SAA to determine the severity of the defect, serious defect, or imminent safety hazard.

(d) The responsible party for the violation shall be required to determine the severity of the problem reported. The severity shall be determined as identified in the definitions as imminent safety hazard, serious defect, defect, or non-compliance. Such records shall be kept for a minimum of five (5) years from the date of completion of the investigation.

(e) If the determination is a serious defect or an imminent safety hazard, the responsible party that caused the serious defect or imminent safety hazard shall be required to determine and identify how many homes have the same serious defect or imminent safety hazard. All homes with the same serious defect or imminent safety hazard must be corrected by the responsible party or their agent in accordance with the DAPIA design, regulation, or prevailing code, subject to the limitations in § 3282.403.

(f) If the determination is a defect that affects the performance of the home, the party responsible for the defect shall be required to make a good faith determination as to the likely cause of the defect and a good faith determination as to whether a class is identifiable because the cause of the defect, actually known to the responsible party, is such that the same defect would probably have been systematically introduced by the responsible party into more than one home during the construction process at the manufacturer's plant, or the same defect would probably have been systematically introduced into more than one home by a non-manufacturer responsible party after the home was sold or otherwise released by the manufacturer. If the responsible party determines that a class exists, the responsible party shall provide notification of the defect to all affected homeowners as set out in this subpart. Such notice shall include a description of the defect and the possible solution or repair. If the SAA chooses to have the item repaired, the responsible party shall be required to make the repair in accordance with the DAPIA design, or the federal standards in effect at the date of manufacture of such home, or prevailing code for items not governed by the federal standards, whichever is applicable, subject to the limitations in

§ 3282.403. Reporting to the appropriate SAA or the Secretary is required as requested.

(g) If the determination is a non-compliance, repair is required, by the responsible party, of only the home involved in a complaint, but only if such a non-compliance affects the performance of the home.

(h) For an individual complaint on a single home, upon discovery, all non-compliances, defects, serious defects, and imminent safety hazards introduced during construction of the home in the manufacturer's construction facility that affects the performance of the home shall be corrected by the manufacturer, and those created as a result of work another responsible party, such as retailer, distributor, installer, contractor, product supplier, product distributor, transporter, developer, or landscaper completed on the home shall be corrected by the party responsible when the performance of the home is affected, subject to the limitations in § 3282.403.

(i) All required work shall be completed within sixty (60) days of the required determination. Providing for the 20-day investigation period and adding the 60-day repair period, there is an 80-day period of time to complete investigation and corrective action. Extensions may be granted by the responsible SAA or the Secretary. Reporting to the appropriate SAA or the Secretary is required as requested.

(j) Damages that take the home out of compliance, resulting from any defect, serious defect, or imminent safety hazard are required to be repaired by the responsible party. Damage to the home as a result of the neglect or an intentional act or omission of the consumer is not required to be repaired. Such conduct may include, but is not limited to a failure of the consumer to report failures to the responsible party in a timely manner and failure to take steps to protect their home and property while awaiting repair.

(k) Listed appliances, materials, fixtures, equipment, and similar items used in the assembly of the home shall be considered a defect if they fail prior to the home manufacturer's warranty, the product warranty, or a period of two years, whichever is greater and affects the performance of the home. Product warranties that extend beyond a period of two years or beyond the manufactured home warranty shall be the sole responsibility of the appliance or product supplier.

(l) Product suppliers who are required to repair or replace products shall be held to the same repair requirements, time requirements, and reporting requirements as the manufacturers and retailers.

(m) The determinations of severity and of the number of homes involved shall be recorded in the home record of each home involved. The determinations for severity are required to be identified for each item listed in the complaint. The identification of the determination may be either individual line entries, full page entries, or a combination thereof. The record must also show if the issue involves more than one home.

(n) All home records shall be kept by the manufacturer and retailer for five (5) years from the date the home was sold to the first purchaser or for a period of five (5) years from the date of completion of an investigation and/or repair campaign.

§ 3282.406 SAA Authority and Responsibilities.

(a) As set out at § 3282.302(b)(5), each SAA is the authority to and is responsible for, overseeing the handling of consumer complaints within their state. As part of that authority and responsibility, including assignment of responsible party after proper investigation, the SAA is required to monitor manufacturer compliance with this subpart, and particularly with § 3282.405. This monitoring will be done primarily by periodically checking the records that manufacturers are required to keep under § 3282.405.

(b) The SAA shall utilize the authority granted by Federal and State laws and regulations to assure the requirements of this consumer assistance subpart are accomplished.

§ 3282.407 Required responsible party correction.

A responsible party shall correct, at its expense, any imminent safety hazard, serious defect or defect that can be related to an error in design, construction, assembly, modification, addition, or alteration of, or to, the manufactured home which would include errors in design, workmanship or assembly of any component or system incorporated in the manufactured home that is discovered, subject to and within the limitations in § 3282.403.

§ 3282.408 Reimbursement for prior correction by owner.

A responsible party that is required to correct, shall provide reimbursement for reasonable cost of correction to any owner of an affected manufactured home who chose to make the correction before the responsible party did so, providing the responsible party was notified prior to the repair being performed.

§ 3282.409 Plan for notification and correction.

(a) This section sets out the requirements that shall be met by responsible parties in preparing plans they are required to submit under § 3282.405. The underlying requirement is that the plan shows how the responsible party will fulfill its responsibilities with respect to notification and correction that arise under this subpart.

(b) The plan shall identify, by serial number and other appropriate identifying criteria, all manufactured homes with respect to which correction and/or notification is required to be provided. Homes identified in the plan shall be those identified in accordance with the criteria set forth in Sections 405 (e) and 405 (f) of this subpart. Methods that may be used in determining the extent of the class, once the existence of a class on manufactured homes has been determined, includes for all responsible parties, but are not limited to:

(1) Inspection of the design of the manufactured home, alteration, or addition in question to determine whether the failure resulted from the design itself;

(2) Identification of the cause as relating to a particular employee, or process that was employed for a known period of time in producing or altering or adding to or affecting the manufactured home;

(3) Inspection of records relating to components supplied by other parties and known to contain or suspected of containing imminent safety hazards, serious defects or defects. The class of manufactured homes identified by these methods may include only manufactured homes actually affected. If it is not possible to identify the precise manufactured homes, the class shall include manufactured homes suspected of containing the failure because the evidence shows that they may have been affected. For manufactured home manufacturers the methods may also include:

(1) Inspection of manufactured homes produced before and after the manufactured homes known to be affected;

(2) Inspection of manufacturer quality control records to determine whether quality control procedures were followed;

(3) Inspection of IPIA records to determine whether the imminent safety hazard or failure to conform was either detected or specifically found not to exist in some manufactured homes;

(4) The plan shall include a statement by the IPIA operating in each plant in

which manufactured homes in question were produced if requested by the SAA. In this statement, the IPIA shall concur in the methods used by the manufacturer to determine the class of potentially affected manufactured homes or state why it believes the methods to have been inappropriate, inadequate, or incorrect.

(c) The plan shall include a deadline for completion of all notifications and corrections subject to 3282.405(j).

(d) If the responsible party disputes a finding, ruling, or determination of the SAA, the responsible party may, within ten days of notice of any such finding, ruling, or determination, appeal such action to the Secretary.

(e) The responsible party may propose a settlement offer that is acceptable to the SAA or Secretary for any situation involving non-compliances, defects, serious defects, or imminent safety hazards. Acceptance of a settlement offer by the SAA or the Secretary shall be binding and may supersede portions of this subpart specifically identified in the agreement.

(f) Compliance with the steps and the methods outlined in this section shall constitute ''good faith'' efforts on the part of the responsible party or parties, and shall be prima facie evidence of compliance with this subpart.

§ 3282.410 Completion of remedial actions and report.

(a) Where the responsible party is required to provide notification under this subpart, the responsible party shall maintain in its files for five (5) years from the date notification is completed, a copy of the notice sent and a complete list of the people and their addresses. The files referred to in this section shall be organized such that each notification and/or correction can be readily identified and reviewed by an SAA or the Secretary.

(b) Where a responsible party is required to provide correction under § 3282.407 or where the responsible party otherwise corrects under § 3282.405, the responsible party shall maintain in its files, for five (5) years from the date the correction work is completed, one of the following, as appropriate, for each manufactured home involved.

(1) Where the correction is made, a certification that the repair was made to satisfy completely the standards in effect at the time the manufactured home was manufactured and that the failure has been eliminated, or

(2) Where the owner refuses to allow repair to the home, a certification by the responsible party that the owner has been informed of the violation and that the owner has refused repair must be placed in the home file and made available upon request.

(c) The responsible party shall, within 30 days after the deadline for completing any notifications and, where required, corrections, under an approved plan or under an order of an SAA or the Secretary, or any accepted settlement, provide a complete report of the action taken to the SAA or the Secretary, whoever approved the plan.

§ 3282.411 Replacement or repurchase of manufactured home from purchaser.

(a) Whenever an imminent safety hazard or serious defect, which must be corrected by the responsible party at their expense under § 3282.407, cannot be repaired within 60 days in accordance with section 615(i) of the Act, the Secretary may require:

(1) That the manufactured home be replaced by the responsible party with a manufactured home substantially equal in size, equipment, and quality, and either new or in the same condition the defective manufactured home would have been in at the time of discovery of the imminent safety hazard or serious defect had the imminent safety hazard or serious defect not existed; or

(2) That the responsible party take possession of the manufactured home and refund the purchase price in full, less a reasonable allowance for depreciation based on actual use if the home has been in the possession of the owner for more than one year. Such depreciation shall be based upon an appraisal system approved by the Secretary, and shall not take into account damage or deterioration resulting from the imminent safety hazard or serious defect.

(b) In determining whether to order replacement or refund by the responsible party, the Secretary shall consider:

(1) The threat of injury or death to manufactured home occupants;

(2) Any costs and inconvenience to manufactured home owners, which will result from the lack of adequate repair within the specified period;

(3) The expense to the responsible party;

(4) Any obligations imposed on the responsible party under contract or other applicable law of which the Secretary has knowledge; and

(5) Any other relevant factors which may be brought to the attention of the Secretary.

(c) In those situations where, under contract or other applicable law, the owner has the right of election between replacement and refund, the manufacturer shall inform the owner of such right of election and shall inform the Secretary of the election, if any, by the owner.

(d) This section applies where an attempted correction of an imminent safety hazard or serious defect relieves the safety problem but does not bring the home in conformity to the standards.

(e) Where replacement or refund by the responsible party is ordered under this section, it shall be carried out within 30 days of the Secretary's order to replace the manufactured home or refund the purchase price unless the Secretary, for good cause shown, grants an extension of time for implementation of such order.

§ 3282.412 Manufactured homes in the hands of retailers and distributors.

(a) The responsible party shall correct any failures to conform and imminent safety hazards that exist in manufactured homes which have been sold or otherwise released to a distributor or retailer but which have not yet been sold to a purchaser. This responsibility does not extend to failures to conform or imminent safety hazards that result from transit damage or alteration by others to the manufactured home after it leaves the control of the manufacturer. This section sets out the procedures to be followed by retailers and distributors for handling manufactured homes in such cases. Regardless of whether the responsible party is responsible for repairing a manufactured home, no retailer or distributor may sell a manufactured home if it contains a failure to conform, which affects the performance of the home.

(b) Whenever a retailer or distributor finds a problem in a manufactured home, which a responsible party is responsible for correcting under paragraph (a) of this section, the retailer or distributor shall contact the responsible party, provide full information concerning the problem, and request appropriate action by the responsible party in accord with paragraph (c) of this section. Where the responsible party agrees to correct, the responsible party shall maintain a complete record of its actions. Where the responsible party authorizes the retailer to make the necessary corrections on a reimbursable basis, the retailer or distributor shall maintain a complete record of its actions. Agreement by the responsible party to correct or to authorize corrections on a reimbursable basis under this paragraph constitutes a determination of the Secretary for purposes of Section 613(b) of the Act with respect to judicial

review of the amount which the responsible party agrees to reimburse the retailer or distributor for corrections.

(c) Upon a final determination by the Secretary or a State Administrative Agency under § 3282.409, or upon a determination by a court of competent jurisdiction that a manufactured home fails to conform to the standard after such manufactured home is sold or otherwise released by a manufacturer to a distributor or retailer and prior to the sale of such manufactured home by such distributor or retailer to a purchaser, the responsible party shall have the option to either:

(1) Immediately furnish, at the responsible party's expense, to the purchasing distributor or retailer the required conforming part or parts or equipment for installation by the distributor or retailer on or in such manufactured home, and the responsible party shall reimburse such distributor or retailer for the reasonable value of such installation plus a reasonable reimbursement of not less than one per centum per month of the manufacturer's or distributor's selling price, prorated from the date of receipt by certified mail of notice of non-compliance to the date such manufactured home is brought into compliance with the standards, so long as the distributor or retailer proceeds with reasonable diligence with the installation after the part or component is received; or

(2) Immediately repurchase, at the responsible party's expense, such manufactured home from such distributor or retailer at the price paid by such distributor or retailer, plus all transportation charges involved and a reasonable reimbursement of not less than one per centum per month of such price paid prorated from the date of receipt by certified mail of notice of the imminent safety hazard, serious defect, defect or non-compliance to the distributor. The value of such reasonable reimbursements as specified in this paragraph shall be fixed by mutual agreement of the parties or by a court in an action brought under Section 613(b) of the Act.

(d) This section shall not apply to any manufactured home purchased by a retailer or distributor, which has been leased by such retailer or distributor to a tenant for purposes other than resale. In that instance the retailer or distributor has the remedies available to a purchaser under this subpart.

§ 3282.413 Notices, bulletins and other communications.

Each responsible party shall, at the time of dispatch, furnish to the SAA or the Secretary a true or representative copy of all notices, bulletins, and other written communications to the retailers or distributors of such responsible party or purchasers or owners of manufactured homes of such responsible parties regarding any serious defect or imminent safety hazard which may exist in any such manufactured homes produced by such manufacturer. Manufacturers shall keep complete records of all communications regarding imminent safety hazards, serious defects, defects, and noncompliances.

§ 3282.414 Supervision of notification and correction actions.

(a) The SAA shall be responsible for assuring that notifications are sent to all owners, purchasers, retailers, or distributors of whom the responsible party has knowledge under § 3282.211 or otherwise as required by these regulations, and the SAA shall be responsible for assuring that the required corrections are carried out by auditing the records required by § 3282.410.

(b) The SAA or Secretary to which the report required by § 3282.410(c) is sent shall be responsible for assuring through oversight that remedial actions described in the report have been carried out as described in the report.

(c) The SAA of the state in which an affected manufactured home is located may inspect that manufactured home to determine whether any required correction is carried out to the approved plan or, if there is no plan, to the standards or other approval obtained by the responsible party.

[FR Doc. 03–20485 Filed 8–11–03; 8:45 am]

BILLING CODE 4210–27–P

DEPARTMENT OF LABOR

Mine Safety and Health Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

30 CFR Part 72

RIN 1219–AB18

Determination of Concentration of Respirable Coal Mine Dust

AGENCIES: Mine Safety and Health Administration (MSHA), Department of Labor, National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention, Department of Health and Human Services.

ACTION: Proposed rule; reopening of the rulemaking record; extension of comment period.

SUMMARY: This document reopens the rulemaking record and extends the comment period for the proposed rule addressing Determination of Concentration of Respirable Coal Mine Dust, (Single Sample) published in the **Federal Register** on July 7, 2000 and reopened for public comment on March 6, 2003.

The Agencies have decided to reopen the rulemaking record and further extend the comment period in order to obtain further information on Personal Dust Monitors (PDMs), a new technology which is currently being tested by NIOSH.

The rulemaking record and comment period will remain open until further notice is published in the **Federal Register**. All comments received will be entered into the rulemaking record.

DATES: The rulemaking record for the proposed rule, published on July 7, 2000 and reopened for comment on March 6, 2003, will remain open until further notice is published in the **Federal Register**.

ADDRESSES: You may use mail, facsimile (fax), or electronic mail to send us your comments. Clearly identify them as comments and send them (1) by mail to MSHA, Office of Standards, Regulations, and Variances, 1100 Wilson Blvd., Room 2313, Arlington, Virginia 22209–3939; (2) by fax to (202) 693–9441; or (3) by electronic mail to: *comments@msha.gov.*

FOR FURTHER INFORMATION CONTACT: Marvin W. Nichols, Jr., Director, Office of Standards, Regulations and Variances, MSHA; phone: (202) 693–9440; facsimile: (202) 693–9441; e-mail: *nichols-marvin@msha.gov.*

You can request a copy of this reopening and extension of comment period notice in an alternate format, such as a large print version, an electronic file or a file on a disk. This reopening and extension of comment period notice is available on MSHA's Internet site, *http://www.msha.gov,* at the ''Statutory and Regulatory Information'' icon.

SUPPLEMENTARY INFORMATION:

I. Rulemaking Background

In 1972, the Secretary of Interior and the Secretary of Health, Education, and Welfare issued a joint finding under the Federal Coal Mine Safety and Health Act of 1969. The finding concluded that a single, full-shift measurement of

respirable dust would not, after applying valid statistical techniques, accurately represent the atmospheric conditions to which the miner is continuously exposed (37 FR 3833).

In 1994, the Secretary of Labor and the Secretary of Health and Human Services tentatively concluded that the 1972 joint finding was incorrect. Therefore, on February 18, 1994, the Secretary of Labor and the Secretary of Health and Human Services published a proposed Joint Notice of Finding in the **Federal Register** (59 FR 8537). That Joint Notice proposed to find that a single, full-shift exposure measurement will accurately represent the atmospheric conditions with regard to the respirable coal mine dust concentration during the shift on which it was taken, and to rescind the 1972 finding by the Secretary of the Interior and the Secretary of Health, Education and Welfare. Also on February 18, 1994, MSHA published in the **Federal Register** (59 FR 8356) a separate notice announcing how MSHA intended to implement its new enforcement procedure utilizing single samples, and to solicit public comment on this procedure.

On February 3, 1998, after a notice and comment procedure extending over three and one-half years, including three public hearings (in Salt Lake City, Utah; Washington, District of Columbia, and Morgantown, West Virginia), MSHA and NIOSH published a final Notice of Finding, and MSHA published an enforcement policy for the Notice of Finding in the **Federal Register** (63 FR 5664 and 5687, respectively).

In May 1998, The National Mining Association (NMA) and the Alabama Coal Association petitioned the United States Court of Appeals for the 11th Circuit to review the 1998 Notice of Finding. On September 4, 1998, the United States Court of Appeals for the 11th Circuit issued a decision based on procedural grounds to vacate the Notice of Finding in the case of *National Mining Association* v. *Secretary of Labor,* (153 F.3d 1264).

In response to the 11th Circuit Court's decision, the Department of Labor and the Department of Health and Human Services published in the **Federal Register** a Notice of Proposed Rulemaking (NPRM), Determination of Concentration of Respirable Coal Mine Dust (65 FR 42068) on July 7, 2000.

In that document, the Secretaries proposed a new mandatory health standard in 30 CFR part 72 that stated that a single, full-shift measurement would accurately represent atmospheric conditions to which a miner is exposed during such shift. The proposed rule would rescind the 1972 Joint Finding. The record of the 1998 final Joint Finding was incorporated into the record for this rulemaking along with new data and information. Those items and all additional data and information were added to the rulemaking docket and made available to the public. A notice of public hearing and close of record was also published in the **Federal Register** (65 FR 42185) on July 7, 2000.

During August 2000, three public hearings were conducted in Morgantown, West Virginia; Prestonsburg, Kentucky; and Salt Lake City, Utah. Transcripts of those proceedings were made available to the public. The close of the rulemaking record was originally scheduled for August 24, 2000. In response to requests from commenters, the comment period was extended until September 8, 2000 (65 FR 49215).

On March 6, 2003 (68 FR 10940), the Secretaries published a notice of reopening addressing the July 7, 2000 proposed rule, (65 FR 42068), Determination of Concentration of Respirable Coal Mine Dust. The Secretaries reopened the rulemaking record to provide interested parties an additional opportunity to comment on any issue relevant to the July 2000 proposed rule; and to solicit comment on new data and information added to the record. The reopening addressed the background, MSHA's current enforcement policy, health effects, quantitative risk assessment, technological feasibility, economic feasibility, compliance costs and benefits, references and supporting documentations.

In May 2003, the Agencies held six public hearings in Washington, Pennsylvania; Charleston, West Virginia; Evansville, Indiana; Lexington, Kentucky; Birmingham, Alabama; and Grand Junction, Colorado. The hearings were attended by over 500 members of the public. In response to requests from the mining community the Agencies extended the post-hearing comment period from June 4, 2003 to July 3, 2003 (68 FR 32005, May 29, 2003). This notice reopens the rulemaking record and extends the comment period until further notice is published in the **Federal Register**.

II. Reasons for Reopening the Rulemaking Record

The Agencies decided to reopen the rulemaking record and extend the comment period on the proposed rule after careful consideration of comments during the May 2003 public hearings concerning the preliminary success of in-mine tests on a prototype of the Personal Dust Monitor (PDM).

The rulemaking record and comment period will remain open during which time:

- The in-mine testing of the pre-production prototype PDMs at mines in Pennsylvania, West Virginia, Alabama, and Utah is completed;
- NIOSH and MSHA commit $150,000 each for further testing contingent upon completion and positive assessment of the in-mine testing; and
- Information is obtained to assist in controlling and monitoring respirable coal mine dust and preventing Black Lung disease.

For all the reasons stated herein, the rulemaking record and comment period for the proposed rule is hereby reopened until further notice is published in the **Federal Register**.

A notice extending the comment period on the proposed rule Verification of Underground Coal Mine Operators' Dust Control Plans and Compliance Sampling for Respirable Dust, (68 FR 10784, 68 FR 32005), was published in the **Federal Register** on July 3, 2003.

Dated: August 6, 2003.

Elaine L. Chao,

Secretary, Department of Labor.

Dated: August 6, 2003.

Tommy G. Thompson,

Secretary, Department of Health and Human Services.

[FR Doc. 03–20499 Filed 8–7–03; 3:01 pm]

BILLING CODE 4510–43–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 194

[FRL–7543–1]

Waste Characterization Program Documents Applicable to Transuranic Radioactive Waste From the Idaho National Engineering and Environmental Laboratory Advanced Mixed Waste Treatment Project for Disposal at the Waste Isolation Pilot Plant

AGENCY: Environmental Protection Agency.

ACTION: Notice of availability; opening of public comment period.

SUMMARY: The Environmental Protection Agency (EPA, or ''we'') is announcing an inspection for the week of August 18, 2003, at the Idaho National Engineering and Environmental Laboratory (INEEL) Advanced Mixed Waste Treatment Project (AMWTP). With this notice, we

also announce availability of Department of Energy (DOE) documents in the EPA Docket, and solicit public comments on these documents for a period of 30 days. The following DOE documents, entitled ''INEEL Advanced Mixed Waste Treatment Project Certification Plan for Contact-Handled Transuranic Waste, MP–TRUW–8.1, Revision 2A'' and ''INEEL Advanced Mixed Waste Treatment Project Quality Assurance Project Plan, MP–TRUW–8.2, Revision 2,'' are available for public review in the public dockets listed in **ADDRESSES**. EPA will conduct an inspection of waste characterization systems and processes at INEEL/AMWTP to verify that the site can characterize transuranic waste in accordance with EPA's WIPP Compliance Criteria.

DATES: EPA is requesting public comment on the documents. Comments must be received by EPA's official Air Docket on or before September 11, 2003.

ADDRESSES: Comments may be submitted by mail to: EPA Docket Center (EPA/DC), Air and Radiation Docket, Environmental Protection Agency, EPA West, Mail Code 6102T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460. Attention Docket ID No. OAR–2003–0177. Comments may also be submitted electronically, by facsimile, or through hand delivery/courier. Follow the detailed instructions as provided in Unit I.B of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Ms. Rajani Joglekar, Office of Radiation and Indoor Air, (202) 564–7734. You can also call EPA's toll-free WIPP Information Line, 1–800–331–WIPP or visit our Web site at *http://www.epa/gov/radiation/wipp.*

SUPPLEMENTARY INFORMATION:

I. General Information

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

1. *Docket.* EPA has established an official public docket for this action under Docket ID No. OAR–2003–0177. 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 Air and Radiation Docket in the EPA Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the Air and Radiation Docket is (202) 566–1742. These documents are also available for review in paper form at the official EPA Air Docket in Washington, DC, Docket No. A–98–49, Category II–A2, and at the following three EPA WIPP informational docket locations in New Mexico: in Carlsbad at the Municipal Library, Hours: Monday–Thursday, 10 a.m.–9 p.m., Friday–Saturday, 10 a.m.–6 p.m., and Sunday 1 p.m.–5 p.m.; in Albuquerque at the Government Publications Department, Zimmerman Library, University of New Mexico, Hours: vary by semester; and in Santa Fe at the New Mexico State Library, Hours: Monday–Friday, 9 a.m.–5 p.m. As provided in EPA's regulations at 40 CFR part 2, and in accordance with normal EPA docket procedures, if copies of any docket materials are requested, a reasonable fee may be charged for photocopying.

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

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

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

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

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

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

B. How and To Whom Do I Submit Comments?

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

1. *Electronically.* If you submit an electronic comment as prescribed below, EPA recommends that you include your name, mailing address, and an e-mail address or other contact

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

i. *EPA Dockets.* Your use of EPA's electronic public docket to submit comments to EPA electronically is EPA's preferred method for receiving comments. Go directly to EPA Dockets at *http://www.epa.gov/edocket,* and follow the online instructions for submitting comments. To access EPA's electronic public docket from the EPA Internet Home Page, select ''Information Sources,'' ''Dockets,'' and ''EPA Dockets.'' Once in the system, select ''search,'' and then key in Docket ID No. OAR–2003–0177. The system is an ''anonymous access'' system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your comment.

ii. *E-mail.* Comments may be sent by electronic mail (e-mail) to *a-and-r-docket@epa.gov,* Attention Docket ID No. OAR–2003–0177. In contrast to EPA's electronic public docket, EPA's e-mail system is not an ''anonymous access'' system. If you send an e-mail comment directly to the Docket without going through EPA's electronic public docket, EPA's e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA's e-mail system are included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket.

2. *By Mail.* Send your comments to: EPA Docket Center (EPA/DC), Air and Radiation Docket, Environmental Protection Agency, EPA West, Mail Code 6102T, 1200 Pennsylvania Avenue, N.W., Washington, DC 20460. Attention Docket ID No. OAR–2003–0177.

3. *By Hand Delivery or Courier.* Deliver your comments to: Air and Radiation Docket, EPA Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC, Attention Docket ID No. OAR–2003–0177. Such deliveries are only accepted during the Docket's normal hours of operation as identified in Unit I.A.1.

4. *By Facsimile.* Fax your comments to: (202) 566–1741, Attention Docket ID. No. OAR–2003–0177.

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

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

1. Explain your views as clearly as possible.

2. Describe any assumptions that you used.

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

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

5. Provide specific examples to illustrate your concerns.

6. Offer alternatives.

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

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

Background

DOE is developing the WIPP near Carlsbad in southeastern New Mexico as a deep geologic repository for disposal of TRU radioactive waste. As defined by the WIPP Land Withdrawal Act (LWA) of 1992 (Pub. L. No. 102–579), as amended (Pub. L. No. 104–201), TRU waste consists of materials containing elements having atomic numbers greater than 92 (with half-lives greater than twenty years), in concentrations greater than 100 nanocuries of alpha-emitting TRU isotopes per gram of waste. Much of the existing TRU waste consists of items contaminated during the production of nuclear weapons, such as rags, equipment, tools, and sludges.

On May 13, 1998, EPA announced its final compliance certification decision to the Secretary of Energy (published May 18, 1998, 63 FR 27354). This decision stated that the WIPP will comply with EPA's radioactive waste disposal regulations at 40 CFR part 191, Subparts B and C.

The final WIPP certification decision includes conditions that (1) prohibit shipment of TRU waste for disposal at WIPP from any site other than the Los Alamos National Laboratory (LANL) until the EPA determines that the site has established and executed a quality assurance program, in accordance with §§ 194.22(a)(2)(i), 194.24(c)(3), and 194.24(c)(5) for waste characterization activities and assumptions (Condition 2 of Appendix A to 40 CFR Part 194); and (2) prohibit shipment of TRU waste for disposal at WIPP from any site other than LANL until the EPA has approved the procedures developed to comply with the waste characterization requirements of § 194.22(c)(4) (Condition 3 of Appendix A to 40 CFR Part 194). The EPA's approval process for waste generator sites is described in § 194.8. As part of EPA's decision-making process, the DOE is required to submit to EPA appropriate documentation of quality assurance and waste characterization programs at each DOE waste generator site seeking approval for shipment of TRU radioactive waste to WIPP. In accordance with § 194.8, EPA will place such documentation in the official Air Docket in Washington, D.C., and informational dockets in the State of New Mexico for public review and comment.

EPA will perform an inspection of the Idaho National Engineering and Environmental Laboratory (INEEL) Advanced Mixed Waste Treatment Project (AMWTP)'s technical program for waste characterization in accordance with Condition 3 of the WIPP certification. We will evaluate the adequacy, implementation, and effectiveness of technical and quality assurance (QA) processes related to the AMWTP's TRU waste characterization and certification activities. The elements of 40 CFR 194.8 waste characterization to be inspected are: (1) acceptable knowledge (AK), real-time radiography (RTR), nondestructive assay (NDA), and visual examination (VE) for the purpose of confirming RTR accuracy processes used to characterize CH TRU solid waste (S3000), and; (2) AK, RTR, and NDA, and VE (solely for the purpose of verifying the contents of newly-generated or repackaged waste) for characterizing debris waste (S5000) drums.

EPA will not inspect VE for confirmation of RTR of debris waste. Also, the Agency intends to conduct an initial inspection to verify the proper execution of the AMWTP QA Program, as required under § 194.8(a)(2). EPA requires the AMWTP to adhere to a QA Program that invokes the following QA standards: (1) ASME NQA–1–1989 edition; (2) ASME NQA–2a–1990

Addenda, Part 2.7, to ASME NQA–2–1989 edition; and (3) ASME NQA–3–1989 edition (excluding Section 2.1(b) and (c) and Section 17.1). The Agency will verify that the AMWTP established these NQA standards in their QA Plan. The inspection is scheduled to take place the week of August 18, 2003.

EPA has placed DOE documents pertinent to the inspection in the public docket described in **ADDRESSES.** These include: (1) INEEL Advanced Mixed Waste Treatment Project Certification Plan for Contact-Handled Transuranic Waste, MP–TRUW–8.1, Revision 2A, and (2) INEEL Advanced Mixed Waste Treatment Project Quality Assurance Project Plan, MP–TRUW–8.2, Revision 2. The documents are included in item II–A2–46 in Docket A–98–49. In accordance with 40 CFR 194.8, as amended by the final certification decision, EPA is providing the public 30 days to comment on these documents.

If EPA determines as a result of the inspection that the proposed processes and programs at INEEL/AMWTP adequately control the characterization of transuranic waste, we will notify DOE by letter and place the letter in the official Air Docket in Washington, DC, as well as in the informational docket locations in New Mexico. A letter of approval will allow DOE to ship transuranic waste characterized by the approved processes from INEEL/AMWTP to the WIPP. The EPA will not make a determination of compliance prior to the inspection or before the 30-day comment period has closed. Information on the certification decision is filed in the official EPA Air Docket, Docket No. A–93–02 and is available for review in Washington, DC, and at three EPA WIPP informational docket locations in New Mexico. The dockets in New Mexico contain only major items from the official Air Docket in Washington, DC, plus those documents added to the official Air Docket since the October 1992 enactment of the WIPP LWA.

Dated: August 5, 2003.

Robert Brenner,

Acting Assistant Administrator for Air and Radiation.

[FR Doc. 03–20525 Filed 8–11–03; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 380 and 391

[Docket FMCSA–97–2176]

RIN 2126–AA08

Minimum Training Requirements for Longer Combination Vehicle (LCV) Operators and LCV Driver-Instructor Requirements

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

ACTION: Notice of proposed rulemaking (NPRM); request for comments.

SUMMARY: The FMCSA is proposing standards for minimum training requirements for the operators of longer combination vehicles (LCVs) and requirements for the instructors who train these operators. This action is in response to section 4007 of the Intermodal Surface Transportation Efficiency Act of 1991, which directed that training for the operators of LCVs include certification of an operator's proficiency by an instructor who has met the requirements established by the Secretary. The purpose of this proposal is to enhance the safety of commercial motor vehicle (CMV) operations on our nation's highways.

DATES: Comments must be received on or before October 14, 2003.

ADDRESSES: You can mail, fax, hand deliver or electronically submit written comments to the Docket Management Facility, U. S. Department of Transportation, Dockets Management Facility, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001, FAX (202) 493–2251, on-line at *http://dms.dot.gov/submit.* You must include the docket number that appears in the heading of this document in your comment. You can examine and copy all comments at the above address from 9 a.m. to 5 p.m., EST, Monday through Friday, except Federal holidays. You can also view all comments or download an electronic copy of this document from the DOT Docket Management System (DMS) at *http://dms.dot.gov/search.htm* by typing the last four digits of the docket number appearing at the heading of this document. The DMS is available 24 hours each day, 365 days each year. You can get electronic submission and retrieval help and guidelines under the ''help'' section of the Web site. If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard or print the acknowledgement page that appears after submitting comments on-line.

Comments received after the comment closing date will be included in the docket, and we will consider late comments to the extent practicable. Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, *etc.*). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78) or you may visit *http://dms.dot.gov*.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Redmond, Office of Safety Programs, (202) 366–9579, Federal Motor Carrier Safety Administration, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590. Office hours are from 8:30 a.m. to 5 p.m., EST, Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION: Section 4007(b) of the Motor Carrier Act of 1991 (Title IV of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA), Pub. L. 102–240, 105 Stat. 1914, 2152; 49 U.S.C. 31307) directs the U.S. Department of Transportation to establish Federal minimum training requirements for drivers of LCVs. The ISTEA also requires that the certification of these drivers' proficiency be accomplished by instructors who meet certain Federal minimum requirements to ensure an acceptable degree of quality control and uniformity. Section 4007(f) of the ISTEA defines an LCV as any combination of a truck-tractor and two or more trailers or semi-trailers with a gross vehicle weight (GVW) greater than 80,000 pounds (36,288 kilograms) which are operated on the Interstate Highway System. The FMCSA is proposing definitions to identify the various configurations being operated on the nation's highways that would be included in the final rule; they will be discussed later in this document.

Background

In the early 1980's, the FHWA [1] determined that a need existed for

[1] On October 9, 1999, the Secretary of Transportation (Secretary) rescinded the authority previously delegated to the Federal Highway Administrator to perform motor carrier functions and operations, and to carry out the duties and powers related to motor carrier safety and redelegated that authority to the Director, Office of Motor Carrier Safety, a new office within the Department of Transportation (Department). On

technical guidance in the area of truck driver training. Research at that time had shown that many driver-training schools offered little or no structured curricula or uniform training programs for any type of CMV.

To help correct this problem, the agency developed, and in 1985 issued, the ''Model Curriculum for Training Tractor-Trailer Drivers'' (1985, GPO Stock No. 050–001–00293–1), which incorporated the agency's ''Proposed Minimum Standards for Training Tractor Trailer Drivers'' (1984). The Model Curriculum, as it is known in the industry, is a broad set of recommendations that incorporates standardized minimum core curriculum guidelines and training materials, as well as guidelines pertaining to vehicles, facilities, instructor hiring practices, graduation requirements, and student placement. Curriculum content includes the following areas: basic operation, safe operating practices, advanced operating practices, vehicle maintenance, and non-vehicle activities.

The Professional Truck Driver Institute (PTDI) was created in 1986 by the motor carrier industry to certify training programs offered by the truck-driver training schools. (Originally named the Professional Truck Driver Institute of America (PTDIA), the group changed its name to reflect the addition of Canada to the organization.) The Model Curriculum is the base from which the PTDI's certification criteria were derived. The PTDI, in mid-1988, began certifying truck-driver training programs across the country. As of February 2003, approximately 64 schools in 27 States and Canada have received the PTDI certification. Although many schools have a number of truck driving courses, most have only one course certified by PTDI.

The Commercial Motor Vehicle Safety Act of 1986 (CMVSA) (49 U.S.C. 31301 *et seq.*), although not directly targeted at driver-training, is intended to improve highway safety. Its goal is to ensure that drivers of large trucks and buses possess the knowledge and skills necessary to safely operate those vehicles on public highways. The CMVSA established the commercial driver's license (CDL) program and directed the FMCSA to establish minimum Federal standards which States must meet when licensing CMV drivers. The CMVSA applies to virtually anyone who operates a CMV in interstate or intrastate commerce, including employees of Federal, State, and local governments. As defined by the implementing regulation (49 CFR 383.5), a CMV is a motor vehicle or combination of motor vehicles used in commerce to transport passengers or property if the vehicle—

(a) Has a gross combination weight rating (GCWR) of 11,794 or more kilograms (26,001 or more pounds) inclusive of a towed unit with a gross vehicle weight rating (GVWR) of more than 4,536 kilograms (10,000 pounds); or

(b) Has a GVWR of 11,794 or more kilograms (26,001 or more pounds); or

(c) Is designed to transport 16 or more passengers, including the driver; or

(d) Is of any size and is used in the transportation of hazardous materials as defined in this section.

In accordance with the CMVSA, all drivers of CMVs must possess a valid CDL in order to be properly qualified to operate the vehicle(s) they drive. In addition to passing the CDL knowledge and skills tests required for the basic vehicle group, all persons who operate or expect to operate the following vehicles, which have special handling characteristics, must obtain endorsements under 49 CFR 383.93:

(a) Double/triple trailers;

(b) Passenger vehicles;

(c) Tank vehicles; or

(d) Vehicles required to be placarded for hazardous materials.

For all endorsements, the driver is required to pass a knowledge test. The driver must also pass a skills test to obtain a passenger endorsement.

The CDL standards do not require the comprehensive driver-training proposed in the Model Curriculum since the CDL is a ''licensing standard'' as opposed to a ''training standard.'' Accordingly, there are no prerequisite Federal or State training requirements to obtain a CDL.

In 1990, the National Transportation Safety Board (NTSB) recommended that drivers of specialized vehicles, including drivers of twin trailer vehicles, be knowledgeable about the special handling characteristics and other variables that influence the controllability and maneuverability of multiple-trailer configurations, and how these variables compare to, and contrast with, those that affect the operation of a semi-trailer combination.

Subsequently, the agency awarded a contract in February 1991 to the PTDI to develop voluntary criteria for training drivers in the safe operation of twin 8.534-meter (28-foot) trailer combination vehicles. The result of this contract was the development of a ''Twin Trailer Driver Curriculum'' which outlines how drivers should be trained in the safe operation of these vehicles. This document is available for review in the public docket.

The ''Twin Trailer Driver Curriculum'' outline was developed with the assistance of subject matter experts from motor carrier fleets, industry associations, training institutions and governmental organizations. The resulting curriculum is a training program that consists of 115 clock-hours of direct driver participation, including a minimum of 56 hours of behind-the-wheel training.

The agency awarded two additional contracts to the PTDI to develop curriculum outlines to address triple-trailer combination vehicles and Rocky Mountain/Turnpike Doubles combination vehicles. Ultimately, the curriculum outlines for twin trailers, Rocky Mountain/Turnpike Doubles and triple-trailer combinations were merged into a single document, entitled ''Multiple Trailer Combination Vehicle (MTCV) Driver Training Guide: Suggested Units of Instruction and Curriculum Outline.'' The PTDI was selected to develop a composite modular training curriculum outline embracing both the LCV driver and instructor.

Upon completion of the curricula, the agency coordinated with the U.S. Department of Education (Education) to ensure that the proposed training requirements are in concert with its accreditation requirements. The agency representatives agreed that the proposed training requirements would be eligible for accreditation by any group that met the criteria and procedures described in the publication ''Nationally Recognized Accrediting Agencies and Associations, Criteria and Procedures for Listing by the U.S. Secretary of Education and Current List.'' This document is available for review in the public docket.

The agency also completed two projects that contributed to an enhanced understanding of driver training. Although they were not specifically designed to address one type of driver training versus another or to address specific items that would be included in a minimum training standard, they do provide perspective on the importance of driver training and the need for minimum training requirements. The following summarizes these projects:

The first project took place during December 1994 when the agency conducted focus groups to obtain information about highway safety issues relating to commercial motor carriers (trucks and buses). The sessions were conducted with representatives of three

December 9, 1999, the Motor Carrier Safety Improvement Act of 1999 established a new administration—the Federal Motor Carrier Safety Administration (FMCSA)—within the Department to improve the motor carrier safety program, effective January 1, 2000.

populations that have an interest in the safety of commercial vehicles: commercial drivers (holders of CDLs), police officers who deal at least in part with traffic enforcement, and the general public. As described in the ''Focus Group Report,'' all three groups reported that driver error is the most important cause of safety problems. All groups said that there is a need to upgrade the CDL through longer training, certification of instructors, higher performance standards and periodic re-testing. This document is available for review in the public docket.

The second project occurred in March 1995 when the FHWA sponsored the first National Truck and Bus Safety Summit. More than 200 experts attended it from all facets of the motor carrier community including Federal, State and local enforcement and legal communities, carriers, drivers, heavy vehicle manufacturers and suppliers, shippers, highway safety researchers, insurers, and other professional organizations. These truck and bus safety experts met for three days to share their views on significant truck and bus safety issues. As described in the ''1995 Truck and Bus Safety Summit, Report of Proceedings'', overall driver training and continuing education (for commercial drivers and the general motoring public) ranked number three out of seventeen safety issues identified by the participants. This document is available for review in the public docket.

The agency has utilized these projects, the research conducted over the past several years and the comments to the 1993 advance notice of proposed rulemaking (ANPRM) on training of LCV drivers to develop the proposals in this notice of proposed rulemaking.

Comments to the ANPRM

On January 15, 1993, the FHWA published an ANPRM in the **Federal Register** (58 FR 4638) seeking comments and responses to 13 specific questions. The FMCSA received 24 comments which are discussed below.

Question 1: Should the definition of LCV that will be used to develop a training requirement be expanded to include vehicles not covered by the ISTEA, such as multiple-trailer combinations operating with a gross weight of less than 36,288 kilograms (80,000 pounds), *i.e.*, ''twin trailers'' or ''western doubles''?

Comments: Of the 13 commenters that provided a response to this question, 6 were in favor of expanding the definition of an LCV to include multiple-trailer combination vehicles with a GCWR of less than 36,288 kilograms (80,000 pounds). They believed that the number and size of the trailers are more important than weight and that LCVs should be easily identifiable for enforcement purposes.

The Advocates for Highway and Auto Safety (AHAS) and the Owner-Operators Independent Drivers Association (OOIDA) supported a training requirement that is expanded to include vehicles not covered by the ISTEA definition of LCV. OOIDA believes that the number and size of the cargo carrying units primarily determine the handling characteristics and overall operational safety of the vehicle as opposed to the gross operating weight and length.

Those commenters opposing the expansion of the definition, including the American Trucking Associations (ATA), the Specialized Carriers and Rigging Association (SCRA), the National Private Truck Council (NPTC), Yellow Freight Systems, Inc. (Yellow Freight), and United Parcel Service (UPS), generally emphasized the importance of a consistent LCV definition and the possibility of expanding the definition at a later date. The ATA and Yellow Freight each submitted a second comment to the docket to reaffirm their opposition to any possible plans to include twins in the definition of LCV. Definition consistency and possible cost considerations, respectively, were the reasons cited.

Question 2: What difficulties would the ISTEA definition create, from an enforcement standpoint, in distinguishing which vehicles meet the definition and in determining which drivers must comply with any LCV training requirements?

Comments: Ten commenters responded to this question. Seven respondents indicated that the ISTEA definition of an LCV would create enforcement difficulties primarily because the weight aspect of the definition would make LCVs difficult to distinguish from a similar vehicle which does not meet the weight requirement. The Colorado DOT was concerned that it may be impossible for enforcement personnel, by merely viewing the combinations, to distinguish which vehicles are operating at greater than 36,288 kilograms (80,000 pounds) and therefore which drivers should have the LCV driving requirements and which should not. Pennzoil went further by recommending that a definition of LCV should ''not require the measuring and weighing of LCVs.''

Three commenters stated that the ISTEA definition would not cause enforcement difficulties. The SCRA reflected the general view of the commenters by stating that ''[if] the LCV definition in the ISTEA of 1991 is adopted by FMCSA we believe that enforcement people will have very little difficulty identifying longer combination vehicles * * *. They should be able to determine gross vehicle weight from shipping papers, manifest and/or weight tickets.''

Question 3: Once the training requirements for LCV drivers are established, what should the FHWA's role be in assuring that the training is actually carried out according to the minimum standards?

Comments: Thirteen respondents commented on this question. Responses were diverse. Some argued that the agency should use the Safety Review/Compliance Review (SR/CR) process to assure programmatic compliance (ATA, OOIDA, PTDI, UPS, Yellow Freight); others said the agency should make those State agencies that receive Motor Carrier Safety Assistance Program (MCSAP) funding responsible for monitoring the LCV training requirements. The NPTC suggested that the ''FHWA should enhance CDL tests by including skills testing for LCV operators.'' Pennzoil recommended that once the FHWA defines the LCV training requirements, it should require LCV driver applicants to provide proof of training when applying for and renewing their CDLs. In addition, Pennzoil recommended that the FHWA and State agencies establish an instructor file record.

Question 4: What standards are necessary to ensure that instructors have been adequately and properly trained and are carrying out their training responsibilities in an acceptable manner?

Comments: Thirteen respondents provided comments to this question. Their underlying theme was that instructors should be fully experienced LCV drivers and be held to a higher standard than the LCV drivers they will train. In addition, comments emphasized that the LCV instructors should be qualified and capable vocational instructors who are thoroughly familiar with course content. Pennzoil recommended that instructors be recertified every one to three years. The Maine DOT recommended instructor certification.

Question 5: Should the initial licensing of LCV instructors and certification of LCV drivers be accomplished by a Federal (FMCSA or other) or State agency? How should this be accomplished?

Comments: Twelve respondents provided comments to this question. The commenters were almost equally divided on the question whether LCV instructor certification should be accomplished by the FMCSA, rather than a motor carrier or a State, to ensure that the instructor met Federal minimum requirements. On the other hand, the commenters tended to prefer State certification of LCV drivers to certification by an LCV instructor, motor carrier, the FMCSA, or self-certification.

With regard to the certification method, the ATA suggested ''LCV instructors should go through a carrier managed certification program much like the certification process for vehicle and brake inspectors. The licensing of drivers should be tied to the CDL testing process.''

The AHAS expressed the opinion ''that uniformity of instruction, certification, and licensure can only be accomplished by Federal Standards through state licensing agencies and must supersede voluntary standards-setting organization and their system of certification.'' Conversely, ''UPS believes that each carrier should be held responsible for certification and recertification of their triples drivers and driver trainers. * * * As a practical matter, the expertise in LCV driver-training resides with motor carriers. We feel that Federal or State certification of LCV driver training is unworkable and unnecessary.'' Essentially, Yellow Freight shares the same position as UPS.

Question 6: What specific Federal, State or local agency should have the responsibility for assuring that the requirements of LCV training are met, and what form of documentation should be established to prove to prospective employers that adequate LCV training has been successfully completed by a driver? Who should be held accountable if the training requirements are not met?

Comments: This question has three distinct parts: responsibility, documentation and accountability. Thirteen respondents provided comments to this question.

Eleven commenters addressed the responsibility aspect of the question. Eight were proponents of State agencies accepting the responsibility and/or linking the training requirement to the CDL program. Three commenters recommended that the FMCSA CR process be employed to further enforce this requirement. With regard to documentation of training, five of 11 commenters were in favor of a certificate issued either by a training institution or the FMCSA. Three other commenters suggested that completion of LCV training be integrated into the CDL process through the use of an appropriate endorsement.

Seven commenters addressed the accountability aspect of the question. Five of the commenters argued that both the motor carrier and the driver should be held accountable. The other two respondents were of the opinion that the driver alone should be held accountable for obtaining the required training.

Question 7: Should nonprofit, private organizations, such as PTDI, be authorized to evaluate and certify the adequacy of LCV training programs?

Comments: Of the fourteen commenters that responded, five opposed private organizations evaluating and certifying LCV training programs. Of these, three believed that this should be a Federal or State governmental function. Nine favored evaluation and certification by private organizations.

Question 8: What types of LCV driver-training programs exist?

Comments: Eight respondents provided comments on this question. The ATA stated that ''[m]ost fleets that operate LCVs have established their own in-house training programs. These carrier-directed programs generally require certain levels of experience and excellent driving records prior to driving LCVs. Key eligibility criteria motor carriers impose upon drivers prior to [their] operating LCVs include no moving violations or accidents within a specified time frame (generally three years). Many carriers that operate LCVs also have age minimums for LCV drivers—typically age 25 as a minimum.'' The PTDI stated that, ''[t]o our knowledge, there are no 'schools'' that teach a specific LCV course.'' Current cost estimates to train an LCV driver range from $400 (ATA and Yellow Freight) to $6,445 per trainee (UPS).

Question 9: Should the implementation of minimum training requirements for LCV operators be ''phased in'' over a certain period of time?

Comments: Ten of the 12 respondents supported a ''phased in'' implementation of a minimum training requirement. The suggested ''phase in'' period ranged from one to four years. The ATA specifically supports the phase-in concept to give smaller motor carriers adequate time to plan and implement the program without undue financial hardship and because of the excellent safety record of the LCV segment of the industry.

The AHAS did not support the phasing-in of LCV training requirements. Instead, it ''strongly favors a specific date by which all drivers of LCVs, western doubles and other multi-unit trucks can take the CDL LCV endorsement only with state-approved certification in hand showing successful completion of an LCV training program based on FMCSA standards.'' The AHAS also suggested that the FMCSA require that the LCV training infrastructure (*e.g.*, certification of instructors and training programs and oversight systems) be in place in advance of any actual driver-training. The NPTC suggested linkage of the LCV training requirements to the CDL program by the introduction of a CDL endorsement for LCVs.

Question 10: Should LCV training be a prerequisite for a double/triple trailer endorsement on a CDL?

Comments: Eleven of the 14 commenters generally supported a training prerequisite.

The SCRA argued that such a prerequisite could cause confusion since it would broaden the definition of LCV to include combination vehicles having a GVWR of less than 36,288 kilograms (80,000 pounds). Yellow Freight stated that ''(t)riple trailer combinations specifically are only authorized in 16 States. It would be an enormous waste of motor carrier time and money to require triples driver-training of drivers in the other 34 States or of drivers, such as city drivers, who may never operate triples.'' The UPS voiced a similar opinion.

Question 11: Should all LCV drivers be required to have previous experience with single trailer vehicles?

Comments: Ten of the 13 respondents contend that an individual should have CMV experience prior to becoming an LCV driver. Eight of these 10 believe that this experience should be in single-trailer vehicles. The minimum amount of single-trailer experience that was recommended ranged from one to five years. Two years was specified most often. Only two commenters (PTDI and SCRA) disagreed with the experience requirement; they contend that if a driver has a CDL and completes the required LCV training, experience should not be a factor.

Question 12: How often should LCV training be offered/repeated for both instructors and drivers?

Comments: Thirteen commenters addressed this question. Comments ranged from the suggestion that driver training be repeated whenever new equipment is introduced into the industry (ATA and Yellow Freight), to the proposal that it be repeated only if the driver is disengaged from LCV activity for more than a year (SCRA). The Colorado DOT and the New York State Thruway Authority (NYSTA) were

proponents of driver retraining at the time of license renewal. Other respondents suggested retraining on a 4- to 10-year cycle, or as needed. The Maine State Police believes that once training and certification are obtained for the operation of LCVs, repeat training is not necessary. The UPS requires each of its LCV drivers to be accompanied by a UPS driver-trainer for a ''certification ride'' which is conducted for a period of 8 to 10 hours every 3 months. The driver is notified of any deficiency or discrepancy noted by the driver-trainer and must take immediate corrective action.

With regard to instructor training, suggestions ranged from never to every 10 years. Among the reasons commenters gave for requiring retraining were: that the instructor had not taught for more than a specified time (often one year); that the curriculum requirements had changed; or that industry technology had changed, since the instructor became qualified.

Question 13: Do specialized vehicle combinations such as triples or those handling special cargo require different training standards?

Comments: Nine of the twelve commenters supported different training requirements for specialized vehicle combinations. It was generally agreed that the focus should be upon the handling characteristics of the vehicle except when special commodities (liquids in bulk, hanging meat, etc.) are being transported. The Specialized Carriers and Rigging Association believes ''* * * Training should focus on vehicle handling characteristics and not on type of cargo being transported. Vehicle combinations that are overweight or overlength because of special cargo do not require different training standards. All LCV drivers should have training which focuses on vehicle handling characteristics (not on types of cargo being transported) and that the driver will have basic knowledge and operating skills necessary for awareness that vehicle handling characteristics change with variations in size, weight and nature of the load being transported.''

Section Analysis

This section of the Supplementary Information discusses *only those sections* of the proposed rule for which the FMCSA believes additional information may be required to facilitate an understanding of this NPRM.

Rule Effective Date

Question 9 in the ANPRM asked whether a phase-in period would be necessary. This question anticipated the need for States to adopt enabling legislation to implement the new requirements. Because this proposal includes no requirement applicable to States, the agency believes that a 2-month phase-in period is adequate and would provide sufficient time to develop the required training curriculum. The effective date of the rule would be 2 months after its publication in the **Federal Register**.

Subpart A—Longer Combination Vehicle (LCV) Driver-Training and Driver-Instructor Requirements—General

Section 380.105 Definitions

Six of 13 respondents to Question 1 recommended that the agency amend the definition of an LCV to include multiple-trailer combinations operating with a GVW less than 80,000 pounds. They believe that the number and size of the trailers are more important than weight and that LCVs should be easily identifiable for enforcement purposes. The ISTEA LCV definition would subject a relatively small segment of multiple-trailer combination vehicle drivers (approximately 35,000) to the LCV training requirements. The most commonly operated MTCVs are twin trailers, also known as ''Western doubles,'' and they are usually not operated at a GVW greater than 80,000 pounds. Revising the definition of an LCV to embrace only the number and size of trailers would significantly increase the number of drivers who are subject to this rule. Because agency research has not indicated a significant safety problem in LCVs or multiple trailer combination vehicles, the FMCSA is not proposing here to require such training for a larger vehicle population. FMCSA believes it can ensure a minimum level of safety by fulfilling the statutory requirement to publish minimum standards for operators of LCVs with a GVW greater than 80,000 pounds and instructors of these drivers.

In 1996, the agency conducted a study to determine, among other things, the relative accident rates, in accidents per million vehicle miles traveled (VMT), of LCVs and non-LCVs. The study findings were published in a final report entitled, Accident Rates for Longer Combination Vehicles, Publication No. FHWA–MC–97–003. A copy of the report is in the public docket. Seventy-five commercial motor carriers participated in this study. All participants operated both LCVs and non–LCVs. Significant findings were as follows:

- For the 75 carriers examined in the study, LCVs were much less likely than non-LCVs to be involved in accidents. These findings pertain only to the carrier population from which the study sample was drawn.
- Among study participants, the mean accident rate was 0.88 accidents per million VMT for LCVs versus 1.79 accidents for non-LCVs; in other words, non-LCVs were more than twice as likely as LCVs to be involved in accidents. The difference in the mean accident rates was found to be statistically significant.
- LCVs and non-LCVs had nearly equal probabilities of involvement in fatal crashes. When fatal and injury crashes were examined in tandem, however, the LCV accident rate was 50 percent lower than the non-LCV rate.
- Non-LCVs were 1.1 times more likely than LCVs to be involved in collisions, and 1.8 times more likely to be involved in non-collisions [2]; these differences were statistically significant. Rocky Mountain Doubles were less likely than Turnpike Doubles and STAA Doubles/GVW Over 80,000 pounds to be involved in collisions.
- LCVs were almost twice as likely as non-LCVs to overturn, and LCV Doubles were more likely than tractors-semi-trailers to jackknife.

In September 1999, the agency published an Analysis Brief entitled ''Longer Combination Vehicles Involved in Fatal Crashes, 1991–1996,'' FHWA–MCRT–99–018. Based on the data presented in the brief, no conclusions could be made on the relative safety of LCVs compared to other truck combinations. First, the data on mileage driven is based partly on weight. Second, since travel by LCVs is rare, it is difficult to calculate the precise number of miles driven. Similarly, LCV fatal crashes are so infrequent that the number varies greatly from year to year. For example, LCV crashes dropped from 46 in 1992 to 31 in 1993 (down 33 percent), then rose to 43 in 1994 (up 39 percent). Based on the existing data, LCVs do not appear to be considerably more or less safe than other combination trucks. A more definitive conclusion would require further collection of data and additional analysis.

FMCSA recognizes that there are different names for different multiple trailer combinations in different parts of the country. The research completed under contract to the FMCSA to develop the ''Multiple-Trailer Combination

[2] A non-collisiion is a commercial vehicle accident in which the primary event does not involve hitting another object. Non-collision accidents include jackknifes, overturns, fires, cargo shifts and spills, and running off the road.

Vehicle Driver-Training Guide,'' and the ''Multiple-Trailer Combination Vehicle Driver-Training Instructor Guide'' was the result of the efforts of the PTDI, and experts from the trucking industry, labor, and government. This group reached consensus on how to best identify and refer to the various combination vehicles. Accordingly, FMCSA has incorporated many of those terms into this proposed rule. In some instances, the agency proposes a different term than the PTDI-recommended one (*i.e.*, longer double trailers would be called an LCV double; a triple trailer would be called an LCV triple.). The agency recognizes that the dynamic nature of the trucking industry may result in the development and operation of combinations that qualify as LCVs but may not be described here. We invite comment on the question of whether additional clarifying information should be added to the final rule.

Section 380.109 Driver testing

This section proposes general requirements pertaining to LCV driver-training tests—comprised of both a knowledge and skills assessment—for all students wishing to obtain an LCV Driver-Training Certificate. It would require the tests to reflect solely the information contained in the LCV driver-training programs offered and that the tests be valid and reliable student assessment tools. This section would also establish 80 percent as the minimum passing score for the knowledge tests, as is the current standard for the CDL knowledge tests offered by the States. If, during the skills portion of the test, the student fails to obey traffic laws or is involved in a preventable accident, he/she would automatically fail the LCV driver-training test.

Section 380.111 Substitute for driver training

FMCSA believes that for many current LCV drivers, the combination of a good driving record and experience with a representative vehicle of the specific LCV category is an appropriate indication that the individual has the minimum knowledge and driving skills to operate such a vehicle. Accordingly, the FMCSA would allow certain drivers to substitute a good driving record and experience for the completion of the LCV driver-training requirements. FMCSA believes grandfathering such drivers would not diminish public safety or overall safe operation of CMVs. The driver would have to provide the employing motor carrier evidence of safely operating those vehicles for a period of at least 2 years prior to application.

The FMCSA is proposing that a motor carrier issue a Certificate of Grandfathering to those drivers who meet the knowledge and experience requirements established in this section. A copy of the certificate would be filed in the Driver Qualification file. Grandfathered drivers would be excluded from the training requirements of this part. This action is consistent with that taken when the agency grandfathered certain drivers from the CDL skills tests contained in part 383. Current drivers could only be grandfathered for a one-year period immediately after the effective date of the final rule. After the one-year period, only those drivers who present an employer with a Certificate of Grandfathering would be exempted from LCV driver-training requirements.

Section 380.113 Employer responsibilities

This section would expressly prohibit a motor carrier from using an individual to operate an LCV unless he/she has first met the requirements under part 380. Section 380.113(b) would address ANPRM Question 2 regarding roadside enforcement challenges and Question 3 regarding the FMCSA role in enforcement. Under the current proposal, FMCSA or MCSAP State enforcement officials would verify compliance with the LCV driver-training and driver-instructor requirements at the carrier's place of business during the compliance review, rather than at the roadside. The enforcement official would not be burdened with trying to determine at roadside whether or not a CMV driver is subject to the LCV training requirement. This enforcement approach would also emphasize that both the motor carrier and the driver have a responsibility for the LCV training requirement. The driver would have to obtain the necessary LCV training and the carrier would have to prohibit a driver from operating an LCV without it.

Subpart B—LCV Driver-Training Program

Sections 380.203 and 380.205 set forth the specific conditions that one would have to meet to qualify for LCV driver training. The individual seeking LCV training would have to possess a valid CDL with a double/triple trailer endorsement, have only one driver's license, have a good driving record, and provide evidence of experience in operating the prerequisite type of vehicle to qualify for the desired LCV training. Evidence of driving experience would consist of a statement from an employer(s) stating the type and amount of driving experience while employed by that motor carrier.

Subpart C—LCV Driver-Instructor Requirements

Section 380.301 General requirements

The FMCSA believes that, initially, persons who are currently conducting double/triple trailer combination vehicle training would become the qualified LCV instructors under the proposed grandfather requirements. Subsequently, when the need arises for new instructors, those qualified (grandfathered) LCV instructors would train new instructors, who would then be qualified to train drivers.

Each instructor that is employed by a training institution offering LCV training would have to meet all State requirements for a vocational education instructor. While the States assume varying degrees of control over education, institutions of post-secondary education are permitted to operate with considerable independence and autonomy. As a consequence, educational institutions can vary widely in the quality and adequacy of their programs. In order to ensure a basic level of quality and adequacy, the Department of Education established accreditation requirements. The FMCSA, therefore, proposes that any entity, for-profit or not-for-profit, private or public, that meets the accreditation requirements of the Department of Education would be allowed to offer the training.

Section 380.303 Substitute for instructor requirements

As is the case for LCV drivers, certain current driver-instructors would be grandfathered from the instructional skills requirements. Those instructors desiring to be grandfathered would provide evidence of eligibility to the motor carrier. The motor carrier would file the proof of eligibility in the LCV instructor qualification file proposed under § 391.53.

Subpart D—Driver-Training Certification

Section 380.401 Certification document

The FMCSA proposes to require a certifying official of the training entity to issue a certificate to each driver who successfully completes LCV driver-training. The driver would provide the motor carrier a copy of the LCV Driver-Training Certificate as proof of eligibility to operate an LCV. The certificate would indicate the type(s) of

LCV which the driver is qualified to operate.

The motor carrier must file the copy of the certificate in the Driver Qualification file and present it to an authorized FMCSA, State or local official, upon request. The driver would need to safeguard the original certificate, as it is proof to future employers of eligibility to operate an LCV.

Appendix to Part 380

The FMCSA believes that specialized vehicle combinations require somewhat different training requirements because of differing operating characteristics. Therefore, the FMCSA proposes two separate training courses for LCV drivers: LCV Doubles and LCV Triples. The proposed curriculum would be identical but must be customized to address the unique operational and handling characteristics of the specific LCV category. Specialized commodity training could be addressed as necessary by training institutions or carriers.

In developing the proposed course content, the FMCSA considered research conducted by the PTDI while under contract to the agency. The FMCSA acknowledges that the actual training materials will be developed by the motor carrier industry or other commercial training entities. Such training materials would have to meet the minimum requirements set forth in the appendix to part 380. This action would allow the training entities a degree of flexibility in the development of specific materials to meet their individual needs.

The FMCSA is seeking very specific comments on whether you consider the topics of instruction described in the appendix to part 380 as adequate, requiring modification or needing to be eliminated. Please submit reasons supporting your response. Comments should address specific subject areas (training units) and include rationale supporting each recommendation with regard to course content. Any recommendations to add to the curriculum outline, with regard to course content, should also be addressed in a similar manner.

Part 391—Qualifications of Drivers and Longer Combination Vehicle (LCV) Driving Instructors

The FMCSA would amend 49 CFR part 391 to add new requirements under § 391.53 for a motor carrier to maintain a qualification file for LCV driver instructors and rename part 391 to reflect these new requirements.

Summary of the Proposed Regulatory Evaluation

In accordance with a Congressional mandate, this NPRM proposes minimum training requirements for operators of certain multiple trailer vehicles. The NPRM proposes, with limited exceptions, that drivers who do not currently operate these vehicles would complete training before operating double- or triple-trailer commercial motor vehicles. Most drivers who currently operate these vehicles will be exempted from these training requirements. The NPRM also outlines requirements for employers of drivers, LCV driver-instructors, and enforcement and administrative personnel. This preliminary regulatory evaluation analyzes the costs and benefits of the NPRM.

Congress directed the FMCSA to publish regulations concerning training of a driver of an LCV, which it defined as ''any combination of a truck tractor and 2 or more trailers or semi-trailers which operate on the National System of Interstate and Defense Highways with a gross vehicle weight greater than 80,000 pounds.''

Approximately 35,000 drivers currently operate LCVs, most of whom will be grandfathered. Approximately 1,200 LCV drivers would require training annually. ANPRM docket comments and information from industry representatives and analysts suggest that LCV drivers are currently obtaining about half the estimated amount of training, approximately 50 hours. The net cost of training (including drivers' wages) is $45.50 an hour. This results in a ten-year cost of approximately $28 million.

Precisely quantifying the benefits of this rule is difficult. Congress clearly assumed that increased training reduces accident rates, and many analysts agree with this position. However, quantitative data examining the relationship between training and accident rates is not plentiful, and those studies we have located have not found a strong and consistent relationship. Therefore, we performed sensitivity analysis, estimating the benefits from a range of reductions in drivers' accident rates for those who have received training. Net benefits ranged from -$10 million for a 5% reduction in the accident rate to $144 million for a 50% reduction. Table 1 presents the results for a number of possible deterrence levels.

TABLE 1.—BENEFIT COST RATIO WITH DIFFERENT ACCIDENT RATE REDUCTIONS

Crash reduction	5%	10%	15%	20%
B/C Ratio	0.6	1.2	1.8	2.5

Table 2 shows costs, benefits, and the number of accidents and drivers that would be affected by these proposals, with an assumed 10% reduction in accidents.

TABLE 2.—SUMMARY RESULTS WITH 10% ACCIDENT RATE REDUCTIONS

[millions of dollars]

# Trained annually	10-Year costs	10-Year benefits	Net benefits	B/C ratio	Crashes prevented
1,172	$28.0	$34.4	$6.4	1.2	315

This analysis assumes that the proposal will require that prospective LCV drivers obtain an additional 50 hours of training. This is a conservative estimate, in that it is on the high end of the range of likely training time. Nonetheless, because of uncertainty over how many hours of training will be required, we performed sensitivity analysis for different assumed hours of training. As expected, the sensitivity analysis shows that net benefits move in the opposite direction of the number of hours. We invite comments from reviewers about the amount of training needed to meet the requirements of this proposal, including supporting rationale.

All costs and benefits are over a ten-year period, and are discounted at a 7% rate. The agency has placed a copy of the full Regulatory Evaluation in the public docket.

Rulemaking Analyses and Notices

Executive Order 12866 (Regulatory Planning and Review) and DOT Regulatory Policies and Procedures

The FMCSA has determined that this action is a significant regulatory action

within the meaning of E.O. 12866, and is significant within the meaning of the Department of Transportation's regulatory policies and procedures (DOT Order 2100.5 dated May 22, 1980; 44 FR 11034, February 26, 1979) because of significant public interest in the issues relating to CMV safety and training of certain CMV drivers. This proposed rule has been reviewed by the Office of Management and Budget under E.O. 12866.

Regulatory Flexibility Act

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), an agency is required to evaluate proposed rulemakings to determine the effects of its action upon small entities. FMCSA does not believe that these proposals meet the threshold values for requiring a full-blown regulatory analysis, since the anticipated impact is relatively small. Nonetheless, because of the public interest in these proposals, we have prepared a regulatory analysis and placed a copy in the docket to this IFR. The mandatory topics to be considered in a Regulatory Flexibility Analysis and agency findings are as follows.

(1) A description of the reasons why the action by the Agency is being considered. This action is being considered in response to Congressional direction. Specifically, section 4007 of the Intermodal Surface Transportation Efficiency Act of 1991 directed the Secretary of Transportation to promulgate regulations requiring training for LCV drivers.

(2) A succinct statement of the objectives of, and legal basis for, the proposed rule. The objective for this action is to reduce the number of crashes caused by drivers of LCVs. Congress was specifically concerned about the number of LCV crashes caused by inadequate driver training, and believes that better training will reduce these types of crashes. As noted above, the legal basis for this rule is section 4007 of the Intermodal Surface Transportation Efficiency Act of 1991.

(3) A description and, where feasible, an estimate of the number of small entities to which the proposed rule will apply. This action would apply to relatively few small entities that own or operate LCVs, and to drivers that drive LCVs.

(4) A description of the projected reporting, recordkeeping, and other compliance requirements of the proposed rule, including an estimate of the classes of small entities that will be subject to the requirement and the types of professional skills necessary for preparation of the report or record. This action would impose a very modest burden on small entities, since it largely regulates the actions of drivers rather than motor carriers. Nonetheless, this action does impose some reporting and recordkeeping requirements on motor carriers. The primary carrier requirement would be to verify drivers' eligibility before allowing them to operate an LCV. In addition, carriers must maintain in the driver qualification (DQ) file a copy of the required driver-training certificate. Carriers are currently required to maintain a DQ file for each driver, as outlined in Part 391 of the FMCSRs. No special skills are required to verify eligibility to operate an LCV or to place a driver training certificate in a DQ file.

(5) An identification, to the extent practicable, of all relevant federal rules that may duplicate, overlap, or conflict with the proposed rule. The FMCSA is not aware of any other rules which duplicate, overlap, or conflict with the proposed action.

Accordingly, the FMCSA hereby certifies that the proposed action discussed in this document will not have a significant economic impact on a substantial number of small entities.

Executive Order 13132 (Federalism)

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 13132. It has been determined that this rulemaking does not have a substantial direct effect on States, nor would it limit the policy-making discretion of the States. Nothing in this document preempts any State law or regulation.

Executive Order 12372 (Intergovernmental Review)

Catalog of Federal Domestic Assistance Program Number 20.217, Motor Carrier Safety. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities do not apply to this program.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct, sponsor, or require through regulations. An analysis of this proposal was made by the FMCSA, and it has determined that the final rule, when promulgated, would create a new collection of information requiring OMB's approval. This PRA section addresses the information collection burden for certifying new LCV drivers, as well as the burden associated with grandfathering, via certification, most current LCV drivers.

The FMCSA estimates that there are 35,000 LCV drivers currently operating, the vast majority of whom would be eligible to be grandfathered under the new training requirements set forth in this NPRM. The agency also estimates that approximately 1,200 new LCV drivers would require training each year. There would be a burden to the motor carrier or other training entity to complete, photocopy, and file the certification form. FMCSA estimates this will take 10 minutes, resulting in an annual burden of 200 hours [1,200 drivers $\times$ 10 minutes per motor carrier/ training entity, divided by 60 minutes = 200].

For grandfathering the current 35,000 drivers, there would be a one-time burden, since drivers could only be grandfathered during the first year after the rule becomes effective. There are two parts to the burden for these 35,000 drivers: the burden for the driver to collect and provide the information to the motor carrier and the burden for the motor carrier to review the documents, complete, duplicate, and file the certification form. FMCSA estimates that it would take approximately 15 minutes for a driver to collect the necessary information and provide the document to the motor carrier, and 15 minutes for the motor carrier to review the information, complete the certification, and duplicate and file the document. Therefore, the burden associated with grandfathering the 35,000 drivers would be 17,500 burden hours [(35,000 $\times$ 15 minutes per driver, divided by 60 minutes = 8,750) + (35,000 $\times$ 15 minutes per motor carrier, divided by 60 minutes = 8,750) = 17,500].

The first-year burden associated with this rule, when promulgated, is 17,700 burden hours [200 + 17,500]. After the first year, the burden would drop to 200 burden hours per year.

Interested parties are invited to send comments regarding any aspect of these information collection requirements, including, but not limited to: (1) Whether the collection of information is necessary for the performance of the functions of the FMCSA, including whether the information has practical utility, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the collected information, and (4) ways to minimize the collection burden without reducing the quality of the information collected.

National Environmental Policy Act

The FMCSA is a new administration within the Department of

Transportation (DOT). The agency is striving to meet all of the statutory and executive branch requirements on rulemaking. The FMCSA is currently developing an agency order that will comply with all statutory and regulatory policies under the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321 *et seq.*). The agency expects the draft FMCSA Order to appear in the **Federal Register** for public comment in the near future. The framework of the FMCSA Order is consistent with and reflects the procedures for considering environmental impacts under DOT Order 5610.1C. The FMCSA analyzed this NPRM under the NEPA and DOT Order 5610.1C. Since this action relates only to driver-training and instructor-qualification standards, the agency believes that it would be among the type of regulations that would be categorically excluded from any environmental assessment.

Executive Order 13211 (Energy Supply, Distribution, or Use)

We have analyzed this action under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. This action is not a significant energy action within the meaning of Section 4(b) of the Executive Order because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. This proposed rule establishes training requirements for operators of LCVs and sets forth requirements for trainers of such operators. This action has no effect on the supply or use of energy, nor do we believe it will cause a shortage of drivers qualified to distribute energy (*e.g.*, gasoline, fuel oil, *etc.*).

Unfunded Mandates Reform Act of 1995

This proposed rule would not impose a Federal mandate resulting in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year. (2 U.S.C. 1531 *et seq.*) Under this proposal, there are no costs to States, and costs to the private sector should be minimal. This action proposes minimum training standards for operators of LCVs. Although not required to do so under the FMCSRs, motor carriers routinely provide similar training to their drivers who operate LCVs. The proposal would not stipulate that motor carriers must provide such training, but requires them to use only those drivers and driver-instructors who have met the proposed standards. LCV drivers and driver-instructors would be responsible for the cost of meeting the requirements.

Executive Order 12630 (Taking of Private Property)

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

Executive Order 12988 (Civil Justice Reform)

This action meets applicable standards in sections 3(a) and 3(b)(2) of E.0. 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Executive Order 13045 (Protection of Children)

We have analyzed this action under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule sets forth training requirements for LCV drivers and sets standards for instructors of such drivers. Therefore, the FMCSA certifies that this action is not an economically significant rule and does not concern an environmental risk to health or safety that may disproportionately affect children.

List of Subjects

49 CFR part 380

Driver training, instructor requirements.

49 CFR part 391

Highways and roads, Motor vehicle safety.

In consideration of the foregoing, the FMCSA hereby proposes to amend title 49, Code of Federal Regulations, chapter III, subchapter B, as set forth below.

1. Chapter III is amended by adding part 380 to read as follows:

PART 380—SPECIAL TRAINING REQUIREMENTS

Subpart A—Longer Combination Vehicle (LCV) Driver-Training and Driver-Instructor Requirements—General

Subpart B—LCV Driver-Training Program

Subpart C—LCV Driver-Instructor Requirements

Subpart D—Driver-Training Certification

Authority: 49 U.S.C. 31136, 31307, and 31502; Sec. 4007(b) of Pub. L. 102–240 (105 Stat. 2152); 49 CFR 1.73.

Subpart A—General

§ 380.101 Purpose and scope.

(a) *Purpose.* The purpose of this part is to establish minimum requirements for operators of longer combination vehicles (LCVs) and LCV driver-instructors.

(b) *Scope.* This part establishes:

(1) Minimum training requirements for operators of LCVs;

(2) Minimum qualification requirements for LCV driver-instructors; and

(3) Procedures for determining compliance with this part by operators, instructors, training institutions, and employers.

§ 380.103 Applicability.

The rules in this part apply to all operators of LCVs in interstate commerce, employers of such persons, and LCV driver-instructors.

§ 380.105 Definitions.

(a) The definitions in part 383 of this subchapter apply to this part, except where otherwise specifically noted.

(b) As used in this part:

Longer combination vehicle (LCV) means any combination of a truck-tractor and two or more trailers or semi-trailers, which operate on the National System of Interstate and Defense Highways with a gross vehicle weight (GVW) greater than 36,288 kilograms (80,000 pounds).

LCV Double means a Rocky Mountain double or a turnpike double.

LCV Triple means an LCV consisting of a truck-tractor in combination with three trailers and/or semi-trailers.

Qualified LCV driver-instructor means an instructor meeting the requirements contained in subpart B of this part.

Rocky Mountain double means an LCV consisting of a truck-tractor in combination with a longer semi-trailer, usually 13.716 to 16.154 meters (45 to 53 feet) long, and a shorter trailer usually 8.230 to 8.687 meters (27 to 28.5 feet) long.

Training institution means any technical or vocational school

accredited by an accrediting institution recognized by the U.S. Department of Education.

Turnpike double means an LCV consisting of a truck-tractor in combination with two trailers or semi-trailers, each 13.716 meters (45 feet) or more in length.

Twin trailers means a truck-tractor in combination with two trailers and/or semi-trailers of approximately equal lengths, each 7.925 to 8.687 meters (26 to 28.5 feet) long and commonly referred to as ''twins'' or ''Western doubles.'' For the purposes of this part, this definition includes a truck in combination with two short trailers, each 7.925 to 8.687 meters (26 to 28.5 feet) long.

Western double means the same thing as twin trailers.

§ 380.107 General requirements.

(a) A driver who wishes to operate an LCV shall first take and successfully complete an LCV driver-training program that provides the knowledge and skills necessary to operate an LCV. The specific types of knowledge and skills that a training program shall include are outlined in the appendix to this part.

(b) Before a person receives training:

(1) That person shall present evidence to the LCV driver-instructor showing that he/she meets the general requirements set forth in subpart B of this part for the specific type of LCV training to be taken.

(2) The LCV driver-instructor shall verify that each trainee applicant meets the general requirements for the specific type of LCV training to be taken.

(c) Upon successful completion of the training requirement, the driver-student shall be issued an LCV driver-training certificate by a certifying official of the training entity in accordance with the requirements specified in subpart D of this part.

§ 380.109 Driver testing.

(a) *Testing Methods.* A qualified LCV driver-instructor must administer to the driver-student knowledge and skills tests in accordance with the following requirements to determine whether a driver-student has successfully completed an LCV driver-training program, as specified in subpart B of this part.

(1) All tests shall be constructed in such a way as to determine if the driver-student possesses the required knowledge and skills set forth in the appendix to this part for the specific type of LCV training program being taught.

(2) Instructors shall develop their own tests for the specific type of LCV-training program being taught, but those tests must be at least as stringent as the requirements set forth in paragraph (b) of this section.

(3) LCV driver-instructors shall establish specific methods for scoring the knowledge and skills tests.

(4) Passing scores must meet the requirements of paragraph (b) of this section.

(5) Knowledge and skills tests shall be based upon the information taught in the LCV training programs as set forth in the appendix to this part.

(6) Each knowledge test shall address the training provided during both theoretical and behind-the-wheel instruction and include at least one question from each of the units listed in the Table to the appendix to this part, for the specific type of LCV training program being taught.

(7) Each skills test shall include all the maneuvers and operations practiced during the Proficiency Development unit of instruction (behind-the-wheel instruction) as described in the appendix to this part, for the specific type of LCV training program being taught.

(b) *Proficiency determinations.* The driver-student must meet the following conditions to be certified as an LCV driver:

(1) Answer correctly at least 80 percent of the questions on each knowledge test; and

(2) Demonstrate that he/she can successfully perform all of the skills addressed in paragraph (a)(7) of this section.

(c) *Automatic test failure.* Failure to obey traffic laws or involvement in a preventable accident during the skills portion of the test will result in automatic failure.

§ 380.111 Substitute for driver-training.

(a) *Grandfather clause.* The LCV driver-training requirements specified in subpart B of this part do not apply to an individual who meets the conditions set forth in paragraphs (b), (c), and (d) of this section. A motor carrier must ensure that an individual claiming eligibility to operate an LCV on the basis of this section meets these conditions before allowing him/her to operate an LCV.

(b) An individual must certify that, during the 2-year period immediately preceding the date of application for a Certificate of Grandfathering, he/she had:

(1) A valid Class A CDL with a ''double/triple trailers'' endorsement;

(2) No more than one driver's license;

(3) No suspension, revocation, or cancellation of his/her CDL;

(4) No convictions for a major offense while operating a CMV as defined in § 383.51(b) of this subchapter;

(5) No convictions for a railroad-highway grade crossing offense while operating a CMV as defined in § 383.51(d) of this subchapter;

(6) No convictions for violating an out-of-service order as defined in § 383.51(e) of this subchapter;

(7) No more than one conviction for a serious traffic violation, as defined in § 383.5 of this subchapter, while operating a CMV;

(8) No convictions for a violation of State or local law relating to motor vehicle traffic control arising in connection with any traffic accident while operating a CMV; and

(9) No accident in which he/she was found to be at fault, while operating a CMV.

(c) An individual must certify and provide evidence that he/she:

(1) Is regularly employed in a job requiring the operation of a CMV that requires a CDL with a double/triple trailers endorsement; and

(2) Has operated, for at least 2 years immediately preceding the date of application for a Certificate of Grandfathering, vehicles representative of the type of LCV that he/she seeks to continue operating.

(d) A motor carrier must issue a Certificate of Grandfathering, which is substantially in accordance with the form below, to an individual that meets the requirements of this section and maintain a copy of the certificate in his/her Driver Qualification file.

Longer Combination Vehicle (LCV) Driver-Training Certificate of Grandfathering

I certify that _____ has presented evidence of meeting the prerequisites set forth in the Federal Motor Carrier Safety Regulations (49 CFR § 380.111) for the substitute for LCV driver-training and is qualified to operate the LCVs indicated below:

YES	NO	
☐	☐	**LCV Doubles**
☐	☐	**LCV Triples**

DRIVER NAME (Firstname, MI, Lastname)	
Commercial Driver's License Number	STATE
ADDRESS OF DRIVER (Street Address, City, State and Zip Code)	
FULL NAME OF MOTOR CARRIER	Telephone Number
ADDRESS OF PRINCIPAL PLACE OF BUSINESS (Street Address, City, State, and Zip Code)	
SIGNATURE OF MOTOR CARRIER OFFICIAL	DATE ISSUED

(e) An applicant may only satisfy the conditions in this section as a substitute for the LCV driver-training requirements specified in subparts A and B of this part during one year after [*The effective date of the final rule.*].

§ 380.113 Employer responsibilities.

(a) No motor carrier shall:

(1) Allow, require, permit or authorize an individual to operate an LCV unless he/she meets the requirements in §§ 380.203 and 380.205 and has been issued the LCV driver-training certificate described in § 380.401. This provision does not apply to individuals that are eligible for the substitute for driver training provision in § 380.111.

(2) Allow, require, permit or authorize an individual to operate an LCV which the LCV driver-training certificate, CDL and endorsement(s) do not authorize the driver to operate. This provision applies to individuals employed by or under contract to the motor carrier.

(b) A motor carrier that employs or has under contract LCV drivers shall provide evidence of the certifications required by § 380.401 or § 380.111 of this part when requested by an authorized FMCSA, State or local official in the course of a compliance review.

Subpart B—LCV Driver Training Program

§ 380.201 General requirements.

(a) The LCV Driver-Training Program that is described in the appendix to this part requires training using an LCV Double or LCV Triple and must include the following general categories of instruction:

(1) Orientation;
(2) Basic operation;
(3) Safe operating practices;
(4) Advanced operations; and
(5) Non-driving activities.

(b) The LCV Driver-Training Program must include the minimum topics of training set forth in the appendix to this part and behind-the-wheel instruction that is designed to provide an opportunity to develop the skills outlined under the Proficiency Development unit of the training program.

§ 380.203 LCV Doubles.

(a) To qualify for the training necessary to operate an LCV Double, a driver-student shall, for at least the 6 months immediately preceding application for training, have:

(1) A valid Class A CDL with a double/triple trailer endorsement;

(2) Driving experience in a Group A vehicle as described in § 383.91 of this subchapter. Evidence of driving experience shall be an employer's statement that the driver has for at least 6 months immediately preceding application operated a Group A vehicle while under his/her employ;

(3) No more than one driver's license;

(4) No suspension, revocation, or cancellation of his/her CDL;

(5) No convictions for a major offense, as defined in § 383.51(b) of this subchapter, while operating a CMV;

(6) No convictions for a railroad-highway grade crossing offense, as defined in § 383.51(d) of this subchapter, while operating a CMV;

(7) No convictions for violating an out-of-service order as defined in § 383.51(e) of this subchapter;

(8) No more than one conviction for a serious traffic violation, as defined in § 383.5 of this subchapter, while operating a CMV;

(9) No convictions for a violation of State or local law relating to motor vehicle traffic control arising in connection with any traffic accident while operating a CMV, and

(10) No accident in which he/she was found to be at fault, while operating a CMV.

(b) Driver-students meeting the preliminary requirements in paragraph (a) of this section shall successfully complete a training program that meets the minimum unit requirements for LCV Doubles as set forth in the appendix to this part.

(c) Driver-students who successfully complete the Driver Training Program for LCV Doubles shall be issued a

certificate, in accordance with subpart D of this part, indicating the driver is qualified to operate an LCV Double.

§ 380.205 LCV Triples.

(a) To qualify for the training necessary to operate an LCV Triple, a driver-student shall, for at least the 6 months immediately preceding application for training, have:

(1) A valid Class A CDL with a double/triple trailer endorsement;

(2) Experience operating the vehicle listed under paragraph (a)(2)(i) or (a)(2)(ii) of this section. Evidence of driving experience shall be an employer's statement that the driver has for at least 6 months immediately preceding application operated the applicable vehicle(s).

(i) Group A truck-tractor/semi-trailer combination as described in § 383.91 of this subchapter; or

(ii) Twin trailer as defined under § 380.105;

(3) No more than one driver's license;

(4) No suspension, revocation, or cancellation of his/her CDL;

(5) No convictions for a major offense, as defined in § 383.51(b) of this subchapter, while operating a CMV;

(6) No convictions for a railroad-highway grade crossing offense, as defined in § 383.51(d) of this subchapter, while operating a CMV;

(7) No convictions for violation of an out-of-service order, as defined in § 383.51(e) of this subchapter;

(8) No more than one conviction for a serious traffic violation, as defined in § 383.5 of this subchapter, while operating a CMV;

(9) No convictions for a violation of State or local law relating to motor vehicle traffic control arising in connection with any traffic accident, while operating a CMV, and

(10) No accident in which he/she was found to be at fault, while operating a CMV.

(b) Driver-students meeting the preliminary requirements in paragraph (a) of this section shall successfully complete a training program that meets the minimum unit requirements for LCV Triples as set forth in the appendix to this part.

(c) Driver-students who successfully complete the Driver Training Program for LCV Triples shall be issued a certificate, in accordance with subpart D of this part, indicating the driver is qualified to operate an LCV Triple.

Subpart C—LCV Driver-Instructor Requirements

§ 380.301 General requirements.

Except as provided in § 380.303, to qualify as an LCV driver-instructor, a person shall:

(a) Provide evidence of successful completion of the Driver-Training Program requirements, as required in subpart B of this part, when requested by employers and/or an authorized FMCSA, State or local official in the course of a compliance review. The Driver-Training Program must be for the operation of CMVs representative of the subject matter that he/she will teach.

(b) Meet all State requirements for a vocational instructor, if employed by a training institution;

(c) Possess a valid Class A CDL with all endorsements necessary to operate the CMVs applicable to the subject matter being taught (LCV Doubles and/or LCV Triples); and

(d) Have at least 2 years CMV driving experience in a vehicle representative of the type of Driver-Training to be provided (LCV Doubles or LCV Triples).

§ 380.303 Substitute for instructor requirements.

Section 380.301 does not apply to a driver-instructor candidate who:

(a) Meets all State requirements for a vocational instructor, if employed by a training institution;

(b) Meets the conditions of § 380.111(b);

(c) Has CMV driving experience during the previous 2 years in a vehicle representative of the type of LCV that is the subject of the training course to be provided;

(d) Has experience during the previous 2 years in teaching applicable programs similar in content to that set forth in the appendix to this part.

§ 380.305 Employer responsibilities.

(a) No motor carrier shall:

(1) Knowingly allow, require, permit or authorize a driver-instructor in its employ or under contract to the motor carrier to provide LCV driver-training unless such person is a qualified LCV driver-instructor under the requirements of this subpart; or

(2) Contract with a training institution to provide LCV driver-training unless the institution:

(i) Uses instructors who are qualified LCV driver-instructors under the requirements of this subpart;

(ii) Is accredited by an accrediting institution recognized by the U.S. Department of Education;

(iii) Is in compliance with all applicable State training school requirements; and

(iv) Identifies drivers certified under § 380.401 of this part, when requested by employers and/or an authorized FMCSA, State or local official in the course of a compliance review.

(b) A motor carrier that employs or has under contract qualified LCV driver-instructors, shall provide evidence of the certifications required by § 380.301 or § 380.303 of this part, when requested by an authorized FMCSA, State or local official in the course of a compliance review.

Subpart D—Driver-Training Certification.

§ 380.401 Certification document.

(a) A student who successfully completes LCV driver-training shall be issued a Driver-Training Certificate that is substantially in accordance with the following form.

Longer Combination Vehicle (LCV) Driver-Training Certificate

I certify that _____ has presented evidence of meeting the training prerequisites set forth in the Federal Motor Carrier Safety Regulations (49 CFR §§ 380.203(a) and 380.205(a)) for LCV training, and has successfully completed the LCV Driver-Training Course(s) indicated below:

YES	NO		
☐	☐	**LCV Doubles**	_____ Date Training Completed
☐	☐	**LCV Triples**	_____ Date Training Completed

I certify that the indicated LCV Driver-Training course(s) was provided by a qualified LCV driver-instructor as defined under 49 CFR § 380.105 and meet(s) the minimum requirements set forth in 49 CFR part 380, subparts A and B.

DRIVER NAME (First Name, MI, Last Name)	
Commercial Driver's License Number	STATE
ADDRESS OF DRIVER (Street Address, City, State and Zip Code)	
FULL NAME OF TRAINING ENTITY	Telephone Number
BUSINESS ADDRESS (Street Address, City, State, and Zip Code)	
SIGNATURE OF TRAINING CERTIFYING OFFICIAL	DATE ISSUED

(b) An LCV driver must provide a copy of the Driver-Training Certificate to his/her employer to be filed in the Driver Qualification File.

Appendix to Part 380—LCV Driver Training Programs, Required Knowledge and Skills

The following table lists topics of instruction required for drivers of longer combination vehicles pursuant to 49 CFR part 380, subpart B. The training courses for operators of LCV Doubles and LCV Triples must be distinct and tailored to address their unique operating and handling characteristics. Each course must include the minimum topics of instruction, including behind-the-wheel training designed to provide an opportunity to develop the skills outlined under the Proficiency Development unit of the training program.

TABLE TO THE APPENDIX—COURSE TOPICS FOR LCV DRIVERS

Section 1: Orientation	
1.1	LCVs in Trucking.
1.2	Regulatory Factors.
1.3	Driver Qualifications.
1.4	Vehicle Configuration Factors.
Section 2: Basic Operation	
2.1	Inspection.
2.2	Coupling and Uncoupling.
2.3	Basic Control and Handling.
2.4	Basic Maneuvers.
2.5	Turning, Steering and Tracking.
2.6	Proficiency Development.
Section 3: Safe Operating Practices	
3.1	Interacting with Traffic.
3.2	Speed and Space Management.
3.3	Night Operations.
3.4	Extreme Driving Conditions.
3.5	Security Issues.
3.6	Proficiency Development.
Section 4: Advanced Operations	
4.1	Hazard Perception.
4.2	Hazardous Situations.
4.3	Maintenance and Troubleshooting.
Section 5: Non-Driving Activities	
5.1	Routes and Trip Planning.
5.2	Cargo and Weight Considerations.

Section 1—Orientation

The units in this section shall provide an orientation to the training curriculum and shall cover the role LCVs play within the motor carrier industry, the factors that affect their operations, and the role the drivers play in the safe operation of LCVs.

Unit 1.1—LCVs in Trucking. This unit must provide an introduction to the emergence of LCVs in trucking and serves as an orientation to the course content. Emphasis shall be placed upon the role the driver plays in transportation.

Unit 1.2—Regulatory Factors. This unit must provide instruction addressing the Federal, State, and local governmental bodies that propose, enact, and implement the laws, rules, and regulations that affect the trucking industry. Emphasis must be placed on those regulatory factors that affect LCVs.

Unit 1.3—Driver Qualifications. This unit must provide classroom instruction addressing the Federal and State laws, rules, and regulations that define LCV driver qualifications. It must also include a discussion on medical examinations, drug and alcohol tests, certification, and basic health and wellness issues. Emphasis must be placed upon topics essential to physical and mental health maintenance, including (1) diet, (2) exercise, (3) avoidance of alcohol and drug abuse, (4) the adverse effects of driver fatigue, and (5) effective fatigue countermeasures.

Unit 1.4—Vehicle Configuration Factors. This unit must provide classroom instruction addressing the key vehicle components used in the configuration of combination vehicles. It also must provide familiarization with various vehicle combinations, as well as provide instruction about unique characteristics and factors associated with LCV configurations.

Section 2—Basic Operation.

The units in this section cover the interaction between the driver and the vehicle. They are intended to teach driver-trainees how to inspect, couple and uncouple LCVs, ensure the vehicles are in the proper operating condition, and control the motion of LCVs under various road and traffic conditions.

During the driving exercises at off-highway locations required by this section, the driver-trainee must first familiarize himself/herself with basic operating characteristics of an LCV. Utilizing an LCV, the students must be able to perform the skills learned in each unit to a level of proficiency required to permit safe transition to on-street driving.

Unit 2.1—Inspection. This unit must provide instruction addressing the systematic vehicle inspection of LCV tractor-trailer combinations, including pre-trip, en route, and post-trip inspection procedures. While vehicle inspections are common in all CMV operations, some factors are peculiar to LCVs. Emphasis must be placed upon component failure recognition.

Unit 2.2—Coupling and Uncoupling. This unit must provide instruction addressing the procedures for coupling and uncoupling LCVs. While vehicle coupling and uncoupling procedures are common with all truck-tractor/semitrailer operations, some factors are peculiar to LCVs. Emphasis must be placed upon preplanning and safe operating procedures.

Unit 2.3—Basic Control and Handling. This unit must provide an introduction to basic vehicular control and handling as it applies to LCVs. This must include instruction addressing brake performance, handling characteristics and factors affecting LCV stability while braking, turning, and cornering. Emphasis must be placed upon safe operating procedures.

Unit 2.4—Basic Maneuvers. This unit must provide instruction addressing the basic vehicular maneuvers that will be encountered by LCV drivers. This must include instruction relative to backing, lane positioning and path selection, merging situations, and parking LCVs. Emphasis must be placed upon safe operating procedures as they apply to brake performance and directional stability while accelerating, braking, merging, cornering, turning, and parking.

Unit 2.5—Turning, Steering, and Tracking. This unit must provide instruction addressing turning situations, steering maneuvers, and the tracking of LCV trailers. This must include instruction relative to trailer sway and off-tracking. Emphasis must be placed on maintaining directional stability.

Unit 2.6—Proficiency Development: Basic Operations. The purpose of this unit is to enable driver-students to gain the proficiency in basic operation needed to safely undertake on-street instruction in the Safe Operations Practices section of the curriculum.

The activities of this unit must consist of driving exercises that provide practice for the development of basic control skills and mastery of basic maneuvers. Driver-students practice skills and maneuvers learned in the Basic Control and Handling; Basic Maneuvers; and Turning, Steering and Tracking Units. A series of basic exercises are practiced on off-highway locations until students develop sufficient proficiency for transition to on-street driving.

Once the driver-student's skills have been measured and found to be adequate, the driver-student must be allowed to move to on-the-street driving.

Nearly all activity in this unit will take place on the driving range or on streets or roads that have low-density traffic conditions.

Section 3—Safe Operating Practices

The units in this section must cover the interaction between student drivers, the vehicle, and the traffic environment. They must teach driver-students how to apply their basic operating skills in a way that ensures their safety and that of other road users under various road, weather, and traffic conditions.

Unit 3.1—Interacting with Traffic. This unit must provide instruction addressing the principles of visual search, communication, and sharing the road with other traffic. Emphasis must be placed upon visual search, mirror usage, signaling and/or positioning the vehicle to communicate, and understanding the special situations encountered by LCV drivers in various traffic situations.

Unit 3.2—Speed and Space Management. This unit must provide instruction addressing the principles of speed and space management. Emphasis must be placed upon maintaining safe vehicular speed and appropriate space surrounding the vehicle under various traffic and road conditions. Special attention must be placed upon understanding the special situations encountered by LCVs in various traffic situations.

Unit 3.3—Night Operations. This unit must provide instruction addressing the principles of Night Operations. Emphasis must be placed upon the factors affecting operation of LCVs at night. Night driving presents specific factors that require special attention on the part of the driver. Changes in vehicle safety inspection, vision, communications, speed management, and space management are needed to deal with the special problems night driving presents.

Unit 3.4—Extreme Driving Conditions. This unit must provide instruction addressing the driving of LCVs under extreme driving conditions. Emphasis must be placed upon the factors affecting the operation of LCVs in cold, hot, and inclement weather and in the mountains and the desert. Changes in basic driving habits are needed to deal with the specific problems presented by these extreme driving conditions.

Unit 3.5—Security Issues. This unit must provide an understanding of the driver's role in America's war on terrorism as it relates to: (1) The driver's role in reducing the risk of LCV hijacking, (2) the importance of notifying the authorities concerning potentially dangerous situations; and (3) the need for heightened vigilance in preparation of travel, while on the road, and when stopping.

Unit 3.6—Proficiency Development. This unit must provide driver-students an opportunity to refine, within the on-street traffic environment, their vehicle handling skills learned in the first three sections. Driver-student performance progress must be closely monitored to determine when the level of proficiency required for carrying out the basic traffic maneuvers of stopping, turning, merging, straight driving, curves, lane changing, passing, driving on hills, driving through traffic restrictions and parking has been attained. The driver-student must also be assessed for regulatory compliance with all traffic laws.

Nearly all activity in this unit will take place on public roadways in a full range of traffic environments applicable to this vehicle configuration. This must include urban and rural uncontrolled roadways, expressways or freeways, under light, moderate and heavy traffic conditions. There must be a brief classroom session to familiarize driver-students with the type of on-street

maneuvers they will perform and how their performance will be rated.

The instructor must assess the level of skill development of the driver-student and increase, in difficulty, the types of maneuvers, roadways and traffic conditions the driver-student is exposed to based upon the level of skill attained.

Section 4—Advanced Operations

The units in this section must introduce higher-level skills that can be acquired only after the more fundamental skills and knowledge taught in sections two and three have been mastered. The purpose of this section is to teach the perceptual skills necessary to recognize potential hazards and to demonstrate the procedures needed to handle an LCV when faced with a hazard.

The Maintenance and Troubleshooting Unit must provide instruction that addresses how to keep the vehicle in safe and efficient operating condition. The purpose of this unit is to teach the correct way to perform simple maintenance tasks and how to troubleshoot and report those vehicle discrepancies or deficiencies that must be repaired by a qualified mechanic.

Unit 4.1—Hazard Perception. This unit must provide instruction addressing the principles of recognizing hazards in sufficient time to reduce the severity of the hazard and neutralize a possible emergency situation. While hazards are present in all motor vehicle traffic operations, some are peculiar to LCV. Emphasis must be placed upon hazard recognition, visual search, and response to possible emergency producing situations encountered by LCV drivers in various traffic situations.

Unit 4.2—Hazardous Situations. This unit must address dealing with specific procedures, appropriate for LCV emergencies. These must include evasive steering, emergency braking, off-road recovery, brake failures, tire blowouts, rearward amplification, hydroplaning, skidding, jackknifing and the rollover phenomenon. The discussion must include a review of unsafe acts and the role they play in producing hazardous situations.

Unit 4.3—Maintenance and Troubleshooting. This unit must introduce driver-students to the basic servicing and checking procedures for the various vehicle components and how to help develop their ability to perform preventive maintenance functions, make simple emergency repairs, and diagnose and report vehicle malfunctions.

Section 5—Non-Driving Activities

The units in this section must cover activities not directly related to the vehicle itself but that must be performed by an LCV driver. The units in this section must ensure that these activities are performed in a manner that ensures the safety of the driver, the vehicle, cargo, and other road users.

Unit 5.1—Routes and Trip Planning. This unit must address the importance of and requirements for planning routes and trips. This must include classroom discussion of Federal and State requirements for a number of topics including, permits, vehicle size and weight limitations, designated highways, local access, the reasonable access rule, staging areas and access zones.

Unit 5.2—Cargo and Weight Considerations. This unit must address the importance of proper cargo documentation, loading, securing and unloading cargo, weight distribution, load sequencing and trailer placement. Emphasis must be placed upon the importance of axle weight distribution, trailer placement and its effect on vehicle handling.

PART 391—QUALIFICATIONS OF DRIVERS AND LONGER COMBINATION VEHICLE (LCV) DRIVING INSTRUCTORS

2. The authority citation for 49 CFR part 391 is revised to read as follows:

Authority: 49 U.S.C. 322, 504, 31133, 31136 and 31502; Sec. 4007(b) of Pub. L. 102–240 (105 Stat. 2152); and 49 CFR 1.73.

3. Part 391 is amended by revising the part name and by adding a new § 391.53 to subpart F to read as follows:

§ 391.53 LCV Instructor qualification files.

(a) Each motor carrier shall maintain an LCV instructor qualification file for each LCV instructor it employs or uses. The LCV instructor qualification file may be combined with his/her personnel file.

(b) The LCV instructor qualification file must include:

(1) All applicable information required by § 391.51;

(2) Evidence that the instructor has met the requirements of 49 CFR § 380.301 or § 380.303;

(3) The medical examiner's certificate of his/her physical qualification to drive a commercial motor vehicle or a legible photographic copy of the certificate; and

(4) A photographic copy of the individual's currently valid CDL with the appropriate endorsements.

Issued on: August 5, 2003.

Annette M. Sandberg,

Administrator.

[FR Doc. 03–20368 Filed 8–12–03; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[I.D. 010903D]

Atlantic Highly Migratory Species (HMS); Atlantic Shark Management Measures

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

ACTION: Notice of public hearings.

SUMMARY: NMFS will hold six public hearings to receive comments from fishery participants and other members of the public regarding proposed shark regulations and draft Amendment 1 to the Fishery Management Plan for Atlantic Tunas, Swordfish and Sharks (Amendment 1). The proposed rule for Amendment 1, published in the **Federal Register** on August 1, 2003, and would change among other things, the rebuilding timeframe for LCS, the commercial regulations, the recreational regulations, and implement a number of measures to reduce bycatch. Additionally, Amendment 1 also proposes updates to essential fish habitat (EFH) identifications for sandbar, blacktip, finetooth, dusky, and nurse sharks.

DATES: The public hearings will be held in August and September 2003. For specific dates and times, see **SUPPLEMENTARY INFORMATION**. Comments on the proposed rule and Amendment 1 must be received no later than 5 p.m., on September 30, 2003.

ADDRESSES: The public hearings will be held in New Orleans, LA; Madeira Beach, FL; Montauk, NY; Pawleys Island, SC; Manteo, NC; and Atlantic Beach, FL. For specific locations, see **SUPPLEMENTARY INFORMATION**. Written comments on this action should be mailed to Christopher Rogers, Chief, NMFS Highly Migratory Species Management Division, 1315 East-West Highway, Silver Spring, MD 20910; or faxed to (301) 713–1917. Comments will not be accepted if submitted via e-mail or Internet. Copies of draft Amendment 1 can be obtained from the HMS website at: *http://www.nmfs.noaa.gov/sfa/*

hmspg.html, or by contacting Karyl Brewster-Geisz, Heather Stirratt, or Chris Rilling at (301) 713–2347 or Greg Fairclough at (727) 570–5741.

FOR FURTHER INFORMATION CONTACT: Karyl Brewster-Geisz, Heather Stirratt, or Chris Rilling at (301) 713–2347 or Greg Fairclough at (727) 570–5741.

SUPPLEMENTARY INFORMATION: The Atlantic shark fisheries are managed under the authority of the Magnuson-Stevens Fishery Conservation and Management Act. The Fishery Management Plan for Atlantic Tunas, Swordfish, and Sharks, finalized in 1999, is implemented by regulations at 50 CFR part 635. Complete descriptions of the measures, as well as the purpose and need for the proposed actions, are contained in the proposed rule (August 1, 2003, 68 FR 45196 and Amendment 1) and are not repeated here.

The public is reminded that NMFS expects participants at the public hearings to conduct themselves appropriately. At the beginning of each public hearing, a NMFS representative will explain the ground rules (e.g., alcohol is prohibited from the hearing room; attendees will be called to give their comments in the order in which they registered to speak; each attendee will have an equal amount of time to speak; and attendees should not interrupt one another). The NMFS representative will attempt to structure the hearing so that all attending members of the public will be able to comment, if they so choose, regardless of the controversial nature of the subject(s). Attendees are expected to respect the ground rules, and, if they do not, they will be asked to leave the hearing.

Schedule of Public Hearings

The dates, times, and locations of the meetings are scheduled as follows:

1. Tuesday, August 26, 2003 - New Orleans, LA, 7–9 p.m.

New Orleans Airport Hilton Hotel, 901 Airline Drive, Kenner, Louisiana

2. Thursday, September 4, 2003 - Madeira Beach, FL, 7–9 p.m.

City of Madeira Beach, 300 Municipal Dr., Madeira Beach, FL 33708

3. Monday, September 8, 2003 - Montauk, NY, 7–9 p.m.

Montauk Fire House, 12 Flamingo Avenue, Montauk, NY 11954

4. Wednesday, September 17, 2003 - Pawleys Island, SC, 7–9 p.m.

Waccamaw Neck Branch Library, 24 Commerce Dr., Pawleys Island, SC 29585

5. Monday, September 22, 2003 - Manteo, NC, 7–9 p.m.

North Carolina Aquarium, Roanoke Island, Airport Road, Manteo, NC 27954

6. Thursday, September 25, 2003 - Atlantic Beach, FL, 7–9 p.m.

City of Atlantic Beach, Atlantic Beach City Chambers, 800 Seminole Rd., Atlantic Beach, FL 32233

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Heather Stirratt, (301) 713–2347, at least 7 days prior to the hearing in question.

Dated: August 7, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20516 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

Notices

Federal Register
Vol. 68, No. 155
Tuesday, August 12, 2003

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

DEPARTMENT OF AGRICULTURE

Forest Service

Forest Plan Amendments for Grizzly Bear Habitat Conservation for the Greater Yellowstone Area National Forests

AGENCY: Forest Service, USDA.

ACTION: Extension of the scoping period in conjunction with amendments of the land and resource management plans (hereafter referred to as forest plans) for the Beaverhead, Custer, and Gallatin National Forests located in the state of Montana; the Targhee National Forest located in the states of Idaho and Wyoming, and the Bridger-Teton and Shoshone National Forests located in the state of Wyoming.

SUMMARY: On July 16, 2003, the Notice of Intent to prepare an environmental impact statement was published in **Federal Register** Vol. 68, No. 136, pages 41999 and 41220, for the proposal to amend six forest plans to provide additional programmatic direction for management of grizzly bear habitat security, developed sites, and livestock within the Grizzly Bear Recovery Area. The 30-day comment period ended August 15, 2003. Interested parties have requested that the comment period be extended so they can provide more substantive, researched comments. The Forest Service has agreed to extend the comment period for an additional 18 days until September 2, 2003.

The July 16, 2003 **Federal Register** notice of intent shows the date of the Forest Supervisor's signature at the end of the notice as July 20, 2003; that date contained a minor typo. The correct date was July 10, 2003.

DATES: Comments concerning the scope of the analysis must be received on or before September 2, 2003.

ADDRESSES: Send written comments to Dave Cawrse, Team Leader, Grizzly Bear Habitat Amendments, Shoshone National Forest, 808 Meadow Lane Avenue, Cody, WY 82414–4549. Comments may be e-mailed to *comments-rocky-mountain-shoshone@fs.fed.us.*

FOR FURTHER INFORMATION CONTACT: Dave Cawrse, Team Leader, telephone (307) 527–6241.

SUPPLEMENTARY INFORMATION: The scoping period has been extended to September 2, 2003, to provide additional time for public comment. Written comments identifying issues for analysis and the range of alternatives are encouraged. More information is available at *http://www.fs.fed.us/r1/wildlife/igbc/Subcommittee/yes/YEamend/gb_internet.htm.*

Dated: August 6, 2003.

Rebecca Aus,

Forest Supervisor.

[FR Doc. 03–20481 Filed 8–11–03; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Del Norte County Resource Advisory Committee

AGENCY: Forest Service, USDA.

ACTION: Notice of meeting.

SUMMARY: The Del Norte County Resource Advisory Committee (RAC) will meet on September 2, 2003 in Crescent City, California. The purpose of the meeting is to discuss the selection of Title II projects under Pub. L. 106–393, H.R. 2389, the Secure Rural Schools and Community Self-Determination Act of 2000, also called the ''Payments to States'' Act.

DATES: The meeting will be held on September 2, 2003 from 6 to 8:30 p.m.

ADDRESSES: The meeting will be held at the Del Norte County Unified School District Board Room, 301 West Washington Boulevard, Crecent City, California.

FOR FURTHER INFORMATION CONTACT: Laura Chapman, Committee Coordinator, USDA, Six Rivers National Forest, 1330 Bayshore Way, Eureka, CA 95501. Phone: (707) 441–3549. e-mail: *1chapman@fs.fed.us.*

SUPPLEMENTARY INFORMATION: The committee will hear the status of Title II projects funded over the last two years. The meeting is open to the public. Public input opportunity will be provided and individuals will have the opportunity to address the committee at that time.

Dated: August 6, 2003.

S.E. 'Lou' Woltering,

Forest Supervisor.

[FR Doc. 03–20478 Filed 8–11–03; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Trinity County Resource Advisory Committee

AGENCY: Forest Service, USDA.

ACTION: Notice of meeting.

SUMMARY: The Trinity County Resource Advisory Committee (RAC) will meet on September 9, 2003 in Mad River, California. The purpose of the meeting is take a field trip to view the Mad Ridge Fuel Break, a Title II project under Pub. L. 106–393, H.R. 2389, the Secure Rural Schools and Community Self-Determination Act of 2000, also called the ''Payments to States'' Act.

DATES: The meeting will be held September 9, 2003 from 10 a.m. to 5 p.m.

ADDRESSES: The meeting will be held at the Mad River Ranger Station, Highway 36, Mad River, California.

FOR FURTHER INFORMATION CONTACT: Ann Garland, Designated Federal Official, USDA, Six Rivers National Forest, P.O. Box 68, Willow Creek, CA 95573. Phone: (530) 629–2118. e-mail: *agarland@fs.fed.us.*

SUPPLEMENTARY INFORMATION: The committee will take a field trip to look at the layout of the Mad Ridge Fuelbreak project, which is being funded through Title II. The meeting is open to the public. Public input opportunity will be provided and individuals will have the opportunity to address the committee at that time.

Dated: August 6, 2003.

S.E. 'Lou' Woltering,

Forest Supervisor.

[FR Doc. 03–20479 Filed 8–11–03; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Notice of Agreement Under the Comprehensive Response, Compensation and Liability Act (CERCLA)

AGENCY: Forest Service.

ACTION: Notice of proposed settlement agreement; request for public comment.

SUMMARY: In accordance with Section 122(i) of the Comprehensive Environmental Response, Compensation and Liability Act (''CERCLA''), 42 U.S.C. 9622(i), notice is hereby given of a proposed administrative settlement between the United States, on behalf of the U.S. Department of Agriculture, Forest Service, and Atlantic Richfield Company (ARCO) for the recovery of costs incurred by the United States in responding to the release or threatened release of hazardous substances at and from the Cashman Mill Site (Site), near Skykomish, King County, Washington. The Forest Service has incurred costs investigating conditions, analyzing cleanup alternatives and overseeing ARCO's work at the Site. In 1997, ARCO removed flue dust and associated contaminated soil from the Site. Under the proposed settlement ARCO will also remove contaminated material from another portion of the Site. ARCO and the Forest Service will each bear their respective costs, while retaining the right to recover those costs from persons not parties to the settlement.

DATES: Comments must be received, in writing, on or before September 11, 2003.

ADDRESSES: Written comments on this proposed settlement agreement may be sent to: James E. Alexander, USDA Office of General Counsel, Room 1734 Federal Building, 1220 SW 3rd Avenue, Portland, Oregon 97204–2825, and should refer to the Cashman Mill Site, Skykomish, King County, Washington, A copy of the proposed settlement agreement may be obtained by mail from Mary Grove, USDA Office of General Counsel, Room 1734 Federal Building, 1220 SW 3rd Avenue, Portland, Oregon 97204–2825.

FOR FURTHER INFORMATION CONTACT: James E. Alexander, USDA Office of General Counsel, Room 1734 Federal Building, 1220 SW 3rd Avenue, Portland, Oregon 97204–2825.

Dated: August 6, 2003.

Linda D. Goodman,

Regional Forester, USDA Forest Service, Region 6.

[FR Doc. 03–20480 Filed 8–11–03; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF COMMERCE

Submission for OMB Review; Comment Request

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

Agency: Bureau of Economic Analysis (BEA), Commerce.

Title: Annual Survey of U.S. Direct Investment Abroad.

Form Number(s): BE–11.

Agency Approval Number: 0608–0053.

Type of Request: Extension of a currently approved collection without any change in the substance or in the method of collection.

Burden: 118,400 hours.

Number of Respondents: 1,600.

Avg Hours Per Response: 74 hours.

Needs and Uses: The survey provides a variety of measures of the overall operations of nonbank U.S. parent companies and their nonbank foreign affiliates, including total assets, sales, net income, employment and employee compensation, taxes, research and development expenditures, and exports and imports of goods. The survey is a cut-off sample survey that covers all foreign affiliates (and their U.S. parent companies) above a size-exemption level. The sample data are used to derive universe estimates in nonbenchmark years by extrapolating forward similar data reported in the BE–10, Benchmark Survey of U.S. Direct Investment Abroad, which is taken once every five years. The data are needed to measure the size and economic significance of direct investment abroad, measure changes in such investment, and assess its impact on the U.S. and foreign economies.

The data from the survey are primarily intended as general purpose statistics. They should be readily available to answer any number of research and policy questions related to U.S. direct investment abroad. Policy areas of particular and lasting interest are trade in goods and services, employment and employee compensation, taxes, and technology.

Affected Public: Businesses or other for-profit institutions.

Frequency: Annual.

Respondent's Obligation: Mandatory.

Legal Authority: Title 22 U.S.C., sections 3101–3108, as amended.

OMB Desk Officer: Paul Bugg, (202) 395–3093.

You may obtain copies of the above information collection proposal by calling or writing Diana Hynek, Departmental Paperwork Clearance Officer, Office of the Chief Information Officer, Department of Commerce, Room 6625, 14th Street and Constitution Avenue, NW., Washington, DC 20230, or via the Internet at *dHynek@doc.gov,* ((202) 482–0266).

Send comments on the proposed information collection within 30 days of publication of this notice to Paul Bugg, OMB Desk Officer, via the Internet at *pbugg@omb.eop.gov* or by fax (202) 395–7245.

Dated: August 6, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–20494 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–06–P

DEPARTMENT OF COMMERCE

Submission For OMB Review; Comment Request

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

Agency: Bureau of Economic Analysis (BEA), Commerce.

Title: Direct Transactions of U.S. Reporter with Foreign Affiliate.

Form Number(s): BE–577.

Agency Approval Number: 0608–0004.

Type of Request: Extension of a currently approved collection without any change in the substance or in the method of collection.

Burden: 67,500 hours.

Number of Respondents: 13,500 respondents, 4 responses each per year.

Avg Hours Per Response: 1¼ hours.

Needs and Uses: The survey obtains quarterly sample data on transactions and positions between U.S.-owned foreign business enterprises and their U.S. parent companies. The survey is a cut-off sample survey that covers all foreign affiliates above a size-exemption level. The sample data are used to derive universe estimates in nonbenchmark years by extrapolating forward similar data reported in the BE–10, Benchmark Survey of U.S. Direct Investment Abroad, which is taken

every five years. The data are used in the preparation of the U.S. international transactions accounts, the input-output accounts, the national income and product accounts, and the international investment position of the United States. The data are needed to measure the size and economic significance of direct investment abroad, measure changes in such investment, and assess its impact on the U.S. and foreign economies.

The data from the survey are primarily intended as general purpose statistics. They should be readily available to answer any number of research and policy questions related to U.S. direct investment abroad. In addition, the data are needed by Government agencies that are responsible for the conduct of U.S. international economic policy. Such policy must be based on an informed analysis of current information on the transactions of U.S. parent companies and their foreign affiliates. The data are particularly valuable to these agencies because they are collected, analyzed, and published within 65 days after the end of each calendar quarter, allowing data users to see the consequences of changes in economic conditions very soon after they occur.

Affected Public: Businesses or other for-profit institutions.

Frequency: Quarterly.

Respondent's Obligation: Mandatory.

Legal Authority: Title 22 U.S.C., sections 3101–3108, as amended.

OMB Desk Officer: Paul Bugg, (202) 395–3093.

You may obtain copies of the above information collection proposal by calling or writing Diana Hynek, Departmental Paperwork Clearance Officer, Office of the Chief Information Officer, Department of Commerce, Room 6625, 14th Street and Constitution Avenue, NW., Washington, DC 20230, or via the Internet at *dHynek@doc.gov,* ((202) 482–0266).

Send comments on the proposed information collection within 30 days of publication of this notice to Paul Bugg, OMB Desk Officer, via the Internet at *pbugg@omb.eop.gov* or by fax at (202) 395–7245.

Dated: August 6, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–20495 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–06–P

DEPARTMENT OF COMMERCE

U.S. Census Bureau

Annual Trade Survey

ACTION: Proposed Collection; Comment request

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

DATES: Written comments must be submitted on or before October 14, 2003.

ADDRESSES: Direct all written comments to Diana Hynek, Departmental Paperwork Clearance Officer, Department of Commerce, Room 6625, 14th and Constitution Avenue, NW., Washington, DC 20230 (or via the Internet at *DHynek@doc.gov).*

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to John Trimble, Bureau of the Census, Room 2682-FOB 3, Washington, DC 20233–6500, (301) 763–2703.

SUPPLEMENTARY INFORMATION:

I. Abstract

The Census Bureau plans to expand the currently approved Annual Trade Survey (ATS) to include manufacturers' sales branches and offices (MSBO). The expanded survey will include a selected sample of firms operating establishments selling goods that they manufacture in the United States. Data will be collected annually on sales, inventories, and operating expenses. Initially, we will request two years of data for all data items. Afterwards, we will request one year of sales and operating expenses data and two years of Inventory data. The expanded survey will be mailed to a sample of firms on a company basis to reduce respondent burden. In order to set up reporting arrangements for companies we will contact them in person, as well as by phone, and by mail. We will request data for calendar year and year-end inventories. Currently two separate forms are used to collect merchant data for ATS. Two additional report forms will also be used to collect MSBO data. Two forms are needed to collect both merchant and MSBO data to accommodate both large and small firms. The mailings will be conducted in January following the survey year requested. Respondents will have thirty days to complete the report form before a follow-up form is sent. Later, as needed, an additional follow-up form will be sent, and a telephone follow-up will be conducted.

This expansion of the ATS survey is being conducted to obtain a missing component of wholesale data. The current ATS collects data for merchant wholesalers but does not obtain data for MSBOs. The Bureau of Economic Analysis (BEA) has made repeated requests for these data that they consider vital to accurately measuring sales and inventories for wholesale trade, important inputs to BEA's preparation of National Income and Product accounts and their annual input-output tables. The expanded ATS will provide annual data for almost 90 percent of the sales from the wholesale sector and over 99 percent of the inventories, as compared to about 58 percent of sales and 85 percent of inventories in the present ATS program. Data will be published at the United States summary level for selected wholesale industries. Further expansion to include all of wholesale trade is planned for the data year 2007 after the next sample revision.

II. Method of Collection

We will collect this information by mail, fax, and telephone follow-up.

III. Data

OMB Number: 0607–0195.

Additional Form Numbers: SA–42(S) and SA–42A(S).

Type of Review: Regular submission.

Affected Public: Business or other for-profit.

Estimated Number of Additional Respondents: 1,800.

Estimated Time for Additional Response: .4444 hrs (approx. 27 minutes).

Estimated Additional Annual Burden Hours: 800 hours.

Estimated Additional Annual Cost: The cost to the respondent is estimated to be $14,560 based on an annual response burden of 800 hours and a rate of $18.20 per hour to complete the form.

Respondent's Obligation: Mandatory.

Legal Authority: Title 13, United States Code, sections 182, 224, and 225.

IV. Request for Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including

whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Dated: August 6, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–20496 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-552–801]

Notice of Antidumping Duty Order: Certain Frozen Fish Fillets from the Socialist Republic of Vietnam

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of Antidumping Duty Order.

EFFECTIVE DATE: August 12, 2003

FOR FURTHER INFORMATION CONTACT: Joe Welton, Alex Villanueva, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–0165, 482–3208, respectively.

SUPPLEMENTARY INFORMATION:

Scope Of Investigation

For purposes of this investigation, the product covered is frozen fish fillets, including regular, shank, and strip fillets and portions thereof, whether or not breaded or marinated, of the species *Pangasius Bocourti*, *Pangasius Hypophthalmus* (also known as *Pangasius Pangasius*), and *Pangasius Micronemus*. Frozen fish fillets are lengthwise cuts of whole fish. The fillet products covered by the scope include boneless fillets with the belly flap intact (''regular'' fillets), boneless fillets with the belly flap removed (''shank'' fillets), boneless shank fillets cut into strips (''fillet strips/finger''), which include fillets cut into strips, chunks, blocks, skewers, or any other shape. Specifically excluded from the scope are frozen whole fish (whether or not dressed), frozen steaks, and frozen belly-flap nuggets. Frozen whole dressed fish are deheaded, skinned, and eviscerated. Steaks are bone-in, cross-section cuts of dressed fish. Nuggets are the belly-flaps.

The subject merchandise will be hereinafter referred to as frozen ''basa'' and ''tra'' fillets, which are the Vietnamese common names for these species of fish. These products are classifiable under tariff article codes 0304.20.60.30 (Frozen Catfish Fillets), 0304.20.60.96 (Frozen Fish Fillets, NESOI), 0304.20.60.43 (Frozen Freshwater Fish Fillets) and 0304.20.60.57 (Frozen Sole Fillets) of the Harmonized Tariff Schedule of the United States (''HTSUS''). This investigation covers all frozen fish fillets meeting the above specification, regardless of tariff classification. Although the HTSUS subheadings are provided for convenience and customs purposes, our written description of the scope of this proceeding is dispositive.

Background

In accordance with section 735(a) of the Tariff Act, the Department made its final determination that certain frozen fish fillets from the Socialist Republic of Vietnam (''Vietnam'') are being sold at less than fair value. *See Notice of Final Antidumping Duty Determination of Sales at Less Than Fair Value and Affirmative Critical Circumstances: Certain Frozen Fish Fillets from the Socialist Republic of Vietnam*(''*Final Determination*'') 68 FR 37116 (June 23, 2003). We received ministerial error allegations from respondents and petitioners and upon consideration of these allegations, we amended the *Final Determination. See Notice of Amended Final Antidumping Duty Determination of Sales at Less Than Fair Value: Certain Frozen Fish Fillets from the Socialist Republic of Vietnam* (''*Amended Final Determination*'') 68 FR 43713 (July 24, 2003).

Antidumping Duty Order

On August 6, 2003, the International Trade Commission (''the Commission'') notified the Department of its final determination pursuant to section 735(b)(1)(A)(e) of the Tariff Act that an industry in the United States is materially injured by reason of less-than-fair-value imports of subject merchandise from Vietnam. In addition, the ITC notified the Department of its final determination that critical circumstances do not exist with respect to imports of subject merchandise from Vietnam that are subject to the Department's affirmative critical circumstances finding. Therefore, in accordance with section 736(a)(1) of the Act, the Department will direct U.S. Bureau of Customs and Border Protection (''Customs'') to assess, upon further advice by the Department, antidumping duties equal to the amount by which the normal value of the merchandise exceeds the export price of the merchandise for all relevant entries of certain frozen fish fillets from Vietnam. These antidumping duties will be assessed on all unliquidated entries of certain frozen fish fillets from Vietnam entered, or withdrawn from the warehouse, for consumption on or after January 31, 2003, the date on which the Department published the *Notice of Preliminary Determination of Sales at Less Than Fair Value, Affirmative Preliminary Determination of Critical Circumstances and Postponement of Final Determination: Certain Frozen Fish Fillets From the Socialist Republic of Vietnam* (''*Preliminary Determination*''), 68 FR 4986.

With regard to the ITC negative critical circumstances determination, we will instruct Customs to lift suspension and to release any bond or other security, and refund any cash deposit made, to secure the payment of antidumping duties with respect to entries of the merchandise entered, or withdrawn from warehouse, for consumption on or after November 2, 2002, but before January 31, 2003. November 2, 2002 is 90 days prior to January 31, 2003, the date of publication of the Department's preliminary determination in the **Federal Register**.

Customs must require, at the same time as importers would normally deposit estimated duties on this merchandise, a cash deposit equal to the estimated weighted-average antidumping duty margins as noted below. The ''Vietnam-Wide'' rates apply to all exporters of subject merchandise not specifically listed. The weighted-average dumping margins are as follows:

Certain Frozen Fish Fillets from Vietnam	
Producer/Manufacturer/Exporter	Weighted-Average Margin
Agifish	47.05
Vinh Hoan	36.84
Nam Viet	53.68
CATACO	45.81
Afiex	45.55
CAFATEX	45.55
Da Nang	45.55
Mekonimex	45.55
QVD	45.55
Viet Hai	45.55
Vinh Long	45.55
Vietnam-Wide	63.88

This notice constitutes the antidumping duty order with respect to certain frozen fish fillets from Vietnam. Interested parties may contact the Department's Central Records Unit, Room B-099 of the main Commerce building, for copies of an updated list of antidumping duty orders currently in effect.

This order is published in accordance with section 736(a) of the Act and 19 C.F.R. 351.211.

Dated: July 31, 2003.

Joseph A. Spetrini,

Acting Assistant Secretary for Grant Aldonas, Under Secretary.

[FR Doc. 03–20509 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

National Construction Safety Team Advisory Committee Meeting

AGENCY: National Institute of Standards and Technology, United States Department of Commerce.

ACTION: Notice of public meeting.

SUMMARY: The Director of the National Institute of Standards and Technology announces that the National Construction Safety Team Federal Advisory Committee will meet on August 26–27, 2003.

DATES: The meeting will convene August 26, 2003, at 10 a.m. and will adjourn at 2 p.m. on August 27, 2003. Members of the public wishing to attend the meeting must notify Stephen Cauffman by c.o.b. Friday, August 22, 2003, per instructions under the **SUPPLEMENTARY INFORMATION** section of this notice.

ADDRESSES: The meeting will be held in the Employees Lounge, Administration Building, at NIST, Gaithersburg, Maryland. Please note admittance instructions under **SUPPLEMENTARY INFORMATION** section of this notice.

FOR FURTHER INFORMATION CONTACT: Stephen Cauffman, National Construction Safety Team Advisory Committee, National Institute of Standards and Technology, 100 Bureau Drive, MS 8611, Gaithersburg, Maryland 20899–8611, telephone number (301) 975–6051, fax (301) 975–6122, or via e-mail at *stephen.cauffman@nist.gov*.

SUPPLEMENTARY INFORMATION: In accordance with the requirements of the Federal Advisory Committee Act, 5 U.S.C. app. 2, notice is hereby given that the National Construction Safety Team (NCST) Advisory Committee (Committee), National Institute of Standards and Technology (NIST), will meet Tuesday, August 26, 2003, from 10 a.m. to 5 p.m. and Wednesday, August 27, 2003, from 9 a.m. to 2 p.m. at NIST headquarters in Gaithersburg, Maryland.

The Committee was established pursuant to Section 11 of the National Construction Safety Team Act (15 U.S.C. 7310). The Committee is composed of ten members appointed by the Director of NIST who were selected for their technical expertise and experience, established records of distinguished professional service, and their knowledge of issues affecting teams established under the NCST Act. The Committee will advise the Director of NIST on carrying out investigations of building failures conducted under the authorities of the NCST Act that became law in October 2002 and will review the procedures developed to implement the NCST Act and reports issued under section 8 of the NCST Act.

The purpose of this meeting is to discuss the implementation of the NCST Act. The agenda will include briefings and discussions on implementation of the Act, criteria for launching an investigation, the process for the selection of outside experts, and the two investigations that NIST is currently conducting under the Act. In addition, there will be a planning session on the preparation of the NCST Advisory Committee Annual Report. The agenda may change to accommodate Committee business. The final agenda will be posted on the Web site (*http://www.nist.gov/ncst*).

Individuals and representatives of organizations who would like to offer comments and suggestions related to the Committee's affairs, NCST Act implementation, the WTC Investigation, and the Rhode Island Nightclub Investigation are invited to request a place on the agenda. Approximately one hour will be reserved for public comments, and speaking times will be assigned on a first-come, first-served basis. The amount of time per speaker will be determined by the number of requests received, but is likely to be 5 minutes each. Speakers who wish to expand upon their oral statements, those who had wished to speak but could not be accommodated on the agenda, and those who were unable to attend in person are invited to submit written statements to the NCST Advisory Committee. Written comments may be submitted via e-mail to *ncstac@nist.gov*. Questions from the public will not be considered during this period.

All visitors to the National Institute of Standards and Technology site will have to pre-register to be admitted. Anyone wishing to attend this meeting must register by c.o.b. Friday, August 22, 2003, in order to attend. Please submit your name, time of arrival, e-mail address and phone number to Stephen Cauffman and he will provide you with instructions for admittance. Non-U.S. citizens must also submit their country of citizenship, title, employer/sponsor, and address. Mr. Cauffman's e-mail address is *stephen.cauffman@nist.gov* and his phone number is (301) 975–6051.

Dated: August 7, 2003.

Arden L. Bement, Jr.,

Director.

[FR Doc. 03–20575 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–13–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080503D]

Gulf of Mexico Fishery Management Council; Public Meeting

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

ACTION: Notice of public meeting.

SUMMARY: The Gulf of Mexico Fishery Management Council will convene a public meeting of the Highly Migratory Species (HMS) Advisory Panel (AP) and a joint meeting of the HMS AP and the Billfish AP.

DATES: The HMS AP meeting is scheduled to begin at 2 p.m. on Tuesday, August 26, 2003. The joint meeting of the HMS AP and the Billfish AP is scheduled to begin at 8:30 a.m. on Wednesday, August 27, 2003, and will conclude by 3 p.m.

ADDRESSES: The meetings will be held at the at the New Orleans Airport Hilton, 901 Airline Highway, Kenner, LA; telephone: 504–469–5000.

Council address: Gulf of Mexico Fishery Management Council, 3018 U.S. Highway 301 North, Suite 1000, Tampa, FL 33619.

FOR FURTHER INFORMATION CONTACT: Mr. Steven Atran, Population Dynamics Statistician, Gulf of Mexico Fishery Management Council; telephone: 813–228–2815.

SUPPLEMENTARY INFORMATION: The HMS AP will convene to receive a presentation from NMFS on bycatch of sharks in the Gulf menhaden purse seine fishery, and will review Draft Amendment 1 to the Fishery Management Plan (FMP) for Atlantic Tuna, Swordfish, and Sharks (HMS Amendment 1), which is being developed by the HMS Division of NMFS.

The HMS AP and Billfish AP will jointly review possible alternatives to be included in an environmental impact statement (EIS) for proposed Amendment 2 to the FMP for Atlantic Tuna, Swordfish, and Sharks (HMS Amendment 2), and proposed Amendment 2 to the FMP for Atlantic Billfish (Billfish Amendment 2), which are also being developed by the NMFS HMS Division.

The APs will also review several draft recommendations made to the International Commission for the Conservation of Atlantic Tunas (ICCAT) concerning integrated monitoring and control measures in the ICCAT Convention Area. These draft recommendations, which were made by the ICCAT Working Group to Develop Integrated Monitoring and Control Measures, held in Madeira, Portugal May 26–28, 2003, include a recommendation to require that all vessels fishing in the ICCAT Convention Area be authorized by licenses or permits; a recommendation that a vessel monitoring system (VMS) be required on fishing vessels exceeding 20 meters (65 feet) in length; and a recommendation that would require the use of fishing logbooks for all fisheries. This would include commercial and recreational.

HMS Draft Amendment 1 includes alternatives to revise the large coastal shark rebuilding plan; outline a procedure to prevent overfishing of finetooth sharks; revise commercial quota levels; implement regional and trimester quotas; eliminate a commercial minimum size; revise recreational retention and size limits; establish handline and rod and reel as the only authorized gears in the recreational shark fishery; remove deepwater and other sharks from the management unit and continue data collection only; retain the existing regulations on the prohibited species group but establish criteria by which to add/remove species to/from the group; allow strikenet gear only in the shark gillnet fishery; implement a time/area closure for bottom longline fishing in the mid-Atlantic region from January through July to protect sandbar and dusky shark nursery and pupping areas; require vessel monitoring systems on shark bottom longline and gillnet vessels to enforce time/area closures; require the use of non-stainless steel hooks and the possession of line clippers, dipnets, and dehooking devices on vessels with shark bottom longline gear; require bottom longline vessels to move 1 nautical mile after an interaction with a protected species; update and revise essential fish habitat identifications for species whose stock status has changed; provide criteria to increase or decrease essential fish habitat for individual species based on special needs; and develop a separate display permitting system for sharks apart from research or exempted fishing permits.

The EIS for proposed HMS Amendment 2 and proposed Billfish Amendment 2 is intended to address issues regarding quota allocation of Atlantic bluefin tuna (BFT), swordfish, and sharks among and within domestic fishing categories, examine management alternatives to improve and streamline the current HMS limited access permit program, conduct a five year review of HMS essential fish habitat (EFH) identifications, and address exempted fishing and scientific research permitting issues consistent with rebuilding plans, the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), Atlantic Tunas Convention Act (ATCA), and other relevant Federal laws. NMFS is requesting comments on the above measures including, but not limited to, HMS quota allocations, permitting, revisions to the limited access management program, and updates to EFH information.

The HMS and Billfish APs will provide their advice on the above actions to the Council. The Council will consider the advice from the APs and will develop its recommendations during the September 8–11, 2003, Council meeting in Baton Rouge, LA. The Council's recommendations and the recommendations of the APs will be submitted to the NMFS HMS Division and to ICCAT as appropriate during the public comment periods for the respective actions.

Although other non-emergency issues not on the agendas may come before the APs for discussion, in accordance with the Magnuson-Stevens Fishery Conservation and Management Act, those issues may not be the subject of formal action during these meetings. Actions of the APs will be restricted to those issues specifically identified in the agendas and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take action to address the emergency.Copies of the agenda can be obtained by calling 813–228–2815.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Anne Alford at the Council (see **ADDRESSES**) by August 19, 2003.

Dated: August 6, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20511 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080503C]

New England Fishery Management Council; Public Meetings

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

ACTION: Notice of a public meeting.

SUMMARY: The New England Fishery Management Council (Council) is scheduling a public meeting of its Herring Oversight Committee in September, 2003. Recommendations from the committee will be brought to the full Council for formal consideration and action, if appropriate.

DATES: The meeting will held on Wednesday, September 3, 2003 at 8 a.m.

ADDRESSES: The meeting will be held at the Crowne Plaza, 801 Greenwich Ave., Warwick, RI 02886.

Council address: New England Fishery Management Council, 50 Water Street, Newburyport, MA 01950.

FOR FURTHER INFORMATION CONTACT: Paul J. Howard, Executive Director, New England Fishery Management Council; telephone: (978) 465–0492.

SUPPLEMENTARY INFORMATION: The committee will review progress to date on development of alternatives for analysis in Amendment 1 to the Herring Fishery Management Plan (FMP). They will review Herring Advisory Panel recommendations regarding the range of alternatives for Amendment 1. They will also receive and discuss Council staff report on information related to the role of herring in the ecosystem and the importance of herring as a forage species. Also on the agenda will be developing Committee recommendations for Council consideration regarding the range of alternatives for analysis in the Amendment 1 Draft Environmental Impact Statement (DSEIS).

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Paul J. Howard (see **ADDRESSES**) at least 5 days prior to the meeting dates.

Dated: August 6, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20510 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080603E]

North Pacific Fishery Management Council; Public Meeting

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

ACTION: Notice of public meetings.

SUMMARY: The North Pacific Fishery Management Council's (Council) Crab Plan Team will meet on September 22–24, 2003 Kodiak, AK.

DATES: The meetings will be held on September 22, 2003, 1 – 5 p.m.; September 23, 8 a.m. – 5 p.m.; and September 24, 8 a.m. – 3 p.m.

ADDRESSES: The meetings will be held at the Alaska Fisheries Research Center, Near Island, Kodiak, AK 99615.

Council address: North Pacific Fishery Management Council, 605 W. 4th Ave., Suite 306, Anchorage, AK 99501–2252.

FOR FURTHER INFORMATION CONTACT: Diana Stram, Council staff, telephone: 907–271–2809.

SUPPLEMENTARY INFORMATION:

Agenda

Assemble the Stock Assessment and Fishery Evaluation; Review the Crab Plan Team 'Terms of Reference'; Guideline Harvest Levels; Pribilof blue king crab rebuilding plan and overfishing definitions; Develop recommendations for Council and Alaska Board of Fisheries.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Gail Bendixen at 907–271–2809 at least 7 working days prior to the meeting date.

Dated: August 6, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20512 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080603F]

North Pacific Fishery Management Council; Public Meeting

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

ACTION: Notice of public meetings.

SUMMARY: The North Pacific Fishery Management Council's (Council) Steller Sea Lion (SSL) Mitigation Committee will meet in Seattle, WA.

DATES: The meetings will be held on August 27, 2003, through August 29, 2003, from 8:30 a.m. until 5 p.m. each day.

ADDRESSES: The meeting will be held at the Alaska Fisheries Science Center, 7600 Sand Point Way NE., Building 4, Traynor Seminar Room 2079, Seattle, WA 98115.

Council address: North Pacific Fishery Management Council, 605 W. 4th Ave., Suite 306, Anchorage, AK 99501–2252.

FOR FURTHER INFORMATION CONTACT: William Wilson, Council staff; telephone: 907–271–2809.

SUPPLEMENTARY INFORMATION: The Committee is scheduled to review proposals to amend Steller sea lion protection measures in the Gulf of

Alaska groundfish fishery management plan to address pertinent fishery management problems and concerns. The Committee will develop recommendations for the Council to consider at its October meeting.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Gail Bendixen at 907–271–2809 at least 7 working days prior to the meeting date.

Dated: August 6, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20513 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 071003F]

Pacific Fishery Management Council; Public Meeting; Cancellation

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

ACTION: Notice of cancellation of public meeting.

SUMMARY: The September 3–5, 2003, meeting of the Ad Hoc Groundfish Habitat Technical Review Committee to be held in Seattle, WA, that was scheduled for 1 p.m. to 6 p.m. on Wednesday, September 3, 2003; 8:30 a.m. to 6 p.m. on Thursday, September 4; and 8:30 to 3 p.m. on Friday, September 5, has been cancelled.

FOR FURTHER INFORMATION CONTACT: Mr. Steve Copps, Senior Policy Analyst, NOAA Fisheries, telephone: 206–526–6187.

SUPPLEMENTARY INFORMATION: The initial notice was published on July 17, 2003 (68 FR 42401). The meeting will be rescheduled for a later date and announced in the **Federal Register**. The purpose of the meeting was to consider the assessment of essential fish habitat for Pacific Coast groundfish in its entirety, including developments in the analytical framework and data consolidation.

Dated: August 6, 2003.

Richard W. Surdi,

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

[FR Doc. 03–20514 Filed 8–11–03; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0034]

Federal Acquisition Regulation; Information Collection; Examination of Records by Comptroller General and Contract Audit

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 (9000–0034).

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 examination of records by comptroller general/audit-negotiation now retitled examination of records by comptroller general and contract audit. The clearance currently expires on November 30, 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 October 14, 2003.

ADDRESSES: Submit comments, including suggestions for reducing this burden, to the General Services Administration, FAR Secretariat (MVA), 1800 F Street, NW, Room 4035, Washington, DC 20405.

FOR FURTHER INFORMATION CONTACT: Edward Loeb, Policy Advisor, Office of Acquisition Policy, GSA, (202) 501–0650.

SUPPLEMENTARY INFORMATION:

A. Purpose

The Audit and Records-Negotiation clause, 52.215–2; Contract Terms and Conditions Required to Implement Statutes or Executive Orders-Commercial Items clause, 52.212–5(d); and Audit and Records-Sealed Bidding clause, 52.214–26, implement the requirements of 10 U.S.C. 2313, 41 U.S.C. 254, and 10 U.S.C. 2306. The statutory requirements are that the Comptroller General and/or agency shall have access to, and the right to, examine certain books, documents and records of the contractor for a period of 3 years after final payment. The record retention periods required of the contractor in the clauses are for compliance with the aforementioned statutory requirements. The information must be retained so that audits necessary for contract surveillance, verification of contract pricing, and reimbursement of contractor costs can be performed.

B. Annual Reporting Burden

Respondents: 19,142.

Responses Per Respondent: 20.

Total Responses: 382,840.

Hours Per Response: 0.167.

Total Burden Hours: 63,934.

Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, FAR Secretariat (MVA), 1800 F Street, NW, Room 4035, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0034, Examination of Records by Comptroller General and Contract Audit in all correspondence.

Dated: August 6, 2003.

Laura G. Auletta,

Director, Acquisition Policy Division.

[FR Doc. 03–20443 Filed 8–11–03; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF DEFENSE

Office of the Secretary

The Joint Staff, National Defense University, Board of Visitors Meeting

AGENCY: National Defense University, DoD.

ACTION: Notice of open meeting.

SUMMARY: The President, National Defense University (NDU) has scheduled a meeting of the Board of Visitors (BOV).

DATES: The meeting will be held on September 9th, 2003 from 09:00 to 14:00.

ADDRESSES: The Board will meet in Room 155 Marshall Hall, Building 62, National Defense University, 300 5th Avenue, Fort McNair, Washington, DC 20319–5066.

FOR FURTHER INFORMATION CONTACT: NDU Deputy Chief Operations Officer & Assist Vice President for Administration, Mr. Michael Mann, National Defense University, Fort Lesley J. McNair, Washington, DC 20319–5066. To reserve seating space, interested persons should contact the NDU, POC Mr. Mann, at (202) 685–3903.

SUPPLEMENTARY INFORMATION: The agenda will address current and future teaching research, and outreach issues for the National Defense University and its components. The meeting is open to the public however, space is limited and will therefore be allocated to observers on a first come, first served basis.

POC for outside interests in Mr. Michael Mann, BOV Executive Secretary, at *mannm@ndu.edu* and/or (202) 685–3903.

Dated: July 31, 2003.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 03–20442 Filed 8–11–03; 8:45 am]

BILLING CODE 5001–08–M

DEPARTMENT OF DEFENSE

Office of the Secretary

Senior Executive Service Performance Review Board

AGENCY: Office of the Inspector General of the Department of Defense.

ACTION: Notice.

SUMMARY: This notice announces the appointment of the members of the Senior Executive Service (SES) Performance Review Board (PRB) for the Office of the Inspector General of the Department of Defense (OIG DoD), as required by 5 U.S.C. 4314(c)(14).

The PRB provides fair and impartial review of SES performance appraisals and makes recommendations regarding performance ratings and performance awards to the Inspector General.

EFFECTIVE DATES: August 11, 2003.

FOR FURTHER INFORMATION CONTACT: Mr. Michael Peterson, Director, Human Capital Directorate, Office of the Chief of Staff, OIG DoD, 400 Army Navy Drive, Arlington, VA 22202, (703) 602–4516.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 4314(c)(4), the following executives are appointed to the OIG, DoD PRB:

Charles W. Beardall, Director, Defense Criminal Investigative Service, ODIG-Investigations.

Patricia A. Brannin, Assistant Inspector General for Audit Policy and Oversight, ODIG-Inspections and Policy.

David A. Brinkman, Director, Audit Follow-Up and Technical Support, ODIG-Auditing.

Thomas F. Gimble, Acting Deputy Inspector General for Intelligence.

Paul J. Granetto, Director, Defense Financial Auditing Service, ODIG-Auditing.

Louis J. Hansen, Deputy Inspector General for Inspections and Policy.

Francis E. Reardon, Deputy Inspector General for Auditing.

Richard T. Race, Deputy Inspector General for Investigations.

David K. Steensma, Deputy Assistant Inspector General of Auditing.

Shelton R. Young, Director, Readiness and Logistic Support, ODIG-Auditing.

Dated: August 5, 2003.

Patricia L. Toppings,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 03–20441 Filed 8–11–03; 8:45 am]

BILLING CODE 5001–08–M

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Leader, Regulatory Information Management Group, Office of the Chief Information Officer invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 11, 2003.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Karen Lee, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503 or should be electronically mailed to the internet address *Karen_F._Lee@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Regulatory Information Management Group, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.*, new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: August 6, 2003.

Angela C. Arrington,

Leader, Regulatory Information Management Group, Office of the Chief Information Officer.

Office of the Under Secretary

Type of Review: New.

Title: Clearance of Data Collection Instruments for the Evaluation of the Teaching American History Program.

Frequency: On occasion.

Affected Public: Not-for-profit institutions; State, local or Tribal Gov't, SEAs or LEAs.

Reporting and Recordkeeping Hour Burden:

Responses: 2,998.

Burden Hours: 2,492.

Abstract: The evaluation of the Teaching American History Grants Program (TAH program) is the first national study of Federal support for teacher training in traditional American history. The study will gather data from the directors of projects supported by TAH grants, and from teachers who

have participated in activities supported by TAH grants. The purpose of the evaluation is to inform future reauthorizations of the TAH program and to inform other Federal programs focusing on teacher training in specific areas.

Requests for copies of the proposed information collection request may be accessed from *http://edicsweb.ed.gov*, by selecting the ''Browse Pending Collections'' link and by clicking on link number 2288. When you access the information collection, click on ''Download Attachments'' to view. Written requests should be addressed to Vivian Reese, Department of Education, 400 Maryland Avenue, SW., Room 4050, Regional Office Building 3, Washington, DC 20202–4651. Requests may also be electronically mailed to the Internet address *OCIO.RIMG@ed.gov* or faxed to 202–708–9346. Please specify the complete title of the information collection when making your request. Comments regarding burden and/or the collection activity requirements should be directed to Sheila Carey at her e-mail address *Sheila.Carey@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 03–20465 Filed 8–11–03; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[CFDA No. 84.200A]

Office of Postsecondary Education; Graduate Assistance in Areas of National Need (GAANN) Program; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2004

Purpose of Program: GAANN provides fellowships in areas of national need to assist graduate students with excellent academic records who demonstrate financial need and plan to pursue the highest degree available in their courses of study.

Eligible Applicants: Academic departments of institutions of higher education that meet the requirements in the program regulations at 34 CFR 648.2.

Applications Available: October 1, 2003.

Deadline for Transmittal of Applications: November 7, 2003.

Deadline for Intergovernmental Review: January 7, 2004.

Estimated Available Funds: The Administration has requested $10,015,000 for the GAANN Program new awards for FY 2004. The actual level of funding, if any, depends on final congressional action. However, we are inviting applications to allow enough time to complete the grant process, if Congress appropriates funds for this program.

Estimated Range of Awards: $124,668–$750,000.

Estimated Average Size of Awards: $208,645.

Estimated Number of Awards: 48.

Note: The Department is not bound by any estimates in this notice.

SUPPLEMENTARY INFORMATION:

Stipend Level: The Secretary will determine the GAANN fellowship stipend for the academic year 2004–2005 based on the level of support provided by the National Science Foundation (NSF) graduate fellowships as of February 1, 2004, except that the amount will be adjusted as necessary so as not to exceed the GAANN fellow's demonstrated level of financial need.

Institutional Payment: The Secretary will determine the institutional payment for the academic year 2004–2005 by adjusting the previous academic year institutional payment, which is $11,296 per fellow, by the U.S. Department of Labor's Consumer Price Index for the 2003 calendar year.

Project Period: Up to 36 months.

Page Limit: The application narrative (Part III of the application) is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. You must limit Part III as follows:

Applications in a single discipline must be limited to no more than 40 pages.

Interdisciplinary applications, as defined below, must be limited to no more than 60 pages.

Multidisciplinary applications, as defined below, must be limited to no more than 40 pages for each academic discipline included in the proposal.

All applications (single discipline, Interdisciplinary and Multidisciplinary) must apply the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, references, and captions. However, you may single space all text in charts, tables, figures, and graphs. Charts, tables, figures, and graphs presented in the application narrative do count toward the page limit.
- Use a font that is either 12-point or larger or no smaller than 10 pitch (character per inch).
- Appendices are limited to the following: Curriculum vitae—no more than two pages per faculty member; a course listing; letters of support; bibliography; and one additional optional appendix relevant to the support of the proposal, not to exceed five pages.

The page limit does not apply to Part I, the cover sheet; Part II, the budget section; the assurances and certifications; the one-page abstract; or the appendices. However, you must include all of the application narrative in Part III.

We will reject your application if—

- You apply these standards and exceed the page limit; or
- You apply other standards and exceed the equivalent of the page limit.

Note: Interdisciplinary applications request funding for a single proposed program of study that involves academic fields in two or more disciplines.

Multidisciplinary applications request funding for two or more proposed programs of study that are independent and unrelated to one another. Applicants must abide by these definitions of ''Interdisciplinary'' and ''Multidisciplinary'' when applying the page limit standards.

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 82, 85, 86, 97, 98, and 99; and (b) The regulations for this program in 34 CFR part 648.

Priority

Absolute Priority: This competition focuses on projects designed to meet a priority in the regulations for this program (34 CFR 648.33).

Areas of National Need: A project must provide fellowships in one or more of the following areas of national need: biology, chemistry, computer and information sciences, engineering, geological and related sciences, mathematics, and physics.

Under 34 CFR 75.105(c)(3) we consider only applications that meet the priority.

Performance Measures

Under the Government Performance and Results Act (GPRA), two measures have been developed for evaluating the overall effectiveness of the GAANN Program: (1) To increase the percentage of GAANN fellows who obtain a doctorate degree in an area of national need; and (2) To increase the percentage of GAANN fellows from traditionally underrepresented populations.

All grantees will be expected to submit an annual performance report

documenting their success in addressing these performance measures.

Application Procedures

The Government Paperwork Elimination Act (GPEA) of 1998 (Pub. L. 105–277) and the Federal Financial Assistance Management Improvement Act of 1999 (Pub. L. 106–107) encourage us to undertake initiatives to improve our grant processes. Enhancing the ability of individuals and entities to conduct business with us electronically is a major part of our response to these Acts. Therefore, we are taking steps to adopt the Internet as our chief means of conducting transactions in order to improve services to our customers and to simplify and expedite our business processes.

Note: Some of the procedures in these instructions for transmitting applications differ from those in the Education Department General Administrative Regulations (EDGAR) (34 CFR 75.102). Under the Administrative Procedure Act (5 U.S.C. 553) the Department generally offers interested parties the opportunity to comment on proposed regulations. However, these amendments make procedural changes only and do not establish new substantive policy. Therefore, under 5 U.S.C. 553(b)(A), the Secretary has determined that proposed rulemaking is not required.

We are requiring that applications for grants for FY 2004 under the GAANN program be submitted electronically using e-Application available through the Department's e-GRANTS system. The e-GRANTS system is accessible through its portal page at: *http://e-grants.ed.gov.*

An applicant who is unable to submit an application through the e-GRANTS system may submit a written request for a waiver of the electronic submission requirement. In the request, the applicant should explain the reason or reasons that prevent the applicant from using the Internet to submit the application. The request should be addressed to: Brandy Silverman, U.S. Department of Education, 1990 K St., NW., room 6018, Washington, DC 20006–8521. Please submit your request no later than two weeks before the application deadline date.

If, within two weeks of the application deadline date, an applicant is unable to submit an application electronically, the applicant must submit a paper application by the application deadline date in accordance with the transmittal instructions in the application package. The paper application must include a written request for a waiver documenting the reasons that prevented the applicant from using the Internet to submit the application.

Pilot Project for Electronic Submission of Applications

In FY 2004, the Department is continuing to expand its pilot project for electronic submission of applications to include additional formula grant programs and additional discretionary grant competitions. The GAANN program-CFDA 84.200A is one of the programs included in the pilot project. If you are an applicant under GAANN, you must submit your application to us in electronic format or receive a waiver.

The pilot project involves the use of the Electronic Grant Application System (e-Application). Users of e-Application will be entering data on-line while completing their applications. You may not e-mail a soft copy of a grant application to us. The data you enter on-line will be saved into a database. We shall continue to evaluate the success of e-Application and solicit suggestions for its improvement.

If you participate in e-Application, please note the following:

- When you enter the e-Application system, you will find information about its hours of operation. We strongly recommend that you do not wait until the application deadline date to initiate an e-Application package.
- You will not receive additional point value because you submit a grant application in electronic format, nor will we penalize you if you submit an application in paper format.
- You must submit all documents electronically, including the Application for Federal Education Assistance (ED 424), Budget Information Sheet, and all necessary assurances and certifications.
- Your e-Application must comply with any page limit requirements described in this notice.
- After you electronically submit your application, you will receive an automatic acknowledgement, which will include a PR/Award number (an identifying number unique to your application).
- Within three working days after submitting your electronic application, fax a signed copy of the Application for Federal Education Assistance (ED 424) to the Application Control Center after following these steps:

1. Print ED 424 from e-Application.

2. The institution's Authorizing Representative must sign the ED 424.

3. Place the PR/Award number in the upper right hand corner of the hard copy signature page of the ED 424.

4. Fax the signed ED 424 to the Application Control Center at (202) 260–1349.

- We may request that you give us original signatures on other forms at a later date.
- *Application Deadline Date Extension in Case of System Unavailability:* If you are prevented from submitting your application on the application deadline date because the e-Application system is unavailable, we will grant you an extension of one business day in order to transmit your application electronically, by mail, or by hand delivery. For us to grant this extension—

1. You must be a registered user of e-Application and have initiated an e-Application for this competition; and

2. (a) The e-Application system must be unavailable for 60 minutes or more between the hours of 8:30 a.m. and 3:30 p.m., Washington, DC time, on the application deadline date; or

(b) The e-Application system must be unavailable for any period of time during the last hour of operation (that is, for any period of time between 3:30 and 4:30 p.m., Washington, DC time) on the application deadline date.

The Department must acknowledge and confirm these periods of unavailability before granting you an extension. To request this extension or to confirm the Department's acknowledgement of any system unavailability, you may contact either: (1) The person listed elsewhere in this notice under **FOR FURTHER INFORMATION CONTACT** or (2) the e-GRANTS help desk at 1–888–336–8930.

You may access the electronic grant application for GAANN at: *http://e-grants.ed.gov.*

FOR FURTHER INFORMATION CONTACT: Brandy Silverman, U.S. Department of Education, Graduate Assistance in Areas of National Need Program, 1990 K Street NW., Suite 6000, Washington, DC 20006–8521. Telephone: (202) 502–7886 or via Internet: *ope_gaann@ed.gov.*

If you use a telecommunication 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 program contact person listed under **FOR FURTHER INFORMATION CONTACT.**

Individuals with disabilities may obtain a copy of the application package in an alternative format by contacting that person. However, the Department is not able to reproduce in an alternative format the standard forms included in the application package.

Electronic Access to This Document

You may view this document, as well as all other Department of Education documents published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/legislation/FedRegister*

To use PDF you must have adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

You may also view this document in PDF at the following site: *http://www.ed.gov/hep/iegps/gaann.html.*

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.access.gpo.gov/nara/index.html.*

Program Authority: 20 U.S.C. 1135.

Dated: August 7, 2003.

Sally L. Stroup,

Assistant Secretary, Office of Postsecondary Education.

[FR Doc. 03–20520 Filed 8–11–03; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Availability of Draft Strategic Plan and Request for Public Comment

AGENCY: Office of Management, Budget and Evaluation/Chief Financial Officer, U.S. Department of Energy.

ACTION: Notice of Availability of Draft Strategic Plan and request for comment.

SUMMARY: This notice announces the availability of the Department of Energy's draft Strategic Plan. The Government Performance and Results Act of 1993 requires that federal agencies update their Strategic Plans every three years and, in doing so, solicit the views and suggestions of those entities potentially affected by or interested in the plan. Therefore, the Department is interested in receiving comments on our draft Strategic Plan.

DATES: Comments are due by September 11, 2003. If comments are received late, we will consider them to the extent practicable.

ADDRESSES: The draft Strategic Plan is available on the Department's homepage at *http://www.doe.gov.* You can provide your comments on-line directly through the Web site or by e-mail to StrategicPlan@hq.doe.gov. You can also send written comments or requests for a hard copy of the plan to: Dr. William G. Kennedy, U.S. Department of Energy, Office of Program Analysis and Evaluation, ME–20, 1000 Independence Avenue SW, Washington, DC 20585.

FOR FURTHER INFORMATION CONTACT: William Kennedy at (202) 586–0423.

SUPPLEMENTARY INFORMATION: The Department of Energy (DOE) was established in October 1977. Twenty-five years later, DOE has a budget of $23.4 billion, operates 24 research laboratories and facilities, four power administrations, employs 14,500 federal and 100,000 contractor employees, and manages the environmental cleanup from 50 years of nuclear defense activities that impacted two million acres in communities across the country. The Department has amassed tremendous scientific and technical capabilities serving America in ways never anticipated 25 years ago. Those capabilities will be applied to our overarching mission of ensuring the national security.

The Government Performance and Results Act (GPRA) requires that each federal agency update their strategic plan every three years, 5 U.S.C. 306, and submit their plan to the Congress. This draft Strategic Plan describes our mission, our strategic goals and strategies to achieve those goals over the next 20 years.

Public Participation Policy

It is the policy of the Department to ensure that public participation is an integral and effective part of DOE activities and that decisions are made with the benefit of significant public perspectives.

The Department recognizes the many benefits to be derived from public participation for both stakeholders and DOE. Public participation provides a means for DOE to gather a diverse collection of opinions, perspectives, and values from the broadest spectrum of the public, enabling the Department to make more informed decisions. Public participation benefits stakeholders by creating an opportunity to provide input on decisions that affect their communities and our nation.

We anticipate publishing the final Strategic Plan in October 2003 and making it available on the Internet at that time.

Issued in Washington, DC on August 6, 2003.

James T. Campbell,

Acting Director, Office of Management, Budget and Evaluation/Acting Chief Financial Officer.

[FR Doc. 03–20498 Filed 8–11–03; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

Department of Energy's Fleet Alternative Fueled Vehicle Acquisition

AGENCY: Office of Energy Efficiency and Renewable Energy, U.S. Department of Energy

ACTION: Notice of Availability of the Department of Energy's Annual Report on its Alternative Fueled Vehicle Acquisitions for Fiscal Year 2002.

SUMMARY: In compliance with the Energy Policy Act of 1992 and Executive Order 13149, this notice announces the availability of the 2002 report which summarizes the U.S. Department of Energy's (DOE) compliance with the annual alternative fueled vehicle acquisition requirement for its vehicle fleet. Additionally, this report includes data concerning DOE's efforts to reduce petroleum consumption.

ADDRESSES: U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, Office of FreedomCAR and Vehicle Technologies, EE–2G, 1000 Independence Avenue, SW, Washington, DC 20585–0121.

FOR FURTHER INFORMATION CONTACT: Shabnam Fardanesh on (202) 586–7011 or *shabnam.fardanesh@ee.doe.gov.*

SUPPLEMENTARY INFORMATION: The Energy Policy Act of 1992 (42 U.S.C. 13211–13219) (EPAct) as amended by the Energy Conservation and Reauthorization Act of 1998 (Pub. L. 105–388) and Executive Order 13149 (April 2000) require Federal fleets to make 75 percent of their new covered vehicle acquisitions alternative fueled vehicles, beginning in fiscal year 1999. In fiscal year 2002, 83 percent of the covered vehicles DOE acquired were alternative fueled vehicles, exceeding the 75 percent requirement by eight percent. DOE also exceeded its alternative fueled vehicle acquisition requirements in fiscal years 1999, 2000 and 2001, and expects a similarly high level of compliance for fiscal years 2003 and 2004.

Pursuant to 42 U.S.C. 13218, DOE and other covered agencies are required annually to submit to Congress reports

on their alternative fueled vehicle acquisitions. These reports must also be placed on a publicly available Web site and a notice of their availability, including the Web site address, must be published in the **Federal Register**.

The DOE report for fiscal year 2002 may be accessed on the Vehicle Technology's Federal Fleet Web site at *http://www.ott.doe.gov/epact/fed_fleet_prog.shtml.*

Issued in Washington, DC, on August 6, 2003.

David K. Garman,

Assistant Secretary, Energy Efficiency and Renewable Energy.

[FR Doc. 03–20497 Filed 8–11–03; 8:45 am]

BILLING CODE 6450–01–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)), of the regular meeting of the Farm Credit Administration Board (Board).

DATE AND TIME: The regular meeting of the Board will be held at the offices of the Farm Credit Administration in McLean, Virginia, on August 14, 2003, from 9:00 a.m. until such time as the Board concludes its business.

FOR FURTHER INFORMATION CONTACT: Jeanette C. Brinkley, 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.

SUPPLEMENTARY INFORMATION: Parts of this meeting of the Board will be open to the public (limited space available), and parts will be closed to the public. In order to increase the accessibility to Board meetings, persons requiring assistance should make arrangements in advance. The matters to be considered at the meeting are:

Open Session

A. Approval of Minutes

July 10, 2003 (Open)

B. Reports

- Strategic Plan—Second Quarter Goal Status Report
- Financial Institution Rating System (FIRS)—Management Discussion
- Loan Underwriting Standards

C. New Business—Regulation

- Young, Beginning, and Small (YBS) Farmers and Ranchers—Proposed Rule

Closed Session*

New Business

- The Baker-Botts Review of Freddie Mac and Related Issues
- FCS Building Association Audit

*Session Closed-Exempt pursuant to 5 U.S.C. 552b(c)(8) and (9).

Dated: August 8, 2003.

Jeanette C. Brinkley,

Secretary, Farm Credit Administration Board.

[FR Doc. 03–20582 Filed 8–8–03; 10:54 am]

BILLING CODE 6705–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 5, 2003.

A. Federal Reserve Bank of Chicago (Phillip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. Wintrust Financial Corporation, Lake Forest, Illinois; to acquire 100 percent of the voting shares of Advantage National Bancorp, Inc., Elk Grove Village, Illinois, and thereby indirectly acquire Advantage National Bank, Elk Grove Village, Illinois.

Board of Governors of the Federal Reserve System, August 7, 2003.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 03–20505 Filed 8–11–03; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention, Department of Health and Human Services

ACTION: Request for nominations of candidates to serve on the Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention, Department of Health and Human Services.

The Centers for Disease Control and Prevention (CDC) is soliciting nominations for possible membership on the Advisory Committee on Immunization Practices (ACIP). This committee provides advice and guidance to the Secretary of the Department of Health and Human Services, and the Director of the CDC, regarding the most appropriate application of antigens and related agents for effective communicable disease control in the civilian population. The committee reviews and reports regularly on immunization practices and recommends improvements in the national immunization efforts.

The committee also establishes, reviews, and as appropriate, revises the list of vaccines for administration to children eligible to receive vaccines through the Vaccines for Children (VFC) Program. Nominations are being sought for individuals who have expertise and qualifications necessary to contribute to the accomplishments of the committee's objectives. Nominees will be selected based upon expertise in the field of immunization practices; multi-disciplinary expertise in public health; expertise in the use of vaccines and immunologic agents in both clinical and preventive medicine; knowledge of vaccine development, evaluation, and vaccine delivery; or knowledge about consumer perspectives and/or social and community aspects of immunization programs. Federal

employees will not be considered for membership. Members may be invited to serve up to four-year terms. Consideration is given to representation from diverse geographic areas, both genders, ethnic and minority groups, and the disabled. Nominees must be U.S. citizens.

The following information must be submitted for each candidate: Name, affiliation, address, telephone number, and a current curriculum vitae. E-mail addresses are requested if available.

Nominations should be sent in writing and postmarked by September 1, 2003, to: Demetria Gardner, National Immunization Program, CDC, 1600 Clifton Road, NE., Mailstop E–61, Atlanta, Georgia 30333. Telephone and facsimile submissions cannot be accepted.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: August 5, 2003.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–20483 Filed 8–11–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Committee for Injury Prevention and Control

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following subcommittee and committee meetings.

The Science and Program Review Subcommittee (SPRS) and the Advisory Committee for Injury Prevention and Control (ACIPC) will meet to evaluate and discuss applications for Program Announcement Numbers 03077, Community-Based Interventions to Reduce Motor Vehicle-Related Injuries; 03100, Research to Improve Smoke Alarm Maintenance and Function; 03106, Development and Validation of Measures to Assess Outcomes of Mild Traumatic Brain Injury; and Small Business Innovation Research applications reviewed by the National Institutes of Health.

Name: Science and Program Review Subcommittee to ACIPC.

Time and Dates: 2 p.m.–3:10 p.m., August 18, 2003.

Place: Koger, Yale Building, Room 2054, 2495 Flowers Road, Atlanta, Georgia 30341.

Status: Open: 2 p.m.–2:10 p.m., August 18, 2003. Closed: 2:20 p.m.–3:10 p.m., August 18, 2003.

Purpose: The Subcommittee provides advice on the needs, structure, progress, and performance of the National Center for Injury Prevention and Control (NCIPC) programs. The Subcommittee provides second-level scientific and programmatic review for applications for research grants, cooperative agreements, and training grants related to injury control and violence prevention, and recommends approval of projects that merit further consideration for funding support. The Subcommittee also advises on priorities for research to be supported by contracts, grants, and cooperative agreements and provides concept review of program proposals and announcements.

Matters To Be Discussed: Agenda items for the open portion of the oversight include information about upcoming meetings. Beginning at 2:20 p.m., August 18, 2003, through 3:10 p.m., the Subcommittee will conduct the secondary review in closed session. The secondary review will include discussion and evaluation of results of the Disease, Disability, and Injury Prevention and Control Special Emphasis Panel's deliberations of applications in response to Program Announcements #03077, Community-Based Interventions to Reduce Motor Vehicle-Related Injuries; #03100, Research to Improve Smoke Alarm Maintenance and Function; and #03106, Development and Validation of Measures to Assess Outcomes of Mild Traumatic Brain Injury. The secondary review will also include discussion and evaluation of Small Business Innovation Research applications reviewed by the National Institutes of Health. This portion of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Name: Advisory Committee for Injury Prevention and Control.

Time and Dates: 3:15 p.m.–4 p.m., August 18, 2003.

Place: Koger/Yale Building, Room 2054, 2495 Flowers Road, Atlanta, Georgia 30341.

Status: Open: 3:15 p.m.–3:35 p.m., August 18, 2003. Closed: 3:35 p.m.–4:00 p.m., August 18, 2003.

Purpose: The committee advises and makes recommendations to the Secretary, Health and Human Services, the Director, CDC, and the Director, NCIPC, regarding feasible goals for the prevention and control of injury. The committee makes recommendations regarding policies, strategies, objectives, and priorities, and reviews progress toward injury prevention and control. The committee provides advice on the appropriate balance of intramural and extramural research, and also provides guidance on the needs, structure, progress and performance of intramural programs, and on extramural scientific program matters. The committee provides second-level scientific and programmatic review for applications for research grants, cooperative agreements, and training grants related to injury control and violence prevention, and recommends approval of projects that merit further consideration for funding support. The committee also recommends areas of research to be supported by contracts and cooperative agreements and provides concept review of program proposals and announcements.

Matters To Be Discussed: Agenda items for the open portion includes an update on Center activities. Beginning at 3:35 p.m., August 18, 2003, through 4 p.m., during the closed portion, the committee will vote on results of the secondary review. This portion of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463. Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Ms. Louise Galaska, Executive Secretary, ACIPC, NCIPC, CDC, 4770 Buford Highway, NE., M/S K02, Atlanta, Georgia 30341–3724, telephone 770/488–4694.

Due to programmatic issues that had to be resolved, the **Federal Register** notice is being published less than fifteen days before the date of the meeting.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: August 5, 2003.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–20482 Filed 8–11–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2003N–0194]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Agreement for Shipment of Devices for Sterilization

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that the proposed collection of information listed below has been submitted to the Office of Management

and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments on the collection of information by September 11, 2003.

ADDRESSES: OMB is still experiencing significant delays in the regular mail, including first class and express mail, and messenger deliveries are not being accepted. To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: Fumie Yokota, Desk Officer for FDA, FAX: 202–395–6974.

FOR FURTHER INFORMATION CONTACT: Peggy Robbins, Office of Management Programs (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Agreement for Shipment of Devices for Sterilization—21 CFR 801.150(e) (OMB Control Number 0910–0131)—Extension

Under sections 501(c) and 502(a) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 351(c) and 352(a)), nonsterile devices that are labeled as sterile but are in interstate transit to a facility to be sterilized are adulterated and misbranded. FDA regulations in § 801.150(e) (21 CFR 801.150(e)) establish a control mechanism by which firms may manufacture and label medical devices as sterile at one establishment and ship the devices in interstate commerce for sterilization at another establishment; a practice that facilitates the processing of devices and is economically necessary for some firms. Under § 801.150(e), manufacturers and sterilizers may sign an agreement containing the following provisions: (1) Instructions for maintaining accountability of the number of units in each shipment; (2) acknowledgment that the devices that are nonsterile are being shipped for further processing; and (3) specifications for sterilization processing.

This agreement allows the manufacturer to ship misbranded products to be sterilized without initiating regulatory action and provides FDA with a means to protect consumers from use of nonsterile products. During routine plant inspections, FDA normally reviews agreements that must be kept for 2 years after final shipment or delivery of devices. The respondents to this collection of information are device manufacturers and contact sterilizers.

In the **Federal Register** of May 21, 2003 (68 FR 27819), FDA published a 60-day notice requesting public comment on the information collection provisions. No comments were received.

FDA estimates the reporting burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
801.150(e)	90	20	1,800	4	7,200

[1]There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2.—ESTIMATED ANNUAL RECORDKEEPING BURDEN[1]

21 CFR Section	No. of Recordkeepers	Annual Frequency of Recordkeeping	Total Annual Records	Hours per Recordkeeper	Total Hours
801.150(a)(2)	90	20	1,800	.5	900

[1]There are no capital costs or operating and maintenance costs associated with this collection of information.

FDA's estimate for the reporting burden is based on actual data obtained from industry during the past 3 years where there are approximately 90 firms subject to this requirement. It is estimated that each of these firms on the average prepares 20 written agreements each year. This estimate varies greatly, from 1 to 100, because some firms provide sterilization services on a part time basis for only one customer while others are large facilities with many customers. The average time required to prepare each written agreement is estimated to be 4 hours. This estimate varies depending on whether the agreement is the initial agreement or is an annual renewal, on the format each firm elects to use, and on the length of time required to reach agreement. The estimate applies only to those portions of the written agreement that pertain to the requirements imposed by this regulation. The written agreement generally also includes contractual agreements that are a customary and usual business practice. On the average, the total annual recordkeeping burden is 7,200 hours (90 firms x 20 agreements x 4 hours).

The recordkeeping requirements for respondents consists of making copies and maintaining the actual reporting requests which were required under reporting section of this collection. To fulfill this requirement, FDA estimates it will take about 30 minutes to copy each package, for a total of 900 recordkeeping hours.

Dated: August 7, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–20523 Filed 8–11–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Docket No. 2003N–0344]

Consumer-Directed Promotion; Public Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public meeting; request for comments.

SUMMARY: The Food and Drug Administration (FDA) is announcing a public meeting on consumer-directed promotion of prescription drugs. The purpose of the meeting is to enable the agency and other persons and organizations to present the results of their research on consumer-directed promotion of prescription drug products through print, broadcast, and other types of media. FDA is particularly

interested in hearing about research by other persons and organizations that provides insight into the effects that consumer-directed promotion has on the public health. The agency is also interested in research on the groups most affected by consumer-directed promotion, including patients, caretakers, physicians, physician assistants, nurses, pharmacists, managed care organizations, and insurers.

Date and Time: The public meeting will be held on September 22, 2003, from 9 a.m. to 5 p.m., and on September 23, 2003, from 9 a.m. to 5 p.m. Presenters must send final electronic presentations in Microsoft PowerPoint, Microsoft Word, or Adobe Portable Document Format (PDF) to FDA by close of business on September 10, 2003.

Persons interested in presenting research should send requests and abstracts in writing to the Division of Dockets Management (HFA–305), Food and Drug Administration, rm. 1061, 5630 Fishers Lane, Rockville MD, 20852, by close of business on August 29, 2003.

Location: The public hearing will be held at the National Transportation Safety Board Boardroom and Conference Center, 429 L'Enfant Plaza, SW., Washington, DC 20594. (Phone: 202–314–6421; Metro: L'Enfant Plaza station on the green, yellow, blue, and orange lines). See: *http://ntsb.gov/events/newlocation.htm*. (FDA has verified the Web site address, but FDA is not responsible for any subsequent changes to the Web site after this document publishes in the **Federal Register**.)

Registration and Requests for Presentation: No registration is required to attend the meeting. Seating will be on a first-come, first-served basis. If you wish to present research during the public meeting, please submit your request and an abstract of your presentation to the Division of Dockets Management (see *Date and Time*). Requests should be identified with the docket number listed in the heading of this document. Transcripts of the meeting will be available for review at the Division of Dockets Management.

For Information Regarding This Notice: Rose Cunningham, Center for Drug Evaluation and Research (HFD–006), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–594–5468, e-mail: *cunninghamr@cder.fda.gov*. If you need special accommodations due to a disability, please inform the contact person.

SUPPLEMENTARY INFORMATION:

I. Background

Part of FDA's Division of Drug Marketing, Advertising and Communication's (DDMAC) mission is to protect public health by helping to ensure that prescription drug promotion directed to professionals and consumers is truthful, contains balanced risk and benefit information, and is accurately communicated. Increased spending on consumer-directed (also called direct to consumer promotion or DTC promotion) promotion, particularly broadcast advertisements, has stimulated public debate about its value or harm to the public. Proponents argue that DTC promotion is of educational value, will improve the physician-patient relationship, will make consumers aware of conditions they have that could benefit from treatment, would potentially improve health care, and could lower long-term health care costs through early recognition and treatment. Opponents contend that: Consumers do not have the expertise to accurately evaluate and comprehend prescription drug advertising, DTC promotion is typically misleading because it fails to adequately communicate risk information, DTC promotion will damage the physician-patient relationship, it will increase drug prices, lead to over-medication and drug abuse, and it will lead to use of the most costly alternatives. FDA needs to consider all points of view in the public debate.

In the **Federal Register** of August 12, 1997 (62 FR 43171), FDA announced the availability of a draft guidance for industry concerning DTC broadcast advertisements. The draft guidance was intended to describe how advertisers could fulfill their obligations under the regulations to provide consumers with necessary risk information in connection with prescription-drug advertisements broadcast, through general public media such as radio, television, and telephone communications systems. The prescription drug advertising regulations under part 202.1 (21 CFR 202.1) distinguish between print and broadcast advertisements. In addition to presenting a fair balance between information relating to side effects and contraindications and information relating to the effectiveness of the drug, print advertisements must include a ''brief summary,'' that generally includes all risks cited in the product's approved package labeling. In contrast, advertisements broadcast through media such as television, radio, or telephone communications systems must disclose the product's major risks in either the audio or audio and visual parts of the presentation (this is sometimes called the ''major statement''); but need not provide the brief summary, as this would generally be impractical in broadcast or telephone media. Instead these advertisements may make ''adequate provision * * * for dissemination of the approved or permitted package labeling in connection with the broadcast presentation'' (§ 202.1(e)(1)). The draft guidance described, and explained the rationale behind, one possible multifaceted approach that would fulfill the ''adequate provision'' requirement.

After considering comments received from the public, the agency revised the draft guidance and published it as a final guidance on August 9, 1999 (64 FR 43197). FDA noted that although the comments did not address the specific issue of telephone advertisements, the lack of a specific discussion concerning such advertisements may have led to the assumption that the same multifaceted approach for television and radio advertisements was also appropriate for telephone advertisements. Therefore, in the final guidance, FDA clarified its position with regard to fulfilling the ''adequate provision'' requirement for telephone advertisements. Aside from this clarification and the revision of introductory language to reinforce the importance in broadcast advertisements of complying with the more general requirements of the advertising regulations, there were no major revisions to the draft guidance. The final guidance and a document entitled ''Consumer-Directed Broadcast Advertisements Guidance: Questions and Answers'' is available on FDA's Web site at *www.fda.gov/cder/guidance/index.htm*.

The agency said in the August 9, 1999, **Federal Register** notice announcing availability of the final guidance, that the agency intended to evaluate the effects of the guidance and DTC promotion, in general, on the public health. FDA said it would determine whether this guidance should be withdrawn, continued, or modified to reflect the agency's current thinking. The public meeting being announced in this document is one component of the approach the agency is taking to fulfill its commitment to this evaluation.

Another component is the research FDA has conducted on DTC promotion, including surveys of consumers in 1999 and 2002, as well as a survey of physicians in 2002 that explored how DTC promotion affects the patient-physician relationship. FDA intends to present the results of those findings at the public meeting.

II. Scope of the Meeting

In light of the many complex public health issues raised by DTC prescription drug promotion, the agency stated, in previous **Federal Register** notices that it needed rigorous studies to assess the actual effects of DTC promotion and to help guide future policy. The agency is soliciting feedback on the results of such research for presentation at this public meeting. The meeting will give parties who have conducted rigorous research an opportunity to present their findings to FDA and the public. The agency will consider its own research and the research of others to explore whether, and, if so, how, the agency's current regulatory approach should be modified, including whether the guidance on DTC broadcast advertisements should be withdrawn, continued, or modified to reflect the agency's current thinking.

FDA is interested in research related to the promotion and advertising of prescription drugs, both DTC advertising and the interaction of DTC and health care professional-oriented promotion. The research may be either broadly defined or specific, and narrowly focused, but it must meet accepted standards for rigorous research. Specific topics of interest include, but are not limited to, the following:

1. What is known about the effects of DTC promotion on patient and physician behavior, and what effects, if any, does DTC promotion have on public health? What measurements should be used as indicators of the influence of DTC promotion, and which are most important?

2. Drugs ads used in DTC promotion include full-product advertisements, which include risk and benefit information, and shorter ''reminder'' ads. These shorter advertisements do not provide contextual and risk information. In what ways do consumers differ in their processing of full product advertisements and drug promotions, such as reminder ads, that do not provide contextual and risk information?

3. Does DTC promotion oversimplify the safety and effectiveness of prescription drugs? If so, what effect does such oversimplification have on public health? Specifically, what effect does it have on consumer understanding of and use of prescription drugs?

4. What impact does DTC promotion have on how patients interact with their health care professionals? Does this interaction affect health care providers' prescribing decisions?

5. Can consumers understand and accurately assess claims regarding the efficacy of prescription drugs? Can consumers understand and accurately assess claims regarding the safety of prescription drugs? Do consumers understand the qualifiers in efficacy and safety claims that represent distinctions about the degree of scientific uncertainty and causality associated with a claim, such as ''may cause,'' ''risk factors include,'' ''individual results may vary,'' and other similar qualifiers? Given the fact that prescription drug use requires participation of a learned intermediary, how important is imperfect understanding?

6. What kind of additional information, if any, should be required in the presentation of comparative drug claims to help consumers understand and critically evaluate them? What kind of additional information, if any, should be required in the presentation of comparative cost claims? Should this information vary if prescription drugs are compared to other prescription drugs, over-the counter drugs, or other types of treatments?

7. Current regulations require inclusion of a ''brief summary'' of prescribing information (side effects, contraindications, and effectiveness) in print advertisements. Does this form of disclosure effectively communicate to consumers? Is it informative? Should there be alternate requirements for risk disclosure, and, if so, what should they be? Current regulations require that broadcast advertisements present a ''brief summary'' of prescribing information unless adequate provision is made for the dissemination of the approved product labeling. Also required is a statement of the major risks of the product. Are these disclosure requirements effective and informative for consumers? Are there alternate types of risk disclosures that would be more effective or informative? If so, what are the strengths and limitations of these alternative types of risk disclosures?

8. The agency issued final guidance in 1999 on how pharmaceutical companies could meet the regulatory requirements to disseminate approved labeling for a prescription product in lieu of a scrolling ''brief summary'' in broadcast advertisements. Are consumers making use of this method for obtaining brief summary information? What, if any, factors hinder effective use of this information, especially among consumer segments most needing it, such as those with limited knowledge of the brand and medical condition?

9. New technologies have spurred the growth of computer-based promotional vehicles, such as the Internet, electronic bulletin boards, and kiosks in pharmacies. These promotions are neither purely print nor broadcast. What kind and format of information is necessary to ensure that these vehicles appropriately communicate risks and benefits of the product.

10. ''Infomercials'' are program-length television or radio programs that promote prescription drugs to consumers. How well do consumers understand the sponsorship of consumer-oriented ''information'' promotions that differ in character from traditional promotion formats (15-, 30-, and 60-second ads)? How well do consumers understand the difference between benefit and risk claims based upon anecdotal evidence, such as a series of testimonials and product claims based upon scientific evidence?

11. To help ensure that advertisements contain ''fair balance,'' FDA currently requests disclosure of key risk and/or limitations of efficacy information, i.e., critical messages, in DTC prescription drug promotion. In general, are such disclosures effective and informative for this audience? What kinds of information should be disclosed?

12. Promotional materials that are disseminated directly by or on behalf of a pharmaceutical company (promotional labeling) are required to include the approved product labeling instead of a brief summary. How do consumers use product labeling, whether it is written for professionals or patients, and how does consumer use of labeling compare to consumer use of the brief summary?

13. Some manufacturer-supported DTC promotion appears to be sponsored by independent, third-party services, such as mailings from, or Web sites posted by, disease-specific foundations or disease management support services. What kind of disclosures would help consumers understand the source of the communication?

14. What additional research is needed to examine the effect of DTC advertising on public health and other DTC advertising issues? Is there research that the agency should conduct, and if so, what should be the focus of that research?

FDA is planning this public meeting to present the findings of its surveys and to hear the results of DTC research conducted by individuals, associations, organizations, academia, and companies. The objective of the meeting is for FDA to gather information to help the agency explore whether, and, if so, how, the agency's current regulatory approach to DTC prescription drug promotion should be modified. The agency believes presentations of

research results will be the best format. Therefore, the 2-day meeting will be conducted as a series of presentations. First, FDA will present the findings of its surveys, then others who have been scheduled will present their findings. A panel of FDA officials will listen to each presenter and ask questions. The audience will then have an opportunity to ask questions and provide comments on the research.

To ensure timely handling, the outer envelope should be clearly marked with the docket number listed in the heading in this document, along with the statement ''DTC Meeting.'' Groups should submit two copies. The request to participate should contain the following information:

- Presenter's name;
- Address;
- Telephone number;
- E-mail address;
- Affiliation, if any;
- Abstract of the presentation;
- Approximate amount of time requested for the presentation.

The agency requests that persons who have collaborated on relevant research coordinate their comments and present them through a single representative. FDA will allocate the time available for the meeting among the persons who request to present research as described in this section II. Due to limited time, the agency will accept only one presenter from each company or organization. FDA reserves the right to turn down requests if the proposal is not research on an appropriate topic or is primarily qualitative. After reviewing the requests to present and the abstracts, the agency will schedule each appearance and notify each participant by e-mail or telephone of the time allotted to the person and the approximate time the person's presentation is scheduled to begin. Presenters must send final electronic presentations in Microsoft PowerPoint, Microsoft Word, or PDF to FDA by close of business on September 10, 2003. Failure to meet the deadline will result in the presenter forfeiting his or her presentation slot.

The meeting schedule will be available both on the Internet at *http://www.fda.gov/cder/ddmac/DTCmeeting2003.html* and at the meeting. After the meeting, the schedule and presentations will be placed on file in the Division of Dockets Management under the docket number listed in the heading in the this document.

III. Comments

Interested persons may submit to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852, written or electronic comments on or before December 1, 2003. You must submit two copies of comments, identified with the docket number found in brackets in the heading of this document. Submit electronic comments by December 1, 2003, to *http://www.accessdata.fda.gov/scripts/oc/dockets/comments/commentdocket.cfm* or *fdadockets@oc.fda.gov*. You should annotate and organize your comments to identify the specific questions to which they refer. Comments to the docket can be reviewed in the Division of Dockets Management, Monday through Friday between 9 a.m. and 4 p.m.

IV. Transcripts

You can request a copy of the transcript of the meeting in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, 5600 Fishers Lane, rm. 12A–16, Rockville, MD 20857, approximately 30 working days after the meeting, at a cost of 10 cents per page or on a compact disk at a cost of $14.25 each. You can also examine the transcript Monday through Friday between 9 a.m. and 4 p.m. in the Division of Dockets Management.

Dated: August 7, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–20522 Filed 8–7–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Report on the Relationship Between the Costs of Administrative, Program Support, and Direct Service-Related Activities and Access of Eligible Individuals to Services and Research Opportunities

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice of request for comments.

SUMMARY: The Health Resources and Services Administration (HRSA) invites comments on the proposed establishment of a limitation on administrative expenses for Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title IV Grants for Coordinated Services and Access to Research for Women, Infants, Children, and Youth. In addition, HRSA invites comments on determining a definition of what costs are to be included in administrative expenses, and on the specific percentage limitation to be applied.

DATES: Comments must be postmarked by September 11, 2003.

ADDRESSES: Written comments should be submitted to the Division of Community Based Programs, HIV/AIDS Bureau (HAB), HRSA, Room 7A–30, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. Respondents should provide a clear rationale for their suggested changes or additions. All comments will be available for public inspection and copying at the Division of Community Based Programs, HAB, Room 7A–30, Parklawn Building weekdays between 8:30 a.m. and 5 p.m. and responses to the comments will be addressed in the final notice.

FOR FURTHER INFORMATION: Wayne E. Sauseda, Director, Division of Community Based Programs, HAB, at (301) 443–0493.

SUPPLEMENTARY INFORMATION: Title IV of the Ryan White CARE Act of 1990, as amended by the Ryan White CARE Act Amendments of 2000, authorizes Grants for Coordinated Services and Access to Research for Women, Infants, Children and Youth. Title IV of the CARE Act appears in section 2671 of the Public Health Service Act, 42 U.S.C. 300ff–71. Section 2671(i)(1) requires ''the Secretary, in consultation with grantees under this part, to conduct a review of the administrative, program support, and direct service-related activities that are carried out under this part to ensure that eligible individuals have access to quality, HIV-related health and support services and research opportunities under this part, and to support the provision of such services.'' Section 2671(i)(2) further requires that ''the Secretary, in consultation with grantees under this part, shall determine the relationship between the costs of the activities referred to in paragraph (1) and the access of eligible individuals to the services and research opportunities described in such paragraph.'' The proposed limitation on administrative expenses is based on a collaborative review process conducted by HRSA. The proposed limitation on administrative expenses is based on the following:

1. An analysis of the current expenditures of Title IV grantees and their relationship to access to services and research opportunities.

- It was determined from an external and internal review that the current administrative expenditures by Title IV grantees of record are an average of 14 percent of the total budget. Currently, of

the 63 grantee budgets analyzed, 24 (38 percent) expend 10 percent or less of their total grant award for administrative expenses; 11 (17.5 percent) expend over 10 percent but less than 15 percent; 10 (16 percent) expend over 15 percent but less than 20 percent; and, 18 (28.6 percent) expend over 20 percent up to 36.6 percent. It was determined that the lower the amount of administrative expenses allocated, the higher the amount of direct services provided to program clients.

• The average Title IV project served 512 HIV-infected clients, 273 uninfected clients, and 198 clients whose serostatus is unknown. The number of HIV infected clients served was not associated with the number of contractors in a Title IV network, receipt of Title I funds, or the organizational type of the lead agency. The number of HIV infected clients served is positively correlated with the number of years of Title IV funding, and of funds received from other Ryan White CARE Act Title sources.

2. In exercising its responsible stewardship of public funds, HRSA seeks to assure that limited Federal dollars will be maximized to the greatest extent possible to fund direct client services. The Title IV program's current absence of a limitation on administrative expenses should not be used to absorb administrative expenses of other related programs that have limitations.

3. HRSA has an established goal of enhancing access to care for HIV-infected women, infants, children, and youth and their affected family members under the Title IV program. We have determined that a limitation on administrative expenses will not diminish the ability of grantees to provide access to appropriate HIV/AIDS services and research opportunities. Furthermore, we believe that the establishment of a limitation on administrative expenses will maximize the dollars available for direct care services and access to research opportunities. With a total of $64,759,964 of funds currently being provided to the 90 fiscal year (FY) 2002 Title IV grantees, we have determined that reducing the administrative expenditure from the current average of 14 percent to 10 percent would result in a shift of $2,590,399 in administrative disbursements to direct services to clients. This increase in available services to Title IV clients is equivalent to the addition of approximately 10 new projects.

4. HRSA has had years of experience in managing other Ryan White CARE Act grantees with legislatively imposed administrative expenses. Titles I, II, and III of the CARE Act limit grantees to 10 percent for administrative costs. Many of the current Title IV programs are also recipients of Title III grant funds and are effectively implementing their Title III programs with a 10 percent limitation on administrative expenses. Although Title IV provides some services that Title III does not, both are expected to assure the provision of health care services to HIV-infected clients and must meet the same standards for quality primary HIV care. HRSA is confident that Title IV grantees can maintain the highest quality of services and provide access to research for clients while expending no more than ten percent on administrative expenses.

5. Although there are a variety of Title IV program models, each of the Title IV programs provides an extensive array of services either directly or through contractual relationships. The proportion of total Title IV grant funds allocated by lead agencies for administrative services is strongly associated with the organizational type of the lead agency. Of the agencies whose administrative expenses exceed 20 percent of the total grant award, the majority were university-based health systems. Of the agencies whose administrative expenses were 10 percent or less, the majority were community-based programs. When comparing similar grantee models on amount allocated for administrative expenses, we found that an administrative budget allocation over 10 percent was not a requisite for serving a greater number of Title IV clients.

Implementation

The limitation on administrative expenses is proposed for implementation as follows:

5.1 The limitation on administrative expenses will be proposed as a specific percent. This limitation also would apply to any contractors of the Grantee who provide client services.

5.2 Recognizing that some grantees may exceed the specified percent limitation at present, we propose that beginning with FY 2004 funding, administrative expenses shall not exceed the specified percentage limitation plus 10 percent of the total grant award to the Grantee. These administrative costs include all administrative costs of the grantee and all payments to contractors or consultants who provide administrative services to the Grantee. The administrative costs of individual client service contractors of the grantee would not be considered part of this limitation to the grantee. Notwithstanding this provision, no Grantee shall claim administrative expenses in excess of the percentage received in FY 2002, if such administrative expenses exceeded 10 percent of the total grant award.

5.3 For FY 2005, no Grantee shall claim administrative expenses in excess of the specified percentage limitation plus 5 percent. Notwithstanding this provision, no Grantee shall claim administrative expenses in excess of the percentage received in FY 2004.

5.4 For FY 2006 and in each succeeding year, no Grantee shall claim administrative expenses in excess of the specified percent limit.

5.5 It is the Grantee's responsibility to enforce the percent limitation on administrative expenses of contractors of the Grantee who provide direct services. This administrative limitation will apply to all contractor payments made in FY 2004 and each succeeding year.

5.6 Administrative expenditures under this section for grant awards shall be clearly specified and documented in grantee applications and budgets in the following categories: direct services; program support; and administrative costs. *Direct services* are those services that are provided to the patients/clients to meet the goals and objectives of the program. This includes the provision of professional, diagnostic, and therapeutic services rendered by a primary care provider. Also included are referrals to and provision of specialty care. *Program support services* are services that sustain program activities and contribute to or help to improve direct service delivery. Such services include capacity building initiatives, prevention and education materials and translation services among others. *Administrative costs* are funds to be used by the grantee for grant management and monitoring activities. This includes costs related to any staff or activity unrelated to direct or support services. Also, indirect costs are included as administrative costs. Indirect costs will be allowed only if the applicant has a Federal negotiated indirect cost rate. All indirect costs are considered administrative and subject to the specified percent limitation. The categorization of all services as direct, program support, and administrative is further addressed in the Title IV Ryan White CARE Act program guidance which can be obtained from HAB at the address noted above.

As required in the Act, ''the Secretary may not make a grant under this part unless the grantee complies with such requirements as may be included in such determination.'' Accordingly, all Ryan White CARE Act Title IV recipients of Grants for Coordinated

Services and Access to Research for Women, Infants, Children, and Youth will be required to comply with the limitation on administrative expenses to be established in the final notice that will follow this comment period.

Dated: August 5, 2003.

Elizabeth M. Duke,

Administrator.

[FR Doc. 03–20439 Filed 8–11–03; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG–2003–15836]

Merchant Marine Personnel Advisory Committee

AGENCY: Coast Guard, DHS.

ACTION: Notice of meetings.

SUMMARY: The Merchant Marine Personnel Advisory Committee (MERPAC) and its working groups will meet to discuss various issues relating to the training and fitness of merchant marine personnel. MERPAC advises the Secretary of Homeland Security on matters relating to the training, qualifications, licensing, certification, and fitness of seamen serving in the U.S. merchant marine. All meetings will be open to the public.

DATES: MERPAC will meet on Thursday, September 18, 2003, from 8 a.m. to 4 p.m. and on Friday, September 19, 2003, from 8 a.m. to 3 p.m. These meetings may adjourn early if all business is finished. Requests to make oral presentations should reach the Coast Guard on or before September 4, 2003. Written material and requests to have a copy of your material distributed to each member of the committee or subcommittee should reach the Coast Guard on or before September 4, 2003.

ADDRESSES: MERPAC will meet on both days in the Fourth Floor Boardroom of the Port of Houston Authority Building, 111 East Loop North, Houston, TX 77029. Further directions regarding the location of the Port of Houston Authority Building may be obtained by contacting Mr. Alistair McNab at (713) 678–4300. Send written material and requests to make oral presentations to Commander Brian J. Peter, Commandant (G–MSO–1), U.S. Coast Guard Headquarters, 2100 Second Street SW., Washington, DC 20593–0001. This notice is available on the Internet at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: For questions on this notice, contact Commander Brian J. Peter, Executive Director of MERPAC, or Mr. Mark C. Gould, Assistant to the Executive Director, telephone 202–267–0229, fax 202–267–4570, or e-mail *mgould@comdt.uscg.mil.*

SUPPLEMENTARY INFORMATION: Notice of these meetings is given under the Federal Advisory Committee Act, 5 U.S.C. App. 2.

Agenda of Meeting on September 18, 2003

The full committee will meet to discuss the objectives for the meeting. The committee will then break up into the following working groups: Task statement 36, concerning the recommendations on a training program for officers in charge of an engineering watch coming up through the hawsepipe; and Task statement 37, concerning credit for sea service on vessels with no, or limited, underway time.

New working groups may be formed to address the following issues: Recommendations concerning training requirements and certification requirements needed to obtain STCW certification as Ship's Security Officer (and Company/Port Facility Security Officer); Competency needed to obtain STCW certification as an able-bodied seaman; Security issues with the new merchant mariner's document; and Practical competency demonstrations needed to obtain STCW certification as Master and Chief Mate on ships of between 500 and 3000 Gross Tonnage, as measured under the International Tonnage Convention on both international and near coastal voyages. At the end of the day, the working groups will make a report to the full committee on what has been accomplished in their meetings. No action will be taken on these reports on this date.

Agenda of Meeting on September 19, 2003

The agenda comprises the following:

(1) Introduction.

(2) Working Groups' Reports—

(a) Task Statement 36, concerning the recommendations on a training program for officers in charge of an engineering watch coming up through the hawsepipe;

(b) Task Statement 37, concerning credit for sea service on vessels with no, or limited, underway time; and

(c) Other task statements which may have been adopted for discussion and action.

(3) Other items to be discussed—

(a) Standing Committee—Prevention Through People, and

(b) Other items brought up for discussion by the committee or the public.

Procedural

Both meetings are open to the public. Please note that the meetings may adjourn early if all business is finished. At the Chair's discretion, members of the public may make oral presentations during the meetings. If you would like to make an oral presentation at a meeting, please notify the Executive Director no later than September 4, 2003. Written material for distribution at a meeting should reach the Coast Guard no later than September 4, 2003. If you would like a copy of your material distributed to each member of the committee or subcommittee in advance of the meeting, please submit 25 copies to the Executive Director no later than September 4, 2003.

Information on Services for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the meetings, contact the Assistant Executive Director as soon as possible.

Dated: August 5, 2003.

Joseph J. Angelo,

Director of Standards, Marine Safety, Security and Environmental Protection.

[FR Doc. 03–20468 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG 2001–9269]

Guidance for Assessing Merchant Mariners Through Demonstrations of Proficiency as Officers in Charge of Engineering Watches in Manned Engine-Rooms or as Designated Duty Engineers in Periodically Unmanned Engine-Rooms

AGENCY: Coast Guard, DHS.

ACTION: Notice of availability and request for public comments.

SUMMARY: The Coast Guard announces the availability of the national performance measures proposed here for use as guidelines when mariners demonstrate their proficiency as officers in charge of engineering watches in manned engine-rooms or as designated duty engineers in periodically unmanned engine-rooms. Because of the comments submitted to the original docket published on April 5, 2001, the Coast Guard is re-publishing these

measures. They were developed from recommendations and input provided by the Merchant Marine Personnel Advisory Committee (MERPAC). We again request your comments on them.

DATES: Comments and related material must reach the Docket Management Facility on or before October 14, 2003.

ADDRESSES: You may submit comments identified by Coast Guard docket number USCG–2001–9269 to the Docket Management Facility at the U.S. Department of Transportation. To avoid duplication, please use only one of the following methods:

(1) Web Site: *http://dms.dot.gov.*

(2) Mail: Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590–0001.

(3) Fax: 202–493–2251.

(4) Delivery: Room PL–401 on the Plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

(5) Federal eRulemaking Portal: *http://www.regulations.gov.*

The Docket Management Facility maintains the public docket for this notice. Comments and material received from the public will become part of this docket and will be available for inspection or copying at room PL–401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find this docket on the Internet at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, write or call Mr. Gould where indicated under **ADDRESSES.** If you have questions on viewing or submitting materials to the docket, call Ms. Dorothy Beard, Chief, Dockets, Department of Transportation, telephone 202–366–5149.

SUPPLEMENTARY INFORMATION:

Public Participation and Request for Comments

We encourage you to submit comments. All comments received will be posted, without change, to *http://dms.dot.gov* and will include any personal information you have provided. We have an agreement with the Department of Transportation (DOT) to use the Docket Management Facility. Please see DOT's ''Privacy Act'' paragraph below.

Submitting comments: If you submit a comment, please include your name and address, identify the docket number for this rulemaking (USCG–2001–9269), indicate the specific section of this document to which each comment applies, and give the reason for each comment. You may submit your comments and material by electronic means, mail, fax, or delivery to the Docket Management Facility at the address under **ADDRESSES**; but please submit your comments and material by only one means. If you submit them by mail or delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit them by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments received during the comment period. We may change these national performance measures in view of them.

Viewing comments and documents: To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://dms.dot.gov* at any time and conduct a simple search using the docket number. You may also visit the Docket Management Facility in room PL–401 on the Plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Privacy Act: Anyone can search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review the Department of Transportation's Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477), or you may visit *http://dms.dot.gov.*

What Action Is the Coast Guard Taking?

Section A–III/1 of the Code accompanying the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (STCW), 1978, as amended in 1995, articulates qualifications for ensuring merchant mariners' attaining the minimum standard of competence through demonstrations of their proficiency as officers in charge of engineering watches in manned engine-rooms or as designated duty engineers in periodically unmanned engine-rooms. The Coast Guard tasked MERPAC with referring to the Section, modifying and specifying it as it deemed necessary, and recommending national performance measures. The Coast Guard reviewed the measures recommended by MERPAC and developed a set of guidelines for assessing proficiency. Those guidelines were published in the original docket on April 5, 2001. A number of comments were made on that proposal and we have now modified those guidelines to incorporate many of the comments. We are now proposing these modified guidelines here for use as the final guidelines for assessing proficiency.

The guidelines are set up as follows: First, we set forth the Competency within the STCW a mariner should demonstrate to meet the STCW section. Next we give a series of examples of Performance Conditions, a set of Performance Behaviors for each Performance Condition, and a set of Performance Standards for each Performance Behavior.

For example, if the Competency to demonstrate is: ''Use appropriate tools for fabrication and repair * * * typically performed on ships''—

A Performance Condition for that competency demonstrating knowledge, understanding, and proficiency is: In a workshop [or] laboratory or other safe working environment, given proper tools, lighting, [and] ventilation, and a thin steel plate of no less than ¼ inch thickness, * * *

A Performance Behavior for that Condition is: * * * the candidate will plan, prepare, and safely cut out a circular blank flange with four 7/16″ bolt-holes 90 degrees apart and corresponding to the dimensions of a two-inch pipe flange, or similar multi-tasked project using oxyacetylene process, and describe actions as they are being performed.

A Performance Standard for that Behavior is—or, in this example, the Standards are—''The applicant (1) correctly plans for and lays out the job, in proper sequence, and incorporates all safety considerations; (2) sets up all required equipment; (3) cuts the hole uniformly according to plan within tolerance of +/− ⅛ inch; and (4) ensures that no safety violations occur.''

If the mariner properly meets all of the Performance Standards, he or she passes the practical demonstration. If he or she fails to carry out any of the Standards, he or she fails it.

Why Is the Coast Guard Taking This Action?

The Coast Guard is taking this action to comply with STCW, as amended in 1995 and 1997 and incorporated into domestic regulations at 46 CFR parts 10, 12, and 15 in 1997 and since. Guidance from the International Maritime Organization on shipboard assessments of proficiency suggests that Parties develop standards and measures of

performance for practical tests as part of their programs for training and assessing seafarers.

How May I Participate In This Action?

We are requesting your comments on these proposed national performance measures. You may participate in this action by submitting comments and related material on the national performance-measures proposed here. (Although the Coast Guard does not seek public comment on the measures recommended by MERPAC, as distinct from the measures proposed here, those measures are available on the Internet at the home page of MERPAC, *http://www.uscg.mil/hq/g-m/advisory/merpac/merpac.htm*.) These measures are available on the Internet at *http://dms.dot.gov*, under this docket number [USCG 2001–9269]. They are also available from Mr. Gould where indicated under **ADDRESSES**. If you submit written comments please include—

- Your name and address;
- The docket number for this notice [USCG 2001–9269];
- The specific section of the measures to which each comment applies; and
- The reason for each comment.

You may mail, deliver, fax, or electronically submit your comments and related material to the Docket Management Facility, using an address or fax number listed in **ADDRESSES**. (But please do not submit the same comment or material more than once.) If you mail or deliver your comments and material, they must be on 8½-by-11-inch paper, and the quality of the copy should be clear enough for copying and scanning. If you mail your comments and material and would like to know whether the Facility received them, please enclose a stamped, self-addressed postcard or envelope. The Coast Guard will consider all comments and material received during the 60-day comment period.

Your comments will be considered in preparing the final version of the national performance measures which will be used as guidelines by the general public. Individuals and institutions assessing the competence of mariners may refine the final version of these measures and develop innovative alternatives. If you vary from the final version of these measures, however, you should submit your alternative to the National Maritime Center for approval by the Coast Guard under 46 CFR 10.303(e) before you use it as part of an approved course or training program.

Dated: July 25, 2003.

Joseph J. Angelo,

Director of Standards, Marine Safety, Security & Environmental Protection.

[FR Doc. 03–20466 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–15–U

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4665–N–11]

Upcoming Meeting of the Manufactured Housing Consensus Committee

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice of upcoming meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of an upcoming meeting of the Manufactured Housing Consensus Committee (the Committee). The meeting is open to the public and the site is accessible to individuals with disabilities.

DATES: The meetings will be held on Wednesday, August 20, 2003, from 8 a.m. to 5 p.m., Thursday, August 21, 2003, from 8 a.m. to 5 p.m., and Friday, August 22, 2003, 8 a.m. to 2 p.m.

ADDRESSES: These meetings will be held at the Radisson Hotel ''Old Town'', 901 North Fairfax Street, Alexandria, Virginia, telephone (703) 683–6000.

FOR FURTHER INFORMATION CONTACT: William W. Matchneer III, Administrator, Office of Manufactured Housing Programs, Office of Deputy Assistant Secretary for Regulatory Affairs and Manufactured Housing, Department of Housing and Urban Development, 451 7th Street SW., Washington, DC 20410, telephone (202) 708–6409 (this is not a toll-free number). Persons who have difficulty hearing or speaking may access this number via TTY by calling the toll-free Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: Notice of this meeting is provided in accordance with section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.2) and 41 CFR 102–3.150. The Manufactured Housing Consensus Committee was established under section 604(a)(3) of the National Manufactured Housing Construction and Safety Standards Act of 1974, 42 U.S.C. 4503(a)(3). The Consensus Committee is charged with providing recommendations to the Secretary to adopt, revise, and interpret manufactured housing construction and safety standards and procedural and enforcement regulations, and with developing proposed model installation standards.

Tentative Agenda:

A. Welcome and Opening Remarks
B. Presentation on Manufactured Housing Resarch
C. Proposed Installation Standards
D. Discussion of HUD's published response to two committee proposals
E. Reports to Full Committee
—Dispute Resolution
—Standards Up-date
—On-site Completion
F. Public Testimony
G. Full Committee meeting
H. Adjournment

Dated: August 1, 2003.

John C. Weicher,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 03–20486 Filed 8–11–03; 8:45 am]

BILLING CODE 4210–27–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NV–025–1232–EA; Special Recreation Permit #NV–025–03–07]

Notice of Temporary Closures of Public Lands; Pershing, Washoe, and Humboldt Counties, NV

AGENCY: Bureau of Land Management, Winnemucca Field Office, Nevada.

ACTION: Notice to the public of a closure on public lands administered by the Bureau of Land Management, Winnemucca Field Office, Nevada.

SUMMARY: Notice is hereby given that certain lands in and around the Civilian Space Exploration Team (CSXT) rocket launch site, located in Pershing, Washoe and Humboldt counties, Nevada, would be temporarily closed for public use from 0900 to 1200 hours, September 15th through the 18th 2003 and October 14th through the 17th 2003. These in the interest of public safety at and around the location of a high-altitude rocket launch site. These events are expected to involve approximately 50 participants. Affected lands are located in the Black Rock Desert—High Rock Canyon Emigrant Trails National Conservation Area, situated northeast of Gerlach, Nevada, in the Mount Diablo Meridian.

The following Public Lands are Closed to public use: Public land areas north of the Union Pacific Railroad tracks and east of State Road 34 and County Road 200, and west of the Pahute Peak and Black Rock Desert Wilderness boundaries, as described below:

T33 ½ N, R24E Sections 25–28, 32–36, T33N R24E Sections 1–5, 8–22, 23, 27–30; T33N, R25E Sections 2, 3, 4, 9; T34N, R24E Sections 1–3, 10–15, 21–27, 34–36; T34N, R25E Sections 1–4, 9–16, 21–28, 33–36; T34N, R26E Sections 1–24, 28–33; T34N, R27E Sections 1–18; T35.5N, R25E Sections 27–34; T35.5N, R26E Sections 25–36; T35N, R24E Sections 6, 13, 22–27, 34–36; T35N, R25E Sections 1–4, 9–16, 21–28, 33–36; All of T35N, R26E; All of T35N R27E; T36N R23.5E Section 1; T36N, R24E Sections 5, 6, 8, 17, 30; T36N, R25E Sections 1–5, 8–18, 21–36; All of T36N, R26E; T36N, R27E Sections 4–9, 16–21, 28–33; T37N, R23 ½ E Section 36; T37N, R24E Sections 11, 14, 23, 23, 30; T37N, R25E Sections 7, 22–27, 34–36; T37N, R26E Sections 19–36; T37N, R27E Sections 19–21, 28–33; T38N, R23E Section 22.

To ensure public safety, these lands would be closed to public use from 0900–1200 hours during the CSXT permit period, under the authority of 43 CFR 8364.1, BLM personnel, law enforcement, emergency medical services, and CSXT staff as designated by the BLM authorized officer would be exempted from the closure. Spectators or other area users who are inconvenienced by the closure could be escorted to the launch site. A map showing these temporary closures, restrictions and prohibitions is available from the following BLM office: BLM-Winnemucca Field Office, 5100 East Winnemucca Blvd., Winnemucca, Nevada 89445–2921.

The map may also be viewed on the Winnemucca Field Office Web site at: *http://www.nv.blm.gov/winnemucca.*

DATES: Closure to public use could occur from 0900–1200 hours, September 15th through the 18th 2003, and October 14th through the 17th 2003.

FOR FURTHER INFORMATION CONTACT: Dave Lefevre, Outdoor Recreation Planner, Bureau of Land Management, Winnemucca Field Office, 5100 E. Winnemucca Blvd., Winnemucca, NV 89445, telephone (775) 623–1500.

Authority: 43 CFR 8364.1.

Penalty: Any person failing to comply with the closure orders may be subject to imprisonment for not more than 12 months, or a fine in accordance with the applicable provisions of 18 U.S.C. 3571, or both.

Terry A. Reed,

Field Manager.

[FR Doc. 03–20463 Filed 8–11–03; 8:45 am]

BILLING CODE 4310–HC–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA–340–03–5101-ER-B171; CACA–44000]

Notice of Intent To Prepare a Plan Amendment and Environmental Impact Statement for Wind Energy; Ukiah Field Office, California

AGENCY: Bureau of Land Management.

ACTION: Notice of intent to prepare a plan amendment and Environmental Impact Statement (EIS) for Wind Energy; Ukiah Field Office, California.

SUMMARY: Pursuant to Section 102 (2)(C) of the National Environmental Policy Act of 1969, the Bureau of Land Management (BLM), Ukiah Field Office, will be directing the preparation of a plan amendment and EIS and conducting public scoping meetings in response to a right-of-way application filed by GE Wind Energy, LLC. GE Wind Energy proposes an array of wind turbines and ancillary facilities including buried power lines, access roads, an electric substation and transmission line interconnect in the Walker Ridge Area of Lake and Colusa Counties, California. BLM will assess the potential impacts of a proposed right-of-way for an array of approximately eighty (80) 1.5-megawatt wind turbines. The project area contains the public land bordered by Bear Valley to the east, State Highway 20 to the south, and Indian Valley Reservoir to the west.

The proposal is located in the Indian Valley Management Area the Clear Lake Management Framework Plan Update, 1984 for the Ukiah Field Office. This management plan does not address long-term management objectives for Walker Ridge and is silent on wind power development projects; thus, a plan amendment is required in accordance with 43 CFR 1610.5–5. Although BLM has tentatively scheduled to begin a Resource Management Plan (RMP) Revision in the fall of 2003, BLM has elected to accelerate this wind energy plan amendment in response to the need for alternative energy sources in California and in support of the President's energy policy. A final decision on the plan amendment is expected in 2004.

DATES: The public is invited to submit comments on the scope of the plan amendment and issues to be addressed in the EIS. Three (3) public scoping meetings will be held. The exact dates, times and locations for these meetings will be announced by BLM, published in local newspapers within 15 days in advance of the event, and posted on BLM's Web site at: *http://www.ca.blm.gov.* The three scoping meetings will be open houses; they will provide opportunities for the applicant and BLM to explain details of the project and gather information from interested individuals or groups. The ''open houses'' will start at 6 p.m. and end at 9 p.m. Starting at 7 p.m. the EIS process will be explained and an opportunity will be given for written comments and general concerns. Meetings are anticipated at the following locations: Sacramento, Colusa, and Clear Lake, California.

The comment period for scoping will commence with the publication of this notice. Those having concerns, issues, or alternatives they would like to see addressed in the EIS must respond with written comments within 45 days of the date of this notice. Comments concerning the Proposed Action and Alternatives, plan amendment, and EIS should address issues to be considered, planning criteria, feasible alternatives to examine, possible mitigation measures, and information relevant to or having a bearing on the Proposed Action. In addition, any persons wishing to be added to a mailing list of interested parties can call or write to BLM as described in this notice. Additional informational meetings may be conducted throughout the process to keep interested parties informed of progress of the EIS.

ADDRESSES: Information and a copy of the Notice of Intent can be obtained by contacting or visiting the following offices:

Bureau of Land Management, Ukiah Field Office, 2550 North State Street, Ukiah, CA 95482, Telephone: (707) 468–4000; or

Public Room, Bureau of Land Management, California State Office, 2800 Cottage Way, Sacramento, CA 95825, Telephone: (916) 978–4400; or

Tom Hurshman, Bureau of Land Management, 2505 South Townsend, Montrose, CO 81401, Telephone: (970) 240–5345.

A copy of the scoping notice and other relevant information concerning the status of the project may also be found on-line at: *http://www.ca.blm.gov.*

FOR FURTHER INFORMATION CONTACT: Tom Hurshman, BLM Project Manager, (970) 240–5345 or e-mail at *tom_hurshman@co.blm.gov.*

SUPPLEMENTARY INFORMATION: The Walker Ridge area is located in north central California, west of the Sacramento Valley and near the southern tip of the Coast Range. Walker Ridge is located north of Highway 20 between Bear Valley and Little Indian

Valley at an elevation of approximately 3,000 feet. The proposed project area is accessible by the Walker Ridge Road, a BLM maintained road that runs north from its junction with State Highway 20. The proposed wind power development area application encompasses approximately 8,200 acres of public lands. On June 2, 2003, GE Wind Energy received a site testing and monitoring right-of-way grant from BLM to study the wind power potential of the project area for a period of three years. Five meteorological towers with anemometers to measure wind characteristics are currently installed on Walker Ridge. No private lands would be utilized for the project. The legal description of the land proposed for the wind power development project is available from the contact information in this notice.

Tentatively identified issues of concern may include: threatened, endangered, and sensitive species; visual resources; loss of wildlife habitat; land use conflicts; and avian mortality. An interdisciplinary approach will be used to develop the plan amendment in order to consider a variety of resource issues and concerns identified. Disciplines involved will include specialists with expertise in archaeology, wildlife, outdoor recreation, visual resources, biology, soils, and realty. BLM has preliminarily identified the following, possible planning criteria:

- Comply with applicable laws, Executive Orders, and regulations,
- Consider all alternatives in the context of their consistency with the President's National Energy Policy, BLM's Interim Wind Energy Development Policy, and State of California Renewable Energy Portfolio Standards.

The Plan Amendment and EIS will analyze the Proposed Action and the No Action Alternative. Other alternatives may include modifying proposed tower/turbine locations, road and power cable and line locations, rerouting linear electric power line right-of-way locations, as well as applying mitigating measures to reduce or eliminate impacts.

Dated: July 14, 2003.

Richard Burns,

Field Manager.

[FR Doc. 03–20464 Filed 8–11–03; 8:45 am]

BILLING CODE 4310–40–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NV–930–4210–05; N–63336]

Notice of Realty Action: Lease/Conveyance for Recreation and Public Purposes

AGENCY: Bureau of Land Management, Interior.

ACTION: Recreation and public purpose lease/conveyance.

SUMMARY: The following described public land in Las Vegas, Clark County, Nevada has been examined and found suitable for lease/conveyance for recreational or public purposes under the provisions of the Recreation and Public Purposes Act, as amended (43 U.S.C. 869 *et seq.*) (R&PP). The City of Las Vegas proposes to use the land for a public park.

SUPPLEMENTARY INFORMATION:

Mount Diablo Meridian, Nevada

T. 20S., R. 60E.,
Section 27,
SW¼NW¼NW¼SW¼, SW¼NW¼SW¼,
S½SE¼NW¼SW¼,
S½S½NE¼SW¼, SW¼NE¼SE¼,
S½NW¼SE¼,
S½NW¼NE¼SW¼SE¼,
SW¼NE¼SW¼SE¼,
S½N½NW¼SW¼SE¼,
W½SE¼SW¼SE¼, E½SE¼SE¼,
Section 28,
N½SW¼, W½NE¼SW¼SW¼,
NW¼SE¼SW¼, E½NE¼SE¼,
W½NW¼NE¼SE¼,
SE¼NW¼NE¼SE¼, SW¼NE¼SE¼
NW¼SE¼, E½NW¼SW¼SE¼.
Containing 266.5 acres, more or less.

The land is not required for any federal purpose. The lease/conveyance is consistent with current Bureau planning for this area and would be in the public interest. This lease/conveyance is subject to all valid and existing rights. The lease/patent, when issued, will be subject to the provisions of the Recreation and Public Purposes Act and applicable regulations of the Secretary of the Interior, and will contain the following reservations to the United States:

1. A right-of-way thereon for ditches or canals constructed by the authority of the United States, Act of August 30, 1890 (43 U.S.C. 945).

2. All minerals shall be reserved to the United States, together with the right to prospect for, mine and remove such deposits from the same under applicable law and such regulations as the Secretary of the Interior may prescribe and will be subject to:

Those rights for public utility purposes which have been granted to Nevada Power Company by Permit Nos. N–51943, N–61618, N–55965, N–59930 and N–43546, Central Telephone Company by Permit Nos. N–33429, N–42514 and N–31028, the Las Vegas Valley Water District by Permit Nos. N–16999, N–48185, N–53358 and N–51605, the City of Las Vegas by Permit Nos. N–37142, N–38851, N–41255, N–46267, N–58670 and N–73906, under the Act of October 26, 1978 (FLPMA).

Detailed information concerning this action is available for review at the office of the Bureau of Land Management, Las Vegas Field Office, 4701 N. Torrey Pines Drive, Las Vegas, Nevada. Upon publication of this notice in the **Federal Register**, the above described land will be segregated from all other forms of appropriation under the public land laws, including the general mining laws, except for lease/conveyance under the Recreation and Public Purposes Act, leasing under the mineral leasing laws and disposals under the mineral material disposal laws.

For a period of 45 days from the date of publication of this notice in the **Federal Register**, interested parties may submit comments regarding the proposed lease/conveyance for classification of the lands to the Field Manager, Las Vegas Field Office, Las Vegas, Nevada 89130.

Classification Comments: Interested parties may submit comments involving the suitability of the land for a public park. Comments on the classification are restricted to whether the land is physically suited for the proposal, whether the use will maximize the future use or uses of the land, whether the use is consistent with local planning and zoning, or if the use is consistent with State and Federal programs.

Application Comments: Interested parties may submit comments regarding the specific use proposed in the application and plan of development, whether the BLM followed proper administrative procedures in reaching the decision, or any other factor not directly related to the suitability of the land for a public park.

Any adverse comments will be reviewed by the State Director.

In the absence of any adverse comments, the classification of the land described in this Notice will become effective 60 days from the date of publication in the **Federal Register**. The lands will not be offered for lease/conveyance until after the classification becomes effective.

Dated: July 15, 2003.

Sharon DiPinto,

Acting Assistant Field Manager, Division of Lands, Las Vegas, NV.

[FR Doc. 03–20462 Filed 8–11–03; 8:45 am]

BILLING CODE 4510–HC–P

UNITED STATES INTERNATIONAL TRADE COMMISSION

[Inv. No. 337–TA–479]

In the Matter of: Certain Coamoxiclav Products, Potassium Clavulanate Products, and Other Products Derived From Clavulanic Acid; Notice of Commission Decision Not to Review an Initial Determination Terminating the Investigation on the Basis of a Settlement Agreement

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade Commission has determined not to review the presiding administrative law judge's (''ALJ'') initial determination (''ID'') terminating the above-referenced investigation in its entirety based on a settlement agreement.

FOR FURTHER INFORMATION CONTACT: Jean Jackson, Esq., Office of the General Counsel, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 205–3104. Copies of the ALJ's ID and all other nonconfidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 205–2000. Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TTD terminal on (202) 205–1810. The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.* General information concerning the Commission may also be obtained by accessing its internet server *(http://www.usitc.gov).*

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation on September 5, 2002, based on a complaint filed by GlaxoSmithKline, PLC of the United Kingdom and SmithKlineBeecham d/b/a GlaxoSmithKline of Philadelphia, Pennsylvania (collectively, GSK) alleging a violation of section 337 of the Tariff Act of 1930 in the importation, sale for importation, and sale after importation of certain coamoxiclav products, potassium clavulanate products, and other products derived from clavulanic acid products and potassium clavulanate by reason of misappropriation of trade secrets and unfair competition. 67 FR 57850. The complainant named Biochemie GmbH, of Austria, Biochemie SpA, of Italy, Novartis AG of Switzerland, and Geneva Pharmaceuticals of New Jersey as respondents.

On July 11, 2003, the ALJ issued an ID granting a joint motion by GSK and all respondents to the investigation to terminate the investigation on the basis of a settlement agreement. The motion was supported by the Commission investigative attorney. No petitions for review of the ID were filed.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 190, as amended, 19 U.S.C. 1337, and in section 210.42(h) of the Commission's Rules of Practice and Procedure, 19 CFR 210.42(h).

Issued: August 5, 2003.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 03–20492 Filed 8–11–03; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Antitrust Division

United States and New Jersey, Plaintiffs; v. Waste Management, Inc., and Allied Waste Industries, Inc., Defendants; Proposed Final Judgment and Competitive Impact Statement

Notice is hereby given pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h), that a proposed Final Judgment, Hold Separate Stipulation and Order, and Competitive Impact Statement have been filed with the United States District Court for the District of Columbia in *United States of America et al.* v. *Waste Management, Inc., et al.,* Civil No. 1:03CV01409(GK).

On June 27, 2003, the United States and the State of New Jersey filed a Complaint alleging that Waste Management's acquisition of certain voting securities and waste-hauling and disposal assets of Allied would lessen competition substantially in the provision of small container commercial waste collection services in the areas of Pitkin County, Colorado; Garfield County, Colorado; Augusta, Georgia; Myrtle Beach, South Carolina; Morris County, New Jersey; and Bergen and Passaic Counties, New Jersey, and in the provision of municipal solid waste disposal services in the Bergen and Passaic Counties, New Jersey and Tulsa and Muskogee, Oklahoma disposal areas, in violation of Section 7 of the Clayton Act, 15 U.S.C. 18. The proposed Final Judgment, filed at the same time as the Complaint, requires, among other things, that defendant Waste Management (1) divest small commercial waste collection assets in the areas of Pitkin County, Colorado; Garfield County, Colorado; Augusta Georgia; Myrtle Beach, South Carolina; Morris County, New Jersey; and Bergen and Passaic Counties, New Jersey; (2) alter the contracts it uses with its existing and new small container commercial waste customers in the areas of Augusta, Georgia and Myrtle Beach, South Carolina; (3) divest transfer station facilities serving Bergen and Passaic Counties, New Jersey; and (4) sell throughput disposal rights at a facility serving Bergen and Passaic Counties, New Jersey. Copies of the Complaint, the proposed Final Judgment, and the Competitive Impact Statement are available for inspection at the U.S. Department of Justice, Antitrust Division, Suite 215 North, 325 7th Street, NW., Washington, DC 20004 (telephone: (202) 514–2692), and at the Clerk's Office of the U.S. Court for the District of Columbia, 333 Constitution Avenue, NW., Washington, DC 20001.

Public comment is invited within 60 days of the date of this notice. Such comments and responses thereto will be published in the **Federal Register** and filed with the Court. Comments should be directed to J. Robert Kramer II, Chief, Litigation II Section, Antitrust Division, U.S. Department of Justice, 1401 H Street, NW., Suite 3000, Washington, DC 20530 (telephone: (202) 307–0924).

Dorothy B. Fountain,

Deputy Director of Operations.

United States District Court for the District of Columbia

[Case No: 03 1409]

Hold Separate Stipulation and Order

It is hereby stipulated and agreed by and between the undersigned parties, subject to approval and entry by the Court, that:

I. Definitions

As used in this Hold Separate Stipulation and Order:

A. *''Acquirer''* means the entity or entities to whom Waste Management divests the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset.

B. *''Allied''* means Defendant Allied Waste Industries, Inc., a Delaware corporation with its headquarters in Scottsdale, Arizona, and its successors and assigns, its subsidiaries, divisions, groups, affiliates, partnerships, joint ventures, and their directors, officers, managers, agents, and employees.

C. *''Alternative Disposal Asset''* means, unless otherwise noted, with respect to each transfer station listed and described herein, all of Defendants' rights, titles, and interests in any tangible asset, related to the operation of each transfer station listed, including all fee simple or ownership rights to offices, garages, related facilities, capital equipment, trucks and other vehicles, scales, power supply equipment, and supplies; and all Defendants' rights, titles, and interests ion any related intangible assets, including all leasehold interests and renewal rights thereto, permits, customer lists, contracts, and accounts, or options to purchase any adjoining property.

Alternative Disposal Asset, as used herein, means one of the following three properties, as selected by Defendant Waste Management in accordance with the terms provided in Sections IV.I., V.B., and V.C. of the final Judgment:

1. Park Ridge, New Jersey

Waste Management's Park Ridge Transfer Station, located at 94 Perry Street, Park Ridge, New Jersey 07656; or

2. Fairview, New Jersey

Allied's Fairview Transfer Station (formerly permitted to BFI Transfer Systems of New Jersey, Inc.), located at 61 Broad Avenue, Fairview, New Jersey 07022; or

3. Hillsdale, New Jersey

Waste Management's Hillsdale Transfer Station, located at 131 Patterson Street, Hillsdale, New Jersey 07642.

D. ''Disposal'' means the business of disposing of waste into approved disposal sites (*i.e.,* landfills, incinerators, and transfer stations).

E. ''Hauling'' means the collection of waste from customers and the shipment of the collected waste to disposal sites. Hauling, as used herein, does not include collection of roll-off containers.

F. ''Fully Permitted'' means a renewal of the operating permit, currently held by Waste Management's Chestnut Ridge Solid Waste Transfer Station of Chestnut Ridge, New York and scheduled to expire on November 30, 2003, by the New York State Department of Environmental Conservation (''NYDEC'') for an additional five (5) years under terms and conditions comparable to those in the currently held permit; and further means that all additional zoning, environmental, and other permits required to operate the facility are valid and lawful. The renewed permit must be granted by NYDEC prior to expiration of the time period set forth in Section IV.A. of the Final Judgment, which time period shall include the sixty (60) day extension.

G. ''Landfill'' means a facility where waste is placed into the land.

H. ''MSW'' means municipal solid waste, a term of art used to describe solid putrescible waste generated by households and commercial establishments such as retail stores, offices, restaurants, warehouses, and non-manufacturing activities in industrial facilities. MSW does not include special handling waste (*e.g.,* waste from manufacturing processes, regulated medical waste, sewage, and sludge), hazardous waste, or waste generated by construction or demolition sites.

I. ''New Jersey Assets'' means the Relevant Disposal Assets and the Relevant Hauling Assets located in New Jersey.

J. ''Relevant Disposal Assets'' means, unless otherwise noted, with respect to each transfer station listed and described herein, all of Defendants' rights, titles, and interests in any tangible asset related to each transfer station listed, including all fee simple or ownership rights to offices, garages, related facilities, capital equipment, trucks and other vehicles, scales, power supply equipment, and supplies, and all Defendants' rights, titles, and interests in any related intangible assets, including all leasehold interests and renewal rights thereto, permits, customer lists, contracts, and accounts, or options to purchase any adjoining property.

Relevant Disposal Assets, as used herein, includes the following transfer stations, or throughput or tolling disposal rights:

1. Garfield, New Jersey

Allied's Garofalo Recycling and Transfer Station (formerly permitted to Garofalo Brothers, Inc., and Garofalo Recyling and Transfer Station Co., Inc.), located at 19–35 Atlantic Street, Garfield, New Jersey 07026.

2. Chestnut Ridge, New York

Waste Management's Fully Permitted Chestnut Ridge Solid Waste Transfer Station (owned by and permitted to Waste Management's subsidiary Marangi Bros., Inc.), located at 560 Chestnut Ridge Road, Chestnut Ridge, New York 10977.

3. North Arlington, New Jersey

Throughout or tolling disposal rights of a maximum of 1,925 tons per week, for the remainder of Waste Management's current lease and if the lease is renewed, for the duration of the period in which Waste Management has contractual rights to operate the facility, not to exceed the termination date of the Final Judgment. These disposal rights are exercisable by the Acquirer (or its designee), at the New Jersey Meadowlands Commission's HMDC Solid Waste Baler Facility (''HMDC Facility''), located at 100 Baler Boulevard, North Arlington, New Jersey 07031, under the following terms and conditions:

a. At the Acquirer's option, Waste Management shall set aside and operate or, allow the Acquirer (or its designee) to operate one (1) disposal bay and a scale and scale house for the sole use of the Acquirer (or its designee);

b. Waste Management shall permit the Acquirer (or its designee) to deliver waste to the HMDC Facility during operating hours from Monday through Saturday up to the weekly maximum of 1,925 tons. Waste Management shall have the right to stop accepting waste from any additional truck owned or operated by the Acquirer (or its designee) and entering the premises after Waste Management has accepted 350 tons of waste from the Acquirer (or its designee) on any day the HMDC Facility is operating;

c. Under the throughput or tolling arrangement, Waste Management shall permit the Acquirer (or its designee) to deliver waste to the HMDC Facility for processing and, at the option of the Acquirer (or its designee), load the processed waste into vehicles designated by the Acquirer (or its designee) for ultimate disposal; and

d. Waste Management shall operate all HMDC Facility gates, scales, scale houses, and disposal areas described in the Acquirer's contract under terms and conditions no less favorable to the Acquirer (or its designee) than those provided to Waste Management or its customers, including any municipality.

K. ''Relevant Hauling Assets'' means with respect to each commercial waste collection route or other hauling asset described herein, all tangible assets, including capital equipment, trucks and other vehicles, containers, interests, supplies, and if requested by the purchaser, real property and improvements to real property (*i.e.,* buildings and garages). It also includes all intangible assets, including hauling-

related customer lists, contracts, leasehold interests, permits and accounts.

Relevant Hauling Assets, as used herein, includes the assets in the following locations:

1. Augusta, Georgia

Allied's commercial waste collection routes 903, 904, 916, and 922 that operate out of Allied's Augusta division located at 683 Commerce Court, Evans, Georgia 30809.

2. Myrtle Beach, South Carolina

Allied's commercial waste collection routes 711, 714, and 715 that operate out of Allied's Rural Sanitation Services Hauling facility located at 3512 Highway 501, Myrtle Beach, South Carolina 29579.

3. Pitkin and Garfield Counties, Colorado

Waste Management's waste collection routes 730, 824, 825, 831, 850, and 853 that operate out of Waste Management's facilities located at 226 North 12th Street, Carbondale, Colorado 81623.

4. Bergen and Passaic Counties, New Jersey

Allied's commercial waste collection routes 700, 705, 706, 401, and 405 that operate out of Allied's VMI Waste Services Hauling facility located at 75 Broad Avenue, Fairview, New Jersey 07022, except that Waste Management is not required to divest real property or improvements to real property (i.e., buildings, garages, or leasehold rights related thereto).

5. Morris County, New Jersey

Allied's commercial waste collection route 702 that operates out of Allied's VMI Waste Services Hauling facility located at 75 Broad Avenue, Fairview, New Jersey 07022, except that Waste Management is not required to divest real property or improvements to real property (*i.e.,* buildings, garages, or leasehold rights related thereto).

L. ''Small container commercial waste collection service'' means the business of collecting MSW from commercial and industrial accounts, usually in ''dumpsters'' (*i.e.,* a small container with one (1) to ten (10) cubic yards of storage capacity), and transporting or ''hauling'' such waste to a disposal site by use of a front- or rear-end loader truck. Typical commercial waste collection customers include office and apartment buildings and retail establishments (*i.e.,* stores and restaurants).

M. ''Waste Management'' means Defendant Waste Management, Inc., a Delaware corporation with its headquarters in Houston, Texas, and includes its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships, joint ventures, and their directors, officers, managers, agents, and employees.

II. Objectives

The Final Judgment filed in this case is meant to ensure Defendants' prompt divestiture of the Relevant Disposal Assets and Relevant Hauling Assets for the purpose of establishing viable competitors in the municipal solid waste (''MSW'') disposal business and the small container commercial waste collection business, to remedy the effects that the United States alleges would otherwise result from the acquisition of Allied's assets by Waste Management. This Hold Separate Stipulation and Order ensures, prior to such divestitures, that the Relevant Disposal Assets and Relevant Hauling Assets remain independent, economically viable, and ongoing business concerns that will remain independent and uninfluenced by Waste Management or Allied, and that competition is maintained during the pendency of the ordered divestitures.

III. Jurisdiction and Venue

The Court has jurisdiction over the subject matter of this action and over each of the parties hereto, and venue of this action is proper in the United States District Court for the District of Columbia.

IV. Compliance With and Entry of Final Judgment

A. The parties stipulate that a Final Judgment in the form attached hereto as Exhibit A may be filed with and entered by the Court, upon the motion of any party or upon the Court's own motion, at any time after compliance with the requirements of the Antitrust Procedures and Penalties Act (15 U.S.C. 16), and without further notice to any party or other proceedings, provided that the United States has now withdrawn its consent, which it may do at any time before the entry of the proposed Final Judgment by serving notice thereof on Defendants and by filing that notice with the Court.

B. Defendants shall abide by and comply with the provisions of the proposed Final Judgment, pending the Judgment's entry by the Court, or until expiration of time for all appeals of any Court ruling declining entry of the proposed Final Judgment, and shall, from the date of the signing of this Stipulation by the parties, comply with all the terms and provisions of the proposed Final Judgment as though the same were in full force and effect as an order of the Court.

C. Defendants shall not consummate the transactions sought to be enjoined by the Complaint herein before the Court has signed this Hold Separate Stipulation and Order.

D. This Stipulation shall apply with equal force and effect to any amended proposed Final Judgment agreed upon in writing by the parties and submitted to the Court.

E. In the event that (1) the United States has withdrawn its consent, as provided in Section IV. A. above, or (2) the proposed Final Judgment is not entered pursuant to this Stipulation; the time has expired for all appeals of any Court ruling declining entry of the proposed Final Judgment; and the Court has not otherwise ordered continued compliance with the terms and provisions of the proposed Final Judgment, then the parties are released from all further obligations under this Stipulation, and the making of this Stipulation shall be without prejudice to any party in this or any other proceeding.

F. Defendants represent that the divestitures ordered in the proposed Final Judgment can and will be made, and that Defendants will later raise no claim of mistake, hardship or difficulty of compliance as grounds for asking the Court to modify any of the provisions contained therein.

V. Hold Separate Provisions

Until the divestitures required by the Final Judgment have been accomplished:

A. Waste Management shall preserve, maintain, and continue to operate the Relevant Hauling Assets and Relevant Disposal Assets as independent, ongoing, economically viable competitive businesses with management, sales and operations held entirely separate, distinct and apart from those of Waste Management's other operations. Waste Management shall not coordinate the marketing of, or sales by, any Relevant Disposal Asset or Relevant Hauling Asset with its other operations. Within twenty (20) days after the filing of the Hold Separate Stipulation and Order, Defendants will inform the United States of the steps Waste Management has taken to comply with this Hold Separate Stipulation and Order.

B. Waste Management shall take all steps necessary to ensure that (1) the Relevant Disposal Assets and Relevant Hauling Assets will be maintained and operated as independent, ongoing, economically viable and advice

competitors in the MSW disposal business and the small container commercial waste collection business; (2) the management of the Relevant Disposal Assets and Relevant Hauling Assets will not be influenced by Waste Management; and (3) the books, records, competitively sensitive sales, marketing and pricing information, and decision-making concerning the Relevant Disposal Assets and the Relevant Hauling Assets will be kept separate and apart from Waste Management's other operations. Waste Management's influence over the Relevant Disposal Assets and Relevant Hauling Assets shall be limited to that necessary to carry out its obligations under this Hold Separate Stipulation and Order and the proposed Final Judgment.

C. Defendants shall use all reasonable efforts to maintain and increase the sales and revenues of the Relevant Disposal Assets and Relevant Hauling Assets, and shall maintain at 2002 levels, or at previously approved levels for 2003, whichever are higher, all promotional, advertising, sales, technical assistance, marketing and merchandising support for the Relevant Disposal Assets and Relevant Hauling Assets.

D. Defendants shall provide sufficient working capital and lines and sources of credit to continue to maintain the Relevant Hauling Assets and Relevant Disposal Assets as economically viable and competitive ongoing businesses consistent with the requirements of Sections V. A. and B.

E. Defendants shall take all steps necessary to ensure that the Relevant Hauling Assets and Relevant Disposal Assets are fully maintained in operable condition at no less than their current capacity and sales, and shall maintain and adhere to normal repair and maintenance schedules for the Relevant Hauling Assets and Relevant Disposal Assets.

F. Defendants shall not, except as part of a divestiture approved by the United States in accordance with the terms of the proposed Final Judgment, remove, sell, lease, assign, transfer, pledge or otherwise dispose of any of the Relevant Hauling Assets or Relevant Disposal Assets.

G. Defendants shall maintain, in accordance with sound accounting principles, separate, accurate and complete financial ledgers, books and records that report on a periodic basis, such as the last business day of every month, consistent with past practices, the assets, liabilities, expenses, revenues and income of the Relevant Hauling Assets and Relevant Disposal Assets.

H. Except in the ordinary course of business or as is otherwise consistent with this Hold Separate Stipulation and Order, Defendants shall not hire, transfer, terminate, or otherwise alter the salary agreements for any Waste Management or Allied employee who, on the date of Defendants' signing of this Hold Separate Stipulation and Order, either: (1) Works with a Relevant Hauling Asset or a Relevant Disposal Asset, or (2) is a member of management referenced in Section V.J. of this Hold Separate Stipulation and Order.

I. Defendants shall take no action that would jeopardize, delay, or impede the sale of the Relevant Disposal Assets or Relevant Hauling Assets.

J. Until such time as the Relevant Hauling Assets and Relevant Disposal Assets are divested pursuant to the terms of the Final Judgment, the Relevant Hauling Assets and Relevant Disposal Assets owned by Waste Management shall be managed by Chuck Wilcox, its Senior Vice President. Mr. Wilcox shall have complete managerial responsibility for the Relevant Hauling Assets and Relevant Disposal Assets owned by Waste Management, subject to the provisions of this Order and the proposed Final Judgment. In the event that Mr. Wilcox is unable to perform his duties, Waste Management shall appoint, subject to the approval of the United States, a replacement within ten (10) working days. Should Waste Management fail to appoint a replacement acceptable to the United States within ten (10) working days, the United States shall appoint a replacement.

K. Defendants shall take no action that would interfere with the ability of any trustee appointed pursuant to the Final Judgment to complete the divestitures pursuant to the Final Judgment to an Acquirer acceptable to the United States.

L. This Hold Separate Stipulation and Order shall remain in effect until consummation of the divestitures contemplated by the proposal Final Judgment or until further order of the Court.

For Plaintiff, United States of America.

Michael K. Hammaker,
DC Bar No. 233684, U.S. Department of Justice, Antitrust Division, 1401 H Street, NW., Suite 3000, Washington, DC 20530, (202) 307–0938.

For Plaintiff, State of New Jersey.

Peter C. Harvey,
Attorney General of New Jersey.

By:

Andrew L. Rossner,
Assistant Attorney General—Deputy Director, New Jersey Division of Criminal Justice, P.O. Box 085, Trenton, New Jersey 08625–0085, (609) 984–0028.

Basil L. Merenda,
Deputy Attorney General, New Jersey Division of Criminal Justice, Antitrust and Procurement Fraud Bureau, P.O. Box 085, Trenton, New Jersey 08625–0085, (609) 292–7497.

For Defendant, Waste Management, Inc.

James R. Weiss,
Preston Gates Ellis & Rouvelas Meeds LLP, 1735 New York Avenue, NW., Suite 500, Washington, DC 20006, (202) 628–1700.

For Defendant, Allied Waste Industries, Inc.

Tom D. Smith, Jones Day,
51 Louisiana Avenue, NW., Washington, DC 20001–2113, (202) 879–3971.

Dated: June 26, 2003.

Order

It is so ordered on this _____ day of _____, 2003.

_____

United States District Judge

United States District Court for the District of Columbia

Final Judgment

Whereas, Plaintiffs, the United States of America (''United States'') and the State of New Jersey (''New Jersey''), filed their Complaint on June 27, 2003, and Plaintiffs and Defendants, Waste Management, Inc. (''Waste Management'') and Allied Waste Industries, Inc. (''Allied''), by their respective attorneys, have consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law, and without this Final Judgment constituting any evidence against or admission by any part regarding any issue of law or fact;

And Whereas, Defendants agree to be bound by the provisions of this Final Judgment pending its approval by the Court;

And Whereas, the essence of this Final Judgment is the prompt and certain divestiture of the Relevant Hauling Assets and Relevant Disposal Assets by Defendant Waste Management to assure that competition is not substantially lessened;

And Whereas, the United States requires Defendant Waste Management to amend certain provisions of waste hauling contracts and the United States and New Jersey require Defendant Waste Management to make certain divestitures in order to remedy the loss of competition alleged in the Complaint;

And Whereas, Defendants have represented to Plaintiffs that the divestitures required below can and will be made and that Defendants will later raise no claims of hardship or difficulty as grounds for asking the Court to modify any of the divestitures or other injunctive provisions contained below;

And Whereas, Defendant Waste Management shall be enjoined from acquiring the Relevant Tulsa and Muskogee Disposal Assets, except as provided in this Final Judgment;

And Whereas, with respect to the New Jersey voting securities and assets to be acquired by Waste Management from Allied pursuant to the stock and asset purchase agreements between them dated January 29, 2003, as amended, this Final Judgment resolves all claims of the State of New Jersey arising under federal and state antitrust laws, including N.J. Stat. Ann. § 56:9–1 *et seq.;*

Now, therefore, before any testimony is taken, and without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is *ordered, adjudged, and decreed:*

I. Jurisdiction

This Court has jurisdiction over the subject matter of and each of the parties to this action. The Complaint states a claim upon which relief may be granted against Defendants under Section 7 of the Clayton Act, as amended, 15 U.S.C. 18.

II. Definitions

As used in this Final Judgment:

A. ''Acquirer'' means the entity or entities to whom Waste Management divests the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset.

B. ''Allied'' means Defendant Allied Waste Industries, Inc., a Delaware corporation with its headquarters in Scottsdale, Arizona, and its successors and assigns, its subsidiaries, divisions, groups, affiliates, partnerships, joint ventures, and their directors, officers, managers, agents, and employees.

C. ''Alternative Disposal Asset'' means, unless otherwise noted, with respect to each transfer station listed and described herein, all of Defendants' rights, titles, and interests in any tangible asset, related to the operation of each transfer station listed, including all fee simple or ownership rights to offices, garages, related facilities, capital equipment, trucks and other vehicles, scales, power supply equipment, and supplies; and all Defendants' rights, titles, and interests in any related intangible assets, including all leasehold interests and renewal rights thereto, permits, customer lists, contracts, and accounts, or options to purchase any adjoining property.

Alternative Disposal Asset, as used herein, means one of the following three properties, as selected by Defendant Waste Management in accordance with the terms provided in Sections IV.I., V.B., and V.C. of the Final Judgment:

1. Park Ridge, New Jersey

Waste Management's Park Ridge Transfer Station, located at 94 Perry Street, Park Ridge, New Jersey 07656; or

2. Fairview, New Jersey

Allied's Fairview Transfer Station (formerly permitted to BFI Transfer Systems of New Jersey, Inc.), located at 61 Broad Avenue, Fairview, New Jersey 07022; or

3. Hillsdale, New Jersey

Waste Management's Hillsdale Transfer Station, located at 131 Patterson Street, Hillsdale, New Jersey 07642.

D. ''Disposal'' means the business of disposing of waste into approved disposal sites (*i.e.,* landfills, incinerators, and transfer stations).

E. ''Hauling'' means the collection of waste from customers and the shipment of the collected waste to disposal sites. Hauling, as used herein, does not include collection of roll-off containers.

F. ''Fully Permitted'' means a renewal of the operating permit, currently held by Waste Management's Chestnut Ridge Solid Waste Transfer Station of Chestnut Ridge, New York and scheduled to expire on November 30, 2003, by the New York State Department of Environmental Conservation (''NYDEC'') for an additional five (5) years under terms and conditions comparable to those in the currently held permit; and further means that all additional zoning, environmental, and other permits required to operate the facility are valid and lawful. The renewed permit must be granted by NYDEC prior to expiration of the time period set forth in Section IV.A. of the Final Judgment, which time period shall include the sixty (60) day extension.

G. ''Landfill'' means a facility where waste is placed into the land.

H. ''MSW'' means municipal solid waste, a term of art used to describe solid putrescible waste generated by households and commercial establishments such as retail stores, offices, restaurants, warehouses, and non-manufacturing activities in industrial facilities. MSW does not include special handling waste (*e.g.,* waste from manufacturing processes, regulated medical waste, sewage, and sludge), hazardous waste, or waste generated by construction or demolition sites.

I. ''New Jersey Assets'' means the Relevant Disposal Assets and the Relevant Hauling Assets located in New Jersey.

J. ''Relevant Disposal Assets'' means, unless otherwise noted, with respect to each transfer station listed and described herein, all of Defendants' rights, titles, and interests in any tangible asset related to each transfer station listed, including all fee simple or ownership rights to offices, garages, related facilities, capital equipment, trucks and other vehicles, scales, power supply equipment, and supplies; and all Defendants' rights, titles, and interests in any related intangible assets, including all leasehold interests and renewal rights thereto, permits, customer lists, contracts, and accounts, or options to purchase any adjoining property.

Relevant Disposal Assets, as used herein, includes the following transfer stations, or throughput or tolling disposal rights:

1. Garfield, New Jersey

Allied's Garofalo Recycling and Transfer Station (formerly permitted to Garofalo Brothers, Inc., and Garofalo Recycling and Transfer Station Co., Inc.), located at 19–35 Atlantic Street, Garfield, New Jersey 07026.

2. Chestnut Ridge, New York

Waste Management's Fully Permitted Chestnut Ridge Solid Waste Transfer Station (owned by and permitted to Waste Management's subsidiary Marangi Bros., Ind.), located at 560 Chestnut Ridge Road, Chestnut Ridge, New York 10977.

3. North Arlington, New Jersey

Throughout or tolling disposal rights of a maximum of 1,925 tons per week, for the remainder of Waste Management's current lease and if the lease is renewed, for the duration of the period in which Waste Management has contractural rights to operate the facility, not to exceed the termination date of this Final Judgment. These disposal rights are exercisable by the Acquirer (or its designee), at the New Jersey Meadowlands Commission's HMDC Solid Waste Baler Facility (''HMDC Facility''), located at 100 Baler Boulevard, North Arlington, New Jersey 07031, under the following terms and conditions:

a. At the Acquirer's option, Waste Management shall set aside and operate or, allow the Acquirer (or its designee) to operate one (1) disposal bay and a scale and scale house for the sole use of the Acquirer (or its designee);

b. Waste Management shall permit the Acquirer (or its designee) to deliver waste to the HMDC Facility during

operating hours from Monday through Saturday up to the weekly maximum of 1,925 tons. Waste Management shall have the right to stop accepting waste from any additional truck owned or operated by the Acquirer (or its designee) and entering the premises after Waste Management has accepted 350 tons of waste from the Acquirer (or its designee) on any day the HMDC Facility is operating;

c. Under the throughput or tolling arrangement, Waste Management shall permit the Acquirer (or its designee) to deliver waste to the HMDC Facility for processing and, at the option of the Acquirer (or its designee), load the processed waste into vehicles designated by the Acquirer (or its designee) for ultimate disposal; and

d. Waste Management shall operate all HMDC Facility gates, scales, scale houses, and disposal areas described in the Acquirer's contract under terms and conditions no less favorable to the Acquirer (or its designee) than those provided to Waste Management or its customers, including any municipality.

K. ''Relevant Hauling Assets'' means with respect to each commercial waste collection route or other hauling asset described herein, all tangible assets, including capital equipment, trucks and other vehicles, containers, interests, supplies, and if requested by the purchaser, real property and improvements to real property (*i.e.,* buildings and garages). It also includes all intangible assets, including hauling-related customer lists, contracts, leasehold interests, permits and accounts.

Relevant Hauling Assets, as used herein, includes the assets in the following locations:

1. Augusta, Georgia

Allied's commercial waste collection routes 903, 904, 916, and 922 that operate out of Allied's Augusta division located at 683 Commerce Court, Evans, Georgia 30809.

2. Myrtle Beach, South Carolina

Allied's commercial waste collection routes 711, 714, and 715 that operate out of Allied's Rural Sanitation Services Hauling facility located at 3512 Highway 501, Myrtle Beach, South Carolina 29579.

3. Pitkin and Garfield Counties, Colorado

Waste Management's waste collection routes 730, 824, 825, 831, 850, 851, and 853 that operate out of Waste Management's facility located at 226 North 12th Street, Carbondale, Colorado 81623.

4. Bergen and Passaic Counties, New Jersey

Allied's commercial waste collection routes 700, 705, 706, 401, and 405 tht operate out of Allied's VMI Waste Services Hauling facility located at 75 Broad Avenue, Fairview, New Jersey 07022, except that Waste Management is not required to divest real property or improvements to real property (*i.e.,* buildings, garages, or leasehold rights related thereto).

5. Morris County, New Jersey

Allied's commercial waste collection route 702 that operates out of Allied's VMI Waste Services Hauling facility located at 75 Broad Avenue, Fairview, New Jersey 07022, except that Waste Management is not required to divest real property or improvements to real property (*i.e.,* buildings, garages, or leasehold rights related thereto).

L. ''Relevant Tulsa and Muskogee Disposal Assets'' means Allied's Porter Landfill (also referred to as 51B Landfill), located at Route 2, Box 120, Porter, Oklahoma 74454, or any other landfill owned by Allied or any third party located within twenty-five (25) miles from the center of either the city of Tulsa or the city of Muskogee, Oklahoma.

M. ''Small container commercial waste collection service'' means the business of collecting MSW from commercial and industrial accounts, usually in ''dumpsters'' (*i.e.,* a small container with one (1) to ten (10) cubic yards of storage capacity), and transporting or ''hauling'' such waste to a disposal site by use of a front- or rear-end loader truck. Typical commerical waste collection customers include office and apartment buildings and retail establishments (*e.g.,* stores and restaurants).

N. ''Waste Management'' means Defendant Waste Management, Inc., a Delaware corporation with its headquarters in Houston, Texas, and includes its successors and assigns, and its subsidaries, divisions, groups, affiliates, partnerships, joint ventures, and their directors, officers, managers, agents, and employees.

III. Applicability

A. This Final Judgment applies to Waste Management and Allied, as defined above, and all other persons in active concert or participation with any of them who receive actual notice of this Final Judgment by personal service or otherwise.

B. Defendants shall require, as a condition of the sale or other disposition of all or substantially all of their assets, or of lesser business units that include Defendants' Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset, that the Acquirer agree to be bound by the provisions of the Final Judgment.

IV. Divestitures

A. Defendant Waste Management is ordered and directed, within ninety (90) calendar days after the filing of the Complaint in this matter, or five (5) days after notice of the entry of this Final Judgment by the Court, whichever is later, to divest the Relevant Disposal Assets and Relevant Hauling Assets, except for the New Jersey Assets, in a manner consistent with this Final Judgment to an Acquirer acceptable to the United States in its sole discretion.

The United States, in its sole discretion, may agree to an extension of this time period of up to sixty (60) calendar days, and shall notify the Court in such circumstances. Defendants agree to use their best efforts to divest the Relevant Disposal Assets and Relevant Hauling Assets as expeditiously as possible.

B. Defendants are ordered and directed, within ninety (90) calendar days after the approval by the New Jersey Department of Environmental Protection of Waste Management's request to acquire Allied's assets in New Jersey, to divest the New Jersey Assets in a manner consistent with this Final Judgment and state law to an Acquirer acceptable to the United States, in its sole discretion, after consultation with New Jersey. The United States, in its sole discretion, after consultation with New Jersey, may agree to an extension of this time period of up to sixty (60) calendar days, and shall notify the Court in such circumstances. Defendants agree to use their best efforts to divest the New Jersey Assets as expeditiously as possible. If the Defendants have not received approval by the New Jersey Department of Environmental Protection of Waste Management's request to acquire Allied's assets in New Jersey within ninety (90) calendar days after the filing of the Complaint in this matter, plus any extension of time granted by the United States of up to sixty (60) calendar days, Waste Management shall not purchase from Allied any of the voting securities or assets located in New Jersey and identified in the January 29, 2003 purchase agreements, as amended.

C. In accomplishing the divestitures ordered by this Final Judgment, Defendant Waste Management promptly shall make known, by usual and customary means, the availability of the

Relevant Disposal Assets and Relevant Hauling Assets. Defendants shall inform any person making inquiry regarding a possible purchase of the Relevant Disposal Assets or Relevant Hauling Assets that they are being divested pursuant to this Final Judgment and provide that person with a copy of this Final Judgment. Defendants shall offer to furnish to all prospective Acquirers, subject to customary confidentiality assurances, all information and documents relating to the Relevant Disposal Assets or Relevant Hauling Assets, whichever is then available for sale, customarily provided in a due diligence process except such information or documents subject to the attorney-client or work-product privileges. Defendants shall make available such information to the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, at the same time that such information is made available to any other person.

D. Defendants shall provide the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, and each prospective Acquirer of the Relevant Disposal Assets or Relevant Hauling Assets information relating to the personnel involved in the operation and management of the Relevant Disposal Assets or Relevant Hauling Assets to enable the Acquirer to make offers of employment. Defendants will not interfere with any negotiations by the Acquirer to employ any Defendant employee whose primary responsibility is the operation or management of the Relevant Disposal Assets or Relevant Hauling Assets.

E. Defendants shall permit each prospective Acquirer of the Relevant Disposal Assets or Relevant Hauling Assets to have reasonable access to personnel and to make inspections of the physical facilities; access to any and all environmental, zoning, and other permit documents and information; and access to any and all financial, operational, or other documents and information customarily provided as part of a due diligence process.

F. With the exception of the facility described in Section II.J.2, Defendant Waste Management shall warrant to the Acquirer of the Relevant Disposal Assets or Relevant Hauling Assets that each asset will be operational on the date of sale.

G. Defendants shall not take any action that will impede in any way, the permitting, operation, or divestiture of the Relevant Disposal Assets or Relevant Hauling Assets.

H. With the exception of the facility described in Section II.J.2, Defendants Waste Management shall warrant to the Acquirer of the Relevant Disposal Assets or Relevant Hauling Assets that there are no material defects in the environmental, zoning or other permits pertaining to the operation of each asset, and that following the sale of the Relevant Disposal Assets or Relevant Hauling Assets, Defendants will not undertake, directly or indirectly, any challenges to the environmental, zoning, or other permits relating to the operation of the Relevant Disposal Assets or Relevant Hauling Assets.

I. Defendant Waste Management warrants that there is an existing NYDEC operating permit for the Chestnut Ridge Solid Waste Transfer Station, which expires November 30, 2003. Waste Management's failure to divest the Chestnut Ridge Solid Waste Transfer Station in accordance with the conditions set forth in this Final Judgment shall result in the appointment of a trustee and the divestiture of the alternative Disposal Asset as provided in Sections V.A., V.B., and V.C. Should Waste Management be required to divest the Alternative Disposal Asset pursuant to Section V.B., it shall be bound by the same terms and provide warranties for the Alternative Disposal Asset comparable to those specified in Sections IV.C. through IV.H.

J. Unless the United States, in its sole discretion, and after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, otherwise consents in writing, the divestitures pursuant to Section IV, or by trustee appointed pursuant to Section V, of the Final Judgment, shall include either the entire Relevant Hauling Assets and Relevant Disposal Assets, or the entire Relevant Hauling Assets, the Relevant disposal Assets (excluding the Chestnut Ridge Solid Waste Transfer Station), and the Alternative Disposal Asset, and shall be accomplished in such a way as to satisfy the United States, in its sole discretion, and after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, that the divested assets will be used by the Acquirer, as part of a viable, ongoing disposal or hauling business. Divestiture of the Relevant Disposal Asset, Relevant Hauling Assets and the Alternative Disposal Asset may be made to an Acquirer, provided that in each instance it is demonstrated to the sole satisfaction of the United States, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, that the Relevant Disposal Assets, Relevant Hauling Assets and the Alternative Disposal Asset will remain viable and the divestiture of such assets will remedy the competitive harm alleged in the Complaint. The divestitures, whether pursuant to Section IV or Section V of this Final Judgment,

1. Shall be made to an Acquirer that, in the United States' sole judgment, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, has the intent and capability, including managerial, operational, and financial capability, to compete effectively in the disposal or hauling business; and

2. Shall be accomplished so as to satisfy the United States, in its sole discretion, after consultation with New Jersey as the New Jersey Assets and the Alternative Disposal Asset, that none of the terms of any agreement between an Acquirer and Defendant Waste Management gives Defendants the ability unreasonably to raise the Acquirer's costs, to lower the Acquirer's efficiency, or otherwise to interfere in the ability of the Acquirer to compete effectively.

V. Appointment of Trustee

A. If Defendant Waste Management has not divested either the Relevant disposal Assets, or the Relevant Hauling Assets, or both, within the time period specified in Section IV.A., Defendant Waste Management shall notify United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, of that fact in writing. Upon application of the United States, in its sole discretion, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Assets, the Court shall appoint a trustee selected by the United States and approved by the Court to effect the divestiture of either the Relevant Disposal Assets, or the Relevant Hauling Assets, or both.

B. After the appointment of a trustee becomes effective, only the trustee shall have the right to sell either the Relevant Disposal Assets, or the Relevant Hauling Assets, or both. In the event the Chestnut Ridge Solid Waste Transfer Station (as defined in Sections II.F. and II.J.2) cannot be sold prior to the expiration of the time period provided in Section IV.A., the trustee shall divest the Alternative Disposal Asset selected by Waste Management from the three facilities identified in Section II.C. of the Final Judgment. Waste Management's selection of one of the three alternative facilities must be communicated to the trustee in writing within three (3) days following a request from the trustee to make the election.

C. Notwithstanding the provisions contained in Sections IV.I. and V.B. of this Final Judgment, if the sole reason for requiring the divestiture of the Alternative Disposal Asset is that the Chestnut Ridge Solid Waste Transfer Station is not fully permitted within the time allowed herein, Waste Management, following the direction of the United States to divest the Relevant Disposal Assets, shall have sixty (60) days to do so.

D. Notwithstanding the provisions contained in Section V.B., The United States may, in its sole discretion, extend the expiration of the time period provided in Section IV.A. relating to the sale of the Chestnut Ridge Solid Waste Transfer Station for an additional ninety (90) days. This extension may occur only if the following conditions are satisfied as of the expiration of the time period provided in Section IV.A.:

1. Waste Management has sold the Chestnut Ridge Solid Waste Transfer Station to an Acquirer acceptable to the United States in its sole discretion, even though the facility is not yet Fully Permitted;

2. The Chestnut Ridge Solid Waste Transfer Station is being operated by the Acquirer or by another party, approved by the United States in its sole discretion, on behalf and for the benefit of the Acquirer, and

3. The United States, in its sole discretion, is satisfied that the Chestnut Ridge Solid Waste Transfer Station is likely to be Fully permitted by the New York Department of Environmental Conservation within the ninety (90) day extension of time granted under this Section.

E. The trustee shall have the power and authority to accomplish the divestiture to an Acquirer acceptable to the United States, in its sole discretion, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, at such price and on such terms as are then obtainable upon reasonable effort by the trustee, subject to the provisions of Sections IV, V, and VI of this Final Judgment, and shall have such other powers as this Court deems appropriate. Subject to Section V.G. of this Final Judgment, the trustee may hire at the cost and expense of Defendant Waste Management any investment bankers, attorneys, or other agents, who shall be solely accountable to the trustee, reasonably necessary in the trustee's judgment to assist in the divestiture.

F. Defendant Waste Management shall not object to a sale by the trustee on any ground other than the trustee's malfeasance. Any such objections by Defendant Waste Management must be conveyed in writing to the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, and the trustee within ten (10) calendar days after the trustee has provided the notice required under Section VI.

G. The trustee shall serve at the cost and expense of Defendant Waste Management, on such terms and conditions as the United States approves, and shall account for all monies derived from the sale of the Relevant Disposal Assets, Relevant Hauling Assets, and the Alternative Disposal Asset sold by the trustee and all costs and expenses so incurred. After approval by the Court of the trustee's accounting, including fees for its services and those of any professionals and agents retained by the trustee, all remaining money shall be paid to Defendant Waste Management and the trust shall then be terminated. The compensation of the trustee and any professionals and agents retained by the trustee shall be reasonable in light of the value of the Relevant Disposal Assets, Relevant Hauling Assets, and any Alternative Disposal Asset selected by Waste Management, and based on a fee arrangement providing the trustee with an incentive based on the price and terms of the divestiture and the speed with which it is accomplished, but timeliness is paramount.

H. Defendants shall use their best efforts to assist the trustee in accomplishing the required divestiture. The trustee and any consultants, accountants, attorneys, and other persons retained by the trustee shall have full and complete access to the personnel, books, records, and facilities of the business to be divested, and Defendants shall develop financial and other information relevant to such business as the trustee may reasonably request, subject to customary confidentiality protection for trade secret or other confidential research, development, or commercial information. Defendants shall take no action to interfere with or to impede the trustee's accomplishment of the divestiture.

I. After its appointment, the trustee shall file monthly reports with the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, and the Court setting forth the trustee's efforts to accomplish the divestiture ordered under this Final Judgment. To the extent that such reports contain information that the trustee deems confidential, such reports shall not be filed in the public docket of the Court. Such reports shall include the name, address, and telephone number of each person who, during the preceding month, made an offer to acquire, expressed an interest in acquiring, entered into negotiations to acquire, or was contacted or made an inquiry about acquiring, any interest in the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset, and shall describe in detail each contact with any such person. The trustee shall maintain full records of all efforts made to divest the Relevant Disposal Assets, Relevant Hauling Assets, and any Alternative Disposal Asset.

J. If the trustee has not accomplished such divestiture within six (6) months after its appointment, the trustee shall promptly file with the Court a report setting forth (1) the trustee's efforts to accomplish the required divestiture, (2) the reasons, in the trustee's judgment, why the required divestiture has not been accomplished, and (3) the trustee's recommendations. To the extent that such reports contain information that the trustee deems confidential, such reports shall not be filed in the public docket of the Court. The trustee shall, at the same time, furnish such report to the United states, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, who shall have the right to make additional recommendations consistent with the purpose of the trust. The Court thereafter shall enter such orders as it shall deem appropriate to carry out the purpose of the Final Judgment, which may, if necessary, include extending the trust and the term of the trustee's appointment by a period requested by the United States.

VI. Notice of Proposed Divestiture

A. Within two (2) business days following execution of a definitive divestiture agreement, Defendant Waste Management or the trustee, whichever is then responsible for effecting the divestiture required herein, shall notify the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Assets, of any proposed divestiture required by Section IV or V of this Final Judgment. If the trustee is responsible, it shall similarly notify Defendant Waste Management. The notice shall set forth the details of the proposed divestiture and list the name, address, and telephone number of each person not previously identified who offered or expressed an interest in or desire to acquire any ownership interest in the Relevant Disposal Assets, Relevant Hauling Assets, or the

Alternative Disposal Asset together with full details of the same.

B. Within fifteen (15) calendar days of receipts by United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Assets, of such notice, the United States, in it sole discretion, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Assets, may request from Defendants, the proposed Acquirer or Acquirers, any other third party, or the trustee, if applicable, additional information concerning the proposed divestiture, the proposed Acquire, and any other potential Acquirer. Defendants and the trustee shall furnish any additional information requested within fifteen (15) calendar days of the receipt of the request, unless the parties shall otherwise agree.

C. Within thirty (30) calendar days after receipt of the notice or within twenty (20) calendar days after the United States has been provided the additional information requested from Defendants, the proposed Acquirer, any third party, and the trustee, whichever is later, the United States, in its sole discretion, after consultation with New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, shall provide written notice to Defendants and the trustee, if there is one, stating whether or not it objects to the proposed divestiture. If the United States provides written notice that it does not object, the divestiture may be consummated, subject only to Defendant Waste Management's limited right to object to the sale under Section V.F. of this Final Judgment. Absent written notice that the United States does not object to the proposed Acquirer or upon objection by the United States, a divestiture proposed under Section IV or Section V shall not be consummated. Upon objection by Defendant Waste Management under Section V.F., a divestiture proposed under Section V shall not be consummated unless approved by the Court.

VII. Financing

Defendants shall not finance all or any part of any purchase made pursuant to Section IV or V of this Final Judgment.

VIII. Hold Separate

Until the divestitures required by this Final Judgment has been accomplished, Defendants shall take all steps necessary to comply with the Hold Separate Stipulation and Order entered by this Court. Defendants shall take no action that would jeopardize the divestitures ordered by this Court.

IX. Affidavits

A. Within twenty (2) calendar days of the filing of the Complaint in this matter, and every thirty (30) calendar days thereafter until the divestiture has been completed under Section IV or V, Defendants shall deliver to the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, an affidavit as to the fact and manner of its compliance with Section IV or V of this Final Judgment. Each such affidavit shall include the name, address, and telephone number of each person who, during the preceding thirty (30) days, made an offer to acquire, expressed an interest in acquiring, entered into negotiations to acquire, or was contacted or made an inquiry about acquiring, any interest in the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset, and shall describe in detail each contact with any such person during that period. Each such affidavit shall also include a description of the efforts Defendants have taken to solicit buyers for the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset, and to provide required information to each prospective Acquirer, including the limitations, if any, on such information. Assuming the information set forth in the affidavit is true and complete, any objection by the United States, after consultation with New Jersey, to information provided by Defendants, including limitations on information, shall be made within fourteen (14) days of receipt of such affidavit.

B. Within twenty (20) calendar days of the filing of the Complaint in this matter, Defendants shall deliver to the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, an affidavit that describes in reasonable detail all actions Defendants have taken and all steps Defendants have implemented on an ongoing basis to comply with Section VIII of this Final Judgment. Defendants shall deliver to the United States, or both the United States and New Jersey as to the New Jersey Assets and the Alternative Disposal Asset, an affidavit describing any changes to the efforts and actions outlined in Defendants' earlier affidavits filed pursuant to this section within fifteen (15) calendar days after the change is implemented.

C. Defendants shall keep all records of all efforts made to preserve the Relevant Disposal Assets, Relevant Hauling Assets, and the Alternative Disposal Asset, and to divest the Relevant Disposal Assets, Relevant Hauling Assets, and Alternative Disposal Asset until one year after such divestiture has been completed.

X. Compliance Inspection

A. For purposes of determining or securing compliance with this Final Judgment, or of determining whether the Final Judgment should be modified or vacated, and subject to any legally recognized privilege, from time to time duly authorized representatives of the United States Department of Justice, including consultants and other persons retained by the United States, upon written request of a duly authorized representative of the Assistant Attorney General in charge of the Antitrust Division, or upon written request of a duly authorized representative of the New Jersey Attorney General's Office, and on reasonable notice to Defendants, be permitted:

1. Access during Defendants' office hours to inspect and copy, or at the United States' option, to require Defendants to provide copies of, all books, ledgers, accounts, records and documents in the possession, custody or control of Defendants, relating to any matters contained in this Final Judgment; and

2. To interview, either informally or on the record, Defendants' officers, employees, or agents, who may have their individual counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee and without restraint or interference by Defendants.

B. Upon the written request of a duly authorized representative of the assistant Attorney General in charge of the Antitrust Division, or upon the written request of the New Jersey Attorney General's Office, Defendants shall submit such written reports, under oath if requested, relating to any of the matters contained in this Final Judgment as may be requested.

C. No information or documents obtained by the means provided in this section shall be divulged by the Plaintiffs to any person other than an authorized representative of the executive branch of the United States, or the New Jersey Attorney General's Office, except in the course of legal proceedings to which the United States or New Jersey is a party (including grand jury proceedings), or for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

D. If at the time information or documents are furnished by Defendants to Plaintiffs, Defendants represent and

identify in writing the material in any such information or documents to which a claim of protection may be asserted under rule 26(c)(7) of the Federal Rules of Civil Procedure, and Defendants mark each pertinent page of such material, ''Subject to claim of protection under Rule 26(c)(7) of the Federal Rules of Civil Procedure,'' then Plaintiffs shall give Defendants ten (10) calendar days notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

XI. Relevant Tulsa and Muskogee Disposal Assets

Waste Management shall not directly or indirectly acquire or propose to acquire any assets of or any interest, including any financial, security, loan equity or management interest, in the Relevant Tulsa and Muskogee Disposal Assets without thirty (30) days advance notification to the Antitrust Division of the United States Department of Justice of any such acquisition. The obligation to provide notice under this Section is met by either a written notification, or if applicable, a premerger notification pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, 15 U.S.C. 18(a) (the ''HSR Act''). In the event that a proposed acquisition of Allied's Porter Landfill (also referred to as 51B Landfill), located at Route 2, Box 120, Porter, Oklahoma 74454 is not subject to the reporting and waiting period requirements of the HSR Act, notification under this Section shall be provided to the Antitrust Division in the same format as, and in accordance with, the instructions relating to the Notification and Report Form set for in the appendix to Part 803 of Title 16 of the Code of Federal Regulations as amended, except that the information requested in items 5 through 9 of the instructions must be provided only about the Tulsa and Muskogee, Oklahoma area. The notification required by this Section shall include, beyond what may be required by the applicable instructions, the names of the principal representatives of the parties to the agreement who negotiated the agreement, and any management or strategic plans discussing the proposed transaction. If, within the thirty (30) day period after notification of a proposed acquisition of a proposed acquisition of Allied's Porter Landfill, representatives of the Antitrust Division make a written request for additional information, Waste Management shall not consummate the proposed transaction or agreement until thirty (30) days after submitting all such additional information. Early termination of the waiting periods in this Section may be requested and, where appropriate, granted. This Section shall be broadly construed, and any ambiguity or uncertainty regarding the filing of notice under this Section shall be resolved in favor of filing notice.

XII. No Reacquisition

Defendant Waste Management may not reacquire any part of the Relevant Disposal Assets, Relevant Hauling Assets, or the Alternative Disposal Asset during the term of this Final Judgment, provided that if Waste Management is required to divest the Alternative Disposal Asset, Waste Management may reacquire the Chestnut Ridge Solid Waste Transfer Station.

XIII. Revisions to Contracts

A. Waste Management shall alter the contracts it uses with its small container commercial waste collection customers in each of the markets specified below to the form contained in Section XIII.B. below.

B. In each of the markets specified below, Waste Management shall offer contracts to all new small container commercial waste collection customers as well as to existing customers that sign new contracts for small container commercial waste collection service effective on or after the date that it acquires Allied's assets in accordance with the following conditions. No contract shall:

1. Have an initial term longer than two (2) years;

2. Have any renewal term longer than one (1) year;

3. Require that the customer give Waste Management notice of termination more than thirty (30) days prior to the end of any initial term of renewal term;

4. Require that the customer pay liquidated damages in excess of three times its average monthly charge during the first year the customer has had service with Waste Management; and

5. Require that the customer pay liquidated damages in excess of two (2) times its average monthly charge after the first year the customer has had service with Waste Management.

Waste Management shall offer such contracts to all other current small container commercial waste collection service customers in the respective markets detailed below on or before January 1, 2005:

Defendant	Cities	Counties or Areas
Waste Management	Myrtle Beach, SC	Georgetown and Horry Counties, SC.
Waste Management	Augusta, GA	Columbia, Lincoln, McDuffie, Richmond, and Warren Counties, GA.

Waste Management agrees that it will not attempt to enforce any contract term affecting commercial waste collection customers in the specified areas that conflicts with or is inconsistent with the above terms, even if those customers choose not to sign a contract with the new terms.

XIV. Retention of Jurisdiction

This Court retains jurisdiction to enable any party to this Final Judgment to apply to this Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

XV. Expiration of Final Judgment

Unless this Court grants an extension, this Final Judgment shall expire ten (10) years from the date of its entry.

XVI. Public Interest Determination

Entry of this Final Judgment is in the public interest.

Date: _____

Court approval subject to procedures of Antitrust Procedures and Penalties Act, 15 U.S.C. 16.

_____

United States District Judge

United States District Court for the District of Columbia

Case No.: 1:03CV01409]

Judge: Gladys Kessler.

Deck Type: Antitrust.

Competitive Impact Statement

Plaintiff United States of America (''United States''), pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act (''APPA''), 15 U.S.C. 16(b)–(h), files this Competitive Impact Statement relating to the proposed Final

Judgment submitted for entry in this civil antitrust proceeding.

Nature and Purpose of the Proceeding

Defendant Waste Management, Inc. (''Waste Management'') and Defendant Allied Waste Industries, Inc. (''Allied'') entered into stock and asset purchase agreements on January 29, 2003, pursuant to which Waste Management would acquire certain voting securities and waste-hauling and disposal assets of Allied in a number of areas throughout the United States. The United States and the State of New Jersey (''New Jersey'') filed a civil antitrust Complaint on June 27, 2003, seeking to enjoin the proposed acquisition. The Complaint alleges that the likely effect of this acquisition would be to lessen competition substantially for waste collection and disposal services in several markets in violation of Section 7 of the Clayton Act. This loss of competition would result in consumers paying higher prices and receiving fewer services for the collection and disposal of waste.

At the same time the Complaint was filed, the United States also filed a Hold Separate Stipulation and Order and proposed Final Judgment, which are designed to eliminate the anticompetitive effects of the acquisition. Under the proposed Final Judgment, which is explained more fully below, Waste Management is required within 90 days after the filing of the Complaint, or five (5) days after notice of the entry of the Final Judgment by the Court, whichever is later, to divest, as viable business operations, specified waste-hauling and disposal assets. The proposed Final Judgment also requires Defendants, within 90 days after approval by the New Jersey Department of Environmental Protection of Waste Management's request to acquire assets in New Jersey, to divest, as viable business operations, certain waste-hauling and disposal assets located in New Jersey and New York. Under the terms of the Hold Separate Stipulation and Order, Waste Management is required to take certain steps to ensure that the assets to be divested will be preserved and held separate from its other assets and businesses. In addition to the divestitures, the proposed Final Judgment also requires Waste Management to comply with certain conditions in its customer contracts in two identified areas.

The United States, New Jersey, and the Defendants have stipulated that the proposed Final Judgment may be entered after compliance with the APPA. Entry of the proposed Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the proposed Final Judgment and to punish violations thereof.

II. Description of the Events Giving Rise to the Alleged Violation

A. The Defendants and the Proposed Transaction

Waste Management, with revenues in 2002 of approximately $11.1 billion, is the nation's largest waste collection and disposal company, operating throughout the United States. Allied, with 2002 revenues of approximately $5.5 billion, is the nation's second largest waste collection and disposal company. The proposed transaction, as initially agreed to by Defendants on January 29, 2003, would lessen competition substantially as a result of Waste Management's acquisition of the following: (1) Hauling assets in Pitkin County, Colorado; (2) hauling assets in Garfield County, Colorado; (3) hauling assets in Augusta, Georgia; (4) hauling assets in Myrtle Beach, South Carolina; (5) hauling assets in Morris County, New Jersey; (6) hauling assets in Bergen and Passaic Counties, New Jersey; (7) voting securities and disposal assets serving Bergen and Passaic Counties, New Jersey; and (8) disposal assets in Tulsa, Oklahoma. This acquisition is the subject of the Complaint and proposed Final Judgment filed by the United States and New Jersey on June 27, 2003.

B. The Competitive Effects of the Transaction

Municipal solid waste (''MSW'') is solid, putrescible waste generated by households and commercial establishments. Waste collection firms, or haulers, contract to collect MSW from residential and commercial customers and transport the waste to private and public disposal facilities (*e.g.,* transfer stations, incinerators, and landfills), which, for a fee, process and legally dispose of the waste. Small container commercial waste collection is one component of MSW collection, which also includes residential and other waste collection. Allied and Waste Management compete in the collection of small container commercial waste and the disposal of MSW.

1. The Effects of the Transaction on Competition in Small Container Commercial Waste Collection Service

a. Small Container Commercial Waste Collection.

Small container commercial waste collection service is the collection of MSW from commercial businesses such as office and apartment buildings and retail establishments (*e.g.,* stores and restaurants) for shipment to, and disposal at, an approved disposal facility. Because of the type and volume of waste generated by commercial accounts and the frequency of service required, haulers organize commercial accounts into special routes, and generally use specialized equipment to store, collect, and transport waste from these accounts to approved disposal sites. This equipment (*e.g.,* one- to ten-cubic-yard containers for waste storage, and front-end load vehicles commonly used for collection and transportation) is uniquely well suited for providing small container commercial waste collection service. Providers of other types of waste collection services (*e.g.,* residential and roll-off services) are not good substitutes for small container commercial waste collection firms. In their waste collection efforts, these firms use different waste storage equipment (*e.g.,* garbage cans or semi-stationary roll-off containers) and different vehicles (*e.g.,* rear-load, side-load, and roll-off trucks), which, for a variety of reasons, cannot be conventionally or efficiently used to store, collect, or transport waste generated by commercial accounts, and hence, are rarely used on small container commercial waste collection routes. In the event of a small but significant and nontransitory increase in price for small container commercial waste collection services, customers would not switch to any other alternative. Thus, the Complaint alleges that the provision of small container commercial waste collection services constitutes a line of commerce, or relevant service, for purpose of analyzing the effects of the transaction.

The Complaint alleges that the provision of small container commercial waste collection service takes place in compact, highly localized geographic markets. it is expensive to ship waste long distances in either collection or disposal operations. To minimize transportation costs and maximize the scale, density, and efficiency of their waste collection operations, small container commercial waste collection firms concentrate their customers and collection routes in small areas. Firms with operations concentrated in a distant area cannot easily compete against firms whose routes and customers are locally based. Distance may significantly limit a remote firm's ability to provide commercial waste collection service as frequently or conveniently as that offered by local firms with nearby routes. Also, local

commercial waste collection firms have significant cost advantages over other firms, and can profitably increase their charges to local commercial customers without losing significant sales to firms outside the area.

Applying this analysis, the Complaint alleges that the areas of Pitkin County, Colorado; Garfield County, Colorado; Augusta, Georgia; Myrtle Beach, South Carolina; Morris County, New Jersey; and Bergen and Passaic Counties, New Jersey constitute sections of the country, or relevant geographic markets, for the purpose of assessing the competitive effects of a combination of Allied and Waste Management in the provision of small container commercial waste collection services.

There are significant entry barriers into small container commercial waste collection. A new entrant into small container commercial waste collection services must achieve a minimum efficient scale and operating efficiencies comparable to those of existing firms in order to provide a significant competitive constraint on the prices charged by market incumbents. In order to obtain comparable operating efficiencies, a new firm must achieve route density similar to existing firms.

An efficient route usually handles 80 or more customers or containers each day. Because most customers have their waste collected once or twice a week, a new entrant must have several hundred customers in close proximity to construct an efficient route. However, the common use of price discrimination and long-term contracts by existing commercial waste collection firms can leave too few customers available to the entrant in a sufficiently confined geographic area to create an efficient route. The incumbent firm can selectively and temporarily charge an unbeatably low price to specified customers targeted by new entrants. Long-term contracts often run for three to five years and may automatically renew or contain large liquidated damage provisions for contract termination. Such terms make it more costly or difficult for a customer to switch to a new hauler and obtain lower prices for its collection service. Because of these factors a new entrant may find it difficult to compete by offering its services at pre-entry price levels comparable to the incumbent and may find an increase in the cost and time required to form an efficient route, thereby limiting a new entrant's ability to build an efficient route and reducing the likelihood that the entrant will ultimately be successful.

The need for route density, the use of long-term contracts with restrictive terms, and the ability of existing firms to price discriminate raise significant barriers to entry by new firms, which will likely be forced to compete at lower than pre-entry price levels. Such barriers in the market for small container commercial waste collection have allowed incumbent firms to raise prices successfully.

b. Anticompetitive Effects in Small Container Commercial Waste Collection Service Markets.

(1) Pitkin County, Colorado. In Pitkin County, Colorado, Waste Management's acquisition of Allied's hauling assets would reduce from two to one the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 89 percent of total market revenues, which exceed $1.8 million annually. There are no other significant small container commercial waste competitors in this market.

(2) Garfield County, Colorado. In Garfield County, Colorado, Waste Management's acquisition of Allied's hauling assets would reduce from two to one the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 93 percent of total market revenues, which approximate $3.2 million annually. There are no other significant small container commercial waste competitors in this market.

(3) Augusta, Georgia Area. Waste Management is acquiring the hauling assets of Allied in Augusta, Georgia. These assets serve small container commercial waste collection customers in Columbia, Richmond, McDuffie, Lincoln, and Warren Counties, Georgia. In the Augusta, Georgia area, the proposed acquisition would reduce from three to two the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 63 percent of total market revenues, which approximate $7.5 million annually.

(4) Myrtle Beach, South Carolina Area. Waste Management is acquiring the hauling assets of Allied in Myrtle Beach, South Carolina. These assets serve small container commercial waste collection customers in Georgetown and Horry Counties, South Carolina. In this area, the proposed acquisition would reduce from three to two the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 58 percent of total market revenues, which exceed $7.4 million annually.

(5) Morris County, New Jersey. In Morris County, New Jersey, Waste Management's acquisition of Allied's hauling assets would reduce from four to three the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 41 percent of total market revenues, which exceed $14 million annually.

(6) Bergen and Passaic Counties, New Jersey. Waste Management is acquiring the hauling assets of Allied that serve Bergen and Passaic Counties, New Jersey. In Bergen and Passaic Counties, New Jersey, the proposed acquisition would reduce from four to three the number of significant firms that compete in the collection of small container commercial waste. After the acquisition, Waste Management would control over 47 percent of total market revenues, which exceed $38 million annually.

The Complaint alleges that a combination of Allied and Waste Management in these areas would remove a significant competitor in small container commercial waste collection services. In each of these markets, the resulting increase in concentration, loss of competition, and absence of any reasonable prospect of significant new entry or expansion by market incumbents likely will result in higher prices for the collection of small container commercial waste.

2. The Effects of the Transaction on Competition in the Disposal of Municipal Solid Waste

a. Municipal Solid Waste.

A number of federal, state, and local safety, environmental, zoning, and permit laws and regulations dictate critical aspects of storage, handling, transportation, processing and disposal of MSW. MSW can be disposed of lawfully in a transfer station, landfill, or incinerator permitted to accept MSW. Anyone who attempts to dispose of MSW in an unlawful manner risks severe civil and criminal penalties. In some areas, landfills are scarce because of significant population density and the limited availability of suitable land. Accordingly, most MSW generated in these areas is burned in an incinerator or brought to transfer stations where it is compacted and transported to a more distant permanent disposal site.

Because of the strict laws and regulations that govern the disposal of MSW, there are no good substitutes for MSW disposal. Firms that compete in the disposal of MSW can profitably

increase their charges to haulers of MSW without losing significant sales to any other firms. Thus, for purposes of antitrust analysis, the disposal of MSW constitutes a line of commerce, or relevant service, for purposes of analyzing the transaction.

The disposal of MSW generally occurs in localized markets. The Complaint alleges that the Bergen and Passaic Counties, New Jersey disposal area (which includes Bergen and Passaic Counties and areas within 10 miles of these counties) constitutes a section of the country, or a relevant geographic market, for purposes of assessing the competitive efforts of the transaction. Due to the high costs of transporting MSW and the substantial travel time to other disposal facilities based on distance, natural barriers, and congested roadways, virtually all of the MSW generated in Bergen and Passaic Counties, New Jersey is disposed of in transfer stations in the Bergen and Passaic Counties, New Jersey disposal area. Firms that compete in the disposal of MSW in the Bergen and Passaic Counties, New Jersey disposal area can profitably increase their charges for MSW disposal without losing significant sales to more distant disposal sites.

The Complaint also alleges that the Tulsa and Muskogee, Oklahoma area (which includes Muskogee, Rogers, Tulsa, and Wagoner Counties, Oklahoma) constitutes a section of the country, or a relevant geographic market, for purposes of assessing the competitive effects of the transaction. Because of transportation costs and travel time to more distant facilities, virtually all of the MSW generated in the Tulsa and Muskogee, Oklahoma area is disposed of in landfills within roughly 25 miles of Tulsa or Muskogee, Oklahoma. Firms that compete in the disposal of MSW in the Tulsa and Muskogee, Oklahoma area can profitably increase their charges for MSW disposal without losing significant sales to more distant disposal sites.

There are significant barriers to entry in MSW disposal. Obtaining a permit to construct a new disposal facility or expand an existing one is a costly and time-consuming process that typically takes many years to conclude. Local public opposition often increases the time and uncertainty of successfully permitting a facility. In the Bergen and Passaic Counties, New Jersey disposal area and the Tulsa and Muskogee, Oklahoma area, entry by a new MSW disposal facility would be costly and time-consuming, and unlikely to prevent market incumbents from significantly raising prices for the disposal of MSW following the acquisition.

b. Anticompetitive Effects in the Disposal of Municipal Solid Waste.

(1) Bergen and Passaic Counties, New Jersey Disposal Area. The proposed acquisition would reduce from four to three the number of significant competitors for the disposal of MSW in the Bergen and Passaic Counties, New Jersey disposal area. Defendants Waste Management and Allied operate five of the nine transfer stations in this market and collectively control over 55 percent of the available disposal capacity for Bergen and Passaic Counties. Annual revenue from disposal of waste in Bergen and Passaic Counties, New Jersey is over $50 million.

(2) Tulsa and Muskogee, Oklahoma Area. In the Tulsa and Muskogee, Oklahoma area, the acquisition would reduce from three to two the number of significant firms competing to dispose of MSW. There are currently four owners of the six landfills that service the Tulsa and Muskogee, Oklahoma area. Two of the six landfills are expected to close in the near future, leaving four landfills owned by three companies to service haulers in the area. After the acquisition, Waste Management would own three of the four remaining landfills in this area.

The Complaint alleges that a combination of Waste Management and Allied in the Bergen and Passaic Counties, New Jersey disposal area and the Tulsa and Muskogee, Oklahoma area would remove a significant competitor in the market for the disposal of MSW. In each of these markets, the resulting increase in concentration, loss of competition, and absence of any reasonable prospect of significant new entry or expansion by market incumbents likely will result in higher prices for the disposal of MSW.

III. Explanation of the Proposed Final Judgment

A. Small Container Commercial Waste Collection Service

The divestiture and contract-revision requirements of the proposed Final Judgment will eliminate the anticompetitive effects of the acquisition in small container commercial waste collection services in the markets identified in the Complaint by establishing a new, independent, and economically viable competitor in each of those markets and, in some areas, by also reducing the barriers to entry created by the contracts currently used by Waste Management. the proposed Final Judgment requires Waste Management, within 90 days after the filing of the Complaint, or five (5) days after notice of the entry of the Final Judgment by the Court, whichever is later, to divest, as a viable ongoing business or businesses, small container commercial waste collection assets (*e.g.,* routes, trucks, containers, and customer lists) in the areas of Pitkin County, Colorado; Garfield County, Colorado; Augusta, Georgia; and Myrtle Beach, South Carolina. On or before January 1, 2005, the proposed Final Judgment also requires Waste Management to alter the contracts it uses with it existing and new small container commercial waste customers in the areas of Myrtle Beach, South Carolina and Augusta, Georgia. The proposed Final Judgment further requires Defendants, within 90 days after approval by the New Jersey Department of Environmental Protection of Waste Management's request to acquire assets in New Jersey, to divest certain waste-hauling and disposal assets located in New Jersey and New York. The assets must be divested in such a way as to satisfy the United States that the operations can and will be operated by the purchaser or purchasers as a viable, ongoing business or businesses that can compete effectively in each relevant market. Defendants must take all reasonable steps necessary to accomplish the divestitures quickly and shall cooperate with prospective purchasers.

In the event that Defendants do not accomplish the divestitures within the periods prescribed in the proposed Final Judgment, the Final Judgment provides that the Court will appoint a trustee selected by the United States to effect the divestitures. If a trustee is appointed, the proposed Final Judgment provides that Waste Management will pay all costs and expenses of the trustee. The trustee's commission will be structured so as to provide an incentive for the trustee based on the price obtained and the speed with which the divestitures are accomplished. After his or her appointment becomes effective, the trustee will file monthly reports with the Court, United States, and New Jersey as appropriate, setting forth his or her efforts to accomplish the divestitures. At the end of six months, if the divestitures have not been accomplished, the trustee, United States, and New Jersey as appropriate, will make recommendations to the Court, which shall enter such orders as appropriate in order to carry out the purpose of the trust, including extending the trust or the term of the trustee's appointment.

1. Pitkin County, Colorado and Garfield County, Colorado

The divestiture provisions of the proposed Final Judgment will eliminate the anticompetitive effects of the acquisition in small container commercial waste collection services in Pitkin County, Colorado and Garfield County, Colorado. Under the proposed Final Judgment, Waste Management is required to divest seven routes that serve small container commercial waste collection customers, among others, in Pitkin County, Colorado and Garfield County, Colorado to a new, independent, and economically viable competitor in these areas. These divestitures include all of Waste Management's existing small container commercial waste collection routes in the two counties. Many of Waste Management's small container commercial accounts in Pitkin County, Colorado and Garfield County, Colorado are not allocated, however, to a specific route, and their collective sale would not likely produce an efficient divestiture package. Accordingly, a majority of the routes that Waste Management must divest serve a mixture of small container commercial customers and residential customers. The package of routes to be divested produces annual revenues roughly equivalent to the $2 million in annual revenues generated by all of Waste Management's small container commercial accounts in Pitkin County, Colorado and Garfield County, Colorado.

2. Myrtle Beach, South Carolina Area and Augusta, Georgia Area

In the Myrtle Beach, South Carolina and Augusta, Georgia areas, the United States determined that competition would be best maintained by requiring a combination of divestiture and contract relief. The divestiture relief in the Myrtle Beach, South Carolina and Augusta, Georgia areas requires Waste Management to divest all but one of Allied's small container commercial waste collection routes in each area. The divestitures of these routes to a new, independent, and economically viable competitor will help to eliminate the anticompetitive effects of the acquisition in small container commercial waste collection in the Myrtle Beach, South Carolina and Augusta, Georgia areas by creating a competitor capable of restoring competition that otherwise would have been lost.

Because these divestitures alone will not fully eliminate the anticompetitive effects of the acquisition in each area, they are augmented by decree provisions that obligate Waste Management to alter all of its contracts with its small container commercial waste customers. The new contracts are less restrictive in duration, renewal terms, and the liquidated damages imposed on a customer who wishes to switch its service to a new hauler. Contract relief is significant because it lowers entry barriers and effectively enables smaller competitors to grow and new competitors to enter. This contract relief will make it easier for customers to consider competitive alternatives, easier for existing small haulers to compete and expand in the future, and more difficult for incumbent haulers to price discriminate successfully. The contract provisions also make it easier for new haulers to enter a market, and raise the prospect that the markets will become less concentrated and more competitive than they were pre-acquisition by enabling smaller firms to compete for customers under contract with incumbent hauling firms.

Waste Management's implementation of the contract relief specified in the proposed Final Judgment should permit the purchaser of the divested assets, and other competitors, to maintain efficient routes and gain customers more easily if Waste Management seeks to raise prices in these markets. The combined route divestitures and contract relief sought in the Myrtle Beach, South Carolina area and Augusta, Georgia area, will ensure that consumers of small container commercial waste collection services will continue to receive the benefits of competition.

3. Morris County, New Jersey and Bergen and Passaic Counties, New Jersey

The proposed Final Judgment requires partial divestitures of the Allied small container commercial waste collection assets being acquired by Waste Management in Morris County, New Jersey and in Bergen and Passaic Counties, New Jersey. The proposed acquisition raised competitive concerns in these areas based upon the significant post-acquisition market concentration and Waste Management's post-acquisition market share. The United States, however, determined that partial divestitures of Allied's small container commercial waste collection routes would be acceptable in each area in light of the other, albeit less substantial, third-party competitors located therein. In addition, the post-acquisition market concentrations identified in Morris County, New Jersey and Bergen and Passaic Counties, New Jersey were lower than those found in other areas addressed in the proposed Final Judgment. These divestitures will ensure that consumers of small container commercial waste collection services in Morris County, New Jersey and Bergen and Passaic Counties, New Jersey will continue to receive the benefits of competition—lower prices and better service.

B. Disposal of Municipal Solid Waste in the Bergen and Passaic Counties, New Jersey Disposal Area and the Tulsa and Muskogee, Oklahoma Area

1. Bergen and Passaic Counties, New Jersey Disposal Area

Waste Management's proposed acquisition of two Allied transfer station disposal facilities in Bergen County, New Jersey raised significant concerns about the availability of sufficient disposal capacity for haulers of MSW generated in Bergen and Passaic Counties, New Jersey. To remedy the anticompetitive effects of the proposed acquisition, the proposed Final Judgment requires Waste Management to divest the Garofalo Transfer Station in Garfield, New Jersey and the Chestnut Ridge Solid Waste Transfer Station in Chestnut Ridge, New York. In addition to the divestitures, the proposed Final Judgment requires that Waste Management sell throughput disposal rights to a third party at the New Jersey Meadowlands Commission's HMDC Transfer Station for the remainder of Waste Management's current lease, and if the lease is renewed, for the duration of the period in which Waste Management has contractual rights to operate the facility, not to exceed the termination date of the proposed Final Judgment. Collectively, the throughput disposal rights and divestitures provide haulers of MSW generated in Bergen and Passaic Counties, New Jersey with a range of options providing at least 1,200 tons per day of uncommitted MSW disposal capacity. In the event that Waste Management is unable to divest the Chestnut Ridge Solid Waste Transfer Station by the date specified in the proposed Final Judgment, it will, in the alternative, divest one of three Bergen County, New Jersey transfer stations. The divestiture and throughput disposal provisions of the proposed Final Judgment will fully eliminate the anticompetitive effects of the acquisition for MSW disposal services in the Bergen and Passaic Counties, New Jersey disposal area.

The proposed Final Judgment requires that all divested assets be acquired by a new, independent, and economically viable competitor. The proposed relief

will thereby ensure that users of disposal services in these areas will continue to receive the benefits of competition.

2. Tulsa and Muskogee, Oklahoma Area

Defendants agreed to exclude from the transaction the proposed sale of all waste-hauling and disposal assets in the Tulsa and Muskogee, Oklahoma area in light of concerns expressed by the United States regarding the increased concentration in MSW disposal that would occur. The proposed Final Judgment requires Waste Management to provide written notice to the United States at least 30 days in advance of its acquisition of any landfill located within 25 miles of the city of Tulsa, Oklahoma or the city of Muskogee, Oklahoma. If Waste Management again proposes to acquire the Porter Landfill originally scheduled to be purchased in this transaction, the notice required from Waste Management shall also include the additional information specified in the proposed Final Judgment. The proposed Final Judgment thus maintains the pre-acquisition structure of MSW disposal competition in the Tulsa and Muskogee, Oklahoma area, and thereby ensures that users of disposal services in the area will continue to receive the benefits of competition.

IV. Remedies Available to Potential Private Litigants

Section 4 of the Clayton Act (15 U.S.C. 15) provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages the person has suffered, as well as costs and reasonable attorneys' fees. Entry of the proposed Final Judgment will neither impair nor assist the bringing of any private antitrust damage action. Under the provisions of Section 5(a) of the Clayton Act (15 U.S.C. 16(a)), the proposed Final Judgment has no *prima facie* effect in any subsequent lawsuit that may be brought against the Defendants.

V. Procedures Available for Modification of the Proposed Final Judgment

The United States, New Jersey, and Defendants have stipulated that the proposed Final Judgment may be entered by the Court after compliance with the provisions of the APPA, provided that the United States has not withdrawn its consent. The APPA conditions entry upon the Court's determination that the proposed Final Judgment is in the public interest.

The APPA provides a period of at least 60 days preceding the effective date of the proposed Final Judgment within which any person may submit the United States written comments regarding the proposed Final Judgment. Any person who wishes to comment should do so within 60 days of the date of publication of this Competitive Impact Statement in the **Federal Register**. The United States will evaluate and respond to the comments. All comments will be given due consideration by the Department of Justice, which remains free to withdraw its consent to the proposed Final Judgment at any time prior to entry. The comments and the response of the United States will be filed with the Court and published in the **Federal Register**.

Written comments should be submitted to:

J. Robert Kramer II, Chief, Litigation II Section, Antitrust Division, United States Department of Justice, 1401 H Street, NW., Suite 3000, Washington, DC. 20530.

The proposed Final Judgment provides that the Court retains jurisdiction over this action, and the parties may apply to the Court for any order necessary or appropriate for the modification, interpretation, or enforcement of the Final Judgment.

VI. Alternatives to the Proposed Final Judgment

The United States considered, as an alternative to the proposed Final Judgment, a full trial on the merits against Defendants. The United States could have continued to litigation and sought preliminary and permanent injunctions against Waste Management's acquisition of certain Allied voting securities and assets. The United States is satisfied, however, that the divestiture of assets and the contract relief described in the proposed Final Judgment will preserve competition for small container commercial waste collection services and MSW disposal in the relevant markets identified by the United States.

VII. Standard of Review Under the APPA for the Proposed Final Judgment

The APPA requires that proposed consent judgments in antitrust cases brought by the United States be subject to a 60-day comment period, after which the Court shall determine whether entry of the proposed Final Judgment ''is in the public interest.'' In making that determination, the Court may consider:

(1) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration or relief sought, anticipated effects of alternative remedies actually considered, and any other considerations bearing upon the adequacy of such judgment;

(2) the impact of entry of such judgment upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

15 U.S.C. 16(e). As the United States Court of Appeals for the D.C. Circuit held, this statue permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the decree is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties. *See United States* v. *Microsoft,* 56 F.3d 1448, 1461–62 (D.C. Cir. 1995).

In conducting this inquiry, ''[t]he court is nowhere compelled to go to trial or to engage in extended proceedings which might have the effect of vitiating the benefits of prompt and less costly settlement through the consent decree process.'' 119 Cong. Rec. 24,598 (1973) (statement of Senator Tunney).[1] Rather,

> [a]bsent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest finding, should * * * carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances.

United States v. *Mid-Am. Dairymen, Inc.,* 1977–1 Trade Cas. (CCH) ¶ 61,508, at 71,980 (W.D. Mo. May 17, 1977).

Accordingly, with respect to the adequacy of the relief secured by the decree, a court may not ''engage in an unrestricted evaluation of what relief would best serve the public.'' *United States* v. *BNS, Inc.,* 858 F.2d 456, 462 (9th Cir. 1988) (citing *United States* v. *Bechtel Corp.,* 648 F.2d 660, 666 (9th

[1] *See also United States* v. *Gillete Co.,* 406 F. Supp. 713, 716 (D. Mass. 1975) (recognizing it was not the court's duty to settle; rather, the court must only answer ''whether the settlement achieved [was] within the reaches of the public interest''). A ''public interest'' determination can be made properly on the basis of the Competitive Impact Statement and Response to Comments filed pursuant to the APPA. Although the APPA authorizes the use of additional procedures, 15 U.S.C. 16(f), those procedures are discretionary. A court need not invoke any of them unless it believes that the comments have raised significant issues and that further proceedings would aid the court in resolving those issues. *See* H.R. Rep. No. 93–1463, 93rd Cong., 2d Sess. 8–9 (1974), *reprinted* in 1974 U.S.C.C.A.N. 6535, 6538.

Cir. 1981)); *see also Microsoft,* 56 F.3d at 1460–62. Case law requires that

> [t]he balancing of competing social and political interests affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is *''within the reaches of the public interest.''* More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted) [2]

The proposed Final Judgment, therefore, should not be reviewed under a standard of whether it is certain to eliminate every anticompetitive effect of a particular practice or whether it mandates certainty of free competition in the future. Court approval of a final judgment requires a standard more flexible and less strict than the standard required for a finding of liability. ''(A) proposed decree must be approved even if it falls short of the remedy the court would impose on its own, as long as it falls within the range of acceptability or is 'within the reaches of public interest.' '' *United States* v. *Am. Tel. & Tel. Co.,* 552 F. Supp. 131, 151 (D.D.C. 1982) (citations omitted) (quoting *Gillete*, 406 F. Supp. at 716), *aff'd sub nom. Maryland* v. *United States,* 460 U.S. 1001 (1983); *see also United States* v. *Alcan Aluminum Ltd.,* 605 F. Supp. 619, 622 (W.D. Ky. 1985) (approving the consent decree even though the court would have imposed a greater remedy).

Moreover, the Court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its Complaint, and does not authorize the Court to ''construct (its) own hypothetical case and then evaluate the decree against that case.'' *Microsoft,* 56 F.3d at 1459. Because the ''court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in the first place,'' it follows that ''the court is only authorized to review the decree itself,'' and not to ''effectively redraft the complaint'' to inquire into other matters that the United States might have but did not pursue. *Id.* at 1459–60.

[2] *Cf. BNS,* 858 F.2d at 463 (holding that the court's ''ultimate authority under the (APPA) is limited to approving or disapproving the consent decree''); *Gillette,* 406 F. Supp. at 716 (noting that, in this way, the court is constrained to ''look at the overall picture not hypercritically, nor with a microscope, but with an artist's reducing glass''). *See generally Microsoft,* 56 F.3d at 1461 (discussing whether ''the remedies (obtained in the decree are) so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest'''').

VIII. Determinative Documents

There are no determinative materials or documents within the meaning of the APPA that were considered by the United States in formulating the proposed Final Judgment.

Dated: July 22, 2003.

Respectfully submitted,

Michael K. Hammaker,
DC Bar No. 233684, U.S. Department of Justice, Antitrust Division, Litigation II Section, 1401 H Street, NW., Suite 3000, Washington, DC 20530, (202) 307–0938.

Certificate of Service

I hereby certify that a copy of the foregoing has been served upon Waste Management, Inc., Allied Waste Industries, Inc., and the State of New Jersey by placing a copy of this Competitive Impact Statement in the U.S. mail, first class and postage prepaid, directed to each of the above-named parties at the addresses given below, this 22nd day of July, 2003.

Counsel for Defendant Waste Management, Inc.,
James R. Weiss,
Preston Gates Ellis & Rouvelas Meeds LLP, 1735 New York Avenue, NW., Suite 500, Washington, DC 20006, (202) 628–1700.

Counsel for Defendant Allied Waste Industries, Inc.,
Tom D. Smith,
Jones Day, 51 Louisiana Avenue, NW., Washington, DC 20001–2113, (202) 879–3971.

Counsel for Plaintiff State of New Jersey,
Andrew L. Rossner,
Assistant Attorney General—Deputy Director, New Jersey Division of Criminal Justice, P.O. Box 085, Trenton, New Jersey 08625–0085, (609) 984–0028.

Michael K. Hammaker,
DC Bar No. 233684, U.S. Department of Justice, Antitrust Division, Litigation II Section, 1401 H Street, NW., Suite 3000, Washington, DC 20530, (202) 307–0938.

[FR Doc. 03–20521 Filed 8–11–03; 8:45 am]
BILLING CODE 4410–11–M

DEPARTMENT OF LABOR

Mine Safety and Health Administration

Petitions for Modification

The following parties have filed petitions to modify the application of existing safety standards under section 101(c) of the Federal Mine Safety and Health Act of 1977.

1. Jim Walter Resources, Inc.

[Docket No. M–2003–054–C]

Jim Walter Resources, Inc., P.O. Box 133, Brookwood, Alabama 35444 has filed a petition to modify the application of 30 CFR 75.503 (Permissible electric face equipment; maintenance) to its No. 4 Mine (MSHA I.D. No. 01–01247) located in Tuscaloosa County, Alabama. The petitioner requests a modification of the existing standard to allow use of extended length cables on underground coal mining equipment. The petitioner proposes to use the extended length cable to power 2,400-volt continuous mining machines. The petitioner has listed in this petition for modification specific terms and conditions that would be followed when its proposed alternative method is implemented. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

2. Jim Walter Resources, Inc.

[Docket No. M–2003–055–C]

Jim Walter Resources, Inc., P.O. Box 133, Brookwood, Alabama 35444 has filed a petition to modify the application of 30 CFR 75.1002 (Location of trolley wires, trolley feeder wires, high-voltage cables and transformers) to its No. 4 Mine (MSHA I.D. No. 01–01247) located in Tuscaloosa County, Alabama. The petitioner proposes to use 2,400-volt high-voltage trailing cable to power a continuous miner inby the last open crosscut and within 150 feet of pillar workings. The petitioner has listed in this petition for modification specific terms and conditions that would be followed when its proposed alternative method is implemented. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

Request for Comments

Persons interested in these petitions are encouraged to submit comments via e-mail to comments@msha.gov, or on a computer disk along with an original hard copy to the Office of Standards, Regulations, and Variances, Mine Safety and Health Administration, 1100 Wilson Boulevard, Room 2352, Arlington, Virginia 22209. All comments must be postmarked or received in that office on or before September 11, 2003. Copies of these petitions are available for inspection at that address.

Dated at Arlington, Virginia this 5th day of August 2003.

Marvin W. Nichols, Jr.,

Director, Office of Standards, Regulations, and Variances.

[FR Doc. 03–20438 Filed 8–11–03; 8:45 am]

BILLING CODE 4510–43–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

National Endowment for the Arts;

Leadership Initiatives Adivsory Panel

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), as amended, notice is hereby given that a meeting of the Leadership Initiatives Advisory Panel, AccessAbility section, will be held by teleconference from 2 p.m.–3:30 p.m. on Friday, August 29, 2003, from Room 724 at the Nancy Hanks Center, 1100 Pennsylvania Avenue, NW., Washington, DC 20506.

This meeting is for the purpose of Panel review, discussion, evaluation, and recommendations on financial assistance under the National Foundation on the Arts and the Humanities Act of 1965, as amended, including information given in confidence to the agency. In accordance with the determination of the Chairman of April 30, 2003, these sessions will be closed to the public pursuant to subsection (c)(6) of section 552b of Title 5, United States Code.

Further information with reference to this meeting can be obtained from Ms. Kathy Plowitz-Worden, Panel Coordinator, National Endowment for the Arts, Washington, DC 20506, or call 202/682–5691.

Dated: August 5, 2003.

Kathy Plowitz-Worden,

Panel Coordinator, Panel Operations, National Endowment for the Arts.

[FR Doc. 03–20450 Filed 8–11–03; 8:45 am]

BILLING CODE 7537–01–P

NATIONAL SCIENCE FOUNDATION

National Science Board and Its Subdivisions; Sunshine Act Meeting

FEDERAL REGISTER CORRECTION OF PREVIOUS ANNOUNCEMENT: Volume 68, Number 153, pp. 47369–47370 **Federal Register,** August 8, 2003, Sunshine Act 03–20353

DATE AND TIME:

August 13, 2003: 8:30 a.m.–5 p.m.

Concurrent Sessions:

9 a.m.–9:40 a.m. Closed Session
9:40 a.m.–12 noon Open Session
12:30 p.m.–12:50 p.m. Open Session
12:50 p.m.–1:15 p.m. Closed Session
1:30 p.m.–3:30 p.m. Open Session
1:30 p.m.–3 p.m. Open Session
3:15 p.m.–3:30 p.m. Closed Session
3:30 p.m.–5:30 p.m. Open Session
3:30 p.m.–4:30 p.m. Open Session

August 14, 2003: 8 a.m.–3:30 p.m.

Concurrent Sessions:

8 a.m.–9:15 a.m. Closed Session
9:15 a.m.–10:30 a.m. Open Session
8:30 a.m.–10:30 a.m. Open Session
10:30 a.m.–12 noon Closed Session
12:30 p.m.–3:30 p.m. Open Session

PLACE: The National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230, *http://www.nsf.gov/nsb.*

FOR FURTHER INFORMATION CONTACT: NSF Information Center (703) 292–5111.

STATUS: Part of this meeting will be closed to the public. Part of this meeting will be open to the public

MATTERS TO BE CONSIDERED:

Wednesday, August 13, 2003

Open

Committee on Strategy and Budget (9:40 a.m.–12 noon)
Room 1235
- Draft Strategic Plan
- Discussion: Report Required by Section 22 of the NSF Authorization Act
- Introduction
- S&E Workforce
- Expanding Institutional Participation
- S&E Research Infrastructure
- Size and Duration of Grants
- Overall Spending Recommendations

Executive Committee (12:30 p.m.–12:50 p.m.)
Room 1295
- Minutes
- Welcome New Executive Officer

Committee on Audit and Oversight (1:30 p.m.–3 p.m.)
Room 1295
- Minutes
- Audit Update—KPMG
- IG Act Anniversary
- GAO Review of NSF Business Analysis Plan Contract
- Cost-Sharing Policy Update
- CFO Update
- CIO Update

Subcommittee on S&E Indicators (1:30 p.m.–3:30 p.m.)
Room 1295
- Approval of Minutes
- S&E Indicators 2004 Overview Chapter
- Distribution of the Orange Book for Agency Review
- S&E Indicators 2004 Companion Piece

Ad Hoc Task Group on Long-Lived Data Collections (3:30 p.m.–5:30 p.m.)
Room 1240
- Issues Facing NSF on Long-Lived Data Collections: Reports from Directorates
- Future Activities

Task Force on S&E Workforce Policy (3:30 p.m.–4:30 p.m.)
Room 1235
- Approval of Minutes, May 21 and July 10
- Discussion of comments from Board members on the revised draft report (NSB–03–69)
- Report on Comments Received
- Publicity Plan and Schedule for the Final Report; Roll-out Event Options
- Cover and Title

Closed

Committee on Strategy & Budget (9 a.m.–9:40 a.m.)
Room 1235
- FY 2005 NSF Budget
- FY 2005 NSB Budget

Executive Committee (12:50 p.m.–1:15 p.m.)
Room 1295
- Director's Items
- Specific Personnel Matters
- Future Budgets

Audit & Oversight (3:15 p.m.–3:30 p.m.)
Room 1295
- Presentation of OIG FY 2005 Budget
- Briefing About Active Investigation

Thursday, August 14, 2003

Open

Committee on Programs and Plans (9:15 a.m.–10:30 a.m.)
Room 1235
- Minutes/Announcements
- Section 14 Authorization—Letter to Congress Regarding Delegation of Authority on Approval of MREFC Items
- High Risk Research
- Management of Large Computational Facilities
- Long-Lived Data Collections: Status Report
- Infrastructure Committee

Committee on Education and Human Resources (8:30 a.m.–10:30 a.m.) Room 1295
Minutes
- Minutes
- Comments from the Chair
- Discussion: NWP Task Force Report
- Reports from Working Groups (K–12, Undergraduate & Graduate)
- Report from Subcommittee on S&E Indicators
- Focus on the Future: BIO 2010

(continued)

• Report from the August 12th Workshop on Broadening Participation
• Report from the EHR AD
• New Business

Plenary Session of the Board (12:30 p.m.–3:30 p.m.)

Room 1235

• Oath of Office
• Minutes
• Closed Items, October 2003
• Chairman's Report
• Director's Report
• NSF Strategic Plan, 2003–2008
• NWP Report
• Multidisciplinary Data Initiative
• NSB Wireless Connectivity Update
• Committee Reports

Closed

Committee on Programs and Plans (8 a.m.–9:15 a.m.)

Room 1235

• Major Research Equipment & Facilities Construction
• Report on Meeting of the MREFC Panel
• New MREFC Project

Plenary Session of the Board (10:30 a.m.–12 Noon)

Room 1235

• Closed Minutes
• Member Proposal
• FY 2005 Budget
• Closed Session Committee Reports

Michael P. Crosby,

Executive Officer, NSB.

[FR Doc. 03–20596 Filed 8–8–03; 12:48 pm]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

Agency Information Collection Activities: Submission for the Office of Management and Budget (OMB) Review; Comment Request

AGENCY: U.S. Nuclear Regulatory Commission (NRC).

ACTION: Notice of the OMB review of information collection and solicitation of public comment.

SUMMARY: The NRC has recently submitted to OMB for review the following proposal for the collection of information under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35). The NRC hereby informs potential respondents that an agency may not conduct or sponsor, and that a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

1. Type of submission, new, revision, or extension: Revision.

2. The title of the information collection: DOE/NRC Form 741, Nuclear Material Transaction Report and NUREG/BR–0006, Instructions for Completing Nuclear Material Transaction Reports.

3. The form number if applicable: DOE/NRC Form 741.

4. How often the collection is required: As occasioned by special nuclear material or source material transfers, receipts or inventory changes that meet certain criteria. Licensees range from not submitting any forms to submitting over 5,000 forms in a year.

5. Who will be required or asked to report: Persons licensed to process specified quantities of special nuclear material or source material, and licensees of facilities on the U.S. eligible list who have been notified in writing by the Commission that they are subject to Part 75.

6. An estimate of the number of annual responses: 36,500 (14,600 NRC licensees and 21,900 Agreement State licensees).

7. The estimated number of annual respondents: 400 (160 NRC licensees and 240 Agreement State licensees).

8. An estimate of the total number of hours needed annually to complete the requirement or request: 45,625 hours (18,250 NRC licensees and 27,375 Agreement State licensees).

9. An indication of whether Section 3507(d), Public Law 104–13 applies: N/A.

10. Abstract: NRC and Agreement State licensees are required to make inventory and accounting reports on DOE/NRC Form 741 for certain source or special nuclear material, or for transfer or receipt of 1 kilogram or more of source material. The use of DOE/NRC Form 740M, and 741, together with NUREG/BR–0006, the instructions for completing the forms, enables NRC to collect, retrieve, analyze as necessary, and submit the data to IAEA to fulfill its reporting responsibilities.

A copy of the final supporting statement may be viewed free of charge at the NRC Public Document Room, One White Flint North, 11555 Rockville Pike, Room O–1 F21, Rockville, MD 20852. OMB clearance requests are available at the NRC World Wide Web site: *http://www.nrc.gov/public-involve/doc-comment/omb/index.html.* The document will be available on the NRC home page site for 60 days after the signature date of this notice.

Comments and questions should be directed to the OMB reviewer listed below by September 11, 2003. 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. Bryon Allen, Office of Information and Regulatory Affairs (3150–0003), NEOB–10202, Office of Management and Budget, Washington, DC 20503.

Comments can also be submitted by telephone at (202) 395–3087.

The NRC Clearance Officer is Brenda Jo. Shelton, 301–415–7233.

Dated at Rockville, Maryland, this 6th day of August, 2003.

For the Nuclear Regulatory Commission.

Brenda Jo. Shelton,

NRC Clearance Officer, Office of the Chief Information Officer.

[FR Doc. 03–20493 Filed 8–11–03; 8:45 am]

BILLING CODE 7590–01–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for OMB Review; Comment Request for Reclearance of a Revised Information Collection: RI 30–9

AGENCY: Office of Personnel Management.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, May 22, 1995), this notice announces that the Office of Personnel Management (OPM) has submitted to the Office of Management and Budget (OMB) a request for reclearance of a revised information collection. RI 30–9, Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity, informs former disability annuitants of their right to request restoration under title 5, U.S.C., Section 8337. It also specifies the conditions to be met and the documentation required for a person to request reinstatement.

Approximately 200 forms are completed annually. The form takes approximately 60 minutes to respond, including a medical examination. The annual estimated burden is 200 hours. Burden may vary depending on the time required for a medical examination.

For copies of this proposal, contact Mary Beth Smith-Toomey on (202) 606–8358, FAX (202) 418–3251 or via E-mail to *mbtoomey@opm.gov.* Please include a mailing address with your request.

DATES: Comments on this proposal should be received on or before September 11, 2003.

ADDRESSES: Send or deliver comments to—

Ronald W. Melton, Chief, Operations Support Group, Center for Retirement and Insurance Services, U.S. Office of

Personnel Management, 1900 E Street, NW., Room 3349, Washington, DC 20415–3540;

and

Allison Eydt, OPM Desk Officer, Office of Information & Regulatory Affairs, Office of Management and Budget, New Executive Office Building, NW., Room 10235, Washington, DC 20503.

FOR INFORMATION REGARDING ADMINISTRATIVE COORDINATION—CONTACT: Cyrus S. Benson, Team Leader, Publications Team, RIS Support Services, Support Group, (202) 606–0623.

Office of Personnel Management.

Kay Coles James,

Director.

[FR Doc. 03–20444 Filed 8–11–03; 8:45 am]

BILLING CODE 6325–50–P

OFFICE OF PERSONNEL MANAGEMENT

Federal Prevailing Rate Advisory Committee; Open Committee Meetings

According to the provisions of section 10 of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that meetings of the Federal Prevailing Rate Advisory Committee will be held on—

Thursday, August 21, 2003,
Thursday, September 18, 2003,
Thursday, October 2, 2003.

The meetings will start at 10 a.m. and will be held in Room 5A06A, Office of Personnel Management Building, 1900 E Street, NW., Washington, DC.

The Federal Prevailing Rate Advisory Committee is composed of a Chair, five representatives from labor unions holding exclusive bargaining rights for Federal blue-collar employees, and five representatives from Federal agencies. Entitlement to membership on the Committee is provided for in 5 U.S.C. 5347.

The Committee's primary responsibility is to review the Prevailing Rate System and other matters pertinent to establishing prevailing rates under subchapter IV, chapter 53, 5 U.S.C., as amended, and from time to time advise the Office of Personnel Management.

This scheduled meeting will start in open session with both labor and management representatives attending. During the meeting either the labor members or the management members may caucus separately with the Chair to devise strategy and formulate positions. Premature disclosure of the matters discussed in these caucuses would unacceptably impair the ability of the Committee to reach a consensus on the matters being considered and would disrupt substantially the disposition of its business. Therefore, these caucuses will be closed to the public because of a determination made by the Director of the Office of Personnel Management under the provisions of section 10(d) of the Federal Advisory Committee Act (Pub. L. 92–463) and 5 U.S.C. 552b(c)(9)(B). These caucuses may, depending on the issues involved, constitute a substantial portion of a meeting.

Annually, the Chair compiles a report of pay issues discussed and concluded recommendations. These reports are available to the public, upon written request to the Committee's Secretary.

The public is invited to submit material in writing to the Chair on Federal Wage System pay matters felt to be deserving of the Committee's attention. Additional information on this meeting may be obtained by contacting the Committee's Secretary, Office of Personnel Management, Federal Prevailing Rate Advisory Committee, Room 5538, 1900 E Street, NW., Washington, DC 20415 (202) 606–1500.

Dated: August 4, 2003.

Mary M. Rose,

Chairperson, Federal Prevailing Rate Advisory Committee.

[FR Doc. 03–20446 Filed 8–11–03; 8:45 am]

BILLING CODE 6325–49–M

OFFICE OF PERSONNEL MANAGEMENT

Personnel Demonstration Project; Alternative Personnel Management System for the U.S. Department of Commerce

AGENCY: Office of Personnel Management.

ACTION: Notice of modification to the Department of Commerce Personnel Management Demonstration Project.

SUMMARY: Title VI of the Civil Service Reform Act, now codified in 5 U.S.C. chapter 47, authorizes the Office of Personnel Management (OPM) to conduct demonstration projects that experiment with new and different human resources management concepts to determine whether changes in policies and procedures result in improved Federal human resources management. On December 24, 1997, OPM approved a demonstration project covering several operating units of the U.S. Department of Commerce (DoC). In accordance with 5 CFR 470.315, this notice modifies the existing provisions for the assignment of augmented service credit for reduction-in-force purposes under the performance appraisal system.

DATES: This notice modifying the DoC Demonstration Project is effective August 12, 2003.

FOR FURTHER INFORMATION CONTACT: Department of Commerce: Edward Liverani, U.S. Department of Commerce, 14th and Constitution Avenue NW., Room 5004, Washington, DC 20230, (202) 482–0272; Office of Personnel Management: Delmar D. White, U.S. Office of Personnel Management, 1900 E Street NW., Room 6H31, Washington, DC 20415, (202) 606–1578.

SUPPLEMENTARY INFORMATION:

1. Background

OPM approved the Department of Commerce Demonstration Project and published the final plan in the **Federal Register** on Wednesday, December 24, 1997, Volume 62, Number 247, part II. The project was implemented on March 29, 1998, and modified in the **Federal Register** on Thursday, September 30, 1999, Volume 64, Number 189 [Notices] [Page 52810–52812]. On February 14, 2003, OPM authorized an extension of the demonstration project to March 28, 2008, to provide time to test and evaluate the large number of innovations implemented under this project.

Office of Personnel Management.

Kay Coles James,

Director.

Table of Contents

I. Executive Summary

The Department of Commerce Demonstration Project utilizes many features similar to those implemented by the National Institute of Standards and Technology (NIST) Demonstration Project in 1988. The key features of the project involve increased delegation of authority and accountability to line managers, simplified classification and broad banding, pay for performance, hiring and pay-setting flexibilities, and modified reduction-in-force procedures. The DoC project is designed to test whether the innovations of the NIST project, which is now a permanent system, can be successful in other DoC environments. The participating organizations include the Technology Administration, the Bureau of Economic Analysis, the Institute for Telecommunication Sciences, and three units of the National Oceanic and

Atmospheric Administration: Office of Oceanic and Atmospheric Research, National Marine Fisheries Service, and the National Environmental Satellite, Data, and Information Service.

II. Basis for Project Plan Modification

There are two types of ratings of record that may be assigned to employees within the DoC Demonstration Project: *eligible* and *unsatisfactory. Eligible* is a rating indicating an acceptable level of performance. *Unsatisfactory* is a rating indicating an unacceptable level of performance.

Currently the demonstration project provides additional service retention credit only to those employees with a rating of record of *eligible* and whose overall performance score ranks within the top 30 percent of all scores within their pay pool. These employees are credited with 10 years of additional service retention credit in the event of a reduction-in-force. The total additional service retention credit that may be awarded to an employee is based on each of the employee's three most recent annual performance scores received during the 4-year period immediately prior to an established cutoff date. The potential additional service retention credit, therefore, totals 30 years. No additional service retention credit is awarded to employees who have not received a score in the top 30 percent of their pay pool. In accordance with the demonstration project, DoC also does not provide any performance-related retention credit to employees who are hired or transfer into the demonstration project from any other performance appraisal system.

Project evaluations and comments received from employees and employee groups (*e.g.*, unions) indicate that the current policy of limiting additional service retention credit to employees within the top 30 percent of all scores in their pay pool is unfairly weighted against other employees who have achieved an acceptable level of performance but who did not score within the top 30 percent.

To address this issue, the DoC Departmental Personnel Management Board (DPMB) has approved a modification to the project plan to provide additional service retention credit to all employees rated *eligible* within the demonstration project, even if their scores do not fall within the top 30 percent of their pay pool. All employees rated *eligible,* other than the top 30 percent, will be awarded an additional 5 years of service retention credit for each *eligible* rating of record in the event of a reduction-in-force. The total additional service retention credit that may be awarded to an employee is based on each of the employee's three most recent annual performance scores received during the 4-year period immediately prior to an established cutoff date.

The Department of Commerce plans to expand the demonstration project to include other organizations within the Department. Various officials expressed concern that the current policy places new employees at a disadvantage because no prior performance-related retention credit is permitted. In response to these concerns, the DPMB approved a new policy of awarding performance-related retention credit for Federal employees who are hired or transfer into the demonstration project.

III. Changes to the Project Plan

The following discussion refers readers to the substantive changes to the project plan. The referenced page number refers to the page in the final plan, published in the **Federal Register** on December 24, 1997, and the notice of modification to that plan published in the **Federal Register** on September 30, 1999.

Page 67451. Replace Paragraph C.3 ''Link between Performance and Retention'' in its entirety as follows: An employee rated *eligible* with an overall performance score within the top 30 percent of scores within a pay pool (See Performance Evaluation and Rewards) will be credited with 10 additional years of service for retention credit. An employee rated *eligible* with an overall performance score that does not fall within the top 30 percent of scores within a pay pool will be credited with 5 additional years of service for retention credit. The total credit will be based on the employee's three most recent annual performance scores received during the 4-year period prior to an established cutoff date.

Employees who convert to this system from any other performance appraisal system within the Federal Government will receive 5 additional years of service for retention credit for each performance rating of record equivalent to an *eligible* rating in the demonstration project. Just as with other employees in the project, the total credit will be based on the employee's three most recent annual performance scores received during the 4-year period prior to an established cutoff date. Career status and veteran preference will continue to have the same effect on retention standing as they now have under current regulations.

[FR Doc. 03–20447 Filed 8–11–03; 8:45 am]

BILLING CODE 6325–38–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #P013]

State of North Dakota

As a result of the President's major disaster declaration for Public Assistance on August 1, 2003, the U.S. Small Business Administration is activating its disaster loan program only for private non-profit organizations that provide essential services of a governmental nature. I find that Barnes County in the State of North Dakota constitutes a disaster area due to damages caused by severe storms and high winds occurring on June 24 and June 25, 2003. Applications for loans for physical damage as a result of this disaster may be filed until the close of business on September 30, 2003 at the address listed below or other locally announced locations: Small Business Administration, Disaster Area 3 Office, 14925 Kingsport Rd., Ft. Worth, TX 76155–2243.

The interest rates are:

	Percent
For Physical Damage:.	
Non-Profit Organizations Without Credit Available Elsewhere	*2.953*
Non-Profit Organizations With Credit Available Elsewhere	*5.500*

The number assigned to this disaster for physical damage is P01311.

(Catalog of Federal Domestic Assistance Program Nos. 59008).

Dated: August 6, 2003.

Cheri L. Cannon,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 03–20518 Filed 8–11–03; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3528, Amdt. 3]

State of Ohio

In accordance with the notice received from the Department of Homeland Security—Federal Emergency Management Agency, effective August 4, 2003, the above numbered declaration is hereby amended to include Columbiana and Mahoning Counties as disaster areas due to damages caused by severe storms and flooding occurring on July 4, 2003, and continuing through July 11, 2003.

In addition, applications for economic injury loans from small businesses located in the contiguous counties of Carroll, Jefferson, Portage, Stark, and

Trumbull in the State of Ohio; Beaver, Lawrence, and Mercer Counties in the State of Pennsylvania; and Hancock County in the State of West Virginia may be filed until the specified date at the previously designated location. All other counties contiguous to the above named primary counties have been previously declared.

The number for economic injury for the State of Pennsylvania is 9W6500 and for the State of West Virginia is 9W6600.

All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is September 15, 2003, and for economic injury the deadline is April 15, 2004.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008).

Dated: August 3, 2003.

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. 03–20471 Filed 8–11–03; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3534]

State of Ohio (Amendment #1)

In accordance with a notice received from the Department of Homeland Security—Federal Emergency Management Agency, effective August 4, 2003, the above numbered declaration is hereby amended to include Carroll, Columbiana, Cuyahoga and Stark counties as disaster areas due to damages caused by tornadoes, flooding, severe storms and high winds occurring on July 21, 2003 and continuing.

In addition, applications for economic injury loans from small businesses located in the contiguous counties of Harrison, Holmes, Jefferson, Lake and Tuscarawas in the State of Ohio; Beaver County in the State of Pennsylvania; and Hancock County in the State of West Virginia may be filed until the specified date at the previously designated location. All other counties contiguous to the above named primary counties have been previously declared.

The number for economic injury for the State of West Virginia is 9W6700.

All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is September 30, 2003, and for economic injury the deadline is May 3, 2004.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008).

Dated: August 6, 2003.

Cheri L. Cannon,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 03–20519 Filed 8–11–03; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3531]

State of Texas (Amendment #4)

In accordance with a notice received from the Department of Homeland Security—Federal Emergency Management Agency, effective August 4, 2003, the above numbered declaration is hereby amended to include Aransas County as a disaster area due to damages caused by Hurricane Claudette occurring on July 15, 2003 and continuing through July 28, 2003.

All other counties contiguous to the above named primary county have been previously declared. All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is September 16, 2003, and for economic injury the deadline is April 19, 2004.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008).

Dated: August 6, 2003.

Cheri L. Cannon,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 03–20517 Filed 8–11–03; 8:45 am]

BILLING CODE 8025–01–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVES

Notice of Meeting of the Industry Sector Advisory Committee on Small and Minority Business (ISAC–14)

AGENCY: Office of the United States Trade Representatives.

ACTION: Notice of a partially opened meeting.

SUMMARY: The Industry Sector Advisory Committee on Small and Minority Business (ISAC–14) will hold a meeting on August 18, 2003, from 9 a.m. to 3 p.m. The meeting will be closed to the public from 9 a.m. to 1 p.m. and opened to the public from 1 p.m. to 3 p.m.

DATES: The meeting is scheduled for August 18, 2003, unless otherwise notified.

ADDRESSES: The meeting will be held at the Ronald Reagan Bldg, USA Trade Center, Training Room A.

FOR FURTHER INFORMATION CONTACT: Amy Ryan, DPO for ISAC–14 at (202) 482–4792, Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230 or Christina Sevilla, Director for Intergovernmental Affairs, on (202) 395–6120.

SUPPLEMENTARY INFORMATION: During the opened portion of the meeting the following agenda items will be discussed.

- Update on the Free Trade Area of the Americas (FTAA).
- An overview of the Minority Business Development Agency's (MBDA) services and held available for small business.
- Small Business Administration's future plans to assist small businesses.
- Update from U.S. Customs on Customs Trade Partnership Against Terrorism (C–TPAT) and Best Practices.

Christopher A. Padilla,

Assistant U.S. Trade Representative for Intergovernmental Affairs and Public Liaison.

[FR Doc. 03–20501 Filed 8–11–03; 8:45 am]

BILLING CODE 3190–01–M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

[Docket OST–03–15863]

In the Matter of the Notice of Substantial Change in Ownership Filed Under 14 CFR 204.5 by ABX Air, Inc.

AGENCY: Department of Transportation.

ACTION: Notice seeking comments.

SUMMARY: The Department of Transportation is directing ABX Air, Inc., to file in the noted docket a copy of the public material that it submitted to the Department on July 15, 2003, with its notice of substantial change. Interested persons are invited to file comments on the procedures the Department should use in conducting its review of the proposed substantial change in ownership and operations on the citizenship of ABX Air, Inc.

DATES: ABX Air, Inc., should file the material at issue within 7 calendar days of the Notice. Public comments on the procedures will be due within 21 days thereafter. Comments should address only the issue of how the Department should proceed with its review, not the merits of the case.

ADDRESSES: All comments should be filed in Docket OST–03–15863 and addressed to Department of Transportation Dockets (M–30, Room PL–401), U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Ms. Janet A. Davis, Air Carrier Fitness Division (X–56, Room 6401), U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, (202) 366–9721.

Dated: August 6, 2003.

Michael W. Reynolds,

Acting Assistant Secretary for Aviation and International Affairs.

[FR Doc. 03–20470 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15869]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel CARPE DIEM.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15869 at *http://dms.dot.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD–2003 15869. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel CARPE DIEM is:

Intended Use: ''Carry passengers for hire on recreational trips.''

Geographic Region: ''Great Lakes, connecting waters and East Coast USA.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20455 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15868]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel DETERMINATION.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15868 at *http://dms.dot.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD–2003 15868. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel DETERMINATION is:

Intended Use: ''Six Pack Charter.''

Geographic Region: ''U.S. Gulf, U.S. East Coast and the Caribbean.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20457 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15867]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel LEAH.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15867 at *http://dms.dot.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD–2003 15867. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel LEAH is:

Intended Use: ''Day and week-long charter sailing voyages and sail training, offshore and coastwise United States.''

Geographic Region: ''Cape Henry (Virginia), Chesapeake Bay, and Coastwise Eastern Seaboard north to Maine.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20456 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15871]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel NEVER BETTER.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15871 at *http://dms.dot.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD 2003–15871. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone: 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel NEVER BETTER is:

Intended Use: ''Family and small corporate harbor tours and near-coastal fishing charters.''

Geographic Region: ''Coastal waters from Maine to Florida including New York Harbor and Chesapeake Bay.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20460 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15866]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel OASIS.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the

Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15866 at *http://dms.dot.gov*. Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD–200315866. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW, Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/*. All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov*.

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW, Washington, DC 20590. Telephone: 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel OASIS is:

Intended Use: ''Occasional sail charters.''

Geographic Region: ''Florida, central, around Cape Canaveral.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20459 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15872]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel ROBERT E WYNNS.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15872 at *http://dms.dot.gov*. Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR Part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD 2003 15872. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/*. All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov*.

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone: 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel ROBERT E WYNNS is:

Intended Use: ''Charters''.

Geographic Region: ''US Waters Excluding AK and HI''.

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20461 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number: MARAD 2003 15870]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel SERENITY.

SUMMARY: As authorized by Pub. L. 105–383 and Pub. L. 107–295, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below. The complete application is given in DOT docket 2003–15870 at *http://dms.dot.gov*. Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (68 FR 23084; April 30, 2003), that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will

not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in section 388.4 of MARAD's regulations at 46 CFR part 388.

DATES: Submit comments on or before September 11, 2003.

ADDRESSES: Comments should refer to docket number MARAD 2003 15870. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/*. All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov*.

FOR FURTHER INFORMATION CONTACT: Michael Hokana, U.S. Department of Transportation, Maritime Administration, MAR–830 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone: 202–366–0760.

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel SERENITY is:

Intended Use: ''Crewed Charters.''

Geographic Region: ''Virginia, Chesapeake Bay and inland rivers and Inland coastal waterway to and including the Florida Keys.''

Dated: August 6, 2003.

By order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 03–20458 Filed 8–11–03; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

[Docket No. 03–18]

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

[No. 03–35]

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

[Docket No. OP–1155]

FEDERAL DEPOSIT INSURANCE CORPORATION

Interagency Guidance on Response Programs for Unauthorized Access to Customer Information and Customer Notice

AGENCIES: Office of the Comptroller of the Currency, Treasury (OCC); Board of Governors of the Federal Reserve System (Board); Federal Deposit Insurance Corporation (FDIC); and Office of Thrift Supervision, Treasury (OTS).[1]

ACTION: Notice and request for comment.

SUMMARY: The OCC, Board, FDIC, and OTS (the Agencies) are requesting comment on proposed guidance entitled Interagency Guidance on Response Programs for Unauthorized Access to Customer Information and Customer Notice (''the proposed Guidance'').

In addition, as part of their continuing efforts to reduce paperwork and respondent burden, the Agencies invite the general public and other Federal agencies to take this opportunity to comment on a proposed information collection, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35).

DATES: Comments must be submitted on or before October 14, 2003

ADDRESSES: Interested parties are invited to submit written comments to:

Office of the Comptroller of the Currency: Public Information Room, Office of the Comptroller of the Currency, 250 E Street, SW, Mail stop 1–5, Washington, DC 20219, Attention: Docket No. 03–18, Fax number (202) 874–4448 or e-mail address: *regs.comments@occ.treas.gov*. Due to delays in the delivery of paper mail in the Washington area, commenters are encouraged to submit their comments by fax or email. Comments may be inspected and photocopied at the OCC's Public Information Room, 250 E Street, SW, Washington, DC. You can make an appointment to inspect the comments by calling (202) 874–5043.

Board of Governors of the Federal Reserve System: Comments should refer to Docket No. OP–1155 and may be mailed to Ms. Jennifer J. Johnson, Secretary, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue, NW., Washington, DC 20551. However, because paper mail in the Washington area and at the Board of Governors is subject to delay, please consider submitting your comments by e-mail to *regs.comments@federalreserve.gov*, or faxing them to the Office of the Secretary at (202) 452–3819 or (202) 452–3102. Members of the public may inspect comments in Room MP–500 between 9 a.m. and 5 p.m. on weekdays pursuant to 12 CFR 261.12, except as provided in 12 CFR 261.14, of the Board's Rules Regarding Availability of Information, 12 CFR sections 261.12 and 261.14.

Federal Deposit Insurance Corporation: Send written comments to Robert E. Feldman, Executive Secretary, Attention: Comments/OES, Federal Deposit Insurance Corporation, 550 17th Street, NW., Washington, DC 20429. Comments also may be mailed electronically to *comments@fdic.gov*. Comments may be hand delivered to the guard station at the rear of the 17th Street building (located on F Street) on business days between 7 a.m. and 5 p.m.; Fax Number (202) 898–3838. Comments may be inspected and photocopied in the FDIC Public Information Center, Room 100, 801 17th Street, NW., Washington, DC 20429, between 9 a.m. and 5 p.m. on business days.

Office of Thrift Supervision: Comments may be sent to Regulation Comments, Chief Counsel's Office, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552, Attention: No.03–35; FAX number (202) 906–6518, Attention: No. 03–35; or e-mail address *regs.comments@ots.treas.gov*, Attention: No. 03–35, and include your name and telephone number. Comments may also be hand delivered to the Guard's Desk, East Lobby Entrance, 1700 G Street, NW., from 9 a.m. to 4 p.m. on business days, Attention: Regulation Comments, Chief Counsel's Office, No. 03–35. Commenters should be aware that there have been unpredictable and lengthy delays in postal deliveries to the Washington, DC area and may prefer to make their comments via facsimile, e-mail, or hand delivery. OTS will post

[1] The National Credit Union Administration (NCUA) participated in the guidance of development process and will separately issue comparable proposed guidance.

comments and the related index on the OTS Internet Site at *http://www.ots.treas.gov*. In addition, you may inspect comments at the Public Reading Room, 1700 G Street, NW., by appointment. To make an appointment for access, you may call (202) 906–5922, send an e-mail to *public.info@ots.treas.gov*, or send a facsimile transmission to (202) 906–7555. (Please identify the materials you would like to inspect to assist us in serving you.) We schedule appointments on business days between 10 a.m. and 4 p.m. In most cases, appointments will be available the business day after the date we receive a request.

FOR FURTHER INFORMATION CONTACT:

OCC: Aida Plaza Carter, Director, Bank Information Technology Operations Division, (202) 874–4740; Clifford A. Wilke, Director, Bank Technology Division, (202) 874–5920; Amy Friend, Assistant Chief Counsel, (202) 874–5200; or Deborah Katz, Senior Attorney, Legislative and Regulatory Activities Division, (202) 874–5090.

Board: Donna L. Parker, Supervisory Financial Analyst, Division of Banking Supervision & Regulation, (202) 452–2614; Thomas E. Scanlon, Counsel, Legal Division, (202) 452–3594; or Joshua H. Kaplan, Attorney, Legal Division, (202) 452–2249.

FDIC: Jeffrey M. Kopchik, Senior Policy Analyst, Division of Supervision and Consumer Protection, (202) 898–3872; Patricia I. Cashman, Senior Policy Analyst, Division of Supervision and Consumer Protection, (202) 898–6534; or Robert A. Patrick, Counsel, Legal Division, (202) 898–3757.

OTS: Robert Engebreth, Director, Technology Risk Management, (202) 906–5631; Lewis C. Angel, Senior Project Manager, Technology Risk Management, (202) 906–5645; Elizabeth Baltierra, Program Analyst (Compliance), Compliance Policy, (202) 906–6540; or Paul Robin, Special Counsel, Regulations and Legislation Division, (202) 906–6648.

SUPPLEMENTARY INFORMATION:

I. Background

The Agencies have published Interagency Guidelines Establishing Standards for Safeguarding Customer Information (''Security Guidelines'').[2] These Security Guidelines were published to fulfill a requirement in section 501(b) of the Gramm-Leach-Bliley Act in which Congress directed the Agencies to establish standards for financial institutions relating to administrative, technical, and physical safeguards to: (1) Insure the security and confidentiality of customer records and information; (2) protect against any anticipated threats or hazards to the security or integrity of such records; and (3) protect against unauthorized access to or use of such records or information that could result in substantial harm or inconvenience to any customer.[3]

Among other things, the Security Guidelines direct financial institutions to: (1) Identify reasonably foreseeable internal and external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems; (2) assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and (3) assess the sufficiency of policies, procedures, customer information systems, and other arrangements in place to control risks.[4]

This proposed Guidance, published as an Appendix to this notice, interprets section 501(b) of the Gramm-Leach-Bliley Act and the provisions of the Security Guidelines noted above.[5] It describes the Agencies' expectations that every financial institution develop a response program to protect against and address reasonably foreseeable risks associated with internal and external threats to the security of customer information maintained by the financial institution or its service provider. The proposed Guidance further describes the components of a response program, which includes procedures for notifying customers about incidents of unauthorized access to customer information that could result in substantial harm or inconvenience to the customer. The proposed Guidance provides that a financial institution is expected to expeditiously implement its response program to address incidents of unauthorized access to or use of customer information. A response program should contain policies and procedures that enable the financial institution to:

A. Assess the situation to determine the nature and scope of the incident, and identify the information systems and types of customer information affected;

B. Notify the institution's primary Federal regulator and, in accordance with applicable regulations and guidance, file a Suspicious Activity Report and notify appropriate law enforcement agencies;

C. Take measures to contain and control the incident to prevent further unauthorized access to or use of customer information, including shutting down particular applications or third party connections, reconfiguring firewalls, changing computer access codes, and modifying physical access controls; and

D. Address and mitigate harm to individual customers.

The proposed Guidance describes the following corrective measures a financial institution should include as a part of its response program in order to effectively address and mitigate harm to individual customers:

A. Flag Accounts—The institution should identify accounts of customers whose information may have been compromised, monitor those accounts for unusual activity, and initiate appropriate controls to prevent the unauthorized withdrawal or transfer of funds from customer accounts.

B. Secure Accounts—The institution should secure all accounts associated with the customer information that has been the subject of unauthorized access or use.

C. Customer Notice and Assistance—The institution should, under certain circumstances, notify affected customers when *sensitive customer information* about them is the subject of unauthorized access. Where the institution can specifically identify affected customers from its logs, notification may be limited to those persons only. Otherwise, the institution should notify each customer in those groups likely to be affected.

The proposed Guidance provides that a financial institution should notify each affected customer when it becomes aware of unauthorized access to *sensitive customer information*, unless the institution, after an appropriate investigation, reasonably concludes that misuse of the information is unlikely to occur, and takes appropriate steps to safeguard the interests of affected customers, including by monitoring affected customers' accounts for unusual or suspicious activity. For the purposes of the proposed Guidance, the Agencies define *sensitive customer information* to mean a customer's social security number, personal identification number (PIN), password, or account number, in conjunction with a personal identifier, such as the individual's name, address, or telephone number. *Sensitive customer information* would also include any combination of components of customer information

[2] 12 CFR part 30, app. B (OCC); 12 CFR part 208, app. D–2, and part 225, app. F (Board); 12 CFR part 364, app. B (FDIC); and 12 CFR part 570, app. B (OTS).

[3] 15 U.S.C. 6805(b).

[4] Security Guidelines, Paragraph III.B.2.

[5] The Agencies may treat an institution's failure to implement final Guidance issued as a violation of the Security Guidelines.

that would allow someone to log onto or access another person's account, such as user name and password.

Under the Security Guidelines, an institution must protect against unauthorized access to or use of customer information that could result in substantial harm or inconvenience to any customer. The Agencies believe that substantial harm or inconvenience is most likely to result from the improper access to and use of *sensitive customer information*. Accordingly, the proposed Guidance requires notice to mitigate or prevent substantial harm or inconvenience to a customer.

The Agencies note that the response program required under the proposed Guidance must address incidents involving the unauthorized access to or use of any form of customer information. However, the customer notice requirement applies only to security breaches involving *sensitive customer information*.

The proposed Guidance provides several examples the Agencies believe typify situations in which customer notification is required and those when it is not. As in other circumstances, the Agencies also expect financial institutions to notify customers upon the direction of the institution's primary Federal regulator.

The proposed Guidance discusses the content and delivery of customer notices. The notice should include a general description of the incident, and provide information to assist customers in mitigating potential harm, including a customer service number, steps customers can take to obtain and review their credit reports and to file fraud alerts with nationwide credit reporting agencies, and sources of information designed to assist individuals in protecting against identity theft.

In addition, institutions are expected to inform each customer about the availability of the Federal Trade Commission's (''FTC'') online guidance regarding measures to protect against identity theft and to encourage the customer to report any suspected incidents of identity theft to the FTC. Further, institutions should provide the FTC's Web site address and telephone number for purposes of obtaining the guidance and reporting suspected incidents of identity theft. Currently, the Web site address is *http://www.ftc.gov/idtheft*, and the toll free number for the identity theft hotline is 1–877–IDTHEFT.

The proposed Guidance also describes other forms of assistance that financial institutions have offered to their customers in incidents of this type. Financial institutions may wish to offer such forms of assistance to their customers and describe them in the customer notice.

II. Request for Comments

The Agencies invite comment on all aspects of the proposed Guidance, including each component of the response program described in Paragraph II of the proposed Guidance. Please consider the following questions in formulating your comments:

- Should any component of the response program be clarified in some way and, if so, how?
- Are there additional components that should be included in a response program to address incidents involving unauthorized access to or use of customer information? If so, please describe the component, and the reasons that support it.
- Should each component of the response program be retained? If not, which components should be deleted and why?
- In preparing the proposed Guidance, the Agencies have attempted to identify a standard that will lead to customer notice when appropriate. The Agencies recognize that there is a spectrum of alternatives for developing a requirement to notify customers. On one side of the spectrum is a standard that would require a financial institution to notify its customers every time the mere possibility of misuse of customer information arises. On the other side is a standard that would require an institution to notify its customers only when it becomes aware of an incident involving unauthorized access to customer information and, based on unusual activity in customers' accounts or other indicia of identity theft, knows that the information is being misused. The Agencies propose a standard that lies in the middle of this spectrum. The Agencies believe that no useful purpose would be served if notices were sent due to the mere possibility of misuse of some customer information because, in general, the notices should alert customers to those situations where enhanced vigilance is necessary to protect against fraud or identity theft. Rather, the Agencies believe that notice to customers should be required in a narrower range of instances involving the unauthorized access to *sensitive customer information*. The standard proposed here would require a financial institution to send notice to each affected customer when the institution becomes aware of an incident of unauthorized access to *sensitive customer information*, unless the institution, after an appropriate investigation, reasonably concludes that misuse of the information is unlikely to occur and takes appropriate steps to safeguard the interests of affected customers, including by monitoring affected customers' accounts for unusual or suspicious activity. The Agencies invite comment on whether this is the appropriate standard for requiring customer notice. For commenters who believe that this standard is inappropriate, the Agencies request that these commenters state specifically their reasoning and offer alternative thresholds for requiring customer notice.
- The proposed Guidance defines *sensitive customer information* as a social security number, a personal identification number (PIN), password, or an account number in conjunction with a personal identifier. *Sensitive customer information* would also include any combination of components of customer information that would allow someone to log onto or access another person's account, such as user name and password. The Agencies request comment on which, if any, additional types of information should be included in this definition, such as mother's maiden name or driver's license number.
- The Agencies invite comment on the potential burden associated with the customer notice provisions. For example, what is the anticipated burden that may arise from the questions posed by those customers who receive the notices? Should the Agencies consider how the burden may vary depending upon the size and complexity of the institution?
- As part of the response program, the Agencies describe certain corrective measures that an institution should take once an incident of unauthorized access occurs. One such measure is to ''secure accounts.'' Is the discussion of securing accounts sufficiently clear to enable institutions to know what is expected of them when instances of unauthorized access occur? To what extent would contracts between financial institutions and service providers need to be modified, if at all, to comply with the proposed Guidance? How much burden, if any, will the Guidance impose on service providers?
- The Agencies also invite comment on whether the proposed standard should be modified to apply to other extraordinary circumstances that compel an institution to conclude that unauthorized access to information, other than *sensitive customer information*, likely will result in substantial harm or inconvenience to the affected customers.

• The proposed Guidance includes examples of circumstances in which customer notice would be expected and those when it would not. Please comment on whether the examples in the proposed Guidance should be modified or supplemented and provide your rationale.

III. Paperwork Reduction Act

A. Request for Comment on Proposed Information Collection

In accordance with the requirements of the Paperwork Reduction Act of 1995, the Agencies may not conduct or sponsor, and the respondent is not required to respond to, an information collection unless it displays a currently valid Office of Management and Budget (OMB) control number. The Agencies are requesting comment on a proposed information collection. The Agencies also give notice that, at the end of the comment period, the proposed collections of information, along with an analysis of the comments and recommendations received, will be submitted to OMB for review and approval.

Comments are invited on:

(a) Whether the collection of information is necessary for the proper performance of the Agency's functions, including whether the information has practical utility;

(b) The accuracy of the estimates of the burden of the information collection, including the validity of the methodology and assumptions used;

(c) Ways to enhance the quality, utility, and clarity of the information to be collected;

(d) Ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology; and

(e) Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

At the end of the comment period, the comments and recommendations received will be analyzed to determine the extent to which the information collections should be modified prior to submission to OMB for review and approval. The comments will also be summarized or included in the Agencies' requests to OMB for approval of the collections. All comments will become a matter of public record.

Comments should be addressed to:

OCC: Public Information Room, Office of the Comptroller of the Currency, 250 E Street, SW, Mail stop 1–5, Attention: Docket 03–18, Washington, DC 20219; fax number (202) 874–4448; Internet address: *regs.comments@occ.treas.gov.* Due to delays in paper mail delivery in the Washington area, commenters are encouraged to submit their comments by fax or e-mail. You can make an appointment to inspect the comments at the Public Information Room by calling (202) 874–5043.

Board: Comments should refer to Docket No. OP–1155 and may be mailed to Ms. Jennifer J. Johnson, Secretary, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue, NW., Washington, DC 20551. However, because paper mail in the Washington area and at the Board of Governors is subject to delay, please consider submitting your comments by e-mail to *regs.comments@federalreserve.gov*, or faxing them to the Office of the Secretary at (202) 452–3819 or (202) 452–3102. Members of the public may inspect comments in Room MP–500 between 9 a.m. and 5 p.m. on weekdays pursuant to 12 CFR section 261.12, except as provided in 12 CFR section 261.14, of the Board's Rules Regarding Availability of Information, 12 CFR sections 261.12 and 261.14.

FDIC: Steven F. Hanft, Legal Division (Consumer and Compliance Unit), Room MB–3064, Federal Deposit Insurance Corporation, 550 17th Street, NW., Washington, DC 20429. All comments should refer to the title of the proposed collection. Comments may be hand-delivered to the guard station at the rear of the 17th Street Building (located on F Street), on business days between 7 a.m. and 5 p.m., Attention: Comments, Federal Deposit Insurance Corporation, 550 17th Street, NW., Washington, DC 20429.

OTS: Information Collection Comments, Chief Counsel's Office, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552; send a facsimile transmission to (202) 906–6518; or send an e-mail to *infocollection.comments@ots.treas.gov.* OTS will post comments and the related index on the OTS Internet site at *http://www.ots.treas.gov.* In addition, interested persons may inspect the comments at the Public Reading Room, 1700 G Street, NW., by appointment. To make an appointment, call (202) 906–5922, send an e-mail to *publicinfo@ots.treas.gov*, or send a facsimile transmission to (202) 906–7755.

B. Proposed Information Collection

Title of Information Collection: Notice Regarding Unauthorized Access to Customer Information.

Frequency of Response: On occasion.

Affected Public:

OCC: National banks, District of Columbia banks, and Federal branches and agencies of foreign banks.

Board: State member banks, bank holding companies, affiliates and certain non-bank subsidiaries of bank holding companies, uninsured state agencies and branches of foreign banks, commercial lending companies owned or controlled by foreign banks, and Edge and agreement corporations.

FDIC: Insured nonmember banks, insured state branches of foreign banks, and certain subsidiaries of these entities.

OTS: Savings associations and certain of their subsidiaries.

Abstract: The proposed Guidance describes the Agencies' expectations regarding a response program, including customer notification procedures, that a financial institution should develop and apply under the circumstances described in the Appendix to address unauthorized access to or use of customer information that could result in substantial harm or inconvenience to a customer.

The information collections in the proposed Guidance would require financial institutions to: (1) Develop notices to customers; (2) determine which customers should receive the notices and send the notices to customers; and (3) ensure that their contracts with their service providers satisfy the proposed Guidance.

Estimated Burden: It is estimated that it will initially take institutions 20 hours (2.5 business days) to develop and produce the notices described in the proposed Guidance and 24 hours per incident (three business days) to determine which customers should receive the notice and notify the customers. For the purposes of this analysis, it is estimated that two percent of supervised institutions will experience an incident of unauthorized access to customer information on an annual basis, resulting in customer notification.[6]

Thus, the burden associated with this collection of information may be summarized as follows. However, the burden estimate does not include time for financial institutions to adjust their contracts with service providers, if needed; nor for service providers to

[6] This estimate is based upon the Agencies' experience and data gathered by the FDIC on 2,000 institutions that indicates slightly less than one percent of those institutions experienced some form of unauthorized access to customer information during any 12 month period. However, the Agencies are assuming that other incidents of unauthorized access to customer information may have occurred, but were not reported.

disclose information pursuant to the proposed Guidance.

OCC

Number of Respondents: 2,200.
Estimated Time per Response:
Developing notices: 20 hrs. × 2,200 = 44,000 hours.
Notifying customers: 24 hrs. × 44 = 1,056 hours.
Total Estimated Annual Burden = 45,056 hours.

Board

Number of Respondents: 6,692.
Estimated Time per Response:
Developing notices: 20 hrs. × 6,692 = 133,840 hours.
Notifying customers: 24 hrs. × 134 = 3,216 hours.
Total Estimated Annual Burden: 137,056 hours.

FDIC

Number of Respondents: 5,500.
Estimated Time per Response:
Developing notices: 20 hrs. × 5,500 = 110,000 hours.
Notifying customers: 24 hrs. × 110 = 2,640 hours.
Total Estimated Annual Burden: 112,640 hours.

OTS

Number of Respondents: 961.
Estimated Time per Response:
Developing notices: 20 hrs. × 961 = 19,220 hours.
Notifying customers: 24 hrs. × 19 = 456 hours.
Estimated Total Annual Burden: 19,676 hours.

Appendix—Interagency Guidance on Response Programs for Unauthorized Access to Customer Information and Customer Notice

I. Background

This Guidance [1] interprets section 501(b) of the Gramm-Leach-Bliley Act (''GLBA'') and the Interagency Guidelines Establishing Standards for Safeguarding Customer Information (the ''Security Guidelines'')[2] and describes the Agencies'' expectations regarding the response programs, including customer notification procedures, that a financial institution should develop and apply to address unauthorized access to or use of customer information that could result in substantial harm or inconvenience to a customer.

Interagency Security Guidelines

Section 501(b) of the GLBA required the Agencies to establish appropriate standards for financial institutions subject to their jurisdiction that include administrative, technical, and physical safeguards, to protect the security and confidentiality of customer information.[3] Accordingly, the Agencies issued Security Guidelines requiring every financial institution to have an information security program designed to:

- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of such information; and
- Protect against unauthorized access to or use of such information that could result in substantial harm or inconvenience to any customer.

Risk Assessment and Controls

The Security Guidelines direct every financial institution to assess the following risks, among others, when developing its information security program:

- Reasonably foreseeable internal and external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;
- The likelihood and potential damage of threats, taking into consideration the sensitivity of customer information; and
- The sufficiency of policies, procedures, customer information systems, and other arrangements in place to control risks.[4]

Following the assessment of these risks, the Security Guidelines require a financial institution to design a program to address the identified risks. The particular security measures an institution should adopt will depend upon the risks presented by the complexity and scope of its business. At a minimum, the financial institution is required to consider the specific security measures enumerated in the Security Guidelines,[5] and adopt those that are appropriate for the institution, including:

- Access controls on customer information systems, including controls to authenticate and permit access only to authorized individuals and controls to prevent employees from providing customer information to unauthorized individuals who may seek to obtain this information through fraudulent means;
- Background checks for employees with responsibilities for access to customer information; and
- Response programs that specify actions to be taken when the bank suspects or detects that unauthorized individuals have gained access to customer information systems, including appropriate reports to regulatory and law enforcement agencies.[6]

Service Providers

The Security Guidelines direct every financial institution to require its service providers by contract to implement appropriate measures designed to protect against unauthorized access to or use of customer information that could result in substantial harm or inconvenience to any customer.[7] Consistent with existing guidance issued by the Agencies, an institution's contract with its service provider should require the service provider to fully disclose to the institution information relating to any breach in security resulting in an unauthorized intrusion into the institution's customer information systems maintained by the service provider.[8] In view of these contractual obligations, the service provider would be required to take appropriate actions to address incidents of unauthorized access to or use of the financial institution's customer information to enable the institution to expeditiously implement its response program.[9]

Response Program

As internal and external threats to the security of customer information are reasonably foreseeable and may lead to the misuse of customer information, the Agencies expect every financial institution to develop a response program to protect against the risks associated with these threats. The response program should include measures to protect customer information in customer information systems maintained by the institution or its service providers. The Agencies expect that customer notification will be a component of an institution's response program, as described below.

II. Components of a Response Program

A response program should be a key part of an institution's information security

[1] This Guidance is being jointly issued by the Board of Governors of the Federal Reserve System (Board), the Federal Deposit Insurance Corporation (FDIC), the Office of the Comptroller of the Currency (OCC), and the Office of Thrift Supervision (OTS).

[2] 12 CFR part 30, app. B (OCC); 12 CFR part 208, app. D–2 and part 225, app. F (Board); 12 CFR part 364, app. B (FDIC); and 12 CFR part 570, app. B (OTS).

[3] The term ''customer information'' is the same term used in the Security Guidelines and means any record containing nonpublic personal information whether in paper, electronic, or other form, maintained by or on behalf of the institution.

[4] *See* Security Guidelines Paragraph III.B.

[5] *See* Security Guidelines Paragraph III.C.

[6] *See* Security Guidelines Paragraph III.D.

[7] *See* Security Guidelines Paragraphs II.B. and III.D.

[8] *See* Federal Reserve SR Ltr. 00–04, Outsourcing of Information and Transaction Processing, Feb. 9, 2000; SR Ltr. 00–17, Guidance on Risk Management of Outsourced Technology Services, Nov. 30, 2000; OCC Bulletin 2001–47, ''Third-party Relationships Risk Management Principles,'' Nov. 1, 2001; AL 2000–12, ''FFIEC Guidance on Risk Management of Outsourced Technology Services,'' Nov. 28, 2000; FDIC FIL 81–2000, Risk Management of Technology Outsourcing, Nov. 29, 2000; FIL 68–99, Risk Assessment Tools and Practices for Information System Security, July 7, 1999; OTS Thrift Bulletin 82, Third Party Arrangements, Mar. 4, 2003; OTS CEO Memorandum 133, Risk Management of Technology Outsourcing, Dec. 13, 2000; CEO Memorandum 109, Transactional Web Sites, June 10, 1999; CEO Memorandum 70, Statement on On-Line Personal Computer Banking, June 23, 1997.

[9] The Agencies note that, in addition to contractual obligations to a financial institution, a service provider may be required to implement its own comprehensive information security program in accordance with the Safeguards Rule promulgated by the FTC. 12 CFR part 314 applies to the handling of all customer information possessed by any financial institution subject to the jurisdiction of the FTC, regardless of whether such information pertains to individuals with whom the institution has a customer relationship or pertains to the customers of other financial institutions that have provided such information to that institution.

program.[10] Having such a program in place will allow the institution to quickly respond [11] to incidents involving the unauthorized access to or use of customer information in its own customer information systems that could result in substantial harm or inconvenience to a customer. Under the Guidelines, an institution's customer information systems consist of all of the methods used to access, collect, store, use, transmit, protect, or dispose of customer information, including the systems maintained by its service providers.[12]

Timely notification of customers, under the circumstances described below, is important to manage an institution's reputation risk. Effective notice may reduce legal risk, assist in maintaining good customer relations, and enable the institution's customers to take steps to protect themselves against the consequences of identity theft.

A response program should contain the following components:

A. Assess the Situation.

The institution should assess the nature and scope of the incident, and identify what customer information systems and types of customer information have been accessed or misused.

B. Notify Regulatory and Law Enforcement Agencies

The institution should promptly notify its primary Federal regulator when it becomes aware of an incident involving unauthorized access to or use of customer information that could result in substantial harm or inconvenience to its customers.

An institution also should file a Suspicious Activity Report (''SAR''), if required, in accordance with the applicable SAR regulations [13] and Agency guidance.[14]

Consistent with the Agencies' SAR regulations, in situations involving Federal criminal violations requiring immediate attention, such as when a reportable violation is ongoing, the institution should immediately notify, by telephone, appropriate law enforcement authorities and its primary regulator, in addition to filing a timely SAR.

C. Contain and Control the Situation

The financial institution should take measures to contain and control the incident to prevent further unauthorized access to or use of customer information, while preserving records and other evidence.[15] Depending upon the particular facts and circumstances of the incident, these measures could include, in connection with computer intrusions: (i) Shutting down applications or third party connections; (ii) reconfiguring firewalls in cases of unauthorized electronic intrusion; (iii) ensuring that all known vulnerabilities in the financial institution's computer systems have been addressed; (iv) changing computer access codes; (v) modifying physical access controls; and (vi) placing additional controls on service provider arrangements.

D. Corrective Measures

Once an institution understands the scope of the incident and has taken steps to contain and control the situation, it should take measures to address and mitigate the harm to individual customers. For example, the institution should take the following measures:

1. Flag Accounts

The institution should immediately begin identifying and monitoring the accounts of those customers whose information may have been accessed or misused. In particular, the institution should provide staff with instructions regarding the recording and reporting of any unusual activity, and if indicated given the facts of a particular incident, implement controls to prevent the unauthorized withdrawal or transfer of funds from customer accounts.

2. Secure Accounts

When a checking, savings, or other deposit account number, debit or credit card account number, personal identification number (PIN), password, or other unique identifier has been accessed or misused, the financial institution should secure the account, and all other accounts and bank services that can be accessed using the same account number or name and password combination until such time as the financial institution and the customer agree on a course of action.[16]

3. Customer Notice and Assistance

Under the Security Guidelines, financial institutions have an affirmative duty to protect their customers' information against unauthorized access or use. An institution may not forgo notifying its customers of an incident because the institution believes that it may be potentially embarrassed or inconvenienced by doing so. Under the circumstances described in Paragraph III., the institution should notify and offer assistance to customers whose information was the subject of the incident.[17] If the institution is able to determine from its logs or other data precisely which customers' information was accessed or misused, it may restrict its notification to those individuals. However, if the institution cannot identify precisely which customers are affected, it should notify each customer in groups likely to have been affected, such as each customer whose information is stored in the group of files in question.

a. Delivery of Customer Notice—Customer notice should be timely, clear, and conspicuous, and delivered in any manner that will ensure that the customer is likely to receive it. For example, the institution may choose to contact all customers affected by telephone or by mail, or for those customers who conduct transactions electronically, using electronic notice.

b. Content of Customer Notice—The notice should describe the incident in general terms and the customer's information that was the subject of unauthorized access or use. It should also include a number that customers can call for further information and assistance. The notice also should remind customers of the need to remain vigilant, over the next twelve to twenty-four months, and to promptly report incidents of suspected identity theft.

Key Elements: In addition, the notice should:

- Inform affected customers that the institution will assist the customer to correct and update information in any consumer report relating to the customer, as required by the Fair Credit Reporting Act;
- Recommend that the customer notify each nationwide credit reporting agency to place a fraud alert [18] in the customer's consumer reports;
- Recommend that the customer periodically obtain credit reports from each nationwide credit reporting agency and have information relating to fraudulent transactions deleted;
- Inform the customer of the right to obtain a credit report free of charge, if the customer has reason to believe that the file at the consumer reporting agency contains inaccurate information due to fraud, together with contact information regarding the nationwide credit reporting agencies; and

[10] *See* FFIEC Information Security Booklet, Dec. 2002; Federal Reserve SR 97–32, Sound Practice Guidance for Information Security for Networks, Dec. 4, 1997; OCC Bulletin 2000–14, ''Infrastructure Threats ''Intrusion Risks'' (May 15, 2000); OTS CEO Memorandum 109, Transactional Web Sites, June 10, 1999; CEO Memorandum 70, Statement on On-Line Personal Computer Banking, June 23, 1997; CEO Memorandum 59, Risk Management of Client/Server Systems, Oct. 24, 1996, for additional guidance on preventing, detecting, and responding to intrusions into financial institution computer systems.

[11] Financial institutions are expected to provide employees with the training necessary to understand their roles and responsibilities in order to expeditiously implement the institution's response program to address incidents of unauthorized access to and use of customer information.

[12] *See* Security Guidelines Paragraph I.C.f.

[13] 12 CFR 21.11 (national banks, federal branches and agencies); 12 CFR 208.62 (state member banks); 12 CFR 211.5(k) (Edge and agreement corporations); 12 CFR 211.24(f) (uninsured state branches and agencies of foreign banks); 12 CFR 225.4(f) (bank holding companies and their nonbank subsidiaries); 12 CFR part 353 (state non-member banks); and 12 CFR part 563 (savings associations).

[14] National banks must file SARs in connection with computer intrusions and other computer crimes. *See* OCC Bulletin 2000–14, ''Infrastructure Threats—Intrusion Risks'' (May 15, 2000); Advisory Letter 97–9, ''Reporting Computer Related Crimes'' (November 19, 1997) (general guidance still applicable though instructions for new SAR form published in 65 FR 1229, 1230 (January 7, 2000)). *See also* Federal Reserve SR 01–11, Identity Theft and Pretext Calling, Apr. 26, 2001; SR 97–28, Guidance Concerning Reporting of Computer Related Crimes by Financial Institutions, Nov. 6, 1997; FDIC FIL 48–2000, Suspicious Activity Reports, July 14, 2000; FIL 47–97, Preparation of Suspicious Activity Reports, May 6, 1997; OTS CEO Memorandum 139, Identity Theft and Pretext Calling, May 4, 2001; CEO Memorandum 126, New Suspicious Activity Report Form, July 5, 2000.

[15] *See* FFIEC Information Security Booklet, Dec. 2002, pp. 68–74.

[16] The institution should also consider the use of new account numbers and steps to ensure that customers do not reuse the same or a similar personal identification number.

[17] The institution should, therefore, ensure that a sufficient number of appropriately trained employees are available to answer customer inquiries and provide assistance.

[18] A fraud alert will put the customer's creditors on notice that the customer may be a victim of fraud.

• Inform the customer about the availability of the FTC's online guidance regarding steps a consumer can take to protect against identity theft, and encourage the customer to report any incidents of identity theft to the FTC. The notice should provide the FTC's Web site address and toll-free telephone number that customers may use to obtain the identity theft guidance and report suspected incidents of identity theft.[19]

Optional Element: Institutions also may wish to provide customers with the following additional assistance that other institutions have offered under these circumstances:

• Provide a toll-free telephone number that customers can call for assistance;

• Offer to assist the customer in notifying the nationwide credit reporting agencies of the incident and in placing a fraud alert in the customer's consumer reports; and

• Inform the customer about subscription services that provide notification anytime there is a request for the customer's credit report or offer to subscribe the customer to this service, free of charge, for a period of time.

The institution may also wish to include with the notice a brochure regarding steps a consumer can take to protect against identity theft, prepared by the Agencies that can be downloaded from the Internet.[20]

III. Circumstances for Customer Notice

Standard for Providing Notice

An institution should notify affected customers whenever it becomes aware of unauthorized access to sensitive customer information unless the institution, after an appropriate investigation, reasonably concludes that misuse of the information is unlikely to occur and takes appropriate steps to safeguard the interests of affected customers, including by monitoring affected customers' accounts for unusual or suspicious activity.

Sensitive Customer Information

Under the Guidelines, an institution must protect against unauthorized access to or use of customer information that could result in substantial harm or inconvenience to any customer. Substantial harm or inconvenience is most likely to result from improper access to sensitive customer information because this type of information is easily misused, as in the commission of identity theft. For purposes of this Guidance, sensitive customer information means a customer's social security number, personal identification number, password or account number, in conjunction with a personal identifier such as the customer's name, address, or telephone number. Sensitive customer information would also include any combination of components of customer information that would allow someone to log onto or access another person's account, such as user name and password. Therefore, institutions are expected to notify affected customers when sensitive customer information has been improperly accessed, unless the institution, after an appropriate investigation, reasonably concludes that misuse of the information is unlikely to occur and takes appropriate steps to safeguard the interests of affected customers.

Examples of When Notice Should Be Given

An institution should notify affected customers when it is aware of the following incidents unless the institution, after an appropriate investigation, can reasonably conclude that misuse of the information is unlikely to occur and takes appropriate steps to safeguard the interests of affected customers:

• An employee of the institution has obtained unauthorized access to sensitive customer information maintained in either paper or electronic form;

• A cyber intruder has broken into an institution's unencrypted database that contains sensitive customer information;

• Computer equipment such as a laptop computer, floppy disk, CD-ROM, or other electronic media containing sensitive customer information has been lost or stolen;

• An institution has not properly disposed of customer records containing sensitive customer information; or

• The institution's third party service provider has experienced any of the incidents described above, in connection with the institution's sensitive customer information.

Examples of When Notice Is Not Expected

An institution is not expected to give notice when it becomes aware of an incident of unauthorized access to customer information, and the institution, after an appropriate investigation, can reasonably conclude that misuse of the information is unlikely to occur and takes appropriate steps to safeguard the interests of affected customers. For example, an institution would not need to notify affected customers in connection with the following incidents:

• The institution is able to retrieve sensitive customer information that has been stolen, and reasonably concludes, based upon its investigation of the incident, that it has done so before the information has been copied, misused or transferred to another person who could misuse it;

• The institution determines that sensitive customer information was improperly disposed of, but can establish that the information was not retrieved or used before it was destroyed;

• A hacker accessed files that contain only customer names and addresses; or

• A laptop computer containing sensitive customer information is lost, but the data is encrypted and may only be accessed with a secure token or similarly secure access device.

Dated: July 31, 2003.

Mark J. Tenhundfeld.

Assistant Director, Office of the Comptroller of the Currency.

By the Board of Governors of the Federal Reserve System on August 5, 2003.

Jennifer J. Johnson,

Secretary of the Board.

Dated: August 6, 2003.

Michael J. Zamorski,

Director, Division of Supervision and Consumer Protection, Federal Deposit Insurance Corporation.

Dated: July 30, 2003.

James E. Gilleran,

Director.

[FR Doc. 03–20440 Filed 8–11–03; 8:45 am]

BILLING CODE 6720–01–P; 4810–33–P; 6210–-1–P; 6714–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 5558

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 5558, Application for Extension of Time To File Certain Employee Plan Returns.

DATES: Written comments should be received on or before October 14, 2003 to be assured of consideration.

ADDRESSES: Direct all written comments to Glenn Kirkland, Internal Revenue Service, room 6411, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Larnice Mack at Internal Revenue Service, room 6407, 1111 Constitution Avenue NW., Washington, DC 20224, or at (202) 622–3179, or through the Internet at *Larnice.Mack@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Application for Extension of Time To File Certain Employee Plan Returns.

[19] Currently, the FTC Web site for the ID Theft brochure and the FTC Hotline phone number are *http://www.ftc.gov/idtheft* and 1–877–IDTHEFT.

[20] *http://www.occ.treas.gov/idtheft.pdf; http://www.federalreserve.gov/consumers.htm; http://www.fdic.gov/consumers/consumer/news/cnsum00/idthft.html; http://www.ots.treas.gov/docs/25139.pdf.*

OMB Number: 1545–0212.

Form Number: 5558.

Abstract: This form is used by employers to request an extension of time to file the employee plan annual information return/report (Form 5500 series) or the employee plan excise tax return (Form 5330). The data supplied on Form 5558 is used to determine if such extension of time is warranted.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations, and not-for-profit institutions.

Estimated Number of Respondents: 335,000.

Estimated Time Per Response: 33 minutes.

Estimated Total Annual Burden Hours: 185,724.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 29, 2003.

Glenn Kirkland,

IRS Reports Clearance Officer.

[FR Doc. 03–20475 Filed 8–11–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 8872

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8872, Political Organization Report of Contributions and Expenditures.

DATES: Written comments should be received on or before October 14, 2003 to be assured of consideration.

ADDRESSES: Direct all written comments to Glenn Kirkland, Internal Revenue Service, room 6411, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Larnice Mack at Internal Revenue Service, room 6407, 1111 Constitution Avenue NW., Washington, DC 20224, or at (202) 622–3179, or through the Internet at *Larnice.Mack@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Political Organization Report of Contributions and Expenditures.

OMB Number: 1545–1696.

Form Number: 8872.

Abstract: Internal Revenue Code section 527(j) requires certain political organizations to report contributions received and expenditures made after July 1, 2000. Every section 527 political organization that accepts a contribution or makes an expenditure for an exempt function during the calendar year must file Form 8872 except for: A political organization that is not required to file Form 8871, or a state or local committee of a political party or political committee of a state or local candidate.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Not-for-profit institutions.

Estimated Number of Respondents: 40,000.

Estimated Time Per Response: 10 hours., 47 minutes.

Estimated Total Annual Burden Hours: 431,200.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 29, 2003.

Glenn Kirkland,

IRS Reports Clearance Officer.

[FR Doc. 03–20476 Filed 8–11–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

[FI–88–86]

Proposed Collection; Comment Request For Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this

opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning an existing final regulation, FI–88–86 (TD 8458), Real Estate Mortgage Investment Conduits (1.860E–2(a)(5), 1.860E–2(a)(7), and 1.860E–2(b)(2)).

DATES: Written comments should be received on or before October 14, 2003 to be assured of consideration.

ADDRESSES: Direct all written comments to Glenn Kirkland, Internal Revenue Service, room 6411, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection should be directed to Allan Hopkins at (202) 622–3179, or at Internal Revenue Service, room 6407, 1111 Constitution Avenue NW., Washington, DC 20224, or through the Internet at *Allan.M.Hopkins@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Real Estate Mortgage Investment Conduits.

OMB Number: 1545–1276.

Regulation Project Number: FI–88–86.

Abstract: Internal Revenue Code section 860E(e) imposes an excise tax on the transfer of a residual interest in a real estate mortgage investment conduit (REMIC) to a disqualified party. The amount of the tax is based on the present value of the remaining anticipated excess inclusions. This regulation requires the REMIC to furnish, on request of the party responsible for the tax, information sufficient to compute the present value of the anticipated excess inclusions. The regulation also provides that the tax will not be imposed if the record holder furnishes to the pass-thru or transferor an affidavit stating that the record holder is not a disqualified party.

Current Actions: There is no change to this existing regulation.

Type of Review: Extension of OMB approval.

Affected Public: Business or other for-profit organizations.

Estimated Number of Respondents: 1,600.

Estimated Time Per Respondent: 20 minutes.

Estimated Total Annual Burden Hours: 525.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: August 5, 2003.

Glenn Kirkland,

IRS Reports Clearance Officer.

[FR Doc. 03–20477 Filed 8–11–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Area 1 Taxpayer Advocacy Panel (This Panel Covers the States of New York, Connecticut, Massachusetts, Rhode Island, New Hampshire, Vermont and Maine)

AGENCY: Internal Revenue Service (IRS) Treasury.

ACTION: Notice.

SUMMARY: An open meeting of the Area 1 Taxpayer Advocacy Panel will be conducted (via teleconference) to discuss various IRS issues. The public is invited to make oral comments.

DATES: The meeting will be held Tuesday, August 26, 2003.

FOR FURTHER INFORMATION CONTACT: Mrs. Marisa Knispel at telephone number 888–912–1227 (toll-free), or 718–488–3557 (non toll-free).

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that an open meeting of the Area 1 Taxpayer Advocacy Panel (TAP) will be held Tuesday, August 26, 2003 from 1 pm EDT to 2 pm EDT via a telephone conference call. The public is invited to make oral comments. Individual comments will be limited to 5 minutes. Due to limited conference lines, notification of intent to participate in the telephone conference call meeting must be made in advance with Marisa Knispel. Mrs. Knispel can be reached at 888–912–1227 or 718–488–3557. If you would like to have the TAP consider a written statement, please call 888–912–1227 or 718–488–3557, or write Marisa Knispel, TAP Office, 10 MetroTech Center, 625 Fulton Street, Brooklyn, NY 11201, or post your comments to the Web site: *http://www.improveirs.org.* The agenda will include the following: Various IRS issues.

Dated: August 6, 2003.

Tersheia Carter,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 03–20474 Filed 8–11–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

[No. 2003–34]

2003–2008 Strategic Plan Notice; Request for Comments

AGENCY: Office of Thrift Supervision (OTS), Treasury.

ACTION: Notice and request for comment.

SUMMARY: The Office of Thrift Supervision (OTS) updates its Strategic Plan every three years. The mission and strategic goals contained in the plan support statutory and regulatory requirements, current and long-range industry issues, feedback from stakeholders, and long-range strategic objectives. The goals and objectives are implemented through annual performance plans.

OTS requests comments on its draft 2003–2008 Strategic Plan. The draft Plan is available on the OTS Internet site at *www.ots.treas.gov* under About OTS: Plans and Reports.

DATES: Comments must be submitted by August 22, 2003.

ADDRESSES: *Mail:* Send comments to: Strategic Plan Comments, ISAF, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552 Attention: Paula Lane, No. 2003–34. Commenters should be aware that there have been unpredictable and lengthy delays in postal deliveries to the Washington, DC

area and may prefer to make their comments via facsimile, e-mail, or hand delivery.

Delivery: Hand deliver comments to the Guard's Desk, East Lobby Entrance, 1700 G Street, NW., from 9 a.m. to 4 p.m. on business days, Attention: Strategic Plan Comments, Paula Lane, No. 2003–34.

Facsimiles: Send facsimile transmissions to Fax number (202) 906–6700, Attention: Paula Lane No. 2003–34.

E-Mail: Send e-mails to *Paula.Lane@ots.treas.gov*; Subject: Strategic Plan Comments No. 2003–34, and include your name and telephone number.

FOR FURTHER INFORMATION CONTACT: Paula Lane, Financial Reporting Analyst, (202) 906–6727, Quality Assurance & Management Support, or Barbara Taylor, Director, Quality Assurance & Management Support, Information Systems, Administration & Finance, (202) 906–7510, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552.

Dated: July 31, 2003.

By the Office of Thrift Supervision.

James E. Gilleran,

Director.

[FR Doc. 03–20472 Filed 8–11–03; 8:45 am]

BILLING CODE 6720–01–P

Corrections

Federal Register
Vol. 68, No. 155
Tuesday, August 12, 2003

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 81

[CA–282–0389; FRL–7515–4]

Approval and Promulgation of Implementation Plans and Designation of Areas for Air Quality Planning Purposes; 1-Hour Ozone Standard for San Diego, California

Correction

In rule document 03–16029 beginning on page 37976 in the issue of Thursday, June 26, 2003 make the following correction:

§ 81.305 [Corrected]

On page 37978, in § 81.305, the table is being reprinted in its entirety.

CALIFORNIA—OZONE (1.–HOUR STANDARD)

Designated area	Designation		Classification	
	Date[1]	Type	Date[1]	Type
* * *	*	*	*	*
San Diego Area: San Diego County	7/28/03	Attainment		
* * *	*	*	*	*

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

[FR Doc. C3–16029 Filed 8–11–03; 8:45 am]
BILLING CODE 1505–01–D

Federal Register

Tuesday,

August 12, 2003

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

[CMS–1471–P]

RIN 0938–AL19

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise 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 would describe proposed 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 would be applicable to services furnished on or after January 1, 2004.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 6, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1471–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1471–P, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

We encourage commenters submitting as comments information that contains beneficiary specific information (for example, medical records, or invoices with beneficiary identification) to remove any individually identifiable information, such as information that identifies an individual, diagnoses, addresses, telephone numbers, attending physician, medical record number, or Medicare or other insurance number. Moreover, individually identifiable beneficiary medical records, including progress notes, medical orders, test results, consultation reports, and photocopies of checks from hospitals or other documents that contain bank routing numbers should not be submitted to us. Persons or organizations submitting proprietary information as public comments must designate in writing if part or all of the information contained in such comments should be considered as exempt from disclosure under Exemption 4 of the Freedom of Information Act (FOIA). Generally, Exemption 4 of the FOIA protects trade secrets and commercial or financial information that is privileged or confidential, and affords the same protections as the Trade Secrets Act, which is also applicable. We will attempt to keep confidential and protect from disclosure information that qualifies under Exemption 4. However, only data that can be available for public inspection would be used for the final rule. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–4532—outpatient prospective payment issues; Suzanne Asplen, (410) 786–4558 or Jana Petze, (410) 786–9374—partial hospitalization and community mental health centers issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7197.

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 Office. 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.

Outline of Contents

Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP—American College of Emergency Physicians
AHA—American Hospital Association
AHIMA—American Health Information Management Association
AMA—American Medical Association
APC—Ambulatory payment classification
ASC—Ambulatory surgical center
AWP—Average wholesale price
BBA—Balanced Budget Act of 1997
BIPA—Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA—Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CAH—Critical access hospital
CCR—Cost center specific cost-to-charge ratio
CMHC—Community mental health center
CMS—Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT—[Physicians'] Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CY—Calendar year
DMEPOS—Durable medical equipment, prosthetics, orthotics, and supplies
DRG—Diagnosis-related group
DSH—Disproportionate Share Hospital
EACH—Essential Access Community Hospital
E/M—Evaluation and management
ESRD—End-stage renal disease
FACA—Federal Advisory Committee Act
FDA—Food and Drug Administration
FI—Fiscal intermediary
FSS—Federal Supply Schedule
FY—Federal fiscal year
HCPCS—Healthcare Common Procedure Coding System
HCRIS—Hospital Cost Report Information System
HHA—Home health agency
HIPAA—Health Insurance Portability and Accountability Act of 1996
ICD–9–CM—International Classification of Diseases, Ninth Edition, Clinical Modification
IME—Indirect Medical Education
IPPS—(Hospital) inpatient prospective payment system
IVIG—Intravenous Immune Globulin
LTC—Long Term Care
MedPAC—Medicare Payment Advisory Commission
MDH—Medicare Dependent Hospital
MSA—Metropolitan statistical area
NECMA—New England County Metropolitan Area
OCE—Outpatient code editor
OMB—Office of Management and Budget
OPD—(Hospital) outpatient department
OPPS—(Hospital) outpatient prospective payment system
PHP—Partial hospitalization program
PM—Program memorandum
PPS—Prospective payment system
PPV—Pneumococcal pneumonia (virus)
PRA—Paperwork Reduction Act
RFA—Regulatory Flexibility Act
RRC—Rural Referral Center
SBA—Small Business Administration
SCH—Sole Community Hospital
SDP—Single drug pricer
SI—Status Indicator
TEFRA—Tax Equity and Fiscal Responsibility Act
TOPS—Transitional outpatient payments
USPDI—United States Pharmacopoeia Drug Information

I. Background

A. Authority for the Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and

SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. The OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking for the Outpatient Prospective Payment System

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services. On 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 November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year (CY) 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. In addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.
- On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.
- On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.
- On November 1, 2002, we published a final rule (67 FR 66718) that revised the Medicare OPPS to update the payment weights and conversion factor for services payable under the 2003 OPPS on the basis of data from claims for services furnished from April 1, 2001 through March 31, 2002. The rule also removed from pass-through status most drugs and devices that had been paid under pass-through provisions in 2002 as required by the applicable provisions of law governing the duration of pass-through payment.

II. Proposed 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, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights.

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

We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule ''in

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

For purposes of this proposed rule, we analyzed the APC groups within this statutory framework.

A. Recommendations of the Advisory Panel on APC Groups

1. Establishment of the Advisory Panel on APC Groups

Section 1833(t)(9)(A) of the Act requires that we consult with an outside panel of experts, the Advisory Panel on APC Groups (the Panel), to review the clinical integrity of the groups and weights. The Act specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of representatives of providers subject to the OPPS (currently employed full-time, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

On November 21, 2000, the Secretary signed the charter establishing an ''Advisory Panel on APC Groups.'' The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Pub. L. 92–463).

On November 1, 2002, the Secretary renewed the charter. The new charter indicates that the Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene ''up to three meetings per year,'' and is chaired by a Federal official.

To establish the Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals nominating either a colleague or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel.

Because of the loss of 6 Panel members in March 2003 due to the expiration of terms of office, retirement, and a career change, a **Federal Register** notice was published on February 28, 2003 (68 FR 9671), requesting nominations of Panel members. From the 40 nominations we received, 6 new members have been chosen and will be identified on the CMS Web site.

2. The Panel's Meetings

The first Panel meeting was held on February 27, February 28, and March 1, 2001. 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 on January 22, 2002, 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 ([Physicians'] Current Procedural Technology) 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 these Subcommittee recommendations.

The third Panel meeting was held on January 21 and 22, 2003, to discuss the APCs of the newly implemented 2003 OPPS. We published a notice in the **Federal Register** on December 27, 2002 (67 FR 79107), to announce the following: The location and time of the third Panel meeting; a list of agenda items; and that the meeting was open to the public. In that document, we solicited public comment specifically on the items included on the agenda for the January 2003 Panel meeting. In this section, ''commenter'' refers to entities that provided comments in response to that **Federal Register** notice. We also provided additional information about the Panel meeting through a press release and on the CMS Web site. Presentations for the 2003 meeting met, at a minimum, the adopted guidelines for presentations referred to above.

3. Establishment of an Observation Subcommittee

At the third annual meeting in January 2003, the Panel suggested numerous changes to the APCs (listed below) and that a subcommittee be established to review observation issues, such as allowable International Classification of Diseases, clinical modification codes, and operational issues. Therefore, before the close of the third annual meeting, the Observation Subcommittee was established. Other Panel members that are not currently participating in this subcommittee are welcome to take part in this subcommittee, which is tasked with reviewing International Classification of Disease Codes, clinical modification codes, and operational issues related to observation. This subcommittee will report its findings to the Panel in 1 year.

4. Recommendations of the Advisory Panel and Our Responses

In this section, we consider the Panel's recommendations affecting specific APCs. The Panel based its recommendations on claims data for the period April 1, 2002 through September 30, 2002. This data set comprises a portion of the data that will be used to set 2004 payment rates. APC titles in this discussion are those that existed when the APC Panel met in January 2003. In a few cases, APC titles have been changed for this proposed rule, and, therefore, some APCs do not have the same title in Addendum A as they have in this section.

The Panel's agenda included APCs that our staff believe violate the 2 times rule as well as APCs for which comments were submitted. As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC appeared to violate the 2 times rule. In section II.B of this preamble, we discuss our proposals regarding the 2 times rule based on the April 1, 2002 through December 31, 2002 data that we used to determine the proposed 2004 APC relative weights. Section II.B also details the criteria we used when deciding to propose exceptions to the 2 times rule.

a. Debridement and Destruction.

APC 0012: Level I Debridement & Destruction.

APC 0013: Level II Debridement & Destruction.

We expressed concern to the Panel that APCs 0012 and 0013 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following codes from APC 0013 to APC 0012:

HCPCS	Description
11001	Debride infected skin add-on.
11302	Shave skin lesion.

HCPCS	Description
15786	Abrasion, lesion, single.
15793	Chemical peel, nonfacial.
15851	Removal of sutures.
16000	Initial treatment of burn(s).
16025	Treatment of burn(s).

(2) Move code 11057 (Trim skin lesions, over 4) from APC 0012 to APC 0013.

The Panel agreed with our staff and recommended that we make these changes. We propose to accept the Panel's recommendation.

b. Excision/Biopsy.

APC 0019: Level I Excision/Biopsy.

APC 0020: Level II Excision/Biopsy.

APC 0021: Level III Excision/Biopsy.

We expressed concern to the Panel that APCs 0019 and 0020 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following HCPCS codes from APC 0019 to a new APC:

HCPCS	Description
11755	Biopsy, nail unit.
11976	Removal of contraceptive cap.
24200	Removal of arm foreign body.
28190	Removal of foot foreign body.
56605	Biopsy of vulva/perineum.
56606	Biopsy of vulva/perineum.
69100	Biopsy of external ear.

(2) Move the following HCPCS codes from APC 0020 to APC 0021:

HCPCS	Description
11404	Removal of skin lesion.
11423	Removal of skin lesion.
11604	Removal of skin lesion.
11623	Removal of skin lesion.

The Panel recommended that we not change the structure of APCs 0019, 0020, and 0021 at this time in the interest of preserving clinical homogeneity. We propose to accept the Panel's recommendation that we make no changes to the structure of these APCs for 2004. We plan to place these APCs on the Panel's agenda for the 2005 update.

c. Thoracentesis/Lavage Procedures and Endoscopies.

APC 0071: Level I Endoscopy Upper Airway.

APC 0072: Level II Endoscopy Upper Airway.

APC 0073: Level III Endoscopy Upper Airway.

We expressed concern to the Panel that APCs 0071 and 0072 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

Move the following HCPCS codes as described below:

TABLE 1.—HCPCS CODES PROPOSED TO BE REDISTRIBUTED FROM APCS 0071 AND 0072 TO APCS 0071, 0072, AND 0073

HCPCS	Description	2003 APC	2004 APC
31505	Diagnostic laryngoscopy	0072	0071
31575	Diagnostic laryngoscopy	0071	0072
31720	Clearance of airways	0072	0073

The Panel recommended that we make the above changes. We propose to accept the Panel's recommendation, with the exception of CPT code 31720. After reviewing an additional quarter of claims data that was not available at the time the Panel convened, placement of CPT code 31720 into APC 0072 better reflects its resource consumption. Therefore, we propose to keep CPT code 31720 in APC 0072.

d. Cardiac and Ambulatory Blood Pressure Monitoring.

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring.

We expressed concern to the Panel that APC 0097 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation, and suggested splitting APC 0097 into two APCs. The Panel recommended that the structure of APC 0097 should not be changed at this time based on clinical homogeneity considerations. We propose to accept the Panel's recommendation that we make no changes to APC 0097 for 2004. We plan to place this APC on the Panel's agenda for the 2005 update.

e. Electrocardiograms.

APC 0099: Electrocardiograms.

APC 0340: Minor Ancillary Procedures.

We expressed concern to the Panel that APC 0099 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation, and suggested moving CPT code 93701 (Bioimpedance, thoracic) from APC 0099 to APC 0340. The Panel felt, however, that the structure of APC 0099 should not be changed at this time based on clinical homogeneity considerations. We propose to accept the Panel's recommendation that we make no changes to APC 0099 for 2004. We plan to place this APC on the Panel's agenda for the 2005 update.

f. Cardiac Stress Tests.

APC 0100: Cardiac Stress Tests.

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 93025 (Microvolt t-wave assessment) out of APC 0100. The presenter believes that the actual cost for this procedure is significantly higher than for other procedures in the same APC. Since this technology is often billed in conjunction with other procedures (for example, stress tests, CPT code 93017), few single-APC claims were available to evaluate the presenter's contention.

The Panel felt the data presented are insufficient to merit moving the code and recommends that CPT code 93025 remain in APC 0100 until more data are available for review. We propose to accept the Panel's recommendation that CPT code 93025 remain in APC 0100 until more claims data become available for review.

g. Revision/Removal of Pacemakers or Automatic Implantable Cardioverter Defibrillators.

APC 0105: Revision/Removal of Pacemakers, AICD, or Vascular.

We asked the Panel to review the codes within APC 0105 for an apparent violation of the 2 times rule, stating that we believe the apparent violation is a result of incorrectly coded claims. The Panel agreed and recommended no changes to APC 0105 at this time. We propose to accept the Panel's recommendation that we make no changes to APC 0105 until more accurate claims data become available and support the need for a change.

h. Sigmoidoscopy.

APC 0146: Level I Sigmoidoscopy.

APC 0147: Level II Sigmoidoscopy.

We expressed concern to the Panel that relatively simple procedures such as anoscopy and rigid sigmoidoscopy have higher median costs than more complex procedures such as flexible sigmoidoscopy. Panel members suggested the high costs may be due to the need to perform an otherwise minor office procedure in a hospital setting (for example, due to the clinical condition of the patient). Panel members also suggested that claims may be incorrectly coded because coding

instructions do not clearly state how to code when the procedure performed is not as extensive as the procedure planned (for example, when a colonoscopy is planned but only a sigmoidoscopy is performed). In these cases, coding instructions are unclear as to whether the planned procedure should be reported with a modifier for reduced services or with the code for the actual procedure performed.

The Panel recommended that we make no changes to APCs 0146 and 0147 at this time. We propose to accept the Panel's recommendation that we make no changes to APCs 0146 and 0147. We plan to place this APC on the Panel's agenda for the 2005 update.

i. Anal/Rectal Procedures.

APC 0148: Level I Anal/Rectal Procedure.

APC 0149: Level III Anal/Rectal Procedure.

APC 0155: Level II Anal/Rectal Procedure.

We expressed concern to the Panel that APCs 0148 and 0149 appear to violate the 2 times rule. We asked the Panel to recommend options for resolving these violations, and suggested rearranging some of the CPT codes within APCs 0148, 0149, and 0155. The Panel recommended that we move CPT code 46040 (Incision of rectal abscess) from APC 0155 to APC 0149. We propose to accept the Panel's recommendation.

j. Insertion of Penile Prosthesis.

APC 0179: Urinary Incontinence Procedures.

APC 0182: Insertion of Penile Prosthesis.

A presenter to the Panel representing manufacturers and providers requested that APC 0182 be split into two APCs, based on whether the procedure used inflatable or non-inflatable penile prostheses. The presenter stated that the complexity of the procedure, the cost of the devices, and related resources were all significantly higher with inflatable prostheses.

The Panel recommended that we eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386 that contain the following CPT codes:

HCPCS	Description
APC 0385:	
52282	Cystoscopy, implant stent.
53440	Correct bladder function.
53444	Insert tandem cuff.
54400	Insert semi-rigid prosthesis.
54416	Remv/repl penis contain prosthesis.
APC 0386:	
53445	Insert uro/ves nck sphincter.
53447	Remove/replace ur sphincter.
54401	Insert self-contained prosthesis.
54405	Insert multi-comp penis prosthesis.
54410	Remove/replace penis prosthesis.

We propose to accept the Panel's recommendation to eliminate APCs 0179 and 0182 and create two new APCs, 0644 and 0645, containing the above CPT code configurations.

k. Surgical Hysteroscopy.

APC 0190: Surgical Hysteroscopy.

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 58563 (Hysteroscopy, ablation) from APC 0190 to a higher paying APC. The presenter noted that endometrial cryoablation is included in a new technology APC, while a thermal ablation system is included with older, less costly techniques. The presenter expressed concern that cryoablation may be reimbursed at a higher rate than the thermal ablation system, giving its manufacturers an unfair competitive advantage.

Panel members agreed that new, more expensive technologies that prove to be more effective merit review for a higher payment rate. Without substantial evidence of greater effectiveness, however, the Panel was reluctant to create APCs that provide an incentive to use a more expensive device. In its discussion of whether or not to recommend moving CPT code 58563 to a higher paying APC, the Panel recommended that we take into account different methods of endometrial ablation associated with hysteroscopy, adequately reflect the resources used for the various procedures, avoid creating a competitive advantage or disadvantage, and collect data needed to track costs on the type of technologies used for this procedure.

After consulting with experts in the field, we propose to split APC 0190 (Surgical Hysteroscopy) into 2 APCs that are more clinically homogeneous. We propose to change the description for APC 0190 from ''Surgical Hysteroscopy'' to ''Level I Hysteroscopy'' and keep the following HCPCS codes in APC 0190:

HCPCS	Description
58558	Hysteroscopy, biopsy.
58559	Hysteroscopy, lysis.
58562	Hysteroscopy, remove fb.
58579	Hysteroscope procedure.

We also propose to move the following HCPCS codes from APC 0190 to newly created APC 0387 titled ''Level II Hysteroscopy'':

HCPCS	Description
58560	Hysteroscopy, resect septum.
58561	Hysteroscopy, remove myoma.
58563	Hysteroscopy, ablation.

In addition, we propose to move the following HCPCS codes as described below:

TABLE 2.—HCPCS CODES PROPOSED TO BE REDISTRIBUTED TO APCS 0130, 0195, AND 0190

HCPCS	Description	2003 APC	2004 APC
58578	Laparoscopic procedure, uterus	0190	0130
58353	Endometrial ablate, thermal	0193	0195
58555	Hysteroscopy, diagnostic, sep. procedure	0194	0190

We believe these proposed changes take into account the different technologies used to perform these procedures while maintaining the clinical comparability of these APCs as well as improving their homogeneity in terms of resource consumption.

l. Female Reproductive Procedures.

APC 0195: Level VII Female Reproductive Proc. APC 0202: Level VIII Female Reproductive Proc.

A commenter requested that we place CPT code 57288 (Repair bladder defect) in its own APC because it requires the use of a device. Our staff suggested that CPT codes 57288 and 57287 remain in APC 0202, while the remaining codes in APC 0202 be moved to APC 0195:

HCPCS	Description
57109	Vaginectomy partial w/nodes.
58920	Partial removal of ovary(s).
58925	Removal of ovarian cyst(s).

The Panel agreed with our staff, and we propose to accept the Panel's recommendation to move CPT codes

57109, 58920, and 58925 from APC 0202 to APC 0195.

m. Nerve Injections.

APC 0203: Level IV Nerve Injections.

APC 0204: Level I Nerve Injections.

APC 0206: Level II Nerve Injections.

APC 0207: Level III Nerve Injections.

Several commenters suggested changes in the configuration of APCs 0203, 0204, 0206, and 0207 because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in these APCs. Several of these APCs include procedures associated with drugs or devices for which pass-through payments are scheduled to expire in 2003.

We requested the Panel's input regarding whether or not these APCs should be restructured. The Panel stated that the current configuration of APCs 0203, 0204, 0206, and 0207 is more clinically cohesive than the previous year's configuration and that more data should be collected before making any changes. We propose to accept the Panel's recommendation that we make no changes to the structure of these APCs until more data become available for review.

n. Laminotomies and Laminectomies; Implantation of Pain Management Device.

APC 0208: Laminotomies and Laminectomies.

APC 0223: Implantation of Pain Management Device.

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 62351 (Implant spinal canal catheter) from APC 0208 to APC 0223 to better capture the device cost that may be involved with the procedure. The Panel felt the data were insufficient to merit moving the code and recommended that CPT code 62351 remain in APC 0208 until more data are available for review. We propose to accept the Panel's recommendation that CPT code 62351 remain in APC 0208 until more claims data become available for review.

o. Extended EEG Studies and Sleep Studies; Electroencephalogram.

APC 0209: Extended EEG Studies and Sleep Studies, Level II.

APC 0213: Extended EEG Studies and Sleep Studies, Level I.

APC 0214: Electroencephalogram.

We expressed concern to the Panel that APC 0213 appears to minimally violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider a commenter's suggestion that we move CPT code 95955 (EEG during surgery) from APC 0214 to APC 0213. The Panel agreed with the commenter's suggestion. We propose to accept the Panel's recommendation to move CPT code 95955 from APC 0214 to APC 0213.

p. Nerve and Muscle Tests.

APC 0215: Level I Nerve and Muscle Tests.

APC 0216: Level III Nerve and Muscle Tests.

APC 0218: Level II Nerve and Muscle Tests.

We expressed concern to the Panel that APC 0218 appears to violate the 2 times rule. In order to remedy this violation, one commenter requested that we move CPT codes 95921 (Autonomic nerve function test) and 95922 (Autonomic nerve function test) from APC 0218 to APC 0216, while another commenter requested that we move CPT code 95904 (Sensory nerve conduction test) from APC 0215 to APC 0218. Alternatively, our staff suggested to the Panel that the following CPT codes be moved from APC 0218 to APC 0215.

HCPCS	Description
95858	Tensilon test & myogram.
95870	Muscle test, nonparaspinal.
95900	Motor nerve conduction test.
95903	Motor nerve conduction test.

After considering all of the above proposals, the Panel recommended that we move CPT codes 95858, 95870, 95900, and 95903 from APC 0218 to APC 0215. We propose to accept the Panel's recommendation.

q. Implantation of Drug Infusion Device.

APC 0227: Implantation of Drug Infusion Device.

APC 0227 contains only two CPT codes: one for implantation of programmable spine infusion pumps, 62362, and for implantation of non-programmable spine infusion pumps, 62361. A commenter requested that we split APC 0227 into two APCs to recognize the cost difference between CPT code 62361 and CPT code 62362. However, since our cost data do not show a significant cost difference between the two devices and APC 227 does not violate the 2 times rule, the Panel recommended that CPT codes 62361 and 62362 remain in APC 0227. We propose to accept the Panel's recommendation.

r. Ophthalmologic APCs.

APC 0230: Level I Eye Tests & Treatments.

APC 0235: Level I Posterior Segment Eye Procedures.

APC 0236: Level II Posterior Segment Eye Procedures.

APC 0698: Level II Eye Tests & Treatments.

We advised the Panel that APCs 0230 and 0235 violate the 2 times rule but that the current configuration of these APCs reflects the Panel's previous recommendations. A presenter to the Panel, who represented a device manufacturer, expressed concern that the pass-through device category ''New Technology: Intraocular Lens'' was discontinued and these devices are now packaged. The presenter asked the Panel to recommend that future new intraocular lens devices be considered for a new pass-through category.

To remedy the violations to the 2 times rule, we asked the Panel to consider moving CPT code 67820 (Revise eyelashes) from APC 0230 to APC 0698 and CPT code 67110 (Repair detached retina) from APC 0235 to APC 0236. The Panel recommended that we make these changes. We propose to accept the Panel's recommendation and monitor the data for APC 0235 for possible review next year. The Panel also acknowledged that making recommendations concerning pass-through categories is beyond their purview.

s. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures.

APC 0341: Skin Tests and Miscellaneous Red Blood Cell Tests.

APC 0345: Level I Transfusion Laboratory Procedures.

We advised the Panel that APCs 0341 and 0345 minimally violate the 2 times rule and suggested moving several CPT codes within these APCs into a new APC because a commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341, asserting that services within this APC cannot be considered comparable with respect to resource usage.

In order to remedy these violations to the 2 times rule, we suggested moving CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to a new APC along with the following CPT codes from APC 0341:

HCPCS	Description
86880	Coombs test, direct.
86885	Coombs test, indirect, qualitative.
86886	Coombs test, indirect, titer.
86900	Blood typing, ABO.

The Panel recommended that we make the above changes. We propose to accept the Panel's recommendation to move HCPCS codes 86880, 86885, 86886, and 86900 from APC 0341 to new APC 0409 and to move CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to new APC 0409.

t. Otorhinolaryngologic Function Tests.

APC 0363: Level I Otorhinolaryngologic Function Tests.

APC 0660: Level II Otorhinolaryngologic Function Tests.

We expressed concern to the Panel that APC 0660 appears to violate the 2 times rule and suggested moving CPT codes 92543 (Caloric vestibular test) and 92588 (Evoked auditory test) from APC 0660 to APC 0363. The Panel recommended that we make these CPT code changes. We propose to accept the Panel's recommendation to move CPT codes 92543 and 92588 from APC 0660 to APC 0363.

u. Tube Changes and Repositioning.

APC 0121: Level I Tube changes and Repositioning

APC 0122: Level II Tube changes and Repositioning

We expressed concern to the Panel that APC 0121 appears to violate the 2 times rule. In order to remedy this violation, we suggested moving the following CPT codes from APC 0121 to APC 0122:

HCPCS	Description
47530	Revise/reinsert bile tube.
50688	Change of ureter tube.
51710	Change of bladder tube.
62225	Replace/irrigate catheter.

The Panel recommended that we make these CPT code changes. We propose to accept the Panel's recommendation to move CPT codes 47530, 50688, 51710, and 62225 from APC 0121 to APC 0122.

v. Myelography.

APC 0274: Myelography.

We advised the Panel that APC 0274 minimally violates the 2 times rule and suggested moving CPT codes 72285 (X-ray c/t spine disk) and 72295 (X-ray c/t spine disk) from APC 0274 to a new APC. A presenter, from an organization representing radiologists, agreed with our proposal. The Panel recommended that we make these CPT code changes. We propose to accept the Panel's recommendation to move CPT codes 72285 and 72295 from APC 0274 to new APC 0388.

w. Therapeutic Radiologic Procedures.

APC 0296: Level I Therapeutic Radiologic Procedures

APC 0297: Level II Therapeutic Radiologic Procedures

We advised the Panel that APCs 0296 and 0297 appear to minimally violate the 2 times rule as a result of changes recommended by the Panel and adopted by CMS last year. The Panel recommended that no changes be made to APCs 0296 and 0297 in the interest of preserving the clinical homogeneity of these APCs. We propose to accept the Panel's recommendation that we make no CPT code changes to APCs 0296 and 0297.

x. Vascular Procedures; Cannula/Access Device Procedures.

APC 0103: Miscellaneous Vascular Procedures

APC 0115: Cannula/Access Device Procedures

A commenter requested that we move CPT code 36860 (External cannula declotting) from APC 0103 to APC 0115, asserting that this procedure is more similar to other procedures in APC 0115 and does not fit well in its current miscellaneous APC. The Panel found that the claims data were insufficient to support moving CPT code 36860 from APC 0103 to the higher paying APC 0115 and recommends that CPT code 36860 remain in APC 0103 until more data are available for review. We propose to accept the Panel's recommendation that CPT code 36860 remain in APC 0103 until more claims data become available for review.

y. Angiography and Venography Except Extremity.

APC 0279: Level II Angiography and Venography except Extremity.

APC 0280: Level III Angiography and Venography except Extremity.

APC 0668: Level I Angiography and Venography except Extremity.

A commenter requested that we move CPT code 75978 (Repair venous blockage) from APC 0668 to APC 0280 and that we move CPT code 75774 (Artery x-ray, each vessel) from APC 0668 to APC 0279. A presenter to the Panel testified that CPT code 75978 is commonly used for dialysis patients and often requires multiple intraoperative attempts to succeed; thus, it should be paid under APC 280. The Panel felt that APCs 0279, 0280, and 0668 were clinically homogenous and recommended that we only make changes after consulting with experts in the field. We propose to accept the Panel's recommendation to make no changes to APCs 0279, 0280, and 0668 until consulting with experts in the field. We plan to place these APCs on the Panel's agenda for the 2005 update.

z. Computed Tomography (CT), Magnetic Resonance (MR), and Ultrasound Guidance Procedures Currently Packaged.

APC 0332: Computerized Axial Tomography and Computerized Angiography without Contrast Material.

APC 0335: Magnetic Resonance Imaging, Miscellaneous.

APC 0268: Ultrasound Guidance Procedures.

A presenter to the Panel expressed concern that the packaging of guidance procedures for tissue ablation does not recognize the significant difference in cost and time required to perform each procedure (for example, MRI vs. CT). This presenter felt that hospitals needed more education on the appropriate application of these codes. Another commenter requested that CPT codes 76362, 76394, and 76490 be changed from a status indicator of N to a status indicator of S and included in an appropriate clinical or new technology APC.

The Panel agreed with the above comments and stated that the packaging of these three procedures made it difficult for hospitals to track their use for the purpose of allocating funds. The Panel recommended changing the following CPT codes from a packaged status (N status indicator) to a separately payable status (S status indicator) within the indicated APCs:

TABLE 3.—HCPCS CODES PROPOSED TO BE DESIGNATED AS SEPARATELY PAYABLE

HCPCS	Description	2003 status	2004 APC
76362	CT scan for tissue ablation	Packaged	0332
76394	MRI for tissue ablation	Packaged	0335
76490	US for tissue ablation	Packaged	0268

We propose to accept the Panel's recommendation to change HCPCS codes 76362, 76394, and 76490 from a packaged status to a separately payable status as indicated above.

aa. Magnetic Resonance Imaging and Magnetic Resonance Angiography Without Contrast.

APC 0336: Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast

A commenter requested that we change CPT code 76393 (MR guidance for needle placement) from a packaged status to a separately payable status within APC 0336. Based on clinical homogeneity considerations, the Panel agreed with the commenter and recommended that CPT code 76393 be changed from a status indicator of N to a status indicator of S and placed in APC 0335. We propose to accept the Panel's recommendation.

bb. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement.

APC 0260: Level I Plain Film Except Teeth.

APC 0261: Level II Plain Film Except Teeth Including Bone Density Measurement.

APC 0272: Level I Fluoroscopy.

A commenter requested that we move CPT codes 76120 (Cine/video x-rays) and 76125 (Cine/video x-rays add-on) from APC 0260 to APC 0261. However, a presenter to the Panel argued that these CPT codes are fluoroscopic procedures that should not be grouped with Level I radiography procedures. The Panel recommended that we move CPT code 76120 from APC 0260 to APC 0272 and that CPT code 76125 remain in APC 0260. This change makes the APCs more clinically coherent. We propose to accept the Panel's recommendation.

cc. Chemotherapy Administration by Other Technique Except Infusion.

APC 0116: Chemotherapy Administration by Other Technique Except Infusion.

A presenter to the Panel requested that we split APC 0116 into three APCs according to the method of administration: (a) Subcutaneous or intramuscular administration (CPT code 96400); (b) ''push'' administration (CPT code 96408); and (c) central nervous system administration (CPT code 96450). The presenter also requested that existing CPT codes should replace the more nonspecific Q codes for administration of chemotherapy because the CPT codes would provide more detailed data on methods of chemotherapy administration, which could be used for future payment policy decisions. Another presenter agreed with this request and stated that CPT codes are preferable to Q codes because other payers require CPT codes.

The Panel agreed with the above suggestions to split APC 0116 into 3 APCs according to the method of administration. The Panel recommended that we require hospitals to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data would be used to determine whether to change the APC structure for chemotherapy administration.

We propose not to accept the Panel's recommendations to split APC 0116 into 3 APCs and to use CPT codes for administration of chemotherapy. We would consider such a split in the future but would like to first address the administration of drugs issue. We believe that making a change in APC 116 would be too complicated for hospitals given the changes for administration in general that we are considering in this proposed rule for implementation in CY 2004. We will consider such a split for APC 116 for CY 2005. We also believe the use of CPT codes would be burdensome to hospitals, would require extensive education, and would result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service is reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we would be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. Please see section VI of this proposed rule for further discussion on payments for drugs and drug administration.

dd. Capturing the Costs of Drugs and Biologicals Packaged Into APCs.

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0294: Level II Therapeutic Nuclear Medicine.

APC 0666: Myocardial Add-on Scans.

We told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a ''per dose'' basis or ''per millicurie'' basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and said they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals would have no incentive to code, and thereby, identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, and these items are now paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of $150 or less were packaged. Beginning in 2003 claims data will not provide specific cost information for packaged items. We requested input from the Panel for methods to determine drug costs.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionucliides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various

radiopharmaceuticals and believe that reorganizing the APCs for nuclear medicine would result in greater clinical and resource homogeneity. Therefore, we propose to eliminate APCs 0286, 0290, 0291, 0292, 0294, 0666 and create 20 new APCs for nuclear medicine that contain the following CPT codes:

HCPCS	Description
APC 0389:	
78000	Thyroid, single uptake.
78001	Thyroid, multiple uptakes.
78003	Thyroid suppress/stimul.
78020	Thyroid met uptake.
78099	Endocrine nuclear procedure.
78190	Platelet survival, kinetics.
78191	Platelet survival.
78199	Blood/lymph nuclear exam.
78299	GI nuclear procedure.
78399	Musculoskeletal nuclear exam.
78499	Cardiovascular nuclear exam.
78599	Respiratory nuclear exam.
78699	Nervous system nuclear exam.
78725	Kidney function study.
78799	Genitourinary nuclear exam.
78999	Nuclear diagnostic exam.
79999	Nuclear medicine therapy.
APC 0390:	
78006	Thyroid imaging with uptake.
78010	Thyroid imaging.
78015	Thyroid met imaging.
78016	Thyroid met imaging/studies.
APC 0391:	
78007	Thyroid image, mult uptakes.
78011	Thyroid imaging with flow.
78018	Thyroid met imaging, body.
78070	Parathyroid nuclear imaging.
APC 0392:	
78075	Adrenal nuclear imaging.
APC 0393:	
78110	Plasma volume, single.
78111	Plasma volume, multiple.
78120	Red cell mass, single.
78121	Red cell mass, multiple.
78122	Blood volume.
78130	Red cell survival study.
78135	Red cell survival kinetics.
78140	Red cell sequestration.
78160	Plasma iron turnover.
78162	Radioiron absorption exam.
78170	Red cell iron utilization.
78172	Total body iron estimation.
APC 0400:	
78102	Bone marrow imaging, ltd.
78103	Bone marrow imaging, mult.
78104	Bone marrow imaging, body.
78185	Spleen imaging.
78195	Lymph system imaging.
APC 0394:	
78201	Liver imaging.
78202	Liver imaging with flow.
78205	Liver imaging (3D).
78206	Liver image (3d) with flow.
78215	Liver and spleen imaging.
78216	Liver & spleen image/flow.
78220	Liver function study.
78223	Hepatobiliary imaging.
APC 0395:	
78230	Salivary gland imaging.
78231	Serial salivary imaging.
78232	Salivary gland function exam.
78258	Esophageal motility study.
78261	Gastric mucosa imaging.
78262	Gastroesophageal reflux exam.
78264	Gastric emptying study.
78278	Acute GI blood loss imaging.
78290	Meckel's divert exam.
78291	Leveen/shunt patency exam.
78270	Vit B–12 absorption exam.
78271	Vit b-12 absrp exam, int fac.
78272	Vit B–12 absorp, combined.
78282	GI protein loss exam.
APC 0396:	
78300	Bone imaging, limited area.
78305	Bone imaging, multiple areas.
78306	Bone imaging, whole body.
78315	Bone imaging, 3 phase.
78320	Bone imaging (3D).
APC 0397:	
78414	Non-imaging heart function.
78445	Venous thrombosis study.
78455	Venous thrombosis study.
78456	Acute venous thrombus image.
78457	Venous thrombosis imaging.
78458	Ven thrombosis images, bilat.
APC 0398:	
78428	Cardiac shunt imaging.
78460	Heart muscle blood, single.
78461	Heart muscle blood, multiple.
78464	Heart image (3d), single.
78465	Heart image (3d), multiple.
78466	Heart infarct image.
78468	Heart infarct image (ef).
78469	Heart infarct image (3D).
78472	Gated heart, planar, single.
78473	Gated heart, multiple.
78481	Heart first pass, single.
78483	Heart first pass, multiple.
78494	Heart image, spect.
APC 0399:	
78478	Heart wall motion add-on.
78480	Heart function add-on.
78496	Heart first pass add-on.
APC 0401:	
78580	Lung perfusion imaging.
78584	Lung V/Q image single breath.
78585	Lung V/Q imaging.
78586	Aerosol lung image, single.
78587	Aerosol lung image, multiple.
78588	Perfusion lung image.
78591	Vent image, 1 breath, 1 proj.
78593	Vent image, 1 proj, gas.
78594	Vent image, mult proj, gas.
78596	Lung differential function.
APC 0402:	
78600	Brain imaging, ltd static.
78601	Brain imaging, ltd w/flow.
78605	Brain imaging, complete.
78606	Brain imaging, compl w/flow.
78607	Brain imaging (3D).
78610	Brain flow imaging only.
78615	Cerebral vascular flow image.
APC 0403:	
78630	Cerebrospinal fluid scan.
78635	CSF ventriculography.
78645	CSF shunt evaluation.
78647	Cerebrospinal fluid scan.
78650	CSF leakage imaging.
78660	Nuclear exam of tear flow.
APC 0404:	
78700	Kidney imaging, static.
78701	Kidney imaging with flow.
78704	Imaging renogram.
78707	Kidney flow/function image.
78708	Kidney flow/function image.
78709	Kidney flow/function image.
78710	Kidney imaging (3D).
78715	Renal vascular flow exam.
APC 0405:	
78730	Urinary bladder retention.
78740	Ureteral reflux study.
78760	Testicular imaging.
78761	Testicular imaging/flow.
APC 0406:	
78800	Tumor imaging, limited area.
78801	Tumor imaging, mult areas.
78802	Tumor imaging, whole body.
78803	Tumor imaging, whole body.
78805	Abscess imaging, ltd area.
78806	Abscess imaging, whole body.
78807	Nuclear localization/abscess.
G0273	Pretx planning, non-Hodgkins.
APC 0407:	
79000	Init hyperthyroid therapy.
79001	Repeat hyperthyroid therapy.
79020	Thyroid ablation.
79030	Thyroid ablation, carcinoma.
79035	Thyroid metastatic therapy.
APC 0408:	
79100	Hematopoetic nuclear therapy.
79200	Intracavitary nuclear trmt.
79300	Interstitial nuclear therapy.
79400	Nonhemato nuclear therapy.
79420	Thyroid metastatic therapy.
79440	Nuclear joint therapy.
G0274	Radiopharm tx, non-Hodgkins.

We believe that the proposed APC structure, which takes into account the organ(s) being examined (or treated) as well as the type and complexity of the procedure, is more homogeneous both clinically and in terms of resource consumption than the current APC structure.

Currently, payment for the radiopharmaceutical ''zevalin'' (Ibritumomab Tiuxetan) is packaged into the payment for HCPCS codes G0273 (Pretx planning, non-Hodgkins) and G0274 (Radiopharm tx, non-Hodgkins). To ensure consistency with our payment policy for other radiopharmaceuticals (that is, making separate payment for radiopharmaceuticals whose costs are greater than $150 per episode of care), we are proposing to make payment for ''zevalin'' (Ibritumomab Tiuxetan) separately from payment for the procedures with which ''zevalin'' (Ibritumomab Tiuxetan) is used.

We propose to use HCPCS A9522 (Indium 111 ibritumomab tiuxetan) to report the use of In-111 Zevalin (In-111 Ibritumomab Tiuxetan) and HCPCS A9523 (Yttrium 90 ibritumomab tiuxetan) to report the use of Y90 Zevalin (Y90 Ibritumomab Tiuxetan). We would place HCPCS A9522 in APC 9118 with a payment amount of $2,084.55 and HCPCS A9523 in APC 9117 with a payment amount of $18,066.09. We note that payment rates for radiopharmaceuticals are not subject to wage index adjustments because no

portion of the payment is attributed to labor-related costs.

Because we propose that payment for G0273 and G0274 no longer include payment for ''zevalin,'' we also propose to place G0273 into newly created APC 0406 and G0274 into newly created APC 0408. These APCs include procedures that are similar clinically and in terms of resource consumption to G0274 and G0273, respectively.

Please see section VI of this proposed rule for further discussion on payments for drugs, biologicals, and radiopharmaceuticals.

ee. Endoscopy Lower Airway.

APC 0076: Endoscopy Lower Airway.

A presenter to the Panel expressed concern that APC 0076 apparently violates the 2 times rule and requested that we move CPT code 31631 (bronchoscopy with tracheal stent placement) from APC 0076 and into a new APC.

The Panel suggested that a new APC comprised of the four most costly procedures in APC 0076 would result in a more homogenous grouping, and recommended that we move the following CPT codes from APC 0076 and into newly created APC 0415.

HCPCS	Description
31630	Bronchoscopy dilate/fracture reduction.
31631	Bronchoscopy, dilate w/stent.
31640	Bronchoscopy w/tumor excise.
31641	Bronchoscopy, treat blockage.

We propose to accept the Panel's recommendation that we move CPT codes 31630, 31631, 31640, and 31641 from APC 0076 to new APC 0415.

ff. Gastrointestinal Endoscopic Stenting Procedures.

APC 0141: Upper GI Procedures.

APC 0142: Small Intestine Endoscopy.

APC 0143: Lower GI Endoscopy.

APC 0147: Level II Sigmoidoscopy.

A commenter requested that we create a new APC that would be comprised of all the gastrointestinal endoscopic stent codes. The Panel agreed with the commenter's suggestion because the resource requirements for all gastrointestinal endoscopic stents appear to be similar.

The Panel recommended that we move the following CPT codes from their 2003 APCs to newly created APC 0384 for 2004:

TABLE 4.—HCPCS CODES TO BE MOVED INTO NEW APC 0646

HCPCS	Description	2003 APC	2004 APC
43219	Esophagus endoscopy	0141	0384
43256	Upper GI endoscopy w/stent	0141	0384
44370	Small bowel endoscopy w/stent	0142	0384
44379	Small bowel endoscopy w/stent	0142	0384
44383	Small bowel endoscopy	0142	0384
44397	Colonoscopy w/stent	0143	0384
45387	Colonoscopy w/stent	0143	0384
45327	Proctosigmoidoscopy w/stent	0147	0384
45345	Sigmoidoscopy w/stent	0147	0384

We propose to accept the Panel's recommendation to move the following gastrointestinal endoscopic stent CPT codes into newly created APC 0384: 43219, 43256 (from APC 0141); 44370, 44379, 44383 (from APC 0142); 44397, 45387 (from APC 0143); 45327, and 45345 (from APC 0147).

gg. Capturing the Costs of Devices That Are Packaged Into APCs.

APC 0081: Non-Coronary Angioplasty or Atherectomy.

APC 0083: Coronary Angioplasty and Percutaneous Valvuloplasty.

APC 0104: Transcatheter Placement of Intracoronary Stents.

APC 0222: Implantation of Neurological Device.

APC 0223: Implantation of Pain Management Device.

APC 0227: Implantation of Drug Infusion Device.

APC 0229: Transcatheter Placement of Intravascular Shunts.

Several commenters requested that the status indicators for the above APCs (all of which include high-cost devices) be changed from T (multiple-procedure discount applies) to S (multiple-procedure discount does not apply). Two presenters to the Panel stated that hospitals do not pay less for devices when they are used in the context of a multiple-procedure claim and suggested that we apply the multiple-procedure reduction to the non-device portion of the claim only. Alternatively, these presenters recommended that we apply the discount policy only when the device cost is below a predetermined proportion of the APC cost. Another presenter to the Panel requested that APCs 0222, 0223, and 0227 be exempt from the multiple procedure discount policy because the cost of the devices used in these procedures makes up more than 50 percent of the APC cost.

We sought the Panel's input as to whether there are situations in which we should not apply our multiple procedure discount policy. The Panel recommended no changes to the status indicators for any of the device-related APCs discussed because they were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary. However, the Panel asked that we analyze our data to determine if we may be underpaying for devices when the multiple procedure discounting policy is applied and recommended that we develop some methodology to track device costs. In section V.C of this proposed rule, we discuss the issue of device costs and multiple procedure reductions and our progress to date in developing ''combination APCs'' to address the Panel's concern.

hh. Discussion of Ways To Increase the Use of Multiple Claims To Set APC Payment Rates.

A presenter to the Panel suggested that we use dates of service on multiple procedure claims to increase the number of claims we use to set payment rates. Another presenter suggested that we could further increase the number of multiple procedure claims that could be used to set payment rates by ignoring codes with status indicator K. Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices.

The Panel recommended that our staff explore ways to increase the number of claims used to set payment rates, including the following methodologies: sort multiple claims by date of service; exclude codes with K status indicator from evaluation; exclude those APCs with nominal costs (the definition of ''nominal'' can be determined by

modeling a variety of possible dollar amounts). In addition, the Panel recommended that we create no G codes as part of the effort to use multiple procedure claims for developing relative weights. If new codes are needed, the Panel suggested that our staff work with the American Medical Association's CPT Board to identify possible new codes. Please see section V.C of this proposed rule for our discussion of the use of multiple procedure claims for developing payment rates for procedures that use devices.

B. Other Changes Affecting the APCs

1. Limit on Variation of Costs of Services Classified Within an APC Group

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within an APC group is more than 2 times greater than the lowest cost item or service within the same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Taking into account the proposed APC changes discussed in relation to the APC Panel recommendations in section II.A.4 of this proposed rule and the use of 2002 claims data to calculate the median cost of procedures classified to APCs, we reviewed all the APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation.

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

The following table contains APCs that we propose to exempt from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the Panel recommendation because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http://www.cms.hhs.gov.*

TABLE 5.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE

Proposed rule APC	Description
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow.
0018	Biopsy of Skin/Puncture of Lesion.
0019	Level I Excision/Biopsy.
0020	Level II Excision/Biopsy.
0032	Insertion of Central Venous/Arterial Catheter.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0046	Open/Percutaneous Treatment Fracture or Dislocation.
0048	Arthroplasty with Prosthesis.
0055	Level I Foot Musculoskeletal Procedures.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0072	Level II Endoscopy Upper Airway.
0073	Level III Endoscopy Upper Airway.
0080	Diagnostic Cardiac Catheterization.
0084	Level I Electrophysiologic Evaluation.
0097	Cardiac and Ambulatory Blood Pressure Monitoring.
0099	Electrocardiograms.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0130	Level I Laparoscopy.
0147	Level II Sigmoidoscopy.
0148	Level I Anal/Rectal Procedure.
0155	Level II Anal/Rectal Procedure.
0164	Level I Urinary and Anal Procedures.
0165	Level III Urinary and Anal Procedures.
0192	Level IV Female Reproductive Proc.
0203	Level IV Nerve Injections
0204	Level I Nerve Injections.
0207	Level III Nerve Injections.
0213	Extended EEG Studies and Sleep Studies, Level I.
0214	Electroencephalogram.
0218	Level II Nerve and Muscle Tests.
0231	Level III Eye Tests & Treatments.
0233	Level II Anterior Segment Eye Procedures.
0235	Level I Posterior Segment Eye Procedures.
0239	Level II Repair and Plastic Eye Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0252	Level II ENT Procedures.
0262	Plain Film of Teeth.
0266	Level II Diagnostic Ultrasound Except Vascular.
0274	Myelography.
0303	Treatment Device Construction.
0330	Dental Procedures.
0340	Minor Ancillary Procedures.

TABLE 5.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE—Continued

Proposed rule APC	Description
0341	Skin Tests.
0344	Level III Pathology.
0363	Level I Otorhinolaryngologic Function Tests.
0364	Level I Audiometry.
0367	Level I Pulmonary Test.
0368	Level II Pulmonary Tests.
0370	Allergy Tests.
0373	Neuropsychological Testing.
0385	Urinary Incontinence Procedures.
0397	Vascular Imaging.
0408	Non-thyroid Radionucliide Treatment.
0409	Red Blood Cell Tests.
0600	Low Level Clinic Visits.
0668	Level I Angiography and Venography except Extremity.
0692	Electronic Analysis of Neurostimulator Pulse Generators.
0698	Level II Eye Tests & Treatments.

2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. The April 7, 2000 final rule initially established the time frame that new technology APCs would be in effect (65 FR 18457). Beginning in 2002, we retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the context of new technology procedures, we create HCPCS codes for services only. We do not create HCPCS codes for equipment that is used in the course of providing an item or service (except in the case of ''C'' codes for devices that meet the criteria for transitional pass-through payments). Equipment that is used to provide an item or service is not separately coded because it is a resource required to furnish the service. Like other resources that are required to furnish a service (for example, cost of a room, cost of staff, cost of supplies), the hospital should show charges either as part of its charge for the procedure or with a revenue code.

As described in more detail below, we propose to delete four HCPCS codes that are currently paid in new technology APCs. These four HCPCS codes do not conform to our current policy to not create HCPCS codes for equipment used to provide a service. In addition, there exist, or soon will exist, CPT codes to describe the services being furnished, including any equipment that is needed to perform them, so we believe it is appropriate at this time to delete the HCPCS codes. The HCPCS codes we propose to delete effective January 1, 2004 are:

C1088: Laser Optic Treatment system, Indigo Laseroptic Treatment System,

C9701: Stretta System,

C9703: Bard Endoscopic Suturing System, and

C9711: H.E.L.P. Apheresis System.

These codes were created and assigned to New Technology APCs when it was CMS policy to create a C code to describe an item of equipment for which there was no other means of making payment for the service in which the equipment was used. In the November 30, 2001 final rule, we announced that we would not use New Technology APCs to pay for drugs, devices, and equipment that are used in the performance of a procedure, but which are not in and of themselves a complete service. It is due to an oversight on our part that we did not delete these codes at that time. We stopped using C codes to describe specific devices in April 2001 and no longer create C codes to describe items of equipment. Moreover, we have found that there are existing CPT codes or, in the case of C9701, there will soon be a CPT tracking code, that will accurately report the services being furnished, and under which the hospital should report the charges for providing the services, including charges related to the equipment needed to furnish the service. Therefore, payment will be appropriate regardless of whether there are separate codes for these items of equipment.

HCPCS code C1088, the Laser Optic Treatment System, Indigo Laseroptic Treatment System, now paid under APC 0980 is no longer needed because our review of data shows that the equipment it describes is appropriately reported under CPT codes 52647 and 52648. The procedures described by these CPT codes may be performed by using several types of equipment, one of which is the type described by C1088. In fact, most of the claims containing line items for C1088 are accompanied by line items for 52647 or 52648. This means that hospitals are appropriately reporting these services under the applicable CPT codes and that any charges associated with C1088 are likely duplicate charges for the service provided. Therefore, we propose to delete C1088 and to have hospitals continue to report these services under CPT codes 52647 and 52648, which are in APC 0163.

HCPCS code C9701, the Stretta System, now paid under APC 0980, is used in a procedure that will soon be given a CPT Category Three Tracking Code by the American Medical Association's CPT Editorial Panel. We propose to use the CPT tracking code to report services using the Stretta System and to delete HCPCS code C9701. We propose to assign the new CPT tracking code in APC 1557.

HCPCS code C9703, the Bard Endoscopic Suturing System, now paid under APC 0979, is used in a procedure that has been granted a CPT Category Three Tracking Code, 0008T, which describes the procedure for which this equipment is used. We propose to delete C9703 and to require hospitals to use 0008T to report services using this equipment. We propose to assign CPT code 0008T to APC 1555 for 2004.

HCPCS code C9711, the H.E.L.P. Apheresis System, now paid under APC

0978, is used to provide apheresis, which is appropriately reported using CPT codes 36511 through 36516. Therefore, we propose to delete C9711 and to require hospitals to report the service in which this equipment is used by using CPT codes 36511 through 36516.

3. Revision of Cost Bands and Payment Amounts for New Technology APCs

In the April 7, 2000 final rule (68 FR 18477), we created 15 new technology APCs (APCs 0970 through 0984) to pay for certain new technology services under the OPPS. As discussed in both the April 7, 2000 and November 30, 2001 final rules, new technology APCs are intended to pay for new or rarely performed procedures for which we lack sufficient cost data to make an assignment to a clinical APC. New technology APCs are defined on the basis of costs, not the clinical characteristics of a service. The payment rate for each new technology APC is based on the midpoint of a range of costs.

In the November 30, 2001 final rule (66 FR 59856), we revised several of the cost bands, added a payment level to the original group of new technology APCs, and assigned status indicator ''T'' to APCs 0970 through 0985. We also created a parallel set of new technology APCs (APCs 0706 through 0721), each of which was assigned status indicator ''S.'' In addition, we changed the definition of what is appropriately paid for under a new technology APC; we refined the criteria for determining assignment of a procedure or service to a new technology APC; we clarified the information that must be supplied for a request for new technology status to be considered; and we removed the restrictions on how long a procedure can be assigned to a new technology APC. These changes, which are discussed in detail in the November 30, 2001 final rule, were implemented effective April 1, 2002.

In the November 1, 2002 final rule, we established two additional new technology APCs, APC 989, and APC 725; as these APCs were not discussed in the proposed rule, they were considered interim with comment.

In this proposed rule, we are proposing to implement a comprehensive restructuring of all the new technology APCs. First, the cost intervals in the current new technology APCs are inconsistent, ranging from $50 to $1,500. Secondly, as the number of procedures assigned to new technology APCs increases, we believe that narrower cost bands are required to avoid significant mispayment for new technology services. The increased number of new technology APCs that would result from narrowing the cost bands cannot be accommodated within the current sequence of available APC numbers. Therefore, we are proposing to dedicate two new series of APC numbers to the restructured new technology APCs, which would allow us to narrow the cost bands and also afford us flexibility in creating additional bands as future needs may dictate.

We propose to establish cost bands from $0 to $100 in increments of $50, from $100 through $2,000 in intervals of $100, and from $2,000 through $6,000 in intervals of $500. We believe that these intervals would allow us to price new technology services more appropriately and consistently. We also propose to retain two parallel sets of new technology APCs, one with status indicator ''S'' and the other with status indicator ''T.'' We invite comments on the hierarchy of cost levels of the restructured new technology APCs.

We would reassign current new technology procedures to the level in the restructured new technology APCs so that the payment amount for the procedure in 2004 closely approximates the current payment amount. As we explained in the November 30, 2001 final rule, we generally keep a procedure in the new technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original new technology APC assignment was based on inaccurate or inadequate information, we may, based on more recent information (including claims data), reassign the procedure or service to a different new technology APC that more appropriately reflects its cost.

The proposed restructured new technology APCs are listed in Addendum A.

4. APC Assignment for New Codes Created During Calendar Year (CY) 2003

During CY 2003, we created several HCPCS codes to describe services payable under the hospital OPPS. These codes have already been assigned to APCs for CY 2003. In this proposed rule, we solicit comment on the APC assignment of these services. In addition, in this proposed rule, we propose to create a new HCPCS code with an effective date of July 1, 2003. Table 6 includes a new procedural HCPCS code created for implementation in July 2003.

Table 6 does not include new codes for drugs and devices for which we established or intend to establish pass-through payment eligibility effective July or October 2003. Furthermore, neither the new procedural HCPCS nor the new pass-through codes proposed for implementation beginning October 2003, or later, are included in Addendum B of this proposed rule.

TABLE 6—NEW G CODE FOR 2003

HCPCS code	Long descriptor	SI	Effective date	APC
G0296	PET imaging, full and partial ring PET scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I–131 whole body scan.	S	07/01/03	0714

5. Creation of APCs for Combinations of Device Procedures

In the course of developing the proposed rule for the 2004 OPPS, we wanted to ensure that the claims we use to set payment rates for APCs into which we package medical devices accurately reflect the costs of both the device and non-device portions of the service. As discussed in section III of this proposed rule, we have made a number of changes to our methodology for the creation of single procedure claims used to set relative weights. These changes enabled us to use charge data from more claims to set relative weights. However, we have noted that in spite of our new methodology, we were unable to significantly increase the number of single procedure claims used to set relative weights for several APCs that use high cost devices. One reason for this is that these APCs are often billed in combination with several other major procedures so that we are unable to generate single procedure claims for these APCs.

In the past, commenters have alleged that without using multiple procedure claims, we will be unable to capture the

costs of the more complex cases in which multiple procedures are performed and multiple devices are used. These commenters further requested that we change the status indicator of certain APCs from ''T'' to ''S'' in order to appropriately capture the cost of high cost devices when multiple procedures, each using devices, were billed. In addition to attempting to find a way to use multiple procedure claims, we also decided to examine our claims data to investigate whether our current payments for multiple procedures performed on the same date, each using high cost devices accurately captured the costs of the device and non-device portion of each procedure.

In order to do this, we reviewed claims from APCs that required high cost devices and from which we were unable to use the majority of claims to set a relative weight for the APC (for example, APCs for insertion of pacemakers, defibrillators, and neurostimulators). We determined the frequency with which other APCs were billed with the high cost device APCs. We then selected those claims where two APCs using high cost devices, or one APC using high cost devices and one high cost, non-device-requiring APC, were billed together with a frequency of more than 100 for the time period April 1, 2002 through September 30, 2002. This number was chosen in order to ensure that we had enough claims to determine reliable median costs. We included the APC combination 0081/0104 unintentionally and performed the analysis without realizing until after the data were developed that it had fewer than 100 claims and therefore should not have been selected. We expected that the data being used to set the 2004 weights would have a similar number of each combination to the number we found in the April 2002 to September 2002 claims. Review of Table 7, Combination APCs Used in Analysis, shows that even starting with 100 claims, we frequently had to determine median costs with very few claims. Additionally, Table 7 reveals that only a few combinations of two high cost device-requiring APCs are billed together 100 or more times. Six of the twelve combinations we analyzed (for example, claims for insertion of pacemakers and defibrillators) contained APC 0105 (Removal of pacemaker defibrillator), which is not a high cost, device-requiring APC. As the data show, APC 0105 is frequently found on multiple procedure claims, but because it is not a high cost device-requiring APC, when it is billed with these APCs, the multiple procedure reductions are applied to APC 0105. Therefore, we have determined that the vast majority of claims for APCs, such as ''insertion of Cardioverter Defibrillators,'' were not usable multiple procedure claims for the purpose of determining relative weights under our single claim process because they were billed with APC 0105.

After selecting the combinations to review, we determined the hospital costs associated with providing these ''combination'' procedures using the following methodology:

1. We selected claims where the two APCs of interest both appeared on the claim with the same date of service, and subjected them to the same trimming methodology we use for single procedure claims.

2. We then required that each APC appear on the claim only once. (For example, if two HCPCS codes from APC 0081 appeared on a claim with one HCPCS code from APC 0229, we did not use the claim. Many claims were discarded because of this requirement.)

3. From the claims in step two, we selected only those claims that included the device category codes for the devices required to perform the service. This is similar to our methodology for using single procedure claims where the procedure requires the use of a device with a category code (for example, for claims involving APCs 0222/0225, we used only claims that contained C codes for both a neurostimulator pulse generator and neuroelectrodes).

4. We ignored any line items for separately payable services under OPPS or the lab fee schedule and any line items with revenue centers containing HCPCS other than those in the APCs of interest.

5. At this point, we were left with claims where the only separately payable services were the line items for the HCPCS in the APCs of interest.

6. We packaged into the payable HCPCS codes all device category codes, all packaged HCPCS codes, and all revenue center codes without HCPCS.

7. We then determined the median cost for each APC pair using the remaining claims.

We believe the median cost estimate determined by this methodology should, if anything, overestimate the costs of the procedure combinations studied since all packaged line items were attributed to the APCs of interest unless they were clearly identified as being associated with other procedures. For example, if line items for a clinic visit and a medical or surgical supply revenue center appeared on the claim, we packaged the charges associated with the revenue center entirely into the APCs of interest and not into the APC for clinic visits.

We also determined the median costs for these APCs using our usual single claims methodology (these medians are contained in Addendum A). We then determined a summed median cost of each APC pair using our current payment policy, which allows payment at 100 percent for the most expensive APC with ''T'' status indicator and 50 percent for each additional APC with ''T'' status indicator. That is, we added the median cost of the more expensive APC and 50 percent of the median cost of the less expensive APC as a proxy for the total median cost (and payment) using our current payment policy. We then compared this figure with the median cost for the ''combination APC.'' (*See* Table 7.) We believe this comparison is an indicator of whether our current payment policy accurately pays for the costs of these APCs when they are billed together on the same date of service.

Our comparison reveals that, of the 12 ''combination APCs'' created, 7 had higher median costs than the median costs obtained with the multiple procedure methodology (we note that because APC 222 has a status indicator of ''S'', we did not apply the multiple procedure reduction for the APC 0222/0225 combination).

For three of these seven combinations, we consider the data unreliable because we were able to use very few claims to determine the ''combination'' median cost. Specifically, for APC combination 0085/0655, we were able to use only 37 claims; for APC combination 0105/0089, we were to use only 16 claims; and for APC combination 0105/0655, we were able to use only 12 claims. This is in distinction to the number of claims we used to determine the median costs for APCs 0655 and 0089 alone (1,170 and 303 respectively). Further, two of these combinations contain only one APC using high cost devices because APC 0105 does not require the use of high cost devices. This means that the multiple procedure reduction was applied to APC 0105. In such cases, we believe the reduction is appropriate because when a pacemaker or defibrillator is removed and replaced, the patient is only anesthetized once, the room only needs to be prepared once, and the time for replacement is usually less than the time for insertion due to the existence of a subcutaneous pocket.

Three other APC combinations, 0105/0090, 0105/0107, and 0105/0654, also contain only one APC requiring the use of high cost devices and therefore

should not pose the problem of underpayment due to the multiple procedure reduction, which was applied to APC 0105. Furthermore, in these three cases, the difference in median costs between the combination median and the median determined by our multiple procedure reduction methodology was, in our view, insignificant (all much less than 5 percent).

For APC combination 0222/0225, the difference in median cost could be considered significant at slightly under 5 percent, but only 74 claims were used to determine the combination median. Because we used approximately 600 claims to determine the median costs for APCs 0222 and APC 0225 individually, we consider the combination median cost comparatively unreliable.

Lastly, we note that for the other five combinations, our current payment policy pays more than the ''combination'' payment methodology.

Based on this comparison we considered several options for payment of these APCs when billed together:

1. Maintain our current payment policy.

2. Change the status indicators of certain APCs requiring the use of high cost devices to ''S.''

3. Create ''combination APCs'' with relative weights calculated using the methodology described above in order to make a single payment when the two APCs in the combination are billed together.

The third option need not result in creation of new HCPCS codes and APCs for hospitals to report. Instead, we could make changes in the logic of the outpatient code editor (OCE) so that when hospitals bill the two APCs in a combination, the OCE would ''map'' the payment to a single amount rather than paying the more expensive APC at 100 percent and the less expensive at 50 percent. The following is an example of how combination APCs might work: If a unit of a code in APC 0081 was billed with a unit of a code in APC 0104 on the same date, the multiple procedure discount would not be applied, so payment would no longer be made at 100 percent of the payment for APC 0104 (the highest paid APC in the pair) and 50 percent of the payment for APC 0081. Instead, if we were to implement combination APCs for this pair, the combination of codes would be mapped to a new ''combination'' APC, and we would make a single payment for both services. The payment rate for the new ''combination'' APC would be based upon a scaled weight calculated from the median cost for all claims containing one unit of a code from APC 0081 and one unit of a code from APC 0104 (using the methodology described above). If either of the APCs were billed without the partner APC for that established ''combination'' APC, then the APC would map to the current APC that contains the code.

Based on our analysis, we are proposing option one: Maintaining our current payment policy. We believe that our analysis shows that our current payments for these APCs adequately reflect the costs of the procedures, even when billed in combination.

We note that only a few APCs requiring the use of high cost devices are billed in combination. Thus, we do not believe there are compelling reasons to establish a new, or special, payment policy in situations where two APCs requiring high cost devices are billed together fewer than 100 times. Even when APCs are billed together, we have shown that frequently the data are unreliable due to the low number of claims we can actually use to determine the total median cost of the ''combined'' procedure. Furthermore, even where the number of usable claims is large enough to give us some assurance that the data are reliable, the median costs as determined by the two methodologies do not support any changes in our current payment policy. In some instances, adoption of the new payment policy would actually reduce payments for these services, and, in most other cases, any increase in payments would be negligible.

One commenter has brought to our attention the fact that, rarely, correct coding does not allow hospitals to bill for two APCs requiring high cost devices. One example is APC 0082 (Coronary Atherectomy) and APC 0104 (Transcoronary Stent Placement) because atherectomy is considered to be a component of stent placement when both are performed together. In those cases, we would expect hospitals to bill for all the devices used to accomplish the atherectomy and the stent placement. To the extent that both were performed, the median cost of stent placement should reflect the cost of performing an atherectomy. Therefore, we do not believe there is a compelling reason to create new payment policy for these rare situations. (See also the discussion below on ''case rate'' purchasing by hospitals.)

It could be reasoned that our analysis of the costs of ''combined'' procedures is faulty because hospital coding and billing inaccuracies may apply to these claims as well as single procedure claims (and may even be magnified). However, that reasoning would undercut, and be contrary to, the repeated comments that we need to use more multiple procedure claims to set relative weights because single procedure claims do not capture the true costs of complex procedures or episodes of care. Our investigation was performed precisely to address these concerns, determine how we might use multiple procedure claims, and what effect use of those claims would have on payment rates. Even with use of a methodology that overestimated the costs of combination procedures, we were unable to show that the median costs (and payments) using our current payment policy do not accurately reflect the costs for performing these procedures.

Other possible factors affecting our analysis include charge compression and/or inadequate charges for these procedures or the devices associated with them. However, it is not possible for us to know the magnitude of how charge compression or inadequate charges might affect costs or what methodologic or payment adjustment would be appropriate to address the problem. Furthermore, we point out that charge compression and inadequate charges should affect our cost data for these APCs when billed alone and when these APCs are billed in combination. It is unknown whether the effects would be similar in each instance but we have no reason to believe they would be different. Therefore, we do not believe that adjusting for charge compression or inadequate charges would change the ''relative'' median costs of the APCs when billed alone or in combination. Finally, we believe that the median costs of the APCs billed in combination support the concept that economies of scale are achieved in those cases. There are at least two reasons why this might occur: First, many hospitals purchase devices on a case rate or capitated basis, which means that the hospitals' device cost ''per case'' is fixed (with quarterly adjustments made based on volume and actual device use in the previous quarter(s)). For example, inserting a stent or cardioverter defibrillator requires the use of multiple devices in addition to the stent or defibrillator. A hospital may agree to pay $XXXX ''per case'' for all the devices used to insert a stent (for example, guidewires, introducers, catheters, rotablators etc.). This ''per case'' payment means that the hospital has the same cost irrespective of whether a rotablator, two catheters, or four catheters were used for a specific patient. Second, even if hospitals purchase devices on a ''per device'' basis, it is possible that no extra catheters, guidewires, and/or

introducers, for example, are used when a second related procedure is performed (for example, an electrophysiology study and a defibrillator lead placement, or an angioplasty and a stent placement).

In summary, we have concluded that there is no compelling reason to change our current payment policy for APCs requiring the use of high cost devices.

We solicit public comments on our methodology, analysis, and payment options for these APCs. We particularly solicit comments on how our analysis should affect any use of external data sources in the final rule. Specifically, we ask commenters to explain why submitted external data should be used in preference to our single or multiple claim data for APCs requiring the use of high cost devices.

We also note that creation of ''combination APCs'' would allow us to set relative weights using a number of claims that we otherwise would not be able to use. Therefore we solicit comments on this approach to using more claims to set relative weights and specifically request comments on how to use those claims even if we do not create ''combination APCs.''

TABLE 7.—COMBINATION APCS USED IN ANALYSIS

Combination of APCs	Descriptions of both APCs in the combination	Sum of single APC medians adjusted for multiple procedure policy	Frequency of combination APC billed on the same date	Frequency of claims used for median cost of services in both APCs	Median cost of services in both APCs	Percent difference median for both APCs to sum of adjusted single medians
0081/0104	Noncoronary Angioplasty/Athectomy & Transcatheter Placement of Intracoronary Stent.	$5,760.50	55	2	$5,589.14	−2.97
0081/0229	Noncoronary Angioplasty/Athectomy & Transcatheter Placement of Iintravascular Stent.	4,507.09	6177	135	4,116.50	−8.67
0085/0108	Level II Electrophysiologic Evaluation & Insertion/Replacement/Convert of Cardioverter Defibrillator.	29,749.68	502	63	20,438.99	−31.30
0085/0655	Level II Electrophysiologic Evaluation & Insertion/Replacement/Conversion of Permanent Dual Chamber Pacemaker.	9,398.45	268	37	10,832.16	15.25
0105/0089	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/replacement of Permanent Pacemaker and Electrodes.	7,360.80	221	16	12,268.96	66.68
0105/0090	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/replacement of Permanent Pacemaker Pulse Generator.	5,668.72	1426	516	5,751.30	1.46
0105/0107	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion of Cardioverter-Defibrillator.	17,579.21	1106	235	18,294.85	4.07
0105/0108	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	29,239.29	294	8	26,843.72	−8.19
0105/0654	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement of a permanent dual chamber pacemaker.	6,639.65	3653	1475	7,014.00	5.64
0105/0655	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker.	8,888.06	237	12	10,290.88	15.78
0222/0225	Implantation of Neurological Device & Implantation of Neurostimulator Electrodes.	14,345.41	368	74	15,002.40	4.58
0223/0227	Implantation of Pain Management Device & Implantation of Drug Infusion Device.	10,350.16	222	65	9,815.08	−5.17

Table 7 lists the combinations that we investigated, abbreviated titles for the single APCs in the pair, the number of times the APCs were billed together, the number of claims used to set the combination APC median, a combined median cost for claims in which both the APCs appeared (derived from the methodology discussed above), the median cost for the two APCs using the multiple procedure reduction policy, and the difference in median costs (expressed in percent).

6. New APC for Antepartum Care

We propose to split APC 0199, Obstetrical Care Service into two APCs. New APC 0700, Antepartum Care Service, would be created and 59412 (external cephalic version) would be assigned there. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) would remain in APC 0199, Obstetrical Care Service. We propose to make this change because of the great difference in cost between vaginal delivery and the external cephalic version procedures. We believe that inclusion of the lower cost procedure in the APC with vaginal deliveries may have an affect on the median cost for the APC that results in less accurate payment.

III. Recalibration of APC Weights for CY 2004

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

To recalibrate the relative APC weights for services furnished on or after January 1, 2004 and before January 1, 2005, we are proposing 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 propose 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 2004, the most recent available claims data are the approximately 115 million final action claims for hospital outpatient department services furnished on or after January 1, 2002 and before January 1, 2003. We then eliminated the following 45.7 million claims because many of these claims were for services that are not paid under OPPS: Claims in the first quarter of calendar year 2002; claims for bill types other than OPPS bill types; claims for services furnished in Maryland, Guam, and the Virgin Islands. We matched the 69.3 million claims that were paid under the 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. Period of Claims Data Used

We propose to use claims for the period beginning April 1, 2002 through and including December 31, 2002 as the base for the CY 2004 OPPS. The statute requires that we take into account new cost data and other relevant information and factors in reviewing and revising the weights, and we believe that this period will give us the most recent costs. We chose not to include the claims for the period beginning on January 1, 2002 through March 31, 2002 because they were used to set the payment rates for the 2003 OPPS and we believe that the most recent 9 months of claims data will result in payment rates that are most representative of the current relative costs of hospital outpatient services.

The claims base used to calculate the proposed payment weights and payment rates in this proposed rule is not the totality of claims on which the final weights and rates will be based. The use of this claims base is due to (1) a lag in claims submission by providers; (2) a statutory limit on the date before which no claim can be paid; and (3) the additional processing time it takes for the claims data to be included in the national claims history, which is the source of our claims data. For these reasons, the claims data used for this proposed rule are for the period of services furnished between April 1, 2002 and November 1, 2002. However, when the final weights and rates are calculated, we will have access to approximately 95 percent of the claims data for services furnished from April 1, 2002 through December 1, 2002.

2. Treatment of ''Multiple Procedure'' Claims

We have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the CY 2004 relative payment weights. Those making the requests believe that relying solely on single-procedure claims to recalibrate APC weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures.

We agree that optimally, it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. We identified certain multiple-procedure claims that could be treated as single-procedure claims, enabling us to greatly increase the number of services used to develop the APC payment weights for CY 2003. However, several inherent features of multiple procedure claims prevented us from using all of them to recalibrate the payment weights. We discussed these obstacles in detail in the August 9, 2002 proposed rule (67 FR 52092, 52108 through 52111), and the November 1, 2002 final rule (67 FR 66718, 66743 through 66746).

For the CY 2004 OPPS, we propose several changes to how we handle and use claims data to enable us to use more claims in the creation of median costs on which our payment weights and rates are based. Specifically, we propose to expand the number of HCPCS codes that we ignore for purposes of creating a pseudo single claim from claims that contain other separately payable HCPCS codes. We also looked at dates of service on packaged HCPCS codes and packaged revenue centers, and propose, where possible, to attribute the charges to major, separately payable HCPCS codes based on the codes' dates of service. Our complete discussion of the use of data to set the weights for CY 2004 OPPS follows in section III.B of this proposed rule.

Expansion of the list of codes to be ignored in creation of single claims. For CY 2003 OPPS, we ignored the presence of HCPCS codes 93005, 71010, and 71020 to create pseudo single claims where there was one remaining separately paid, major HCPCS code on the claim. This enabled us to attribute the costs of packaged HCPCS codes and packaged revenue centers to the remaining separately paid HCPCS codes and, therefore, to use the charge data on the claim. We did this based on our belief that these three separately payable HCPCS codes would not have charges related to them that would be placed in packaged HCPCS codes or packaged revenue centers. Instead, we believe that the charges found in the packaged HCPCS or packaged revenue centers would be appropriately associated with the only other separately payable HCPCS that remained on the claim when these codes are ignored.

For CY 2004 OPPS, we propose to expand the list of HCPCS codes that we would ignore for purposes of creating pseudo single claims. On claims that contain other separately payable HCPCS, we propose to ignore the HCPCS codes in the APCs identified in Table 9. As with HCPCS codes 93005, 71010, and 71020, we believe that these codes are highly unlikely to have charges that are found in packaged HCPCS or in packaged revenue centers. Therefore, we believe that they can be ignored for the purpose of creating a pseudo single claim from the remaining charges on the claim. We solicit comments on the proposed methodology to create pseudo single claims, on the list of codes in Table 9 that we propose to ignore, and whether there are other low cost services that we could ignore in using this methodology. We also request comments on whether we should use the charges for the codes in the APCs in Table 9 to create pseudo single claims to be used in setting the median costs for these APCs.

Use of dates of service to create single claims. For CY 2003, we did not use dates of service to attribute charges on packaged HCPCS and packaged revenue centers to major separately payable HCPCS codes. For CY 2004, we propose to use dates of service on HCPCS codes and on packaged revenue centers to attribute charges to a major payable HCPCS code where the dates of service match. We can only use this approach where there are different dates of service for the separately payable major HCPCS codes. Where there are multiple major payable HCPCS codes on a claim with the same date, we cannot use this approach because there is no way to tell to which major payable HCPCS code the charges from the packaged HCPCS or packaged revenue center belong. Moreover, where the hospital does not provide dates for all packaged revenue centers, we cannot attribute charges based on the date of service.

We believe that this methodology yields more single claims than if we did not use dates of service. However,

because hospitals are not required to put dates of service for line items with only a revenue center but no HCPCS code, we will not be able to perform this analysis routinely for each claim. Therefore, the claims from hospitals that do provide those dates are more likely to be used for weight-setting than claims of hospitals that do not provide those dates on the claim. We are unable to determine what impact, if any, this methodology has on the weights for the services and we solicit comments on the approach.

We invite comments on whether we should require hospitals to enter a line item date of service for every OPPS charge. We are interested in receiving comments regarding the implications the policy would have for hospitals, including potential obstacles and estimates on the amount of time that would be required to implement this change.

3. Adjustment of Median Costs for CY 2003 OPPS

The relative weights of several APCs, especially APCs requiring the use of high cost devices, that were developed for the 2003 OPPS fee schedule, using claims data from April 1, 2001 to March 31, 2002, showed a significant decrease from the relative weights that were established for the 2002 OPPS fee schedule. The 2002 OPPS relative weights were based on both claims data and packaging of 75 percent of the manufacturer submitted costs for devices into the APC cost. Using our April 1, 2001, through March 31, 2002 claims data resulted in significant decreases in payment for many blood products and separately payable drugs. In order to minimize any beneficiary access problems related to the reduction in payment for blood products, separately payable drugs, and certain device-related APCs, we created a limit for any payment reductions as follows:

Device and Procedural APCs

For APCs requiring the use of one or more devices receiving pass-through payments, we determined the median cost of the APC using only claims that contained device category ''C'' codes. For selected APCs, we used only claims containing the device ''C'' code specific to the service furnished (for example, we used only claims containing the ''C'' codes for cardioverter defibrillators to determine the median cost for the APC for inserting cardioverter defibrillators).

We then compared the median costs established for the 2002 OPPS fee schedule and the median costs based on our April 1, 2001, through March 31, 2002 claims data and limited decreases in median costs (from the 2002 fee schedule) by 15 percent plus half the amount of any reduction beyond 15 percent (for example, if the claims data showed the median cost of an APC decreased 45 percent, the amount of allowed reduction would have been 15 percent + ½ × (45 percent − 15 percent) = 30 percent). For a few APCs where device costs accounted for more than 80 percent of the total cost of the APC, we also incorporated external data into our calculation of the median cost.

Blood and Blood Products

We limited reductions in median costs to 11 percent as compared to the 2002 median costs so that the reduction in payments, after other adjustments, for these items would generally not exceed 15 percent.

Separately Payable Drugs

We noted in the November 1, 2002 final rule that the reason our April 1, 2001, through March 31, 2002 claims data resulted in lower median costs for many drugs was that the payment rates for 2002 were based on 95 percent of average wholesale price (AWP) as required by law for pass-through drugs. We believed, and continue to believe, that the acquisition cost for many drugs is considerably less than 95 percent of AWP. However, we limited reductions in median costs for separately payable drugs and for administration of packaged drugs using the same methodology as described above for device and procedural APCs.

Procedural and Device Intense APCs for 2004 OPPS

Comparison of procedural APC medians for 2004 OPPS to adjusted medians for 2003 OPPS. Our analysis of the April 1, 2002, through December 31, 2002 claims data, which is the basis for the proposed median costs for the 2004 OPPS, reveals a distribution of changes in median costs that are not unusual. Compared to the adjusted median costs used for the 2003 OPPS, most of the median cost increases and decreases were for nondevice-related APCs. Very few device-related APCs saw their median costs decrease significantly. We also note that, with a few exceptions, the median cost increases and decreases were not unusually distributed; we believe that the fluctuations should not be unexpected in a new payment system. For example, the cost of providing items and services changes yearly and, in a new payment system, the accuracy of coding services will improve year to year. We also compared the actual median costs from the April 1, 2001 through March 31, 2002 claims data with the actual median costs from the April 1, 2002 through December 31, 2002 claims data. Given the level of consistency we see in our claims data, we believe that adjustment of median costs last year may have resulted in payment amounts for some APCs that were too high.

The medians we propose to use to set weights for the 2004 OPPS for APCs in Table 8 have decreased more than 10 percent in median cost when compared to the adjusted median costs for 2003 OPPS. For reference, we also provide the actual median cost from the claims data we used to set 2003 OPPS payment rates. Some changes appear to be the result of normal fluctuation in the costs of services. In other cases the actual median cost in the April through December 2002 data (the 2004 OPPS medians) is consistent with the actual median cost in the April 1, 2001 through March 31, 2002 data (used for the 2003 OPPS medians), but decreased significantly only in comparison to the adjusted 2001 medians used for 2003 OPPS. In general, where there is consistency between the 2001 (2003 OPPS) and 2002 (2004 OPPS) unadjusted medians or where a change appears to represent normal fluctuations in costs, and we know of no special circumstances that would cause us to believe that there are problems in the claims data, we conclude that the claims data accurately represent the cost of the service. After reviewing the data, we believe that there is no sound basis for making an across-the-board adjustment to our April through December 2002 median costs, notwithstanding that using the unadjusted 2004 median may result in a reduced payment compared to the payment that was based on adjusted medians under 2003 OPPS.

TABLE 8.—APCs WITH MEDIAN COST DECREASES OF 10 PERCENT OR MORE

Final APC	Description	SI	Final 2003 dampened median cost	2004 proposed rule APC median cost	% diff APC median cost (2003 dampened vs. 2004 proposed rule)
0312	Radioelement Applications	S	$3,141.77	$216.18	−93.12
0330	Dental Procedures	S	284.02	32.87	−88.43
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	371.55	56.40	−84.82
0651	Complex Interstitial Radiation Source Application	S	3,250.63	588.67	−81.89
0225	Implantation of Neurostimulator Electrodes	S	8,277.07	3,283.68	−60.33
0352	Level I Injections	X	13.10	6.31	−51.83
0068	CPAP Initiation	S	123.29	65.83	−46.61
0124	Revision of Implanted Infusion Pump	T	2,975.12	1,608.78	−45.93
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	4,429.71	2,495.57	−43.66
1719	Brachytx seed, Non-HDR Ir–192	K	31.04	17.89	−42.36
0699	Level IV Eye Tests & Treatments	T	223.07	130.15	−41.65
0199	Obstetrical Care Service	T	232.46	142.74	−38.59
0313	Brachytherapy	S	1,249.57	769.14	−38.45
0236	Level II Posterior Segment Eye Procedures	T	1,873.66	1,153.59	−38.43
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	380.54	234.84	−38.29
0223	Implantation or Revision of Pain Management Catheter	T	2,437.21	1,525.61	−37.40
0385	Level I Prosthetic Urological Procedures	T	6,199.09	3,895.76	−37.16
0681	Knee Arthroplasty	T	8,780.47	5,669.25	−35.43
0302	Level III Radiation Therapy	S	548.35	363.26	−33.75
0301	Level II Radiation Therapy	S	187.53	125.03	−33.33
0094	Level I Resuscitation and Cardioversion	S	228.18	154.77	−32.17
0671	Level II Echocardiogram Except Transesophageal	S	140.57	96.05	−31.67
0098	Injection of Sclerosing Solution	T	99.06	68.15	−31.20
0346	Level II Transfusion Laboratory Procedures	X	30.59	22.72	−25.73
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	148.63	112.70	−24.17
0687	Revision/Removal of Neurostimulator Electrodes	T	1,535.37	1,171.45	−23.70
0359	Level II Injections	X	67.50	51.53	−23.66
0122	Level II Tube changes and Repositioning	T	638.40	494.56	−22.53
0363	Level I Otorhinolaryngologic Function Tests	X	64.56	50.02	−22.52
0081	Non-Coronary Angioplasty or Atherectomy	T	2,584.47	2,041.29	−21.02
0191	Level I Female Reproductive Proc	T	12.27	9.84	−19.80
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	355.90	286.61	−19.47
0371	Level I Allergy Injections	X	29.69	23.93	−19.39
0152	Percutaneous Abdominal and Biliary Procedures	T	595.64	486.01	−18.41
0222	Implantation of Neurological Device	T	13,528.13	11,061.74	−18.23
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	325.75	267.63	−17.84
0086	Ablate Heart Dysrhythm Focus	T	3,138.30	2,611.43	−16.79
0202	Level VIII Female Reproductive Proc	T	2,706.38	2,273.91	−15.98
0228	Creation of Lumbar Subarachnoid Shunt	T	3,541.71	2,996.28	−15.40
0347	Level III Transfusion Laboratory Procedures	X	66.49	56.52	−14.99
0245	Level I Cataract Procedures without IOL Insert	T	863.71	736.87	−14.69
0189	Level III Female Reproductive Proc	T	90.69	77.39	−14.67
0085	Level II Electrophysiologic Evaluation	T	2,478.31	2,128.77	−14.10
0665	Bone Density: AppendicularSkeleton	S	49.02	42.34	−13.63
0670	Intravenous and Intracardiac Ultrasound	S	1,796.55	1,555.61	−13.41
0368	Level II Pulmonary Tests	X	62.61	54.62	−12.76
0107	Insertion of Cardioverter-Defibrillator	T	19,378.60	17,025.21	−12.14
0362	Level III Otorhinolaryngologic Function Tests	X	168.41	148.74	−11.68
0287	Complex Venography	S	415.06	368.16	−11.30
0120	Infusion Therapy Except Chemotherapy	T	129.56	115.11	−11.15
0212	Nervous System Injections	T	196.63	175.73	−10.63
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	103.36	92.43	−10.57
0676	Level II Transcatheter Thrombolysis	T	245.24	219.77	−10.39
0268	Ultrasound Guidance Procedures	S	82.47	74.07	−10.19
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	3,256.61	2,927.17	−10.12

We solicit comments on the proposed weights for all APCs and for the APC placement of all HCPCS codes. However, because we believe the public may be interested in commenting on APCs where the payment rate decreases, we discuss several APCs whose payment rates decrease by more than 10 percent. We are particularly interested in comments, including the submission of external data (as discussed below) regarding these APCs.

Discussion of Selected APCs

APC 312 Radioelement Applications—The proposed median for this APC falls 93.12 percent in comparison with the 2003 adjusted median (from $3,141.77 to $216.18). The 2003 OPPS median was adjusted against

the 2002 OPPS median ($7,080.00) into which we packaged the cost of brachytherapy seeds. However, for 2003 and 2004, we are making separate payment for bracytherapy seeds (with the exception of prostate brachytherapy) and, therefore, the costs of those seeds is not packaged into the APC payment (except for prostate brachytherapy). The 2003 OPPS unadjusted median was $265.53, which is comparable to the proposed 2004 OPPS median. Hence, we think the 2003 OPPS median reflects the costs of brachytherapy, with seeds paid separately.

APC 692 Electronic Analysis of Neurostimulator Pulse Generators—The proposed median for this APC falls 84.82 percent in comparison with the 2003 OPPS adjusted median (from $371.55 to $56.40). The 2003 OPPS median was adjusted against the 2002 OPPS median ($819.00), which contained costs for devices that should not have been packaged. Moreover, the 2003 OPPS unadjusted median for the service was $46.95, and this is comparable to the 2004 OPPS median of $56.40. Hence, we believe that the proposed 2004 OPPS median reflects the cost of the service.

APC 651 Complex Interstitial Radiation Source Application—The proposed median for this APC falls 81.89 percent in comparison with the 2003 OPPS adjusted median (from $3,250.63 to $588.67). The 2003 OPPS median was adjusted against the 2002 OPPS median ($7,080.00), which contained costs for brachytherapy seeds that are currently paid separately. Moreover, the 2003 OPPS unadjusted median for the service was $483.25, and this is comparable to the proposed 2004 OPPS median of $588.67. Hence, we believe that the proposed 2004 OPPS median reflects the cost of the service because brachytherapy seeds are paid separately.

APC 225 Implantation of Neurostimulator Electrodes—The proposed median for this APC fell 60.33 percent (from $8,277.07 to $3,283.68) as compared to the adjusted median used for the 2003 OPPS. The 2003 OPPS median was adjusted against the 2002 OPPS median ($15,286.00), which reflected the manufacturer(s) price(s) for the devices packaged into the APC. However, the proposed 2004 OPPS median ($3,283.68) is very close to the unadjusted 2003 OPPS median ($3,561.03), causing us to believe that the 2004 proposed median accurately reflects the costs of the procedure. Because this APC is commonly performed with implantation of a neurostimulator pulse generator (APC 222), we changed the status indicator of APC 225 to ''S'' so that it would not be subjected to the multiple procedure reduction when it is performed with implantation of a neurological device. We do not propose to change the status indicator this year, and the multiple procedure reductions would not be applied in CY 2004 to APC 0225.

We determined the proposed 2004 OPPS median for APC 225, using only claims that contained the C codes for the neurostimulator leads (either C1778 Lead, neurostimulator, or C1897 Lead, neurostimulator test kit) in order to ensure that we captured the costs for the leads in the data used to calculate the median. We solicit comments concerning the accuracy of our data and whether they appropriately reflect the cost of neurostimulator electrodes, as well as submission of data on the acquisition cost of neurostimulator electrodes (both permanent and test electrodes).

APC 352 Level 1 Injections—The proposed 2004 OPPS median for this APC fell 51.83 percent (from $13.10 to $6.31) as compared to the adjusted 2003 OPPS median. The 2003 OPPS median was adjusted against the 2002 OPPS median ($23.00). However, the 2003 OPPS median ($6.65) is very close to the proposed 2004 OPPS median ($6.31), and this leads us to believe that the proposed 2004 median reflects the cost of the service.

APC 313 Brachytherapy.—The proposed median for this APC falls 38.45 percent in comparison with the 2003 OPPS adjusted median (from $1,249.57 to $769.14) because the 2003 OPPS median was adjusted against the 2002 OPPS median ($2,030.00), which contained costs for brachytherapy seeds that should not have been included because the radioelement sources used in this APC are not single use seeds. Moreover, the 2003 OPPS unadjusted median for the service was $773.63, and this is comparable to the proposed 2004 OPPS median of $769.14. Hence, we believe that the proposed 2004 OPPS median reflects the cost of the service.

APC 223 Implantation or Revision of Pain Management Catheter.—The proposed median for this APC falls 37.40 percent in comparison with the 2003 OPPS adjusted median (from $2,437.21 to $1,525.61). The single CPT code in this APC describes three procedures: revision, repositioning, and insertion of a pain management catheter. Therefore, the median cost of this APC should reflect the relative frequencies with which these three procedures are performed. Furthermore, the descriptor makes it inappropriate to use only claims containing ''C'' codes to determine the median cost for this APC because a device is not always used when this procedure is performed. To require that a ''C'' code be on claims for this procedure would result in inaccurate median costs. We believe the decrease in median cost is due to the packaging of 75 percent of the cost of the catheter into the APC amount for the 2002 OPPS fee schedule.

APC 385 Level 1 Prosthetic Urological Procedures.—The proposed median for this APC fell 37.16 percent compared to the adjusted median for this APC in 2003 OPPS ($3895.76 compared to $6,199.09). This occurred because we removed the more expensive inflatable penile prosthesis and prosthetic urinary sphincters from APC 179 and placed them in a new APC (APC 386 with proposed 2004 OPPS median of $6,298.89). Hence, we believe that the proposed medians for both APCs reflect the costs of the services that they now contain.

APC 687 Revision/Removal of Neurostimulator Electrodes—The proposed median costs of this APC decreased 23.7 percent as compared to the adjusted median used for the 2003 OPPS fee schedule ($1,171.45 compared to $1,535.37). (*See* Table 8.) However, none of the procedures in this APC require the use of high cost devices, and we believe the change in median cost reflects fluctuation in the costs of providing these services.

APC 359 Level II Injections—*See* section VI.B.4 of this proposed rule for the discussion of administration of drugs.

APC 81 Non Coronary Angioplasty or Atherectomy—The median for this APC fell 21.02 percent in comparison with the actual median cost used in the 2003 OPPS fee schedule (from $2,584.47 to $2,041.29). The median cost used for OPPS 2003 was significantly higher than the median cost used for the 2002 OPPS, which included packaging of 75 percent of the devices used in this APC. We believe the decrease this year, which is still substantially higher than the median used for 2002, reflects the fluctuating costs of providing this service.

APC 222 Implantation of Neurological Device—The proposed median for this APC fell 18.23 percent in comparison with the 2003 OPPS adjusted median (from $13,528.13 to $11.528.13). The 2003 OPPS adjusted median was adjusted against the 2002 OPPS median, which packaged 75 percent of the cost (based on manufacturer submitted data) of the devices ($17,284.00) into the APC. However, the proposed 2004 OPPS median of $11,061.74 compares favorably with the unadjusted 2003 OPPS median of $9,146.22. Because we

developed the proposed 2004 median for APC 222 using only claims that contained charges for device code C1767, we believe our current cost data better reflect the cost of these devices. We solicit comments on the accuracy of our data as well as the submission of data on the acquisition cost of these devices.

APC 118 Chemotherapy Administration by Both Infusion and Other Technique—See section VI.B.4 of this proposed rule for the discussion of administration of drugs.

APC 86 Ablate Heart Dysrhythm Focus—The proposed median for this APC fell 16.79 percent for 2004 OPPS when compared to the adjusted median for 2003 (from $3,138.30 to $2,611.43). The proposed 2004 OPPS median is comparable to the unadjusted median for 2003 OPPS of $2,745.69. Because this APC requires the use of a device, we required that the claims used to set the median for this APC contain a device code to qualify. We believe that our cost data accurately reflect the cost of providing this service. We note that the high payment rate for 2003 was adjusted against the 2002 median, which reflected packaging 75 percent of the device cost (based on manufacturer submitted costs) into the APC.

APC 202 Level VIII Female Reproductive Procedure—We made several changes to the structure of this APC and the proposed median for this APC fell 15.98 percent for 2004 OPPS when compared to the adjusted median for the 2003 (from $2,706.38 to $2,273.91). The proposed 2004 OPPS median is comparable to the unadjusted median for 2003 OPPS of $2,327.25. This APC requires the use of a device and, therefore, we required that the claims used to set the median for this APC must contain one or more specified device codes to qualify (C1771 Repair device, urinary incontinence, with sling graft, C2631 Repair device, urinary incontinence, without sling graft). We believe our cost data accurately reflect the costs of providing this service.

APC 670 Intravenous and Intracardiac Ultrasound—The proposed median for this APC fell 13.41 percent for the 2004 OPPS when compared to the median for 2003 OPPS (from $1,796.55 to $1,555.61). This APC requires the use of a device and therefore we required that the claims used to set the median for this APC must contain a device code to qualify. We believe that our cost data accurately reflect the cost of providing this service and that any change in median cost is due to fluctuations in hospital costs.

APC 107 Insertion of Cardioverter-Defibrillator—The proposed 2004 OPPS median for this APC fell 12.14 percent (from $19,378.60 to $17,025.21) as compared to the adjusted median cost for the 2003 OPPS fee schedule. The 2003 OPPS median was adjusted against the 2002 OPPS median ($21,679.00) which reflected packaging 75 percent of the manufacturer submitted prices for the devices used in this APC. The proposed 2004 OPPS median is much closer to the adjusted median than it is to the unadjusted 2003 OPPS median ($13,572.62).

We acquired the proposed 2004 OPPS median for APC 107 by using only claims that contained the C codes for cardioverter-defibrillators (either C1721 Cardioverter-defibrillator dual chamber, C1722 Cardioverter-defibrillator, single chamber, or C1882 Cardioverter-defibrillator, other than single or dual chamber) in order to ensure that we captured the costs for the device in the data used to calculate the median. Although the proposed median cost of this APC is lower than the adjusted median used last year, it is considerably higher than the actual median from last year, and we have confidence that it reflects the cost of the devices used in the procedure. We would also note that the proposed median cost for APC 108 also rose dramatically and is higher than the adjusted median used for the 2003 OPPS fee schedule. Assuming that the proposed median cost for APC 108 accurately reflects the cost of inserting a cardioverter-defibrillator with leads, we would expect that the proposed median cost of APC 107, which also rose significantly as compared to the actual median cost used for OPPS 2003, accurately reflects the cost of inserting a cardioverter-defibrillator without leads.

APC 120 Infusion Therapy Except Chemotherapy—See section VI.B.4 of this proposed rule for a discussion of infusion therapy other than chemotherapy.

APC 106 Insertion/Replacement/Repair of Pacemaker and/or Electrodes—The proposed 2004 OPPS median for this APC fell 10.12 percent compared to the 2003 OPPS median (from a final 2003 OPPS median of $3,256.61 to a proposed 2004 Median of $2,927.17). This APC contains both CPT codes for insertion of temporary pacemaker leads (CPT codes 33210 and 33211) and repair and revision of pacemaker leads (33216, 33217, 33218, and 33220). This APC contains a mixture of services and, therefore, its median cost should reflect the mixture of services provided. We solicit comments on whether the proposed median cost for this APC reflects the cost of providing these services as well as the submission of data on the acquisition costs of the leads used for each service in this APC.

Preferred Characteristics of External Data Submitted in Comments. We will consider external data on devices that are provided to the extent that they enable us to verify or adjust claims data where we are convinced that an adjustment is appropriate. All data we use to create payment amounts for the final rule will be available for public inspection.

External data must meet the following criterion:

- Be available for public inspection.

External data that are likely to be of optimal use should meet the following criteria:

- Represent a diverse group of hospitals both by location (for example, rural, urban) and by type (for example, community, teaching). We would prefer that commenters identify each hospital including location with city and State, nonprofit vs. for profit status, teaching vs. nonteaching status, and the percent of Medicare vs. non-Medicare patients receiving the service; a pseudo identifier could be used for the hospital identification. Data should be submitted both ''per hospital'' and in the aggregate.
- Identify the number of devices billed to Medicare by each hospital as well as any rebates or reductions for bulk purchase or similar discounts and identify the characteristics of providers to which any such price rebates or reductions apply.
- Identify all HCPCS codes with which each item would be used.
- Identify the source of the data.
- Include both the charges and costs for each hospital, by quarter for the last 3 quarters of 2002. Cost data for 2003 are not compatible with 2002 claims data.

This information would enable us to compare our claims data to the external data and help us determine whether the submitted data are representative of hospitals that submit claims under OPPS.

Please note that information that contains beneficiary-specific information (for example, medical records, invoices with beneficiary identification on it) should be altered, if necessary, to remove any individually identifiable information, such as information that identifies an individual, diagnoses, addresses, telephone numbers, attending physician, medical record number, Medicare or other insurance number, etc. Moreover, individually identifiable beneficiary medical records, including progress notes, medical orders, test results, consultation reports, etc. should

not be submitted to us. Similarly, photocopies of checks from hospitals or other documents that contain bank routing numbers should not be submitted to us.

Blood and Blood Products

See section VI.B.8 of this proposed rule for our discussion of the analysis of data for blood and blood products and our proposal.

Separately Paid Drugs

See section VI.B.3 of this proposed rule for our discussion of the analysis of data for separately paid drugs and our proposal.

B. Description of How We Propose To Calculate Weights for CY 2004

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).
- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's CY 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 325 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, only 166 hospitals had claims data.
- We eliminated from our data claims for critical access hospitals that are not paid under OPPS and whose claims are therefore not suitable for use in setting weights for services paid under OPPS.
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 29 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.
- We excluded from our data approximately 2.1 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of claims to hospital CCRs.
- We separated the 66.345 million claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify at least one OPPS covered service. Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Thus, dividing the claims yielded approximately 21.92 million single-procedure claims and 14.8 million multiple-procedure claims. Approximately 19.57 million claims without at least one covered OPPS service were set aside.

We converted 8.47 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for preoperative procedures and for those services in the APCs identified in Table 9. These are services with payment amounts below $50 (under CY 2003 OPPS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 9) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 9. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 9.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

0001	Level I Photochemotherapy	S
0060	Manipulation Therapy	S
0077	Level I Pulmonary Treatment	S
0099	Electrocardiograms	S
0215	Level I Nerve and Muscle Tests	S
0215	Level I Nerve and Muscle Tests	S
0230	Level I Eye Tests & Treatments	S
0260	Level I Plain Film Except Teeth	X
0262	Plain Film of Teeth	X
0271	Mammography	S
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X
0342	Level I Pathology	X
0343	Level II Pathology	X
0344	Level III Pathology	X
0345	Level I Transfusion Laboratory Procedures	X
0364	Level I Audiometry	X
0367	Level I Pulmonary Test	X
0669	Digital Mammography	S
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S
0706	New Technology—Level I ($0–$50)	S

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight setting. We created an additional 23.58 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 except as described otherwise. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this proposed rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 10, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 10.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

APC	APC description	Status
0032	Insertion of Central Venous/Arterial Catheter	T
0048	Arthroplasty with Prosthesis	T
0080	Diagnostic Cardiac Catheterization	T
0081	Non-Coronary Angioplasty or Atherectomy	T
0082	Coronary Atherectomy	T
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T
0085	Level II Electrophysiologic Evaluation	T
0086	Ablate Heart Dysrhythm Focus	T
0087	Cardiac Electrophysiologic Recording/Mapping	T
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T
0090	Insertion/Replacement of Pacemaker Pulse Generator	T
0104	Transcatheter Placement of Intracoronary Stents	T
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T
0107	Insertion of Cardioverter-Defibrillator	T
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T
0115	Cannula/Access Device Procedures	T
0119	Implantation of Devices	T
0122	Level II Tube Changes and Repositioning	T
0167	Level III Urethral Procedures	T
0182	Insertion of Penile Prosthesis	T
0202	Level VIII Female Reproductive Proc	T
0222	Implantation of Neurological Device	T
0225	Implantation of Neurostimulator Electrodes	S
0226	Implantation of Drug Infusion Reservoir	T
0227	Implantation of Drug Infusion Device	T
0229	Transcatheter Placement of Intravascular Shunts	T
0259	Level VI ENT Procedures	T
0313	Brachytherapy	S
0384	GI Procedures with Stents	T
0385	Level I Prosthetic Urological Procedures	T
0386	Level II Prosthetic Urological Procedures	T
0648	Breast Reconstruction with Prosthesis	T
0652	Insertion of Intraperitoneal Catheters	T
0653	Vascular Reconstruction/Fistula Repair with Device	T
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T
0670	Intravenous and Intracardiac Ultrasound	S
0674	Prostate Cryoablation	T
0680	Insertion of Patient Activated Event Recorders	S
0681	Knee Arthroplasty	T

• For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. We used the most recent settled or submitted cost reports. Using the most recent ''submitted to settled ratio,'' we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital's overall CCR for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 11 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged into surgery codes. We propose to convert these categories to a single set of revenue codes (*see* Table 11) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished.

Table 11 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 11.—PACKAGED SERVICES BY REVENUE CODE

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

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (See the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes.

• We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care

provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours) that also showed one or more of the ICD–9 (International Classification of Diseases, Ninth Edition) diagnosis codes required for payment of APC 339. We ignored other separately payable codes so that the claims with G0244 would not be excluded for having multiple major procedures on a single claim. We packaged the costs of allowable revenue centers and HCPCS codes with status indicator ''N'' into the cost of G0244, and trimmed as was done for the calculation of the median costs for other APCs.

To calculate the weights for APCs 649 (Prostate Brachytherapy with Palladium seeds) and 684 (Prostate Brachytherapy with Iodine seeds) into which the cost of brachytherapy seeds are packaged, we selected claims that contained HCPCS codes 77778 and 55859 where the lines containing codes 77778 and 55859 have the same date of service and the claim contained either HCPCS code C1720 (Palladium seeds) or C1718 (Iodine seeds) (which need not be the same date of service as 77778 and 55859). We ignored line items for services paid on the laboratory fee schedule and lines with separately payable HCPCS (even if multiple majors). We packaged all remaining costs from allowable revenue centers and packaged HCPCS into the claim (regardless of date of service). We separated the claims with Palladium seeds from claims with Iodine seeds. We then created a median cost for prostate brachytherapy with Palladium seeds (APC 0649; G0256) from the claims containing 77778, 55859, and C1720 (Palladium seeds), and we created a median cost for prostate brachytherapy with Iodine seeds (APC 0684; G0261) from claims containing 77778, 55859, and C1718 (Iodine seeds).

- Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using 2002 data, the median cost for APC 0601 is $58.78.

Section 1833(t)(9)(B) of the Act requires that APC revisions, relative payment weight revisions, and wage index and other adjustments be made in a manner that ensures that estimated aggregate payments under the OPPS for 2004 are neither greater than nor less than the estimated aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2003 relative weights to aggregate payments using the CY 2004 proposed weights. Based on this comparison, we are proposing to make an adjustment of 1.003107132 to the weights. The weights that we are proposing for CY 2004, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

IV. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act, Public Law 107–186; current drugs, biological agents, and brachytherapy devices used for the treatment of cancer; and current drugs and biological products.

For those drugs, biological agents, and devices referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), 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 were not being paid for as a hospital outpatient service as of December 31, 1996 and whose cost is ''not insignificant'' in relation to the OPPS payment for the procedures or services associated with the new device, drug, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years.

Section 1833(t)(6)(B)(i) of the Act required that we establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum (PM). On March 22, 2001, we issued two PMs, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at: *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf,* respectively.

Transmittal A–01–41 includes a list of the initial device categories, a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments, and the initial category code by which the cross-walked individual device was to be billed beginning April 1, 2001. Items eligible for transitional pass-through payments are generally coded using a Level II HCPCS code with an alpha prefix of ''C.'' Pass-through device categories are identified by status indicator ''H'' and pass-through drugs and biological agents are identified by status indicator ''G.'' Subsequently, we added a number of additional categories, retired 95 categories effective January 1, 2003, and made clarifications to some of the categories' long descriptors found in various program transmittals. A list of device category codes in effect as of July 1, 2003, can be found in Transmittal A–03–051, which was issued on June 13, 2003. This PM can be accessed on our Web site at *http://www.cms.gov.*

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 were the subject of a separate interim final rule with comment period published in the **Federal Register** on November 2, 2001 (66 FR 55850) and made final in the November 1, 2002 **Federal Register** (67 FR 66781) announcing the 2003 update to the OPPS.

Transitional pass-through categories are for devices only; they do not apply to drugs or biological agents. The regulations at § 419.64 governing transitional pass-through payments for eligible drugs and biological agents are unaffected by the creation of categories.

The process to apply for transitional pass-through payment for eligible drugs and biological agents or for additional device categories can be found on respective pages on our Web site at *http://www.cms.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) as required under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes is generally posted on the OPPS Web site at *http://www.cms.gov.*

B. Discussion of Pro Rata Reduction

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent. We propose to set the percentage at 2.0 percent for the 2004 OPPS.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payment exceeds the applicable percentage but also to determine the appropriate reduction to the conversion factor.

For devices, making an estimate of pass-through spending in 2004 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data (that is, items that were eligible in 2002 and that will continue to be eligible in 2004). The second group consists of those items for which we have no direct claims data (that is, items that became, or will become, eligible in 2003 and will retain pass-through status and items that will be newly eligible beginning in 2004).

To estimate 2004 pass-through spending for device categories in the first group, we would use volume and hospital cost (derived from charges on claims using cost-to-charge ratios) information from 2002 claims data. This information would be projected forward to 2004 levels using appropriate inflation and utilization factors. For existing categories with no claims data in 2002 that are, or will be, active in 2004, we would follow the method described in the November 2, 2001 final rule (66 FR 55857). We would use price information from manufacturers and volume estimates from claims related to procedures that use the devices in question. This information would be projected forward to 2004 using appropriate inflation and utilization factors to estimate 2004 pass-through spending for this group of categories. For categories that become eligible in 2004, we would use the same method as described for categories that were newly active in 2002. We anticipate that any new categories for January 1, 2004 will be announced after the publication of this proposed rule but before the publication of the final rule. Therefore, the estimate of pass-through spending would incorporate pass-through spending for categories made effective January 1, 2004.

To estimate 2004 pass-through spending for drugs and biological agents, we would make estimates of utilization, collect data on average wholesale price (AWP) and combine these with ratios used to represent hospital acquisition costs for these drugs. We would collect drug-specific information on Medicare use from the pharmaceutical manufacturer where possible and rely on other sources (such as peer-reviewed clinical studies) as needed. In the past, we relied upon the AWP published in the Redbook to establish the AWP of pass-through drugs payable under the OPPS. As described elsewhere in this preamble, we plan to adopt and apply the provisions outlined in the Payment Reform for Part B drugs. For the purpose of calculating payments for transitional pass-through items, we would determine 95 percent of the drug's average wholesale price based on the newly established AWP. We would use published ratios on hospital acquisition costs reported in our proposed rule of August 9, 2002 (67 FR 52129). For sole source drugs the ratio of acquisition cost to AWP equals 0.71; for multi-source drugs, the ratio is 0.68; and for multi-source drugs with generic competitors, the ratio equals 0.46.

For drugs and biological agents that may receive pass-through status effective January 1, 2004, we propose to use the same methodology as described for drugs and biological agents that received pass-through status in 2003. Any new pass-through drugs and biological agents effective beginning in 2004 would be announced after the publication of this proposed rule but before the publication of the final rule. Therefore, the estimate of pass-through spending would incorporate pass-through spending for these drugs and biological agents made effective January 1, 2004.

After using the methodologies described above to determine projected 2004 pass-through spending for the groups of devices, drugs, and biological agents, we would calculate total projected 2004 pass-through spending as a percentage of the total projected payments (Medicare and beneficiary payments) under OPPS to determine if the pro rata reduction will be required.

Table 12 shows our current estimate of 2004 pass-through spending for known pass-through drugs, biologicals, and devices based on information available at the time this table was developed. We are uncertain whether estimated pass-through spending in 2004 will exceed $456 million (2.0 percent of total estimated OPPS spending). We have not yet completed the estimate of pass-through spending for a number of drugs and devices. In particular, we do not have estimates for those drugs still under agency review for additional pass-through payments beginning October 2003 or the changes in pass-through spending that could result from quarterly rather than annual updates of AWP for pass-through drugs. Finally, we would incorporate an estimate of pass-through spending for items for which pass-through payment becomes effective later in 2004 (that is, April 1, 2004; July 1, 2004; and October 1, 2004) based on estimates of items that become eligible for pass-through payment on October 1, 2003 and January 1, 2004. Specifically, we would assume a proportionate amount of spending for items that become eligible later in the year while making an adjustment to account for the fact that items made eligible later in the year will not receive pass-through payments for the entire year. We invite comments on the methodology as described above and the estimates for utilization that appear in the table below.

TABLE 12.—ESTIMATES FOR 2004 TRANSITIONAL PASS-THROUGH SPENDING

New HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
		Existing Pass-through Drugs/Biologicals			
C9111	9111	Injection Bivalrudin, 250 mg per vial	$100.50	21,007	2,111,200
C9112	9112	Perflutren lipid microsphere, per 2 ml	$37.44	67,000	2,508,480

TABLE 12.—ESTIMATES FOR 2004 TRANSITIONAL PASS-THROUGH SPENDING—Continued

New HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
C9113	9113	Inj Pantoprazole sodium, per vial	$5.76	20,000	115,200
C9116	9116	Ertapenum sodium, per 1 gm vial	$11.45	7,200	82,440
Q4053	9119	Pegfilgrastim, per 1 mg single dose vial	$118.00	662,062	78,123,329
C9120	9120	Faslodex, per 50 mg injection	$44.25	137,078	6,065,702
C9121	9121	Argatroban, per 5 mg	$3.60	50,000	180,000
C9200	9200	Orcel, per 36 cm2	$286.80	1,000	286,800
C9203	9203	Perflexane lipid microspheres, per single use vial	$36.00	82,400	2,966,400
J2324	9114	Nesiritide, per 0.5 mg vial	$36.48	60,000	2,188,800
J3315	9122	Triptorelin pamoate, per 3.75 mg	$104.90	219,600	23,036,040
J3487	9115	Zoledronic acid, 1 mg	$51.38	539,000	27,693,820
C9204	9204	Ziprasidone mesylate, per 20 mg	$10.50	117,143	1,230,000
C9205	9205	Oxaliplatin, per 5 mg	$23.86	280,756	6,698,845
HCPCS	**APC**	**Description**		**2004 estimated utilization**	**2004 anticipated payment**
		Existing Pass-through Devices			
C1783	1783	Ocular implant, aqueous drainage assist device		323	159,756
C1814	1814	Retinal tamponade device, silicone oil		35106	13,649,018
C1884	1884	Embolization Protective System		25000	38,601,544
C1888	1888	Catheter, ablation, non-cardiac, endovascular (implantable).		214	129,128
C1900	1900	Lead, left ventricular coronary venous system		2091	2,814,528
C2614	2614	Probe, percutaneous lumbar discectomy		899	1,748,555
C2632	2632	Brachytherapy solution, iodine-125, per mCi		225	1,890,000
C1818	1818	Integrated keratoprosthesis		4	27,800

V. Payment for Devices

A. Pass-Through Devices

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We propose that two device categories currently in effect would expire effective January 1, 2004. Our proposed payment methodology for devices that have been paid by means of pass-through categories, and for which pass-through status would expire effective January 1, 2004, is discussed in the section below.

Although the device category codes became effective April 1, 2001, most of the item-specific ''C'' codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000 and as of January 1, 2001. (The crosswalk for item-specific ''C'' codes to category codes was issued in Transmittals A–01–41 and A–01–97). We based the expiration dates for the category codes listed in Table 13, on when a category was first created, or when the item-specific devices that are described by, and included in, the initial categories were first paid as pass-through devices, before the implementation of device categories. These proposed device category expiration dates are listed in Table 13. We propose to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate that category. There are two categories for devices that will have been eligible for pass-through payments for over 2 1/2 years as of December 31, 2003, and we propose that they would not be eligible for pass-through payments effective January 1, 2004. The two categories we propose for expiration are C1765 and C2618, as indicated in Table 13. Each category includes devices for which pass-through payment was first made under OPPS in 2000 or 2001.

A comprehensive list of all pass-through device categories effective on or before July 2003 is displayed in Table 13. Also displayed are the dates the devices described by the category were populated and their respective proposed expiration dates.

The methodology used to base expiration of a device category is the same as that used to determine the 95 initial categories that expired as of January 1, 2003. A list including those 95 categories that expired as of January 1, 2003 (as well as 5 categories that continue to be paid in 2003) is found in the November 1, 2002 final rule (67 FR 66761 through 66763).

TABLE 13.—LIST OF CURRENT PASS-THROUGH DEVICE CATEGORIES WITH PROPOSED EXPIRATION DATES

	HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
	C1765	Adhesion Barrier	10/1/00–3/31/01; 7/1/01	12/31/03
	C2618	Probe, cryoblation	4/1/01	12/31/03
	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
	C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04

TABLE 13.—LIST OF CURRENT PASS-THROUGH DEVICE CATEGORIES WITH PROPOSED EXPIRATION DATES—Continued

	HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
.....	C1884	Embolization protective system	1/1/03	12/31/04
.....	C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
.....	C2632	Brachytherapy solution, iodine-125, per mCi	1/1/03	12/31/04
.....	C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
.....	C1818	Integrated keratoprosthesis	7/1/03	12/31/05

The methodology that we propose to use to package pass-through device costs is consistent with the packaging methodology that we describe in section II.B.5. For the codes in APCs displayed in Table 10, we propose to use only those claims on which the hospital included the ''C'' code and to discard the claims on which no ''C'' code is billed.

We propose to limit our analysis to the claims with ''C'' codes because we are not confident that the claims for the relevant APCs include the charges for the devices unless the ''C'' codes are specifically billed.

To calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator ''N.'' We also packaged the costs of devices that we propose would no longer be eligible for pass-through payment in 2004 into the HCPCS codes with which the devices were billed.

B. Expiration of Transitional Pass-Through Payments in CY 2004

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). We stated that we would package the costs of the devices no longer eligible for pass-through payments in 2003 into the costs of the procedures with which the devices were billed in 2001. There were very few exceptions to the policy (for example, brachytherapy seed for other than prostate brachytherapy), and we propose to continue this policy. Therefore, we propose that the payment for the devices that populate C1765 and C2618, which we propose will cease to be eligible for pass-through payment on January 1, 2004, would be made as part of the payment for the APCs with which they are billed.

C. Other Policy Issues Relating to Pass-Through Device Categories

Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the 2002 OPPS update (April 1, 2002), we deduct from the pass-through payments for the identified devices an amount that offsets the portion of the APC payment amount that we determine is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for 2003 (67 FR 66801).

For the 2002 and 2003 OPPS updates, we estimated the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data from the period used for recalibration of the APC rates. Using these claims, we calculated a median cost for every APC without packaging the costs of associated ''C'' codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of associated device category ''C'' codes that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging to the median APC cost including device packaging enables us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to the median APC costs, we determined the applicable offset amount. We included any APC on the offset list for which the device cost was at least 1 percent of the APC's cost.

As we discussed in our November 1, 2002 final rule (67 FR 66801), the listed offsets are those that may potentially be used because we do not know which procedures would be billed with newly created categories.

After publication of the November 1, 2002 final rule, we received a comment indicating that in some cases it may be inappropriate to apply an offset to a new device category because the device category is not replacing any device whose costs have been packaged into the APC. We agree with this comment. Therefore, we propose to modify our policy for applying offsets. Specifically, we would apply an offset to a new device category only when we can determine that an APC contains costs associated with the device. At this time, we propose to continue our existing methodology for determining the offset amount, described above. However, we solicit comments for alternative methodologies for determining the offset amounts that potentially could be applied to the payment amounts for new device categories.

We can use this methodology to establish the device offset amounts for the 2004 OPPS because we are using 2002 claims on which device codes are reported. However, for the 2005 update to OPPS, we would use 2003 claims that would not include device coding. Thus, for 2005, we are considering whether or not to use the charges from lines on the claim having no HCPCS code but have charges under revenue codes 272, 275, 276, 278, 279, 280, 289, and 624 as proxies for the device charges that would have been billed with HCPCS codes for these devices in previous years. We are also considering the reinstitution of the ''C'' codes for expired device categories and requiring hospitals to use one or more newly created ''C'' codes for identification of devices and costs on claims. See section VI.B of this proposed rule for further discussion.

We propose to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are packaged into the existing APC structure.

We reviewed the device categories eligible for continuing pass-through payment in 2004 to determine whether the costs associated with the device

categories are packaged into the existing APCs. For the categories existing as of publication of this proposed rule, we have determined that there are no close or identifiable costs associated with the devices in our data related to the respective APCs that are normally billed with those devices. Therefore, for these categories we are proposing to set the offset to $0 for 2004.

If we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we would apply an offset. We propose, if any offsets apply, for new categories, to announce the offsets in the program memorandum that announces the information regarding the new category.

VI. Payment for Drugs, Biologicals, Radiopharmaceutical Agents, Blood, and Blood Products

A. Pass-Through Drugs and Biologicals

Section 1833(t)(6)(D)(i) of the Act requires us to make transitional pass-through payment for new drugs equal to the amount by which 95 percent of the average wholesale price (AWP) of the drug exceeds the proposed payment rate. In the past, we have used the AWP published in the Red Book to determine payment amounts for pass-through drugs as we explain in the correction notice issued on February 10, 2003 (68 FR 6637). However, we are concerned about the extent to which Medicare pays more for drugs than other payers and more than the market-based price of drugs. To address this problem of how to pay appropriately for drugs that are priced using the AWP, we are developing regulations that would revise the current payment methodology for part B covered drugs paid under section 1842(o) of the Act. When the AWP regulations are made final, we propose to adopt and apply the provisions of the final AWP rule to establish the AWP of pass-through drugs payable under the OPPS. If implementation of the AWP final rule necessitates mid-year changes in the 2004 OPPS payment rates for pass-through drugs, we propose to make those changes on a prospective payment basis through our regular OPPS PM and PRICER quarterly updates. We further propose to issue instructions by program memorandum regarding implementation of the provisions of the AWP final rule to set payment rates for pass-through drugs under the OPPS.

An AWP final rule could be published before 2004. However, if the AWP final rule is not issued in time to permit us to apply its provisions to price pass-through drugs furnished on or after January 1, 2004, we propose to use 95 percent of the AWP listed in the most recent quarterly update of the Single Drug Pricer (SDP). In the past, we have relied solely on the Red Book to determine the AWP for a pass-through drug, as we explain in the correction notice issued on February 10, 2003 (68 FR 6637). However, on January 1, 2003, we introduced for the first time a single pricing source for approximately 400 drugs and biologicals for which the Medicare payment allowance is based on 95 percent of their AWP. We established the SDP to address apparent discrepancies in drug pricing that were the unintended result of delegating calculation of AWP to multiple contractors, whose application of the pricing methodology established under 42 CFR 405.517 sometimes varied. The SDP continues to rely on published compilations such as the Red Book and First Data Bank to identify wholesale drug prices. However, using the SDP enables us to establish a uniform Medicare payment allowance for drugs whose payment is based on 95 percent of their AWP, which results in greater consistency in Medicare drug pricing nationally. If a drug with pass-through status is not included in the SDP, we propose to forward to the SDP contractor the AWP information submitted as part of the pass-through application.

Because the January SDP would not be available in time, we propose to announce the January 1, 2004 prices for pass-through drugs in our January 2004 OPPS implementing instructions to fiscal intermediaries and in the January 2004 OPPS PRICER rather than in the 2004 final rule, which is to be published in the **Federal Register** by November 1, 2003. We further propose to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with the quarterly updates of the SDP. The updated rates for pass-through drugs and biologicals would also be issued through our quarterly OPPS program memoranda and PRICER updates.

Additional information regarding the SDP can be found on the CMS Web site in Program Memorandum AB–02–174, issued December 3, 2002.

B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the OPPS, we currently pay for radiopharmaceuticals, drugs, and biologicals including blood, and blood products, which do not have pass-through status, in one of three ways: packaged payment, separate payment (individual APCs), and reasonable cost. As we explained in the April 7, 2000 final rule (65 FR 18450), we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services). As we explained in the November 1, 2002 final rule (67 FR 66757), we do not classify diagnostic and therapeutic radiopharmaceutical agents as drugs or biologicals as described in section 1861(t) of the Act.

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

As discussed in the November 1, 2002 final rule (67 FR 66774), we packaged payment for drugs and radiopharmaceuticals into the APCs with which they were billed if the median cost per line for the drug or radiopharmaceutical was less than $150, and we established a separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeded than $150. This supported our general view that payment for drugs and radiopharmaceuticals should be made as part of the payment for the services in which they are used in order to encourage efficient purchase and use of drugs and radiopharmaceuticals provided in the hospital outpatient department.

Payment Rates for 2003

To limit the dramatic reduction in payment rates for many of the separately payable drugs and radiopharmaceuticals from 2002 to 2003, we limited the decrease in their median costs from 2002 median costs to 15 percent plus half of the difference between the total proposed reduction and 15 percent reduction. (For example, for a drug whose cost decreased by 35 percent from the applicable 2002 median cost, the allowed reduction from 2002 to 2003 was 15 percent plus (½ times 35–15) percent = 25 percent.) For each blood and blood product, we provide separate payment in an individual APC and limited any decrease in payment rate from 2002 to 2003 to 15 percent. In 2003, we also excluded from OPPS certain vaccines and orphan drugs (that met our orphan criteria) and paid for these items at reasonable cost. Our intent in implementing these policies was to avoid adversely affecting beneficiary access to needed treatment.

Drugs for Which We Propose Pass-Through Status Will Expire in 2004

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years nor any longer than 3 years. The drugs that are due to expire December 31, 2003 meet that criterion. Table 14 lists the drugs and biologicals for which we propose pass-through status will expire on December 31, 2003.

TABLE 14.—PROPOSED LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES CY 2004

HCPCS	APC	Long descriptor	Trade name	Proposed pass-through Expiration date
A9700	9016	Injection, Octafluoropropane, per 3 ml	Optison (single source)	12–31–03
J0587	9018	Injection, Botulinum toxin, type B, per 100 units.	Myobloc (single source)	12–31–03
J0637	9019	Injection, Caspofungin acetate, 5 mg	Cancidas (single source)	12–31–03
J7517	9015	Mycophenolate mofetil, oral per 250 mg	CellCept (single source)	12–31–03
J9010	9110	Injection, Alemtuzumab, per 10 mg	Campath (single source)	12–31–03
J9017	9012	Injection, Arsenic trioxide, per 1 mg	Trisenox (single source)	12–31–03
J9219	7051	Implant, Leuprolide acetate, per 65 mg implant.	Viadur (single source)	12–31–03
C9201	9201	Dermagraft, per 37.5 sq. centimeters	Dermagraft (single source)	12–31–03

2. Proposed Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

To the maximum extent possible, our intention is to package into the APC payment the costs of any items and supplies that are furnished with an outpatient procedure. We considered several options for packaging in 2004 and propose the following policy:

For 2004, we propose to continue with our policy of paying separately for drugs and radiopharmaceuticals whose median cost per day exceeds $150 and packaging the cost of drugs and radiopharmaceuticals with median cost per day of less than $150 into the procedures with which they are billed.

As discussed in the November 1, 2002 final rule, we received several comments on our methodology of analyzing single line items on drug claims for the 2003 OPPS (67 FR 66772). Commenters stated that our methodology was not consistent with how hospitals bill for certain drugs, biologicals, and radiopharmaceuticals. They believe that this inconsistency affected whether or not a drug, biological, or radiopharmaceutical fell below the $150 median cost per line threshold. Commenters claimed that we incorrectly assumed ''that a single administration of a drug was billed as a single line item on a claim.'' These commenters alleged that hospitals often bill for certain drugs administered during a single patient encounter using multiple lines on a claim. For example, if 10 units of a drug were administered at a cost of $100 but the hospital billed 2 line items of 5 units at a cost of $50 each, then a methodology that determines median costs on a per line basis would incorporate 2 line items at $50 when the real cost was one line item at $100. If a significant percentage of administrations for this drug was billed in this manner, it would result in median costs that underestimate the true cost of the drug. We agree with this comment. Therefore, we propose to change our packaging methodology to account for such hospital billing practices.

We calculated the median cost per day using claims data from April 1, 2002 to December 31, 2002 for all drugs and radiopharmaceuticals paid under the OPPS that had a HCPCS code during this time period including drugs for which transitional pass-through payment ended on January 1, 2003. Although we included orphan drugs in this methodology, we discuss them separately below. We excluded from these calculations vaccines and blood and blood products that are discussed below. In order to calculate the median cost per day for the drugs, biologicals, and radiopharmaceuticals, we took the following steps:

- After application of the cost-to-charge ratios, we aggregated all line items for a single date of service on a single claim for each drug or radiopharmaceutical. This resulted in creating a single line item with the total number of units and the total cost of a drug or radiopharmaceutical given to a patient in a single day.
- A separate record was then created for each drug or radiopharmaceutical by date of service, regardless of the number of lines the drug or radiopharmaceutical was billed in each claim. For example, drug X is billed on a claim with two different dates of service, and for each date of service, the drug is billed on 2 line items with costs of $10 and 5 units in each line item. In this case, the computer program would have created two records for this drug, and each record would have a total cost of $20 and 10 units.
- For each record created for a drug or radiopharmaceutical, the cost per unit of the drug was calculated. If drug X's descriptor is ''per 1 mg'' and one record was created for a total of 10 mg (as indicated by the total number of units for the drug on the claim for each unique date of service), then the computer program divided the total cost for the record by 10 to give a per unit cost. This unit cost was then weighted by the total number of units in the record. This was done by generating a number of line items equivalent to the number of units in that particular claim. Thus, a claim with 100 units and a total cost of $200 would be given 100 line items each with a cost of $2 while a

claim of 50 units with a cost of $50 would be given 50 line items each with a cost of $1.

- The unit records with cost per unit greater or less than 3 standard deviations from the geometric mean were then trimmed.
- The remaining unit observations were arrayed and the median cost per unit of the drug or radiopharmaceutical was established.
- Next, the total number of units billed on all claims for the drug or radiopharmaceutical was divided by the total number of unique per-day records for the drug or radiopharmaceutical to arrive at an average number of units per day.
- The average number of units per day for each drug or radiopharmaceutical was then multiplied by the median cost per unit to arrive at its ''median cost'' per day.
- We then arrayed the median cost per day for all drugs and radiopharmaceuticals in ascending order and examined the distribution.

Many commenters have alleged that hospitals do not accurately bill the number of units for drugs and radiopharmaceuticals. Because this methodology assumes that hospitals bill the number of units accurately, we compared the median cost per day obtained by the above methodology with the median cost per day derived as follows: We aggregated line items as above and created records for each drug and radiopharmaceutical based on date of service. However, instead of calculating costs on a per-unit basis, we simply reduced total charges to total costs for each record and determined the median. This methodology assumes that hospitals record charges more accurately than units. We believed that calculating median costs using the second methodology would address the concerns of commenters and would help us determine whether our median cost per unit calculation accurately reflected the costs of drugs and radiopharmaceuticals.

In most cases, the median costs determined by the two methodologies were similar. Based on this comparison, we believe that calculating median costs per unit accurately reflects the actual cost of the drug or radiopharmaceutical. Furthermore, given the wide variability of doses used for many drugs, we believe that it is important to pay on a ''per unit'' basis for separately payable drugs and radiopharmaceuticals. For example, many chemotherapy agents are dosed based on both body area and frequency of administration. Thus, a patient with a body area of 2 m squared could receive 600 mg of a drug every 3 weeks, 400 mg every 2 weeks, or 200 mg every week depending on the chemotherapy regimen.

Based on our analyses, we believe that it is reasonable to continue our current policy of packaging drugs and radiopharmaceuticals with a median cost of less than $150 per day. This means that approximately 52 percent of the drugs and radiopharmaceuticals will be packaged and 48 percent of the drugs and radiopharmaceuticals will be paid separately.

We noticed that several drugs and radiopharmaceuticals with median cost per line that were under $150 for the 2003 OPPS have median costs per day that are equal to or greater than $150 based on the data used for the 2004 OPPS. For some other drugs and radiopharmaceuticals, we saw that their median costs per line were equal to or greater than $150 for 2003 OPPS; however, using the 2002 data, their median costs per day fell below $150. These shifts from 2003 to 2004 would affect packaging decisions for a number of drugs.

Given that these variations exist, we propose to provide an exception in 2004 to the packaging rule for drugs and radiopharmaceuticals whose payment status would change as a result of using newer data and a different methodology. As we explain elsewhere in this proposed rule, we expect to use additional 2002 claims data for the establishment of our final policies for CY 2004. Based on this additional data and comments from the public, we intend to re-evaluate whether to package or pay separately for drugs for which the per-day median cost would cross the threshold from 2003 to 2004. For 2004, we propose that:

- Currently packaged drugs and radiopharmaceuticals with median costs per day that are at or above $150 would receive separate payment in 2004.
- Currently separately payable drugs and radiopharmaceuticals with median costs per day that are under $150 would continue to receive separate payment in CY 2004.
- Drugs whose pass-through status would expire on December 31, 2003, and whose median costs per day are under $150 would receive separate payment in 2004.
- Currently packaged drugs and radiopharmaceuticals with median costs per day below $150 would remain packaged in 2004.

We request comments on the methodology we used to determine the median cost per day, on the threshold we propose to use for packaging drugs and radiopharmaceuticals, and on the proposal to pay separately for drugs and radiopharmaceuticals whose payment status would change based on use of recent claims data and our proposed methodology.

Although in the future we expect to expand packaging the costs of drugs and radiopharmaceuticals into the APCs for the services with which they are billed, we request comments on alternatives to packaging.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals That Are Not Packaged

For the 2003 OPPS, the APC payment rate for separately payable drugs and radiopharmaceuticals with status indicator ''K'' is based on a relative weight calculated in the same way that the relative weights for procedural APCs are calculated. As with procedural APCs, we observed a decrease in the proposed payment rates for many separately payable drugs and radiopharmaceuticals; therefore, we dampened the payment reduction for APCs whose median costs decreased by more than 15 percent from 2002 to 2003.

In order to establish payment rates for separately payable drugs and radiopharmaceuticals for the 2004 OPPS, we first determined each drug's and radiopharmaceutical's median cost as described above. When we compared the median cost per unit used for determining the 2003 payment rate (for example, the true or dampened median cost) for separately payable drugs and radiopharmaceuticals with their 2004 median cost per unit, we found fluctuations in costs from 2003 to 2004.

CY 2004 median costs decreased more than 15 percent from the corresponding 2003 median cost for many of the separately payable drugs and radiopharmaceuticals. Many of these decreases affected low-volume drugs and radiopharmaceuticals and may be the result of inaccurate coding. Similarly, the 2004 median costs increased by more than 15 percent from the corresponding 2003 median cost for approximately 12 (mostly low volume) drugs and radiopharmaceuticals. For many of the high-volume, separately payable drugs and radiopharmaceuticals, the 2004 median costs increased or decreased by less than 15 percent as compared to the corresponding 2003 median cost. We solicit comments concerning the reasons for the fluctuations in median costs from 2003 to 2004. We are interested in determining whether these fluctuations reflect changes in the market prices of these drugs and radiopharmaceuticals or problems in the hospital claims data (for example, inaccurate coding, improper

charges) that we use for setting payment rates.

We considered several options to address the fluctuations in median costs for separately payable drugs and radiopharmaceuticals. One option was to base payment on our 2002 claims data without modification. A second option was to adopt for 2004 the same methodology that we used to moderate payment decreases in 2003.

A third option was to create drug and radiopharmaceutical cost bands for separately payable drugs and radiopharmaceuticals (for example, all drugs with median costs per unit of $60.01 to $70 would be assigned a proxy median of $70), which would be based on their median costs calculated using 2002 claims data. We considered adopting two sets of cost bands: one for separately payable drugs and biologicals other than radiopharmaceutical agents and one for separately payable radiopharmaceutical agents. The cost bands for drugs and radiopharmaceuticals would be assigned based solely on cost, with no consideration given to the therapeutic use or chemical composition of the drug.

When we applied the dampening methodology used for the 2003 OPPS to drugs and radiopharmaceuticals that will be separately payable in 2004, we observed that this methodology did not sufficiently limit payment reductions for many of the drugs and radiopharmaceuticals with large decreases in median cost from 2003 to 2004. Therefore, a fourth option that we considered and are proposing for 2004 is a variation of the methodology used for the 2003 OPPS. For separately payable drugs and radiopharmaceuticals whose 2004 median costs decreased by more than 15 percent from the applicable 2003 median cost, we propose to limit the reduction in median costs to one fourth of the difference between the value derived from claims data and a 15 percent reduction (for example, for a drug whose cost decreased by 35 percent from the applicable 2003 median cost, the allowed reduction from 2003 to 2004 would be 15 percent + (¼ times 35 − 15) percent = 20 percent). For separately payable drugs and radiopharmaceuticals whose median costs decreased by less than 15 percent from 2003 to 2004, we propose to establish their payment rates using the median costs derived from the 2002 claims data. We believe that it is appropriate to determine payment rates based on our claims data where those data show the cost of drugs and radiopharmaceuticals to be stable over 2 years. In cases where costs show significant fluctuation, we believe it is appropriate to mitigate the potential for underpayment. We believe our proposal bases payment rates on our claims data as required by statute and addresses the potential for making underpayments. However, based on more complete claims data we expect to have for the final rule and on the comments from the public, we will re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

We also propose a separate payment policy, which is described below, for drugs, biologicals, and radiopharmaceuticals that have generic alternatives approved by the Food and Drug Administration (FDA) between October 2001 and December 2002.

We solicit comment on both our proposed methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004. Commenters who disagree with the proposed rate for a drug or radiopharmaceutical should submit verifiable information that shows our payment rate does not reflect the price that is widely available to the hospital market. Thus, information should demonstrate actual, market-based pricing of drugs and radiopharmaceuticals and should be prices at which a broadly based, national sample of hospitals are routinely able to procure the drug or radiopharmaceutical. We do not consider the published average wholesale price (AWP) for a drug to be an indication of its market-based price.

4. Proposed Payment Methodology for Drug Administration

Currently, payment for drug administration is made separately using HCPCS codes Q0081, Q0083, Q0084, Q0085, 90782, 90783, 90784, and 90788 with certain drugs packaged into the median cost for administration. The amount packaged should reflect the costs of the packaged drugs in relation to the frequency with which they are administered. Each of these codes is to be reported once per visit no matter how many drugs are administered. When a hospital administers only packaged drug(s), the appropriate HCPCS code is reported once and no separate payment is made for the drugs. When a hospital administers only separately payable drug(s) the appropriate HCPCS code is reported once; in addition, separate payment is made for the drugs. Because the payment for administration includes payment for packaged drugs, a hospital receives inappropriate reimbursement every time it administers a separately payable drug.

In order to facilitate accurate payments for drugs and drug administration, we are considering whether to make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085. We are not considering changes to payment policy for HCPCS codes 90782, 90783, 90784, and 90788 at this time, although we are interested in receiving comments regarding payment for these codes.

We are proposing to continue our current policy of packaging drugs and radiopharmaceuticals that cost less than $150 per episode of care into the APC with which they are associated (for example, nuclear medicine scans, drug administration).

We are considering whether and how to make different payments to hospitals for administration of packaged drugs and administration of unpackaged drugs. We would like to ensure that when a hospital administers a separately paid drug, it would receive payment for the drug and the drug administration, but not for any drugs packaged into the administration. We also would like to ensure that the payments that are made for administration of packaged drugs are appropriate for the costs of the drugs as well as the cost of the administration.

In order to achieve the above objectives, we considered several coding and payment options and analyzed our claims data for the period April 1, 2002 through December 31, 2002.

Summary of Findings and Alternatives

As explained in greater detail below, we carefully examined data for administration of packaged and separately paid drugs billed under Q0081, Q0083, Q0084 and Q0085. We found that the data showed that paying based on a median cost for the APC for each of the current four codes generally results in underpayment when packaged drugs are billed on the claim and overpayment when separately paid drugs are billed on the claim. In the sections that follow, we discuss our data analysis in detail. We also discuss four alternatives to the current codes and APC payments in detail. In summary, those alternatives are:

1. Maintain the current codes and APCs with payments based on the median costs of all claims in the APC.

2. Eliminate the four current codes and create eight new codes to enable hospitals to report that they administered a packaged drug or a separately paid drug. We would pay a different APC amount for each of the

eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both ''infusion'' and administration of chemotherapy by ''other than infusion'' occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by ''infusion'' or ''other than infusion,'' hospitals would report two codes, one for administration by ''infusion'' and one for administration by ''other than infusion.'' This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim.

Claims Data Analysis

Using our methodology for creating single procedure claims, we looked at all single claims for HCPCS codes Q0081, Q0083, Q0084, and Q0085. We created separate files for each HCPCS code and further subdivided those into four subgroups for each code. The subgroups were for the HCPCS code billed (1) without any HCPCS for drugs; (2) with HCPCS only for packaged drugs; (3) with HCPCS only for separately payable drugs; and (4) with HCPCS for both packaged and separately packaged drugs.

We then reviewed the median costs for each of these subgroups and determined that we could use these subgroups to create two median costs for each existing administration HCPCS code (Q0081, Q0083, Q0084, and Q0085). See Table 15 for median cost data for HCPCS subgroups. We used claims where packaged drugs appeared (subgroups W and X) to create a median cost for administration of packaged drugs. We used claims without HCPCS codes for drugs and claims with HCPCS for only separately payable drugs (subgroups Y and Z) to create a median cost for the administration of separately payable drugs.

We believe that the resultant median costs accurately reflect the costs of packaged drugs and the costs of administration of separately payable drugs. It is obvious that there are significant differences in median costs of services within the same drug administration code, depending on whether a packaged or separately paid drug was administered, the type of drug administered (chemotherapy versus non-chemotherapy) and the route of administration (infusion versus other route or both).

TABLE 15.—MEDIAN COSTS BY TYPES OF DRUGS ON THE CLAIM

HCPCS	Description	Neither packaged nor separate drug (W)	With packaged drug but no separate drug (X)	No packaged drug but with separate drug (Y)	Both packaged drug and separate drug (Z)
Q0081	Infusion therapy other than chemo	$104.97	$276.98	$117.89	$231.56
Q0083	Chemotherapy other than infusion	35.16	119.88	42.26	188.98
Q0084	Chemotherapy by infusion	127.34	250.97	159.01	265.46
Q0085	Chemotherapy by both infusion and other	97.11	154.01	203.43	318.05

We then calculated medians for circumstances in which there were neither packaged nor separately paid drugs on the claim, and there were no packaged drugs, but there were separately paid drugs on the claim (both W and Y). We also calculated medians for circumstances in which there were packaged drugs on the claim (both X and Z). The resultant medians and the number of claims used to set the medians appear in Table 16 below with the HCPCS medians for all claims (packaged and separately paid drugs together).

TABLE 16.—NUMBERS OF CLAIMS AND MEDIANS BY CODE

HCPCS code	Number of claims with packaged drugs	Median of claims with packaged drugs	Number of claims with no drug or separately paid drug	Median for claims with no drug or separately paid drug	HCPCS Median for all claims for 2004
Q0081	19,116	$274.47	280,939	$107.93	$115.11
Q0083	8,681	125.86	24,710	39.10	48.25
Q0084	34,085	257.57	23,933	142.38	205.70
Q0085	17,749	303.87	3,242	126.55	267.63

Review of the data reveals that the median costs for all claims for Q0081 and Q0083 more closely reflect the median cost of claims where no drug or only separately payable drugs were on the claim because that subset of claims represents the vast majority of claims for Q0081 and Q0083. Therefore, if we do not differentiate payment for Q0081 and Q0083 based on whether or not a packaged drug was administered, we would underpay the cases in which a packaged drug was administered. The opposite is true of Q0084 and Q0085 in which more claims reflect packaged drugs than separately paid drugs, and, therefore, the claims with packaged drugs will determine the median cost for the code, thus overpaying cases in which the drug is separately paid.

We also examined the mean and median number of drugs billed with each of the Q codes when only packaged drugs were billed, only separately paid drugs were billed, and both packaged and separately payable drugs were billed (see Table 17). With the exception of Q0085, we believe the data on the number of drugs billed per claim is consistent with the cost data in Table 15. Again, with the exception of Q0085, we are confident that the cost of packaged drugs is accurately reflected in the median cost of the codes for administration of packaged drugs. We are also confident that the median cost for administration of separately payable drugs is appropriate.

TABLE 17.—NUMBERS OF DRUGS BILLED PER SPECIFIED CODES

HCPCS	Mean number of drugs packaged	Median number of drugs packaged	Mean number of drugs separately paid	Median number of drugs separately paid
Q0081	1.05	1	1.01	1
Q0083	1.77	2	1.02	1
Q0084	1.68	1	1.10	1
Q0085	2.33	2	1.19	1

We have some concerns about the cost data for Q0085. The cost for administration of only separately payable drugs is less than the comparable cost for Q0084 ($126 vs. $142). This is counterintuitive as Q0085 describes administration of, at minimum, two drugs, while Q0084 describes administration of one or more drugs. These cost data for Q0085 also raise the concern that proper usage of the code is not understood by hospitals and, therefore, the data are not being used properly.

We believe our analysis supports the need for creating different payment amounts for the administration of packaged drugs and for the administration of separately payable drugs (and, in the case of Q0081, the administration of no drug).

While reviewing options for coding and payment for drug administration we kept five major considerations in mind:

1. Ensuring beneficiary access to drugs.
2. Making accurate payment for both packaged and separately payable drugs.
3. Collecting sufficient data on drugs and drug administration to ensure that future policy development in this area will be properly informed.
4. Facilitating proper coding by hospitals.
5. Avoiding complicated billing rules and hospital burden to the extent possible.

We thought that three basic coding and payment options were available:

1. Continuing the current coding structure and payment policy (for example, a single payment for drug administration per day no matter how many drugs were administered). (Option 1 below).

2. Creation of new codes and new payment policy to describe drug administration (for example, different sets of codes for administration of packaged and separately payable drugs along with allowance for more than one payment for drug administration per day). (Options 2 and 3 below).

3. Continuation of the current drug administration codes but creating new payment policy (for example, allowance for more than one payment for drug administration per day).

After reviewing these three basic options, we developed more fully four specific options. Under all of these options, hospitals would be required to bill all drugs using the HCPCS code for the drug.

Moreover, although we have included an expanded option for Q0085 (Chemotherapy by both infusion and other technique) in option 2, and have retained Q0085 in option 1, we have serious concerns about the extent to which Q0085 is used correctly and about the extent to which the data for this code validly reflect the costs of an identifiable service. Hence, we are particularly interested in comments regarding whether we should eliminate Q0085. (Option 4 below).

Option 1—Retain the current codes and continue to pay on a per-visit basis, based on median costs for each code regardless of whether or not packaged or separately paid drugs are administered.

We would retain the current codes, use all claims for these services to set a relative weight, and make a single payment based on the median costs for the code regardless of whether or not packaged or separately paid drugs are administered. This would result in significant underpayment for administration of packaged drugs because the largest volume of claims with this code are either for administration of no drug (Q0081) or for drugs that are separately paid (and have no packaged drug costs). See Table 16 for the median costs determined on the basis of all claims for the existing codes. We would require hospitals to report HCPCS codes for both packaged and separately payable drugs in order to inform future policy decisions in this area.

We do not propose payment amounts for this option because the budget neutrality scalar would be different under this proposal than under option 2 (which was used in the scalar and impact analysis).

Option 2—Create eight new drug administration codes to enable hospitals to report administration of both packaged and separately payable drugs.

We would create two new sets of HCPCS codes to describe administration of packaged and separately payable drugs. Each of the eight codes would have its own APC payment. The descriptions and median costs for these proposed codes would be as follows:

TABLE 18.—MEDIAN COSTS OF PROPOSED G CODES UNDER OPTION 2

HCPCS	2004 APC	2004 SI	Description	Median costs
GXXX1	0382	S	Infusion of packaged non-cancer chemotherapy drug(s), per day.	$274.47
GXXX3	0376	S	Administration of packaged cancer chemotherapy drug(s) by other than infusion, per day.	125.86

TABLE 18.—MEDIAN COSTS OF PROPOSED G CODES UNDER OPTION 2—Continued

HCPCS	2004 APC	2004 SI	Description	Median costs
GXXX4	0378	S	Administration of packaged cancer chemotherapy drug(s) by infusion, per day.	257.57
GXXX5	0380	S	Administration of packaged cancer chemotherapy drugs by both infusion and other than infusion, per day.	303.87
GYYY1	0383	S	Infusion of separately payable non-cancer chemotherapy drug(s) or non-drug infusion therapy, per day.	107.93
GYYY3	0377	S	Administration of separately payable cancer chemotherapy drug(s) by other than infusion, per day.	39.10
GYYY4	0379	S	Administration of separately payable cancer chemotherapy drug(s) by infusion, per day.	142.38
GYYY5	0381	S	Administration of separately payable cancer chemotherapy drugs by both infusion and other than infusion, per day.	126.55

The median costs for administration of packaged drugs would be determined from claims that contain at least one packaged drug and the median costs for administration of separately payable drugs (or no drugs in the case of Q0081) would be determined from claims that contained only separately payable (or no) drugs.

Although payment would not depend on accurate reporting of HCPCS codes for drugs, we would require hospitals to use HCPCS codes for both packaged and separately payable drugs in order to ensure that we had reliable data upon which to base future relative weights for these services. As described under option 4, we would create six lists of drugs in order to facilitate proper payment in the future.

Hospitals would report the appropriate code for the type of drug administered and the route(s) of administration. In this option, hospitals could bill for administration of both chemotherapy agents and administration of non-chemotherapy agents (or non-drug infusions). We would permit a maximum of one chemotherapy and one non-chemotherapy administration per day.

We are concerned that creation of these codes could require complicated billing rules and cause burden to hospitals. We would need to specify how to bill different combinations of route and category of drug (for example, two infused drugs, one pushed drug, antiemetics, and hydration). Because hospital billers would have to review both the type of administration and the type of drug administered to determine the correct code to bill, we are concerned about the potential for miscoding (with resultant mispayment) under this option, and we solicit comments on both of these issues. In some cases, this additional coding burden might result in less payment for administration (particularly Q0081).

Under this option, all codes would have a status indicator of S, and no multiple procedure reductions would apply.

This option is modeled for purposes of the budget neutrality scalar and the impact analysis (*see* Table 18).

Option 3—Create six new drug administration codes to enable hospitals to report administration of both packaged and separately payable drugs.

This option is similar to option 2 except that we would eliminate the codes used to describe administration of chemotherapy by both infusion and other techniques. Where a code is billed with a packaged drug suitable for the code, we would pay the APC for the packaged drug. Where both a packaged drug and a separately paid drug were administered via the same route of administration (and therefore only one code was billed), we would pay the APC only for the administration of the packaged drug and would pay separately for the separately paid drug and would not pay the APC for administration of the separately paid drug. Under this option, we would allow up to three payments for administration of drugs or infusions. We would allow one payment for non-chemotherapy drugs/infusions (for example, antiemetics, fluids), one payment for chemotherapy administered by infusion, and one payment for chemotherapy administered by ''other than infusion.'' As stated above, we would not allow payment for administration of packaged chemotherapy drugs by infusion and payment for administration of separately payable chemotherapy by infusion. This coding scheme would allow us to more accurately recognize the true costs of administering multiple drugs. For example, there are some economies of scale when infusing two or more drugs (for example, only one I. V. line needed), but each drug requires its own mixing and nursing care. This option would allow up to three payments for administration of drugs or non-drug infusion, thereby recognizing the unique costs of administering each drug while not making duplicate payment. In order to ensure that we do not make duplicate payment for patients receiving chemotherapy drugs and non-chemotherapy drugs (and/or hydration), we would pay GXXX1 and GYYY1 at 50 percent of their payment when one of these codes is paid in addition to chemotherapy administration (GXXX3, GXXX4, GYYY3, and GYYY4). This is because we believe there are economies of scale achieved for multiple drug administrations and that the additional resources used to provide non-chemotherapy treatment are minimal.

Following are examples of how payment would be made:

- When both packaged and separately payable chemotherapy drugs are infused, we would make payment for GXXX4—Administration of packaged chemotherapy drugs by infusion and for each separately payable chemotherapy drug, but we would not make payment for GYYY4—Infusion of separately payable chemotherapy drugs.
- When packaged chemotherapy drugs are pushed and infused, and separately payable chemotherapy drugs are infused, we would make payment for GXXX3 and GXXX4 and for each separately payable chemotherapy drug, but we would not make payment for GYYY4.
- When packaged chemotherapy drugs are infused and pushed; separately payable chemotherapy drugs are infused and packaged; and separately payable non-chemotherapy drugs are infused (for example, antiemetics), and hydration is given; we would make payment for GXXX3, GXXX4, each separately infused chemotherapy drug, GXXX1, and each separately payable non-chemotherapy drug. We would not make payment for GYYY1 or GYYY3. Note that payment for GXXX1 in this case would be made at 50 percent because it was billed with chemotherapy (if it was billed without

chemotherapy, then payment would be made at 100 percent).

Medians for these codes would be as follows:

TABLE 19.—MEDIAN COSTS UNDER OPTION 3

HCPCS	2004 APC	2004 SI	Description	Median costs
GXXX1	XXX1	T	Infusion of packaged non-cancer chemotherapy drug(s), per day.	$274.47
GXXX3	XXX3	S	Administration of packaged cancer chemotherapy drug(s) by other than infusion, per day.	125.86
GXXX4	XXX4	S	Administration of packaged cancer chemotherapy drug(s) by infusion, per day.	257.57
GYYY1	YYY1	T	Infusion of separately payable non-cancer chemotherapy drug(s) or non-drug infusion therapy, per day.	107.93
GYYY3	YYY3	S	Administration of separately payable cancer chemotherapy drug(s) by other than infusion, per day.	39.10
GYYY4	YYY4	S	Administration of separately payable cancer chemotherapy drug(s) by infusion, per day.	142.38

As modeled, these codes would have status indicator S (except as described above for GXXX1 and GYYY1).

Similar to option 2, we would require hospitals to report HCPCS codes for packaged and separately payable drugs to ensure that we have reliable data upon which to base future relative weights for these services. As described under option 4, we would create six lists of drugs in order to facilitate proper coding and payment in the future.

We do not propose payment amounts for this option because the budget neutrality scalar would be different under this proposal than under option 2 (which was used in the scalar and impact analysis).

Option 4—Use of codes Q0081, Q0083, and Q0084 and deletion of Q0085 with creation of logic in the outpatient code editor (OCE) to enable differential payment for administration of packaged and separately payable drugs.

This option is similar to option 3 in terms of payment policy. However, instead of creating six new codes, hospitals would continue to report codes Q0081, Q0083, Q0084, and the HCPCS codes for all packaged and separately payable drugs. We would delete Q0085 in order to simplify hospital reporting and to facilitate creation of payment logic in the OCE.

We would create six lists of drugs (see Addenda L, M, N, O, P, Q): packaged chemotherapy agents administered by other than infusion, separately payable chemotherapy agents administered by other than infusion, packaged chemotherapy agents administered by infusion, separately payable chemotherapy agents administered by infusion, packaged non-chemotherapy agents administered by infusion, and separately payable non-chemotherapy agents administered by infusion. These lists would be coded into the OCE, and would be updated quarterly by program memoranda. We realize that a few drugs may be administered by both infusion and other techniques. In these lists, we would assign each drug to its predominant form of administration in a hospital outpatient setting. If we could not determine whether a drug was infused or administered by a technique other than infusion (for example, we receive a claim with Q0083 and Q0084 and two drugs that may be administered by either infusion or another technique), we would associate each drug with its predominant administration code.

We would create logic in the OCE that would base payment on the combination of administration and drug codes on the claim but would only allow one unit of each administration type as described in option 3. The medians for the APCs to which OCE would assign the codes are described in Table 20.

TABLE 20.—MEDIANS FOR APCS UNDER OPTION 4

Drug administration codes on the claim	Nonchemo drug, packaged list (subgroup X)	Chemo drug, packaged list (subgroup W)	Nonchemo drug, separately paid list or no drug billed (subgroup Z)	Chemo drug, separately paid list (subgroup Y)	Admin APC	APC median	Applicable addenda
Q0081	X				A	$274.47	L
Q0081			X		B	107.93	M
Q0083		X			C	125.86	N
Q0083				X	D	39.10	O
Q0084		X			E	257.57	P
Q0084				X	F	149.38	Q

The payment policy is identical to the policy described in option 3 including the discount for Q0081 when billed with Q0083 and/or Q0084. Although this option would not require hospitals to change coding of drug administration it would, unlike options 2 and 3, require accurate coding of HCPCS codes for drugs in order to ensure proper payment. Additionally, we would revise the definitions of the administration codes to ''per day'' instead of ''per visit.''

Similar to option 3, we would make payment for up to three drug administrations per day, if appropriate. Where a code is billed with a packaged drug suitable for the code, we would pay the APC for the packaged drug. Where both a packaged drug and a

separately paid drug were administered via the same route of administration (and therefore only one code was billed), we would pay the APC only for the administration of the packaged drug and would pay separately for the separately paid drug and would not pay the APC for administration of the separately paid drug. In no case would we pay for more than one unit of an administration code.

Under options 2, 3, and 4, we would return a claim to the provider when a chemotherapy administration code was reported without a HCPCS code for a chemotherapy drug. Therefore, it is very important that commenters advise us as to whether there are any cancer chemotherapy drugs that are not included in Addenda L, M, N, O, P, or Q. Specifically, we solicit comments as to whether there are any cancer chemotherapy drugs that do not have HCPCS codes.

We do not propose payment amounts for this option because the budget neutrality scalar would be different under this proposal than under option 2 (which was used in the scalar and impact analysis). We solicit comment on each option described above.

General Billing Instructions

Any previous regulatory or sub-regulatory guidance notwithstanding, we propose to implement the following billing rules under any of the above payment options:

(1) Q0081 may not be used to bill separately for the hanging of a bag of solution for which the sole purpose is to administer chemotherapy drugs; that charge should be billed as part of the charge for Q0084 or Q0085.

(2) Q0081 may not be billed when it is an integral part of another procedure. In those cases, the charge for the procedure should reflect the costs of the infusion therapy, either as part of the charge for the HCPCS code or as a revenue code charge (for example, hydration or drug administration during a surgical procedure performed under general anesthesia).

(3) Q0081, Q0083, and Q0084 should not be used to bill for the administration of radiopharmaceuticals that are administered as part of diagnostic or therapeutic nuclear medicine procedures. In those cases, the radionucliide should be billed with the appropriate nuclear medicine HCPCS code.

(4) Q0081, Q0083, and Q0084 may not be used to report the transfusion of blood, platelets, or any other blood products. Those transfusions should be reported by use of the appropriate HCPCS code(s) in APC 0110.

5. Generic Drugs, and Radiopharmaceuticals

In general, hospital acquisition costs for drugs, biologicals, and radiopharmaceutical agents with generic competitors are lower than the acquisition costs for sole source or multi-source drugs. In order to ensure that Medicare recognizes these lower costs in a timely manner, we are proposing a new method of calculating payment amounts for drugs, biologicals, and radiopharmaceuticals that are separately paid under the OPPS and for which the Food and Drug Administration (FDA) has recently approved generic alternatives when we determine our claims data do not reflect the costs of the generic alternatives.

Because many hospitals have long term purchasing arrangements for drugs and radiopharmaceuticals, we believe that there is generally a 12-month lag between the time that generic items are made available and when our claims data will accurately reflect the costs associated with the availability of the generic alternative. Therefore, during the interval between FDA approval of a generic item and the time when we would reasonably expect claims data to reflect the cost of generic alternatives, we propose to adopt the following methodology to price the affected drugs, biologicals, and radiopharmaceuticals under the OPPS.

We would first identify items approved for generic availability by the FDA during the 6 months before the first day of the claims period we would use as the basis for an annual OPPS update. Where we determine that our claims data do not reflect the costs of generic alternatives for a separately payable drug, biological, or radiopharmaceutical, we propose to base our payment rate on 43 percent of the AWP for the drug, biological, or radiopharmaceutical. As described in the 2003 OPPS rule (67 FR 66768), the ratio of hospital acquisition cost, on average, to AWP for multisource drugs with generic competitors equals 0.43. We believe that using this ratio would allow us to appropriately calculate the costs that hospitals incur when purchasing generic drugs or radiopharmaceuticals. When we determine that our claims data accurately reflect the cost of the generic alternative(s), we would use the claims data to set payment rates in preference to 43 percent of AWP for the drug or radiopharmaceutical.

We considered another payment option where we would base our payment rate on the lower of: (1) The median cost (with dampening if applicable) based on claims data; or (2) the Federal Supply Schedule price. We are not proposing this policy because we believe we would not be able to calculate payment rates that are close to the actual hospital acquisition costs of generic alternatives since the Federal Supply Schedule represents prices that are lower than the prices paid by most hospitals. Also, median costs from the claims data would not reflect the actual cost of generics because of the time lag described above.

To apply this payment methodology to the 2004 OPPS update, we reviewed FDA approvals for generic drugs, biologicals, and radiopharmaceuticals issued between October 2001 and December 2002. We found six drugs, which we propose to be separately paid under the 2004 OPPS that had generic alternatives approved during that time. These drugs are: Daunorubicin, Bleomycin, Pamidronate, Paclitaxel, Ifosfomide, and Idarubicin. Table 21 shows the dates when the FDA approved generic alternatives for these drugs.

We understand that there is a wide range of utilization for these drugs in the OPPS and that price reductions for generic drugs will depend on their utilization and the types of illnesses for which they are used. However, we would not expect claims data from April 1, 2002 through December 31, 2002 to reflect fully the availability of the generic alternatives.

Table 21 shows the median cost for these six drugs as determined by claims data (with any adjustments for APCs that decreased in median cost by more than 15 percent from 2003 to 2004) and their costs at 43 percent of AWP as determined under the July 2003 update of the Medicare Single Drug Pricer.

We solicit comments on this proposed method of calculating payment for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have recently been approved. Specifically, we are interested in comments concerning our proposed methodology for identifying these items, whether we properly identified all the items, and whether our proposed payment policy for these generic alternatives is appropriate.

TABLE 21.—PROPOSED LIST OF SEPARATELY PAYABLE OPPS DRUGS WITH GENERIC ALTERNATIVES APPROVED BETWEEN OCTOBER 2001 AND DECEMBER 2002

APC	Description	Date of Generic Approval by the FDA	43% of AWP	2004 Median cost (with dampening if applicable)
0832	Idarubicin hcl injection	May 2002	$190.08	$188.25
0831	Ifosfomide injection	May 2002	68.07	115.46
0863	Paclitaxel injection	May 2002	74.27	116.61
0730	Pamidronate disodium	May 2002	120.34	184.40
0857	Bleomycin sulfate injection	October 2001	130.98	169.28
0820	Daunorubicin hcl injection	November 2001	35.46	89.65

6. Orphan Drugs

In response to last year's proposed rule, many commenters explained that many orphan drugs were life-saving therapies used solely for the treatment of rare disorders where no other treatment was available. They further stated that many of these drugs would be received by very few Medicare beneficiaries and that if we packaged these drugs into other procedures, our payment rates would be insufficient to recognize their high cost, thus impairing the access of beneficiaries who needed the drugs. These commenters also stated that the claims data we used to set payment rates for 2003 did not accurately reflect the cost of these drugs. We shared these concerns, and in the November 1, 2002 final rule (67 FR 66772), we set forth the following payment policy:

We identified orphan drugs that are used solely for orphan conditions by applying the following criteria:

- The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

Payment for drugs that met these criteria was made outside of OPPS under reasonable cost.

In that same rule, we identified four orphan drugs (J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; and J1785 Injection, imiglucerase, per unit) as meeting these criteria. Therefore, we excluded them from payment under OPPS and paid for them at reasonable cost in 2003.

We received several comments in response to the final rule, stating that we had not identified all drugs that qualified for special payment as orphans under our criteria. After reviewing these comments, we have identified 7 additional drugs that meet our criteria. These drugs are: J2355 Injection, oprelvekin, 5 mg; J3240 Injection, thyrotropin alpha, 0.9 mg; J7513 Daclizumab parenteral, 25 mg; J9015 Aldesleukin, per vial; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1–b, 3 million units; and Q2019 Injection, basiliximab, 20 mg.

We have now identified a total of 11 drugs that meet our orphan drug criteria, and we expect to identify more such drugs in the future. Last year's policy was intended to narrowly target a very small number of drugs received by very few Medicare beneficiaries in order to ensure beneficiary access to life saving therapies. The aggregate number of Medicare beneficiaries who will receive the 11 drugs that meet our criteria for orphans is significantly higher than the number who receive the 4 we identified last year. Furthermore, as we identify more drugs that meet our criteria, we expect the number of beneficiaries who receive these drugs to grow. As the number of beneficiaries who receive these drugs increases, so do total payments for the drugs. Therefore, we no longer believe that paying for these drugs at reasonable cost, outside of OPPS, is appropriate. Our goal is to pay for as many hospital outpatient department (OPD) services as possible under the OPPS system. We believe that any payments made outside of OPPS should remain relatively small and, as in the case of vaccines, be made because it is unlikely our claims data will reflect the cost of the item or service (see discussion of vaccines below).

In the case of orphan drugs, we believe that our claims data for April 1, 2002 through December 31, 2002 do reflect the cost of orphan drugs, and we are concerned about the potential of making ever increasing payments for these drugs outside of the OPPS. Furthermore, we believe that many of the concerns expressed by commenters would be addressed if we continue to make separate payment for these drugs.

Therefore, we propose the following payment policy for orphan drugs:

- We propose to continue using the same criteria to identify orphan drugs used solely for an orphan condition under the OPPS.
- We propose to discontinue retrospective cost payments and to make prospective payments under the OPPS for those identified orphan drugs.
- We propose to base payments on the same methodology we use to pay for other drugs including any limitation on payment reductions (as described above).
- We propose to make separate payment for orphan drugs and place them in APCs.

We solicit comment on each of these proposals and request that commenters submit information meeting the same criteria as comments for other drugs (as discussed above).

7. Vaccines

Outpatient hospital departments administer large amounts of the vaccines for influenza (flu) and pneumococcal pneumonia (PPV), typically by participating in immunization programs. In recent years, the availability and cost of some vaccines (particularly the flu vaccine) have fluctuated considerably. As discussed in the November 1, 2002 final rule (67 FR 66718), we were advised by providers that OPPS payment was insufficient to cover the costs of the flu vaccine and that access of Medicare beneficiaries to flu vaccines might be limited. They cited the timing of updates to OPPS rates as a major concern. They said that our update methodology, which uses 2-year-old claims data to recalibrate payment rates would never be able to take into account yearly fluctuations in the cost of the flu vaccine. We agreed with this concern and decided to pay hospitals for influenza and pneumococcal pneumonia vaccines based on a reasonable cost methodology. As a result of this change, hospitals, home health agencies (HHAs), and hospices,

which were paid for these vaccines under OPPS in 2002 are being paid at reasonable cost for these vaccines in 2003. We are aware that access concerns continue to exist for these vaccines; therefore, we propose to continue paying for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology.

8. Blood and Blood Products

From the onset of the OPPS, we have made separate payment for blood and blood products in APCs 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), 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 we did not create any incentives that were inconsistent with the promotion of blood safety and access. Therefore, we propose to continue to pay separately for blood and blood products.

As described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For 2003, we limited the decrease in payment rates for blood and blood products to approximately 15 percent.

After careful comparison of the 2003 dampened medians with the 2004 medians from our claims data, we believe that establishing payment rates based on the 2004 median costs would, for many blood and blood products, result in payments that are significantly lower than hospital acquisition costs. In order to mitigate any significant payment reductions and to minimize any compromise in access of beneficiaries to these products, we propose to limit the decrease in payment rates for blood and blood products from 2003 to 2004 by approximately 10 percent.

This is different than the amount by which we limited payment decreases last year because when we applied the dampening methodology used for the 2003 OPPS to blood and blood products, we observed that it did not sufficiently limit payment reductions for the blood and blood products with large decreases in median cost from 2003 to 2004. Therefore, we are proposing for 2004 a variation of the methodology used for the 2003 OPPS because we believe that a 10 percent limit in the decrease in payment rates for blood and blood products would better reflect hospital acquisition costs, ensure appropriate reimbursement to hospitals, and enable continued beneficiary access to blood and blood products.

The list of APCs containing blood and blood products can be found in the November 1, 2002 final rule (67 FR 66750). We note that the APCs for these products are intended to make payment for the costs of the products. Costs for storage and other administrative expenses are packaged into the APCs for the procedures with which the products are used.

We solicit comment on this proposal especially from hospitals. We are especially interested in comments that include verifiable information about the widely available acquisition cost of commonly used blood and blood products.

9. Intravenous Immune Globulin

Following publication of the proposed rule on August 9, 2002, we received comments urging us to reclassify intravenous immune globulin (IVIG) as a blood product. After carefully reviewing these comments with our medical advisors, we decided to make final our proposal to classify immune globulin as a biological, subject to the same payment policy we implemented for other drugs and biologicals. Our reasons were set forth in the November 1, 2002 final rule (67 FR 66774). Since implementation of the 2003 OPPS update, we have received further comments on this decision. These commenters continue to assert that we should make special payment provisions for IVIG and reclassify IVIG as a blood and blood product. They have expressed particular concern about the potentially negative impact of our payment policy for IVIG on patient access, especially for those individuals who have primary immune deficiency diseases.

We appreciate the concerns regarding our decision to pay for IVIG in accordance with the payment methodology we applied to other drugs and biologicals in the 2003 update of the OPPS. We have reviewed the claims data that are the basis for the payment rates in this proposed rule, and our analysis reveals that IVIG would be separately payable in 2004. The claims data for IVIG are robust, and the most recent claims data, when compared with claims data used in earlier updates of the OPPS suggest that hospital costs are consistent and that hospitals are billing accurately for these products. Therefore, we believe that payment for these products is appropriate using the methodology we propose to implement for other drugs and biologicals. Therefore, we propose to continue to classify IVIG as a biologic. We solicit comments on this proposal.

10. Drug and Device Coding

We propose to require hospitals to report individual codes for all drugs and devices used during the episode, including those that are packaged.

Last year (CY 2003), the pass-through status of many drugs and devices expired. These drugs and devices were packaged, consistent with the fundamental principles of a prospective payment system. By packaging the costs of items and services into the payment for the primary procedure or service with which they are associated, we encourage hospital efficiency and provide hospitals with the ability to manage their resources with maximum flexibility. We believed that an additional advantage of increased packaging would be that hospitals would no longer need to report codes for the individual items and services included in the package. While we continue to support packaging to the greatest extent possible, the loss of coding information on claims creates some obstacles to accurate rate-setting.

The data for 2002 that we are using for CY 2004 rate-setting still have considerable drug and device coding information. However, for the CY 2005 OPPS update, for which 2003 data would be used, there will be much less information regarding specific drug and device costs. We do not expect to have as much Medicare claims information on which to base certain decisions such as which drugs to remove from packaged status and pay separately.

This concerns us and has led us to consider the need for drug and device coding. Even though payment is not directly related to that information, we believe that reporting the codes may be in hospitals' best interest because it may result in the most accurate payments. For example, in setting the weights of certain device-related APCs, we discovered that the median costs of those APCs were higher when we used only claims on which the device codes appeared. Similarly, certain drug administration APCs have higher median costs when separate HCPCS for drugs are reported on the claims.

If we are to continue to price drugs and devices using up-to-date median costs from claims data, we need information on the costs of the items, even when packaged. We propose to require the separate coding of individual drugs and device categories,

even where their costs are packaged, to address this need. We would like comments on whether or not to require coding of devices. We also solicit comments regarding our proposal to report drug codes on claims and alternative methods for rate-setting if codes for drugs and/or devices are no longer present on the claims. We are particularly interested in receiving comments from hospitals on this proposal.

11. Payment for Split Unit of Blood

Since implementation of the OPPS, we have assigned status indicator ''E'' to HCPCS code P9011, blood (split unit). Status indicator ''E'' designates services for which payment is not allowed under the OPPS or services that are not covered by Medicare. P9011 was created to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient. Because use of split units is not uncommon, we propose to change the status indicator for P9011 from ''E'' to ''K'' and assign it to a blood and blood product APC that pays approximately 50 percent of the payment for the whole unit of blood. We propose to assign P9010 to APC 0957 (Platelet concentrate) with a payment rate of $37.30. We invite comments on this proposed change in the status indicator and payment amount for P9010.

12. Other Issues

We propose to continue our payment policy for Procrit and Aranesp for calendar year 2004. As explained in detail in the November 1, 2002 final rule (67 FR 66758), Aranesp and Procrit are in separate APCs, and are paid at equivalent rates with the application of a ratio to convert the dosage units of Aranesp into units of Procrit. The current conversion ratio is based on the best information available at the time we developed the final rule for calendar year 2003. In the final rule, we explained that we based our conclusion regarding the appropriate conversion ratio on the FDA labeling for each product and the body of available clinical evidence contained in published and unpublished articles and abstracts and in materials provided by the products' manufacturers. We indicated that we might refine the conversion ratio as soon as feasible based on information not available at the time we established the current conversion ratio.

Consistent with our statements in the final rule, we have continued to gather information regarding an appropriate conversion ratio by reviewing recent published studies and data from alternative sources. We have met with the manufacturers of the products and consulted with clinicians. We are continuing to evaluate this additional data and information. However, we have not yet determined whether the data would support a change to the current policy. We remain open to establishing a different conversion ratio in the final rule if we conclude that a change is warranted based on public comments and information submitted during the public comment period and/or any other information we consider in developing the final rule.

Therefore, we propose to continue with the current policy regarding payment for Procrit and Aranesp, including the current conversion ratio. We solicit comments on this issue and are especially interested in submission of articles in peer-reviewed publications and other clinical data concerning the frequency of administration and the dosage amounts of these agents. Submission of prospective, randomized, controlled trials comparing the dosage amounts, frequency of administration, and clinical outcomes of these agents are preferred. All data submitted would be available to the public. We would base any changes to our current payment policy for these two drugs only on data that we could make available to the public.

VII. Wage Index Changes for CY 2004

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2004 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in this proposed rule. The proposed FY 2004 hospital inpatient wage index published in the May 19, 2003 **Federal Register** (68 FR 27154) is reprinted in this proposed rule as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J—Wage Index for Hospitals That Are Reclassified. We propose to use the final FY 2004 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that we will publish in the final rule implementing the OPPS for CY 2004.

VIII. Copayment for CY 2004

In the November 30, 2001 final rule (66 FR 59887), we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001 final rule either did not address or whose applicability was ambiguous. For example, rules 2 and 3 refer to payment rate changes resulting from the recalibration of relative payment weights but do not clearly apply to payment rate changes resulting from the reclassification of HCPCS codes from one APC group to another APC group. Therefore, we propose to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts, including situations in which recalibration of the relative payment weight of an existing APC results in a change in the APC payment; to situations in which reclassification of HCPCS codes from an existing APC to another APC results in a change in the APC payment; and to payment rates for newly created APCs that are comprised of HCPCS codes from existing APCs.

As a general rule, we would seek to lower the coinsurance rate for the services in an APC from the prior year. This principle is consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services and with section 1833(t)(3)(B), which indicates the congressional goal of achieving 20 percent coinsurance when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts to new services. However, in no event is the proposed 2004 coinsurance rate for an APC group lower than 20 percent or greater than 50 percent of the payment rate.

We propose to determine copayment amounts in 2004 and subsequent years in accordance with the following rules.

1. When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If a new APC that did not exist during the prior year is created and

consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

3. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the copayment amount remains constant (unless the resulting coinsurance rate is less than 20 percent).

4. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

5. If HCPCS codes are added to or deleted from an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

6. If HCPCS codes are added to an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance rate of the codes being added to the reconfigured APC.

This methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or the recalibration of relative payment weights.

IX. Conversion Factor Update for CY 2004

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that for 2004, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2004 published in the inpatient PPS proposed rule on May 19, 2003 is 3.5 percent. To set the proposed OPPS conversion factor for 2004, we increased the 2003 conversion factor of $52.151 (the figure from the November 1, 2002 final rule (67 FR 66788) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2004 to ensure that the revisions we are proposing to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of 1.003 for wage index changes by comparing total payments from our simulation model using the proposed FY 2004 hospital inpatient PPS wage index values to those payments using the current (FY 2003) wage index values. In addition, for CY 2004, allowed pass-through payments have decreased to 2 percent of total OPPS payments, down from 2.3 percent in CY 2003. The 0.3 percent was also used to adjust the conversion factor.

The increase factor of 3.5 percent for 2004, the required wage index budget neutrality adjustment of approximately 1.003, and the 0.3 percent adjustment to the pass-through estimate, result in a proposed conversion factor for 2004 of 54.289.

X. Proposed Outlier Policy and Elimination of Transitional Corridor Payments for CY 2004

A. Proposed Outlier Policy for CY 2004

For OPPS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we 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 propose to continue to set the target for outlier payments at 2.0 percent, as we did for CYs 2001, 2002, and 2003. For 2003, the outlier threshold is met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the current outlier payment percentage is 45 percent of the amount of costs in excess of the threshold. For the reasons discussed in detail in section XI.E of this preamble, we are proposing to establish two separate outlier thresholds, one for community mental health centers (CMHCs) and one for hospitals. For CY 2004, we propose to continue to set the target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.36 percent, would be allocated to CMHCs for PHP services). Based on our simulations for 2004, we propose to set the hospital threshold for 2004 at 2.75 times the APC payment amount, and the proposed 2004 payment percentage applicable to costs over the threshold at 50 percent. We propose to set the threshold for CMHCs for 2004 at 11.75 times the APC payment amount and the 2004 outlier payment percentage applicable to costs over the threshold at 50 percent.

B. Elimination of Transitional Corridor Payments for CY 2004

Since the inception of the OPPS, providers have been eligible to receive additional transitional payments if the payments they received under the OPPS were less than the payments they would have received for the same services under the payment system in effect before the OPPS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPPS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPPS. Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. Beginning January 1, 2004, in accordance with section 1833(t)(7) of the Act, transitional corridor payments will no longer be paid to providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently under the transitional corridor provisions of the statute.

We are concerned that small rural hospitals are not able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, and we are concerned that the decrease in payments these hospitals may experience once they stop receiving transitional corridor payments will result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas.

In light of these concerns, one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. We invite comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

XI. Other Policy Decisions and Proposed Changes

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

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education). An example to illustrate the services that are billed using E/M codes in the hospital outpatient department follows:

An adult male patient presents to a clinic after a fall while working in his yard. As a result, he has scraped off the top layer of skin covering his entire back. The physician examines the patient, finds a dirty and possibly infected wound, which is the only injury. The physician orders the nurse to clean the wound, apply antiseptic medication, and dress the wound. In addition, the physician orders an intramuscular antibiotic and a tetanus injection.

The nurse will spend a considerable amount of time cleaning and dressing the wound with large amounts of sterile supplies (because of the large body surface area) as well as administering medications. The nurse also will give the patient discharge instructions regarding the care of the wound.

Although the physician services are captured using existing E/M codes, the additional staff and supplies integral to the outpatient department services are not. The low level E/M code that describes the physician services in the example is not reflective of the services provided by the nurse (and any other staff that may have become involved) or of the quantity of supplies used in the treatment.

In the April 7, 2000 final rule (65 FR 18434), we stated that in order to ensure proper payment to hospitals, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. Commenters recommended that we should keep the current E/M coding system until facility specific E/M codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand, implement, and that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

APC Panel Recommendations

During its January 2002 meeting, the APC Panel made the following recommendations regarding coding for evaluation and management services:

1. Propose, and make final, facility coding guidelines for E/M services for CY 2004.

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 American College of Emergency Physicians (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.

After careful review and consideration of written comments, oral testimony, and the APC Panel's recommendations, we proposed the following in the August 9, 2002 proposed rule (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services:

GXXX1—Level 1 Facility Emergency Services;

GXXX2—Level 2 Facility Emergency Services;

GXXX3—Level 3 Facility Emergency Services;

GXXX4—Level 4 Facility Emergency Services; and

GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic services:

GXXX6—Level 1 Facility Clinic Services;

GXXX7—Level 2 Facility Clinic Services;

GXXX8—Level 3 Facility Clinic Services;

GXXX9—Level 4 Facility Clinic Services; and

GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

In our November 1, 2002 final rule (67 FR 66792), we stated that the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that would make recommendations to us. We wanted to ensure that definitions and guidelines were developed using an open process involving a variety of experts in the field. We stated that it is critically important to the development, acceptance, and implementation of facility visit code definitions and guidelines that the organizations that develop the guidelines also maintain and update the guidelines and provide ongoing education to providers on use of the codes. In light of the expertise of organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we felt that these organizations were particularly well equipped to make recommendations to us and to provide ongoing education to providers. Furthermore, we stated that the process should provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the new codes and guidelines.

On their own initiative, the AHA and the AHIMA convened an independent expert panel of individuals from various

organizations to develop code descriptions and guidelines for hospital emergency department and clinic visits and make recommendations to us.

The panel recommended the following to us.

1. We should make payment for emergency and clinic visits based on four levels of care.

2. We should create HCPCS codes to describe these levels of care as follows:

GXXX1—Level 1 Emergency Visit.
GXXX2—Level 2 Emergency Visit.
GXXX3—Level 3 Emergency Visit.
GXXX4—Critical Care provided in the emergency department.
GXXX5—Level 1 Clinic Visit.
GXXX6—Level 2 Clinic Visit.
GXXX7—Level 3 Clinic Visit.
GXXX8—Critical Care provided in the clinic.

3. We should replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.

4. Based on the above recommendations, we would crosswalk payments as follows: GXXX1 to APC 610, GXXX2 to APC 611, GXXX3 to APC 612, GXXX4 to APC 620, GXXX5 to APC 600, GXXX6 to APC 601, GXXX7 to APC 602, and GXXX8 to APC 620. These crosswalks and code descriptions are listed in Table 22 below.

TABLE 22.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Emergency department visit	Level 1 Emergency Visit	99281 99282	GXXX1	0610	$76.80
Emergency department visit	Level 2 Emergency Visit	99283	GXXX2	0611	$135.08
Emergency department visit	Level 3 Emergency Visit	99284 99285	GXXX3	0612	$234.72
Critical care	Level 4 Critical Care provided in the emergency department.	99291 99292	GXXX4	0620	$503.03
Office/outpatient visit, new	Level 1 Clinic Visit	99201 99202	GXXX5	0600	$50.90
Office/outpatient visit, new	Level 2 Clinic Visit	99203	GXXX6	0601	$54.46
Office/outpatient visit, new	Level 3 Clinic Visit	99204 99205	GXXX7	0602	$84.71
Office/outpatient visit, established	Level 1 Clinic Visit	99211 99212	GXXX5	0600	$50.90
Office/outpatient visit, established	Level 2 Clinic Visit	99213	GXXX6	0601	$54.46
Office/outpatient visit, established	Level 3 Clinic Visit	99214 99215	GXXX7	0602	$84.71
Office consultation	Level 1 Clinic Visit	99241 99242	GXXX5	0600	$50.90
Office consultation	Level 2 Clinic Visit	99243	GXXX6	0601	$54.46
Office consultation	Level 3 Clinic Visit	99244 99245	GXXX7	0602	$84.71
Critical care	Level 4 Critical Care provided in the clinic.	99291 99292	GXXX8	0620	$503.03

The independent panel convened by the AHA and AHIMA recommended these levels in anticipation of the development of national coding guidelines for emergency and clinic visits that meet the following criteria we announced in the August 9, 2002 proposed rule (67 FR 52131):

1. Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, rather than physician resource use.

2. Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and comply with HIPAA.

3. Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

4. Coding guidelines should not create incentives for inappropriate coding (for example, up-coding).

We have received recommendations for a set of coding guidelines from the independent E/M panel comprised of members of the AHA and AHIMA. We propose to implement new evaluation and management codes only when we are also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education. We also propose to use cost data from the current HCPCS codes in these APCs to determine the relative weights of these APCs until cost data from GXXX1 through GXXX8 are available to set relative weights. We note that this proposal requires discontinuing the use of all HCPCS codes in these APCs and would not allow us to collect cost data for the five levels of emergency and clinic visits that are currently described by CPT codes. We further note that we would no longer be able to distinguish among the costs for visits by new patients, established patients, consultation patients, or patients being seen for more specialized care (for example, pelvic screening exams and glaucoma screening exams).

We would be using claims data from current HCPCS codes and crosswalking those data to the new codes in the same APCs; therefore, there would be no change in payment for any of these services as a result of these coding changes. Once cost data become available from the new HCPCS codes, we would use those data to set the relative weights, and, therefore, there should be no budgetary impact.

We are currently considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel. We plan to make any proposed guidelines available to the public for comment on the OPPS Web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS

listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;
2. To minimize the information collection and reporting burden on facilities;
3. To minimize any incentives to provide unnecessary or low quality care;
4. To minimize the extent to which separately billable services are counted as E/M services;
5. To develop coding guidelines that are consistent with facility resource use; and
6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before implementation of the codes and coding guidelines, adequate time will be provided for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. We are requesting comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for facility coding of emergency and clinic visits.

B. Status Indicators and Issues Related to OCE Editing

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. We are providing our proposed status indicator (SI) 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 must be able to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through 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 2004 we propose to use the status indicators in the following manner:

- We use ''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.
- We use ''C'' to indicate inpatient services that are not payable under the OPPS.
- We use ''D'' to indicate a code that was deleted effective with the beginning of the calendar year.
- We use ''E'' to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- We use ''F'' to indicate acquisition of corneal tissue, which is paid at reasonable cost. (In 2003, we also use ''F'' to indicate those orphan drugs that are paid at reasonable cost.) In 2004, we propose to revise the definition of ''F'' solely to indicate acquisition of corneal tissue paid at reasonable cost.
- We use ''G'' to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- We use ''H'' to indicate devices that are paid under OPPS transitional pass-through rules.
- We use ''K'' to indicate drugs, biologicals (including blood and blood products), radiopharmaceutical agents, and certain brachytherapy seeds that are paid in separate APCs under the OPPS but that are not paid under OPPS transitional pass-through rules.
- We use ''L'' to indicate flu and pneumococcal immunizations which are paid at reasonable cost but to which no coinsurance or copayment apply.
- We use ''N'' to indicate services that are paid under the OPPS but for which payment is packaged into another service or APC group.
- We use ''P'' to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- We use ''S'' to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.
- We use ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
- We use ''V'' to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.
- We use ''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 are proposing the status indicators identified for each HCPCS code and each APC in Addenda A and B and are requesting comments on the appropriateness of the indicators we have assigned.

C. Observation Services

In the November 1, 2002 update to the OPPS (67 FR 66794), we summarized and clarified previously published guidance (Transmittal A–02–026) regarding payment requirements for HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum of 8 hours, maximum 48 hours. We also implemented HCPCS codes G0263 and G0264 to identify patients directly admitted to observation. In January 2003, we published Transmittal A–02–129, which provides further instructions regarding billing for observation services. In this proposed rule, we are neither proposing anything new with regard to observation services, nor are we seeking public comment on observation issues at this time. As we have in the past, we will update by Program Memorandum any changes in the list of ICD–9–CM codes required for payment of HCPCS code G0244 resulting from October 1 annual update of ICD–9–CM. Any such changes will be included in the 2004 final OPPS rule with comment period and the public will have an opportunity to comment at that time.

D. Procedures That Will Be Paid Only as Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and

that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 and the November 30, 2001 final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule, we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ambulatory surgical center (ASC) procedures or proposed by us for addition to the ASC list.

At its January 2003 meeting, the APC Panel did not make recommendations regarding procedures on the inpatient list, and we are not proposing to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicit comments on whether any procedures in Addendum E should be paid under the OPPS. We ask commenters recommending reclassification of a procedure to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We also solicit comments on the appropriate APC assignment for the procedure in the event that we determine in the final rule, based on comments, that the procedure would be payable under the OPPS in 2004.

Following our review of any comments that we receive about the procedures in Addendum E, we propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments do not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2004 meeting.

Proposed New APC To Pay for Services Furnished on Same Date as Service with Modifier –CA:

In the 2003 update of the OPPS, we implemented a new modifier –CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of modifier –CA when submitting a claim on bill type 13x for a procedure that is on the inpatient list and that is assigned payment status indicator ''C.'' (Transmittal A–02–129 can be found on our Web site at *cms.hhs.gov*.) We also implemented in the November 1, 2002 final rule (67 FR 66799) a new payment policy to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as the HCPCS code billed with modifier –CA. A single payment for outpatient services on the claim, other than those coded with status indicator ''C'' and modifier –CA, is currently made under APC 977.

We reviewed this policy and determined that assigning payment for these services to APC 977, which is a New Technology APC, is problematic because payment under New Technology APCs is a fixed amount that does not have a relative payment weight and is, therefore, not subject to recalibration based on hospital costs. We propose to establish a new APC for which payment would be made under certain conditions for otherwise payable outpatient services furnished on the same date of service that a procedure with status indicator ''C'' is performed emergently on an outpatient who dies before admission to the hospital as an inpatient. Beginning in 2004, hospitals would be paid under APC 375 instead of APC 977 for services furnished on the same date of service that a procedure with status indicator ''C'' and modifier –CA is billed. We propose at the outset to set the payment rate for APC 375 in the amount of $1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 977. When the APC weights are recalibrated in 2005, we would use charge data from CY 2003 claims for line items that have the same date of service as the line with modifier –CA and that show a HCPCS code with status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' or ''K'' to calculate a median cost and relative payment weight for APC 375. Once we have claims data, we would be able to determine whether it is appropriate to calculate a relative payment weight based on median costs from our claims data or to continue a fixed payment rate for these special cases. We invite comments on these proposed changes.

E. Partial Hospitalization Payment Methodology

1. Background

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000.

The PHP per diem amount was based solely on hospital data. Section 1833(t)(2)(C) of the Act required that we initially establish relative payment weights based on median (or mean, at the discretion of the Secretary) hospital costs determined by 1996 claims and cost report data. We analyzed the service components billed by hospitals over the course of a billing period and determined the median hospital cost of furnishing a day of partial hospitalization. The analysis of hospital partial hospitalization claims resulted in a per diem payment of $202.19, effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to $206.82 and $212.27, respectively.

Although we did not use CMHC data in establishing the initial APC amount

for partial hospitalization, in the April 7, 2000 final rule, we committed to analyzing future data from hospitals and CMHCs to determine whether refinements to the per diem were warranted. As a result, for payment rates presented in the proposed and final rules in 2002, we used data from both hospitals and CMHCs to compute the CY 2003 per diem rate. A description of the methodology we followed in developing the CY 2003 PHP payment rate is presented below.

We based the CY 2003 per diem amount on hospital and CMHC claims data for services furnished from April 1, 2001 through March 31, 2002. We used data from all the hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs, since CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used cost-to-charge ratios from the most recently available hospital and CMHC cost reports to convert each provider's line item charges as reported on bills, to estimate the provider's cost for a day of PHP. Unlike hospitals, CMHCs do not file cost reports electronically and the cost report information is not included in the Hospital Cost Report Information System (HCRIS). The CMHC cost reports are held by the Medicare fiscal intermediaries (FIs). As a result, we requested that the FIs forward to us the most recently available CMHC cost-to-charge ratios so that we could apply the ratio to the CMHC's billed charges and approximate the CMHC's per diem cost for PHP.

Per diem costs are computed by summing the line item costs on each bill and dividing by the number of days on the bill. Using this method of computing costs, preliminary per diem cost estimates for CMHCs were much higher than expected, in many cases more than twice the average per diem for *inpatient* psychiatric care. Closer examination of the CMHC cost report data summaries showed that costs from CMHC settled cost reports were considerably lower than costs from ''as submitted'' CMHC cost reports. To account for the difference between settled and as submitted cost report data, we computed the ratio of total settled costs to total as submitted costs over a 3-year period (CMHC FYs 1998 through 2000) and calculated an average adjustment factor (0.583), which we applied to the costs on each claim. As stated in the 2002 proposed and final OPPS rules, we thought that an adjustment factor of 0.583 was adequate to account for the difference between settled and ''as submitted'' CMHC cost reports and was more reflective of CMHC costs for PHP. However, we did not have an opportunity to examine the data in depth before publishing the OPPS final rule on November 1, 2002.

The adjusted CMHC per diem costs on each claim were summed, then divided by the number of days on the claim. We then combined the CMHC and hospital PHP data files and determined the median per diem cost for PHP. Effective January 1, 2003, the PHP APC amount was $240.03, of which $48.17 is the beneficiary's coinsurance.

2. PHP APC Update for CY 2004

For CY 2004, we analyzed hospital and CMHC PHP claims for services furnished between April 1, 2002 and December 31, 2002. We intended to propose to use the same methodology for computing median costs per day for CY 2004, including the adjustment factor, as we used to compute the CY 2003 PHP median cost per day. However, when we applied the adjustment factor to the CMHC claims to compute the CY 2004 per diem, the CMHC median cost per day was determined to be $605. Without the adjustment, the median cost per day for CMHCs to provide partial hospitalization services is $1,038. The median cost per day for hospital outpatient departments to provide the same benefit is $225. We do not believe it is reasonable for CMHCs to incur costs that are more than double those incurred by hospital outpatient departments providing PHP services. In addition, the median CMHC cost for a day of outpatient PHP services exceeds the average per diem cost for *inpatient* psychiatric facilities, which provide a full 24 hours of care, medications, and other ancillary services. We do not believe it is appropriate for Medicare to pay more for a day of outpatient treatment than for a day of inpatient psychiatric care.

In addition to the vast difference in median costs between CMHCs and hospital outpatient departments, we are concerned that this difference has grown significantly larger since last year. The median per diem cost for hospitals is about the same for 2003 and 2004 ($224 for CY 2003 compared to $225 for the proposed CY 2004 update), while the median per diem cost for CMHCs (after adjustment) has increased by 58 percent ($384 for CY 2003 compared to $605 for the proposed CY 2004 update). We believe that the increase in the median CMHC per diem cost is primarily due to large increases in CMHC charges, coupled with the application of outdated cost-to-charge ratios to determine the per diem cost. In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed FIs to recalculate hospital and CMHC cost-to-charge ratios using the most recently settled or tentatively settled cost reports by April 30, 2003. However, we did not receive the updated CMHC cost-to-charge ratios in time to use in our data analysis for this proposed rule.

Therefore, we are proposing a per diem rate for PHP services furnished during CY 2004 based solely on hospital PHP data. The resulting PHP APC 0033 amount, after scaling, is $208.95, of which $41.69 is the beneficiary's coinsurance. We are not inclined to use the CMHC data in computing the per diem amount until the data discrepancies can be more fully resolved. We anticipate receipt of the revised CMHC cost-to-charge ratios this summer and will analyze the updated CMHC cost data. To the extent we believe the updated cost-to-charge ratios result in a more reasonable median per diem rate, we propose to use the CMHC data in developing the final rate for CY 2004.

3. Outlier Payments to CMHCs

In a related matter, the use of outdated cost-to-charge ratios applied to current charges has resulted in an excessive amount of outlier payments being made to CMHCs. As a result of more in-depth analysis of the 2001 data files that were used to compute the CY 2003 PHP per diem amount, we discovered a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Of the approximately 660 hospital programs with claims for PHP in CY 2001, 25 hospitals received approximately $9,000 in outlier payments. By contrast, almost half of the 155 CMHCs in our CY 2001 data file were paid outlier payments, totaling approximately $48 million.

Based on preliminary analysis of the 125 CMHCs with claims in the CY 2002 data files, that is, April 1, 2002 through December 31, 2002, we have determined that CMHCs received approximately $37 million in outlier payments, compared to approximately $13,000 for all hospitals in the PHP data file. The $37 million in outlier payments to CMHCs almost equals the total amount paid to CMHCs in regular APC payments.

CMHCs have indicated that they are unable to reduce their costs to the per diem payment amount and that outlier payments are needed to cover operating expenses. This use of outlier payments is contrary to the intent of an outlier policy. Establishing an outlier policy allows us to ensure beneficiary access to services by sharing in the loss

associated with services for specific patients that are extraordinarily expensive. Through a comparison of the median per diem costs, we have determined that CMHCs dramatically increased their charges between CY 2001 and CY 2002. During this period, the median per diem cost for CMHCs increased by 58 percent. We believe that in most cases, these increases in charges were not related to a corresponding increase in costs. Since the CMHC cost-to-charge ratios used to calculate outlier payments remained constant during this period, we believe that the 58 percent increase in computed cost is attributable to artificial increases in charges designed to enhance outlier payments. Approximately two-thirds of outlier payments made to PHP providers were paid to 20 of the 125 CMHCs. The charges reported by these providers, on average, were over 10 times more than hospital per diem charges.

Given the difference in PHP charges between hospitals and CMHCs, we no longer believe it is appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, we are proposing to designate a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments. CMHCs are projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments. Therefore, we are proposing to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we are proposing to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We believe that this approach would neutralize the impact of inflated CMHC charges on outlier payments. We are proposing to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we are proposing to pay 50 percent of CMHC per diem costs over the threshold. To the extent charges remain relatively constant, CMHCs would qualify for outlier payments in CY 2004 only for truly high cost patients.

As noted previously, we expect to receive updated cost-to-charge ratios from the FIs this summer. Many of the cost-to-charge ratios are expected to be considerably lower than those currently used to determine a provider's cost for the purpose of outlier and transitional pass-through or corridor payments. For example, we are aware of a number of situations where the updated cost-to-charge ratios have declined by more than 50 percent.

We specifically request public comments on this proposed outlier policy. We intend to monitor the extent to which the current pattern of escalating charges continues. CMS and the Office of the Inspector General will be further examining the excessive outlier payments to CMHCs.

XII. Summary of and Responses to MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) in its March 2002 Report to the Congress: ''Medicare Payment Policy,'' makes a number of recommendations relating to the OPPS. This section provides responses to those recommendations.

Recommendation: The Congress should increase payment rates for the OPPS by the rate of increase in the hospital market basket, less 0.9 percent, for CY 2004.

Response: Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor annually. Under section 1833(t)(3)(C)(iv) of the Act, the update must be equal to the hospital market basket percentage increase applicable under the hospital inpatient PPS. For years 2000 and 2002 only, the statute required the update to be determined by reducing the increase by one percentage point, but current law specifies such a reduction only for those 2 years. For 2004, we propose to increase the conversion factor by the rate of increase in the hospital market basket.

Recommendation: The Secretary should introduce clinical criteria for eligibility of drugs and biologicals to receive pass-through payments under the outpatient PPS.

Response: In accordance with section 402 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), pass-through payments for medical devices is made on the basis of categories of devices. On November 2, 2001, we published in the **Federal Register** (66 FR 55850) a rule that specified the criteria for establishment of a new category of devices for purposes of pass-through payments. Among these is the requirement that the devices to be included in a possible category must demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to benefits obtained by devices in previously established categories or other available treatments. We elaborated further about this criterion in the final rule updating the OPPS for CY 2003, published in the **Federal Register** on November 1, 2002. As we stated at that time, ''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.'' (67 FR 66782)

At present, pass-through payment for drugs and biologicals is not made on the basis of categories, and no comparable criterion applies to them. Whether we should apply such a requirement to drugs and biologicals is an important question. On the one hand, as noted above, limiting extra payment to those items that have the potential to make a significant difference in treatment of Medicare beneficiaries appears useful. On the other hand, developing an appropriate mechanism for identifying which drugs or biologicals might qualify is difficult. Because the clinical characteristics of particular cases that are relevant for drug use may vary substantially, we believe that this challenge is more difficult than in the case of devices. Consequently, we have not developed a proposal in this area, and we are not prepared to advance one at this time.

XIII. Summary of Proposed Changes for 2004

A. Changes Required By Statute

We are proposing the following changes to implement statutory requirements:

- Add APCs, delete APCs, and modify the composition of some existing APCs.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and the wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Cease transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Cease transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children's hospitals.

B. Additional Changes

We are proposing the following additional changes to the OPPS:

- Adjust payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Implement a new method for paying for drug administration.
- Create new evaluation and management service codes for outpatient clinic and emergency department encounters.
- Change status indicators for HCPCS codes.
- List midyear and proposed HCPCS codes that are paid under OPPS.
- Allocate a portion of the outlier percentage target amount to CMHCs and create a separate threshold for outlier payments for partial hospitalization services.
- Create methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085 to facilitate accurate payments for drugs and drug administration.
- Change the status indicator and payment amount for P9010 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The OPPS provisions set forth in this proposed rule do not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XV. Response to Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule.

XVI. Regulatory Impact Analysis

A. 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 would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the proposed rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2004 compared to CY 2003 to be approximately $0.457 billion. Therefore, this proposed 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 would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (*see* 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (*see* the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds (or New England County Metropolitan Area (NECMA)). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this proposed rule would 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 proposed rule would have a significant impact on a substantial number of small entities.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not mandate any requirements for State,

local, or tribal governments. This proposed rule would not impose unfunded mandates on the private sector of more than $110 million dollars.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a 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 proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (*see* Table 23) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) would increase by 3.9 percent under the proposed rule.

B. Changes in This Proposed Rule

We are proposing 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 proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2004 as we discuss in sections IX and VII, respectively, of this proposed rule. We are also proposing to revise the relative APC payment weights based on claims data from April 1, 2002 through December 31, 2002. Finally, we are proposing to remove two devices and eight drugs and biologicals from pass-through payment status. Alternatives to the changes we are proposing and why we did not accept them are discussed throughout this proposed rule. In particular, see section V.B with regard to the expiration of pass-through payment for devices; *see* section VI.B with regard to the expiration of pass-through payment for drugs and biological agents.

Under this proposed rule, the change to the conversion factor as provided by statute would increase total OPPS payments by 3.8 percent in 2004. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) would not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes would change the distribution of payments within the budget neutral system as shown in Table 23 and described in more detail in this section.

Alternatives Considered

Alternatives to the changes we are proposing and the reasons that we are proposing 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 V.B of this proposed rule regarding the expiration of pass-through payment for devices and section VI.B of this proposed rule regarding the expiration of pass-through payment for drugs and biological agents.

Payment for the Administration of Drugs

As discussed in detail in section VI.B of this proposed rule, we considered the following alternatives with regard to payment for administration of packaged and separately paid drugs:

- Continue to pay under the current drug administration codes (Q0081, Q0083, Q0084, and Q0085). This alternative would pay the same amount for administration of packaged or separately paid drugs, although the data show that the costs are considerably more when packaged drugs are administered and considerably less if separately paid drugs are administered.
- Create eight new HCPCS codes (based on the existing Q codes listed above), with one set of codes for packaged drugs and one set for separately paid drugs. Establish an APC for each. This alternative permits more accurate payment for packaged and separately paid drugs than use of the current codes but imposes a significant burden on hospitals to bill correctly.
- Create six new HCPCS codes (based on the existing Q codes with deletion of Q0085). Establish an APC for each. This alternative permits more accurate payment for packaged and separately paid drugs than use of the current codes and imposes slightly less burden on hospital billing than the eight-code alternative.
- Delete Q0085 and revise the definitions of the other Q codes to once per day. Crosswalk each code billed to one of two APCs that would be paid dependent on the drugs billed on the same date of service. This alternative permits more accurate payment for packaged and separately paid drugs. It also simplifies hospital billing for drug administration. Under this option, however, hospitals would be required to bill for all drugs they administer, whether packaged or separately paid so that the outpatient code editor (OCE) could properly assign the APC that applies in the case. The systems changes required for this alternative are much more substantial than under any of the other alternatives, and we are considering whether we can implement this change before January 2005.

We modeled the second alternative for purposes of budget neutrality and impact analysis. We await comments before determining what alternative we will undertake for the 2004 OPPS.

Payment for Drugs That Are Not Packaged

As a result of marked and erratic fluctuations in median costs for drugs, biologicals, and radiopharmaceutical agents that are paid separately under the OPPS, we explored several options to determine how best to provide accurate payment for CY 2004. One option was to pay based on our 2002 claims data without any adjustment. We were certain that this would not result in accurate payments because of the magnitude of some of the fluctuations in median costs seen in the data.

Another option considered, to create cost bands similar to those used for New Technology APCs, was rejected because unless very narrow bands were created, this option also would result in inaccurate payments.

Finally, we looked at using the same methodology for moderating payment decreases that we used last year, to limit median cost decreases of 15 percent or more to 50 percent of the difference between the median cost and the amount of decrease greater than 15 percent. This option would enable us to moderate the decreased payment amount on an individual drug, biological, or radiopharmaceutical agent level, which is important in light of the great variations in the data; but the 50 percent adjustment level was not adequate for the level of moderation we believed was required for CY 2004.

The adjustment we put forth in this proposed rule is a 75 percent moderation of decreases of 15 percent or more. Thus, for separately payable drugs, biologicals, and radiopharmaceutical agents for which median costs decreased by 15 percent or more, we are proposing to limit the reduction in median costs to 15 percent plus 25 percent of the difference

between the value derived from claims data and any decrease of 15 percent or more.

Our analyses indicate that application of this method of adjustment would result in payment levels that will be fair and accurate. However, based on more complete claims data we expect to have for the final rule and on the comments from the public, we will re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

Conclusion

It is clear that the changes in this proposed rule would 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 proposed rule, constitutes a regulatory impact analysis.

The OPPS rates for CY 2004 would have, overall, a positive effect for every category of hospital with the exception of cancer hospitals and children's hospitals, which are held harmless under the OPPS. These changes in the OPPS for 2004 would result in an overall 3.8 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 relative 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 23.

The overall projected increase in payments for urban hospitals is slightly lower (3.7 percent) than the average increase for all hospitals (3.8 percent) while the increase for rural hospitals is slightly greater (4.0 percent) than the average increase. The introduction of a new wage index combined with changes to the APC structure would result in small distributional changes for all categories of hospitals. Rural hospitals would gain 0.1 percent from the wage index change but show no gains from APC changes. Large urban hospitals would lose 0.1 percent from the wage index change, whereas ''other'' urban hospitals show a decrease of −0.2 percent from the APC changes. A discussion of the distribution of outlier payments that we project under this proposed rule can be found under section XV.E below. Table 24 presents the outlier distribution that we expect to see under this proposed rule.

C. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we are not proposing to make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

D. Estimated Impacts of This Proposed Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistribution of hospital payments among providers as a result of a new wage index and APC structure. In some cases, under this proposed rule, hospitals would receive more total payment than in 2003 while in other cases they would receive less total payment than they received in 2003. The impact of this proposed rule would 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 would change) and the impact of the wage index changes on the hospital.

Column 4 in Table 23 represents the full impact on each hospital group of all the changes for 2004. Columns 2 and 3 in the table reflect the independent effects of the proposed 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 proposed 2004 OPPS rates that is summarized in Table 23. For that reason, the total number of hospitals included in Table 23 (4,352) is lower than in previous years. CAHs are excluded from the OPPS.

To a very limited extent, wage index changes favor all hospital categories with the exception of large urban hospitals with 500 or more beds that show a −0.3 percentage change. Rural hospitals show modest increases of 0.1 percent for most bed sizes but show the largest gains for categories with 200 or more beds, a 0.3 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (−2.2 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic, South Atlantic, and in the East North Central part of the country experience a negative impact due to wage index changes regardless of urban or rural designation. However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals with the exception of rural hospitals with 200 or more beds that show a negative effect (−1.2 percent). Conversely, urban hospitals with 200 to 299 beds (−0.1 percent decrease), and urban hospitals with 300 to 499 beds (−0.5 percent) show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.1 percent increase as a result of APC recalibration. In general, APC changes are small and result in very few distributional changes among hospital categories.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes of fewer than 5,000 services are projected to experience an increase in payments (4.4 percent). Urban hospitals that provide low-volume services experience an even larger increase (5.0 percent) in payments attributable to both wage index and APC changes. Conversely, urban and rural hospitals providing more than 21,000 services are projected to lose as a result of APC recalibration but gain from the introduction of the new wage index for a combined effect in the range of 3.4 to 3.9 percent.

Major teaching hospitals are projected to experience a smaller increase in payments (3.4 percent) than the aggregate for all hospitals (3.8 percent) due to negative impacts of the wage index (−0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.7 percent) that is smaller than the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 3.4 to 4.2 percent higher than in 2003.

TABLE 23.—IMPACT OF CHANGES FOR CY2004 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)	New wage index (2)	APC changes (3)	All CY2003 changes (4)
ALL HOSPITALS	4,352	0.0	0.0	3.8
NON-TEFRA HOSPITALS	3,849	0.0	0.0	3.8
URBAN HOSPS	2,390	0.0	0.0	3.7
LARGE URBAN (GT 1 MILL.)	1,377	−0.1	0.0	3.8
OTHER URBAN (LE 1 MILL.)	1,013	0.0	−0.2	3.7
RURAL HOSPS	1,459	0.1	0.0	4.0
BEDS (URBAN):				
0–99 BEDS	546	0.2	0.4	4.4
100–199 BEDS	875	0.0	0.2	4.1
200–299 BEDS	456	0.0	−0.1	3.7
300–499 BEDS	364	0.1	−0.5	3.4
500 + BEDS	149	−0.3	0.1	3.6
BEDS (RURAL):				
0–49 BEDS	694	0.1	1.0	4.9
50–99 BEDS	449	0.1	0.2	4.1
100–149 BEDS	190	0.1	0.0	3.9
150–199 BEDS	65	0.1	0.1	4.0
200 + BEDS	61	0.3	−1.2	2.9
VOLUME (URBAN):				
LT 5,000	225	0.0	1.1	5.0
5,000–10,999	396	0.0	1.0	4.9
11,000–20,999	529	−0.2	0.8	4.5
21,000–42,999	736	0.1	−0.1	3.9
GT 42,999	504	−0.1	−0.3	3.4
VOLUME (RURAL):				
LT 5,000	419	0.1	0.4	4.4
5,000–10,999	483	0.1	0.9	4.9
11,000–20,999	318	0.0	0.4	4.3
21,000–42,999	191	0.2	−0.6	3.5
GT 42,999	48	0.3	−0.7	3.4
REGION (URBAN):				
NEW ENGLAND	128	0.0	−0.7	3.1
MIDDLE ATLANTIC	367	−0.6	−0.5	2.7
SOUTH ATLANTIC	355	−0.1	−0.1	3.7
EAST NORTH CENT.	401	−0.1	0.4	4.1
EAST SOUTH CENT.	152	0.6	−0.2	4.3
WEST NORTH CENT.	166	0.3	0.1	4.2
WEST SOUTH CENT.	293	−0.1	0.1	3.9
MOUNTAIN	122	0.6	0.0	4.5
PACIFIC	366	0.1	0.0	3.9
PUERTO RICO	40	0.3	2.1	6.3
REGION (RURAL):				
NEW ENGLAND	36	0.8	−0.1	4.6
MIDDLE ATLANTIC	66	−0.2	0.2	3.8
SOUTH ATLANTIC	213	−0.2	−0.1	3.5
EAST NORTH CENT.	192	−0.1	−0.5	3.3
EAST SOUTH CENT.	225	0.4	0.2	4.4
WEST NORTH CENT.	244	0.6	0.0	4.4
WEST SOUTH CENT.	267	0.2	0.5	4.6
MOUNTAIN	123	0.1	0.0	3.9
PACIFIC	88	0.3	0.7	4.8
PUERTO RICO	5	−2.2	1.4	3.0
TEACHING STATUS:				
NON-TEACHING	2,803	0.1	0.1	4.0
MINOR	758	0.1	−0.2	3.7
MAJOR	288	−0.4	0.0	3.4
DSH PATIENT PERCENT:				
0	11	2.7	3.0	9.8
GT 0–0.10	862	−0.1	−0.3	3.4
0.10–0.16	845	0.0	−0.2	3.6
0.16–0.23	778	0.1	0.4	4.2
0.23–0.35	757	0.0	0.0	3.8
GE 0.35	596	0.0	0.2	4.0
URBAN IME/DSH:				
IME & DSH	963	−0.1	−0.1	3.6
IME/NO DSH	1	0.0	−1.3	2.4
NO IME/DSH	1,417	0.0	0.1	3.9
NO IME/NO DSH	9	2.8	3.0	10.0
RURAL HOSP. TYPES:				

TABLE 23.—IMPACT OF CHANGES FOR CY2004 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)	New wage index (2)	APC changes (3)	All CY2003 changes (4)
NO SPECIAL STATUS	481	−0.2	0.3	4.0
RRC	159	0.3	−0.6	3.5
SCH/EACH	483	0.2	0.6	4.7
MDH	249	0.1	0.7	4.7
SCH AND RRC	78	0.3	−0.5	3.6
TYPE OF OWNERSHIP:				
VOLUNTARY	2,362	0.0	−0.1	3.6
PROPRIETARY	696	0.1	0.6	4.6
GOVERNMENT	791	0.1	0.0	3.9
SPECIALTY HOSPITALS:				
EYE AND EAR	13	−0.4	1.7	5.2
CANCER	11	−0.3	−4.7	−1.3
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	159	0.5	0.3	4.6
PSYCH	167	0.8	7.2	12.2
LTC	135	1.8	4.3	10.3
CHILDREN	42	0.0	−1.1	2.7

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 FY2004 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient proposed rule for FY2004 was published in the FEDERAL REGISTER on May 19, 2003.

3. This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2002 hospital claims data.

4. This column shows changes in total payment from CY2003 to CY2004, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2004 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

E. Projected Distribution of Outlier Payments

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2004 expenditures to outlier payments. In Table 24 below, we provide a table that illustrates the percentage of outlier payments relative to the total projected payments for the categories of hospitals that we show in the impact table.

We project, based on the mix of services for the hospitals that would be paid under the OPPS in 2004, that most hospitals would receive outlier payments—approximately 94 percent would 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 24.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
ALL HOSPITALS	4,352	96.4	4,097	2.0
NON–TEFRA HOSPITALS	3,849	85.2	3,831	2.0
URBAN HOSPS	2,390	52.8	2,376	2.1
LARGE URBAN (GT 1 MILL.)	1,377	30.4	1,368	2.3
OTHER URBAN (LE 1 MILL.)	1,013	22.4	1,008	1.9
RURAL HOSPS	1,459	32.2	1,455	1.7
BEDS (URBAN):				
0–99 BEDS	546	12.0	534	2.6
100–199 BEDS	875	19.4	874	1.8
200–299 BEDS	456	10.0	455	2.0
300–499 BEDS	364	8.0	364	2.0
500 + BEDS	149	3.2	149	2.6
BEDS (RURAL):				
0–49 BEDS	694	15.4	691	2.2
50–99 BEDS	449	10.0	448	1.8
100–149 BEDS	190	4.2	190	1.4
150–199 BEDS	65	1.4	65	1.7
200 + BEDS	61	1.4	61	1.4
VOLUME (URBAN):				
LT 5,000	225	5.0	212	3.0
5,000–10,999	396	8.8	395	3.4
11,000–20,999	529	11.8	529	2.1
21,000–42,999	736	16.2	736	1.9
GT 42,999	504	11.2	504	2.1

TABLE 24.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT—Continued

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
VOLUME (RURAL):				
LT 5,000	419	9.2	416	2.7
5,000–10,999	483	10.6	482	2.1
11,000–20,999	318	7.0	318	1.7
21,000–42,999	191	4.2	191	1.4
GT 42,999	48	1.0	48	1.5
REGION (URBAN):				
NEW ENGLAND	128	2.8	127	1.9
MIDDLE ATLANTIC	367	8.2	367	3.2
SOUTH ATLANTIC	355	7.8	355	1.9
EAST NORTH CENT	401	8.8	398	1.7
EAST SOUTH CENT	152	3.4	150	1.4
WEST NORTH CENT	166	3.6	166	1.8
WEST SOUTH CENT	293	6.4	292	2.6
MOUNTAIN	122	2.6	120	1.8
PACIFIC	366	8.0	363	2.0
PUERTO RICO	40	0.8	38	0.6
REGION (RURAL):				
NEW ENGLAND	36	0.8	36	2.4
MIDDLE ATLANTIC	66	1.4	66	1.4
SOUTH ATLANTIC	213	4.8	212	1.6
EAST NORTH CENT	192	4.2	192	1.5
EAST SOUTH CENT	225	5.0	225	1.2
WEST NORTH CENT	244	5.4	243	1.8
WEST SOUTH CENT	267	6.0	266	1.7
MOUNTAIN	123	2.8	123	2.8
PACIFIC	88	2.0	87	2.2
PUERTO RICO	5	0.2	5	0.9
TEACHING STATUS:				
NON–TEACHING	2,803	62.0	2,786	1.8
MINOR	758	16.8	757	1.7
MAJOR	288	6.4	288	3.1
DSH PATIENT PERCENT:				
0	11	0.2	10	6.7
GT 0–0.10	862	19.0	853	1.9
0.10–0.16	845	18.6	845	1.7
0.16–0.23	778	17.2	777	1.8
0.23–0.35	757	16.8	752	2.2
GE 0.35	596	13.2	594	3.1
URBAN IME/DSH:				
IME & DSH	963	21.4	963	2.3
IME/NO DSH	1	0.0	0	0.0
NO IME/DSH	1,417	31.4	1,404	1.9
NO IME/NO DSH	9	0.2	9	6.8
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	481	10.6	478	1.8
RRC	159	3.6	159	1.4
SCH/EACH	483	10.6	483	2.1
MDH	249	5.6	249	1.8
SCH AND RRC	78	1.8	78	1.4
TYPE OF OWNERSHIP:				
VOLUNTARY	2,362	52.2	2,359	1.9
PROPRIETARY	696	15.4	685	2.4
GOVERNMENT	791	17.6	787	2.5
SPECIALTY HOSPITALS:				
EYE AND EAR	13	0.2	13	2.5
TRAUMA	151	3.4	151	2.6
CANCER	11	0.2	11	5.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	159	3.6	94	5.8
PSYCH	167	3.6	46	0.6
LTC	135	3.0	88	2.7
CHILDREN	42	1.0	38	11.8

F. Estimated Impacts of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which OPPS payments would rise and would decrease for services for which OPPS payments would fall. For example, for a mid level office visit (APC 0601), the minimum unadjusted copayment in 2003 was $10.11; under this proposed rule, the minimum unadjusted copayment for APC 601 would be $10.89 because the OPPS payment for the service would increase under this proposed 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 would 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 $840 for 2003, but is not yet determined for 2004. In general, the impact of this proposed rule on beneficiaries would vary based on the service the beneficiary receives and whether the copayment for the service is one that is frozen under the OPPS.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Dated: July 16, 2003.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 22, 2003.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.3940	$21.39	$7.09	$4.28
0002	Fine needle Biopsy/Aspiration	T	1.0937	$59.38	.....	$11.88
0003	Bone Marrow Biopsy/Aspiration	T	2.2627	$122.84	.....	$24.57
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	1.5774	$85.64	$22.10	$17.13
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	3.3675	$182.82	$71.59	$36.56
0006	Level I Incision & Drainage	T	1.7487	$94.94	$24.12	$18.99
0007	Level II Incision & Drainage	T	11.4943	$624.01	.....	$124.80
0008	Level III Incision and Drainage	T	16.8303	$913.70	.....	$182.74
0009	Nail Procedures	T	0.6597	$35.81	$8.34	$7.16
0010	Level I Destruction of Lesion	T	0.6806	$36.95	$10.08	$7.39
0011	Level II Destruction of Lesion	T	2.1800	$118.35	$27.88	$23.67
0012	Level I Debridement & Destruction	T	0.8203	$44.53	$11.18	$8.91
0013	Level II Debridement & Destruction	T	1.1420	$62.00	$14.20	$12.40
0015	Level III Debridement & Destruction	T	1.5832	$85.95	$20.35	$17.19
0016	Level IV Debridement & Destruction	T	2.7343	$148.44	$57.31	$29.69
0017	Level VI Debridement & Destruction	T	16.7332	$908.43	$227.84	$181.69
0018	Biopsy of Skin/Puncture of Lesion	T	0.9567	$51.94	$16.04	$10.39
0019	Level I Excision/ Biopsy	T	3.9807	$216.11	$71.87	$43.22
0020	Level II Excision/ Biopsy	T	7.3105	$396.88	$113.25	$79.38
0021	Level III Excision/ Biopsy	T	14.5749	$791.26	$219.48	$158.25
0022	Level IV Excision/ Biopsy	T	18.6725	$1,013.71	$354.45	$202.74
0023	Exploration Penetrating Wound	T	3.1587	$171.48	$40.37	$34.30
0024	Level I Skin Repair	T	1.7847	$96.89	$34.75	$19.38
0025	Level II Skin Repair	T	6.2703	$340.41	$115.49	$68.08
0027	Level IV Skin Repair	T	15.8319	$859.50	$329.72	$171.90
0028	Level I Breast Surgery	T	17.7459	$963.41	$303.74	$192.68
0029	Level II Breast Surgery	T	29.2783	$1,589.49	$632.64	$317.90
0030	Level III Breast Surgery	T	37.2809	$2,023.94	$763.55	$404.79
0032	Insertion of Central Venous/Arterial Catheter	T	11.5584	$627.49	.....	$125.50
0033	Partial Hospitalization	P	3.8397	$208.45	$41.83	$41.69
0035	Placement of Arterial or Central Venous Catheter	T	0.2236	$12.14	$3.51	$2.43
0041	Level I Arthroscopy	T	27.2538	$1,479.58	.....	$295.92
0042	Level II Arthroscopy	T	42.8551	$2,326.56	$804.74	$465.31
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.9233	$104.41	.....	$20.88
0045	Bone/Joint Manipulation Under Anesthesia	T	13.5546	$735.87	$268.47	$147.17
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	31.9719	$1,735.72	$535.76	$347.14
0047	Arthroplasty without Prosthesis	T	30.3786	$1,649.22	$537.03	$329.84
0048	Arthroplasty with Prosthesis	T	47.4707	$2,577.14	$695.60	$515.43
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	19.9376	$1,082.39	.....	$216.48
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	25.1166	$1,363.56	.....	$272.71
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	34.9381	$1,896.75	.....	$379.35
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	42.6430	$2,315.05	.....	$463.01
0053	Level I Hand Musculoskeletal Procedures	T	14.8188	$804.50	$253.49	$160.90
0054	Level II Hand Musculoskeletal Procedures	T	24.2685	$1,317.51	.....	$263.50
0055	Level I Foot Musculoskeletal Procedures	T	18.8851	$1,025.25	$355.34	$205.05
0056	Level II Foot Musculoskeletal Procedures	T	25.1591	$1,365.86	$405.81	$273.17
0057	Bunion Procedures	T	25.4248	$1,380.29	$475.91	$276.06
0058	Level I Strapping and Cast Application	S	1.0785	$58.55	.....	$11.71

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0060	Manipulation Therapy	S	0.3151	$17.11	$3.43	$3.42
0068	CPAP Initiation	S	1.1234	$60.99	$30.49	$12.20
0069	Thoracoscopy	T	28.6334	$1,554.48	$591.64	$310.90
0070	Thoracentesis/Lavage Procedures	T	3.1393	$170.43	.....	$34.09
0071	Level I Endoscopy Upper Airway	T	0.9012	$48.93	$12.89	$9.79
0072	Level II Endoscopy Upper Airway	T	1.6987	$92.22	$26.68	$18.44
0073	Level III Endoscopy Upper Airway	T	3.4396	$186.73	$73.38	$37.35
0074	Level IV Endoscopy Upper Airway	T	14.4952	$786.93	$295.70	$157.39
0075	Level V Endoscopy Upper Airway	T	20.4113	$1,108.11	$445.92	$221.62
0076	Level I Endoscopy Lower Airway	T	9.3560	$507.93	$189.82	$101.59
0077	Level I Pulmonary Treatment	S	0.2772	$15.05	$7.52	$3.01
0078	Level II Pulmonary Treatment	S	0.7731	$41.97	$14.55	$8.39
0079	Ventilation Initiation and Management	S	2.2837	$123.98	.....	$24.80
0080	Diagnostic Cardiac Catheterization	T	36.0982	$1,959.74	$838.92	$391.95
0081	Non-Coronary Angioplasty or Atherectomy	T	34.8355	$1,891.18	.....	$378.24
0082	Coronary Atherectomy	T	100.3996	$5,450.59	$1,293.59	$1,090.12
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	59.3417	$3,221.60	.....	$644.32
0084	Level I Electrophysiologic Evaluation	S	10.3392	$561.30	.....	$112.26
0085	Level II Electrophysiologic Evaluation	T	36.3284	$1,972.23	$435.09	$394.45
0086	Ablate Heart Dysrhythm Focus	T	44.5652	$2,419.40	$822.28	$483.88
0087	Cardiac Electrophysiologic Recording/Mapping	T	40.4579	$2,196.42	.....	$439.28
0088	Thrombectomy	T	34.6065	$1,878.75	$655.22	$375.75
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	116.1611	$6,306.27	$1,722.59	$1,261.25
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	87.2850	$4,738.62	$1,705.90	$947.72
0091	Level II Vascular Ligation	T	28.5187	$1,548.25	$348.23	$309.65
0092	Level I Vascular Ligation	T	25.1347	$1,364.54	$505.37	$272.91
0093	Vascular Reconstruction/Fistula Repair without Device	T	20.6662	$1,121.95	$277.34	$224.39
0094	Level I Resuscitation and Cardioversion	S	2.6412	$143.39	$48.46	$28.68
0095	Cardiac Rehabilitation	S	0.5984	$32.49	$16.24	$6.50
0096	Non-Invasive Vascular Studies	S	1.7332	$94.09	$47.05	$18.82
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0565	$57.36	$23.80	$11.47
0098	Injection of Sclerosing Solution	T	1.1630	$63.14	$15.17	$12.63
0099	Electrocardiograms	S	0.3708	$20.13	.....	$4.03
0100	Cardiac Stress Tests	X	1.6726	$90.80	$41.44	$18.16
0101	Tilt Table Evaluation	S	4.3675	$237.11	$105.27	$47.42
0103	Miscellaneous Vascular Procedures	T	12.1256	$658.29	$223.63	$131.66
0104	Transcatheter Placement of Intracoronary Stents	T	80.8877	$4,391.31	.....	$878.26
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	18.9084	$1,026.52	$370.40	$205.30
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	49.9534	$2,711.92	$542.39	$542.38
0107	Insertion of Cardioverter-Defibrillator	T	290.5429	$15,773.28	$3,429.62	$3,154.66
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	489.5275	$26,575.96	.....	$5,315.19
0109	Removal of Implanted Devices	T	7.7075	$418.43	$131.49	$83.69
0110	Transfusion	S	3.7128	$201.56	.....	$40.31
0111	Blood Product Exchange	S	14.0169	$760.96	$211.96	$152.19
0112	Apheresis, Photopheresis, and Plasmapheresis	S	34.8318	$1,890.98	$609.71	$378.20
0113	Excision Lymphatic System	T	19.9529	$1,083.22	.....	$216.64
0114	Thyroid/Lymphadenectomy Procedures	T	37.3583	$2,028.14	$485.91	$405.63
0115	Cannula/Access Device Procedures	T	25.6233	$1,391.06	$459.35	$278.21
0119	Implantation of Infusion Pump	T	129.8988	$7,052.08	.....	$1,410.42
0121	Level I Tube changes and Repositioning	T	2.2058	$119.75	$43.80	$23.95
0122	Level II Tube changes and Repositioning	T	8.4398	$458.19	$93.97	$91.64
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	4.0076	$217.57	.....	$43.51
0124	Revision of Implanted Infusion Pump	T	27.4545	$1,490.48	$298.10	$298.10
0125	Refilling of Infusion Pump	T	2.5105	$136.29	.....	$27.26
0130	Level I Laparoscopy	T	32.5959	$1,769.60	$659.53	$353.92
0131	Level II Laparoscopy	T	40.8955	$2,220.18	$1,001.89	$444.04
0132	Level III Laparoscopy	T	56.6318	$3,074.48	$1,239.22	$614.90
0140	Esophageal Dilation without Endoscopy	T	6.3480	$344.63	$107.24	$68.93
0141	Upper GI Procedures	T	7.8542	$426.40	$143.38	$85.28
0142	Small Intestine Endoscopy	T	9.0138	$489.35	$152.78	$97.87
0143	Lower GI Endoscopy	T	8.3227	$451.83	$186.06	$90.37
0146	Level I Sigmoidoscopy	T	3.9986	$217.08	$64.40	$43.42
0147	Level II Sigmoidoscopy	T	7.5876	$411.92	.....	$82.38
0148	Level I Anal/Rectal Procedure	T	4.1171	$223.51	$63.38	$44.70
0149	Level III Anal/Rectal Procedure	T	16.8557	$915.08	$293.06	$183.02

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0150	Level IV Anal/Rectal Procedure	T	22.2565	$1,208.28	$437.12	$241.66
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.8763	$1,024.78	$245.46	$204.96
0152	Percutaneous Abdominal and Biliary Procedures	T	8.2940	$450.27	$113.02	$90.05
0153	Peritoneal and Abdominal Procedures	T	21.2745	$1,154.97	$410.87	$230.99
0154	Hernia/Hydrocele Procedures	T	26.8861	$1,459.62	$464.85	$291.92
0155	Level II Anal/Rectal Procedure	T	9.9148	$538.26	$188.89	$107.65
0156	Level II Urinary and Anal Procedures	T	3.1438	$170.67	$46.55	$34.13
0157	Colorectal Cancer Screening: Barium Enema	S	2.4771	$134.48	.....	$26.90
0158	Colorectal Cancer Screening: Colonoscopy	T	7.4187	$402.75	$100.69	$80.55
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.7168	$147.49	$36.87	$29.50
0160	Level I Cystourethroscopy and other Genitourinary Procedures.	T	6.8152	$369.99	$105.06	$74.00
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	16.5822	$900.23	$249.36	$180.05
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	21.8578	$1,186.64	.....	$237.33
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	33.6435	$1,826.47	.....	$365.29
0164	Level I Urinary and Anal Procedures	T	1.2115	$65.77	$17.59	$13.15
0165	Level III Urinary and Anal Procedures	T	14.0780	$764.28	.....	$152.86
0166	Level I Urethral Procedures	T	16.8401	$914.23	$218.73	$182.85
0167	Level III Urethral Procedures	T	30.1066	$1,634.46	$555.84	$326.89
0168	Level II Urethral Procedures	T	30.3485	$1,647.59	$405.60	$329.52
0169	Lithotripsy	T	44.5329	$2,417.65	$1,115.69	$483.53
0170	Dialysis	S	5.9427	$322.62	.....	$64.52
0180	Circumcision	T	18.4967	$1,004.17	$304.87	$200.83
0181	Penile Procedures	T	29.0094	$1,574.89	$621.82	$314.98
0183	Testes/Epididymis Procedures	T	21.7612	$1,181.39	.....	$236.28
0184	Prostate Biopsy	T	3.8073	$206.69	$96.27	$41.34
0187	Miscellaneous Placement/Repositioning	X	4.4274	$240.36	$90.71	$48.07
0188	Level II Female Reproductive Proc	T	1.1079	$60.15	.....	$12.03
0189	Level III Female Reproductive Proc	T	1.3207	$71.70	$16.70	$14.34
0190	Level I Hysteroscopy	T	19.8088	$1,075.40	$424.28	$215.08
0191	Level I Female Reproductive Proc	T	0.1679	$9.12	$2.65	$1.82
0192	Level IV Female Reproductive Proc	T	2.6966	$146.40	$39.11	$29.28
0193	Level V Female Reproductive Proc	T	15.7365	$854.32	$171.13	$170.86
0194	Level VI Female Reproductive Proc	T	18.8194	$1,021.69	$397.84	$204.34
0195	Level VII Female Reproductive Proc	T	25.3207	$1,374.64	$483.80	$274.93
0196	Dilation and Curettage	T	16.1823	$878.52	$338.23	$175.70
0197	Infertility Procedures	T	5.1958	$282.07	.....	$56.41
0198	Pregnancy and Neonatal Care Procedures	T	1.3718	$74.47	$32.19	$14.89
0199	Obstetrical Care Service	T	16.8630	$915.48	.....	$183.10
0200	Therapeutic Abortion	T	18.3633	$996.93	$307.83	$199.39
0201	Spontaneous Abortion	T	17.2803	$938.13	$329.65	$187.63
0202	Level VIII Female Reproductive Proc	T	38.8053	$2,106.70	$1,032.28	$421.34
0203	Level IV Nerve Injections	T	11.8511	$643.38	$276.76	$128.68
0204	Level I Nerve Injections	T	2.2209	$120.57	$40.13	$24.11
0206	Level II Nerve Injections	T	5.2584	$285.47	$75.55	$57.09
0207	Level III Nerve Injections	T	6.5998	$358.30	$123.69	$71.66
0208	Laminotomies and Laminectomies	T	40.6521	$2,206.96	.....	$441.39
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.5352	$626.23	$280.58	$125.25
0212	Nervous System Injections	T	2.9989	$162.81	$74.92	$32.56
0213	Extended EEG Studies and Sleep Studies, Level I	S	3.2422	$176.02	$70.41	$35.20
0214	Electroencephalogram	S	2.2459	$121.93	$58.12	$24.39
0215	Level I Nerve and Muscle Tests	S	0.6390	$34.69	$15.76	$6.94
0216	Level III Nerve and Muscle Tests	S	2.8332	$153.81	$67.98	$30.76
0218	Level II Nerve and Muscle Tests	S	1.1296	$61.32	.....	$12.26
0220	Level I Nerve Procedures	T	16.5293	$897.36	.....	$179.47
0221	Level II Nerve Procedures	T	25.8194	$1,401.71	$463.62	$280.34
0222	Implantation of Neurological Device	T	188.7735	$10,248.32	.....	$2,049.66
0223	Implantation or Revision of Pain Management Catheter	T	26.0352	$1,413.42	.....	$282.68
0224	Implantation of Reservoir/Pump/Shunt	T	34.0161	$1,846.70	$453.41	$369.34
0225	Implantation of Neurostimulator Electrodes	S	56.0375	$3,042.22	.....	$608.44
0226	Implantation of Drug Infusion Reservoir	T	159.6795	$8,668.84	.....	$1,733.77
0227	Implantation of Drug Infusion Device	T	163.6124	$8,882.35	.....	$1,776.47
0228	Creation of Lumbar Subarachnoid Shunt	T	51.1329	$2,775.95	$621.80	$555.19
0229	Transcatherter Placement of Intravascular Shunts	T	59.4977	$3,230.07	$771.23	$646.01
0230	Level I Eye Tests & Treatments	S	0.7379	$40.06	$14.97	$8.01
0231	Level III Eye Tests & Treatments	S	2.0880	$113.36	$50.94	$22.67

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0232	Level I Anterior Segment Eye Procedures	T	4.9739	$270.03	$103.17	$54.01
0233	Level II Anterior Segment Eye Procedures	T	14.5435	$789.55	$266.33	$157.91
0234	Level III Anterior Segment Eye Procedures	T	21.5482	$1,169.83	$511.31	$233.97
0235	Level I Posterior Segment Eye Procedures	T	4.9900	$270.90	$72.04	$54.18
0236	Level II Posterior Segment Eye Procedures	T	19.6866	$1,068.77	.....	$213.75
0237	Level III Posterior Segment Eye Procedures	T	34.0324	$1,847.58	$818.54	$369.52
0238	Level I Repair and Plastic Eye Procedures	T	3.2016	$173.81	$58.96	$34.76
0239	Level II Repair and Plastic Eye Procedures	T	6.2432	$338.94	$110.62	$67.79
0240	Level III Repair and Plastic Eye Procedures	T	17.3397	$941.35	$315.31	$188.27
0241	Level IV Repair and Plastic Eye Procedures	T	21.9830	$1,193.44	$384.47	$238.69
0242	Level V Repair and Plastic Eye Procedures	T	29.2193	$1,586.29	$597.36	$317.26
0243	Strabismus/Muscle Procedures	T	21.1035	$1,145.69	$431.39	$229.14
0244	Corneal Transplant	T	37.4885	$2,035.21	$803.26	$407.04
0245	Level I Cataract Procedures without IOL Insert	T	12.5751	$682.69	$226.11	$136.54
0246	Cataract Procedures with IOL Insert	T	22.8428	$1,240.11	$495.96	$248.02
0247	Laser Eye Procedures Except Retinal	T	5.0192	$272.49	$104.31	$54.50
0248	Laser Retinal Procedures	T	4.7544	$258.11	$95.08	$51.62
0249	Level II Cataract Procedures without IOL Insert	T	28.3307	$1,538.05	$524.67	$307.61
0250	Nasal Cauterization/Packing	T	1.5381	$83.50	$29.23	$16.70
0251	Level I ENT Procedures	T	1.8643	$101.21	.....	$20.24
0252	Level II ENT Procedures	T	6.5416	$355.14	$113.41	$71.03
0253	Level III ENT Procedures	T	15.1698	$823.55	$282.29	$164.71
0254	Level IV ENT Procedures	T	21.4368	$1,163.78	$321.35	$232.76
0256	Level V ENT Procedures	T	35.0866	$1,904.82	.....	$380.96
0258	Tonsil and Adenoid Procedures	T	21.0273	$1,141.55	$437.25	$228.31
0259	Level VI ENT Procedures	T	389.1764	$21,128.00	$9,394.83	$4,225.60
0260	Level I Plain Film Except Teeth	X	0.7845	$42.59	$21.29	$8.52
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.3238	$71.87	.....	$14.37
0262	Plain Film of Teeth	X	0.7851	$42.62	$9.82	$8.52
0263	Level I Miscellaneous Radiology Procedures	X	2.1875	$118.76	$43.58	$23.75
0264	Level II Miscellaneous Radiology Procedures	X	3.0022	$162.99	$79.41	$32.60
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.0245	$55.62	$27.81	$11.12
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.6234	$88.13	$44.07	$17.63
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4805	$134.66	$65.52	$26.93
0268	Ultrasound Guidance Procedures	S	1.2640	$68.62	.....	$13.72
0269	Level III Echocardiogram Except Transesophageal	S	3.2517	$176.53	$87.24	$35.31
0270	Transesophageal Echocardiogram	S	5.9057	$320.61	$146.79	$64.12
0271	Mammography	S	0.6548	$35.55	$16.80	$7.11
0272	Level I Fluoroscopy	X	1.4086	$76.47	$38.24	$15.29
0274	Myelography	S	3.5837	$194.56	$92.92	$38.91
0275	Arthrography	S	3.2967	$178.97	$69.09	$35.79
0276	Level I Digestive Radiology	S	1.6025	$87.00	$41.72	$17.40
0277	Level II Digestive Radiology	S	2.4462	$132.80	$60.47	$26.56
0278	Diagnostic Urography	S	2.7365	$148.56	$66.07	$29.71
0279	Level II Angiography and Venography except Extremity	S	11.0678	$600.86	$174.57	$120.17
0280	Level III Angiography and Venography except Extremity	S	19.0237	$1,032.78	$353.85	$206.56
0281	Venography of Extremity	S	6.6888	$363.13	$115.16	$72.63
0282	Miscellaneous Computerized Axial Tomography	S	1.6813	$91.28	$44.51	$18.26
0283	Computerized Axial Tomography with Contrast Material	S	4.6121	$250.39	$125.19	$50.08
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	7.0207	$381.15	$190.57	$76.23
0285	Myocardial Positron Emission Tomography (PET)	S	19.5044	$1,058.87	$409.56	$211.77
0287	Complex Venography	S	6.2829	$341.09	$107.20	$68.22
0288	Bone Density:Axial Skeleton	S	1.2854	$69.78	.....	$13.96
0289	Needle Localization for Breast Biopsy	X	3.6386	$197.54	$44.80	$39.51
0296	Level I Therapeutic Radiologic Procedures	S	3.1381	$170.36	$69.20	$34.07
0297	Level II Therapeutic Radiologic Procedures	S	8.1532	$442.63	$172.51	$88.53
0299	Miscellaneous Radiation Treatment	S	5.7427	$311.77	$62.36	$62.35
0300	Level I Radiation Therapy	S	1.5112	$82.04	.....	$16.41
0301	Level II Radiation Therapy	S	2.1337	$115.84	$23.17	$23.17
0302	Level III Radiation Therapy	S	6.1992	$336.55	$127.49	$67.31
0303	Treatment Device Construction	X	2.8636	$155.46	$66.95	$31.09
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6599	$90.11	$41.52	$18.02
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6649	$198.96	$91.38	$39.79
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7085	$744.22	$325.27	$148.84
0312	Radioelement Applications	S	3.6892	$200.28	$40.06	$40.06
0313	Brachytherapy	S	13.1258	$712.59	.....	$142.52
0314	Hyperthermic Therapies	S	5.0930	$276.49	$101.77	$55.30

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0320	Electroconvulsive Therapy	S	5.4480	$295.77	$80.06	$59.15
0321	Biofeedback and Other Training	S	1.2462	$67.65	$21.78	$13.53
0322	Brief Individual Psychotherapy	S	1.3091	$71.07	.....	$14.21
0323	Extended Individual Psychotherapy	S	1.7955	$97.48	$21.26	$19.50
0324	Family Psychotherapy	S	2.8219	$153.20	.....	$30.64
0325	Group Psychotherapy	S	1.5820	$85.89	$18.27	$17.18
0330	Dental Procedures	S	0.5609	$30.45	$6.09	$6.09
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.3916	$184.13	$91.27	$36.83
0333	Computerized Axial Tomography and Computerized Angio .... w/o Contrast Material	S	5.4299	$294.78	$146.98	$58.96
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.4453	$349.91	$151.46	$69.98
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	6.4817	$351.89	$175.94	$70.38
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	9.3215	$506.05	$240.77	$101.21
0339	Observation	S	7.2016	$390.97	.....	$78.19
0340	Minor Ancillary Procedures	X	0.6232	$33.83	.....	$6.77
0341	Skin Tests	X	0.1468	$7.97	$3.08	$1.59
0342	Level I Pathology	X	0.2169	$11.78	$5.88	$2.36
0343	Level II Pathology	X	0.4662	$25.31	$12.55	$5.06
0344	Level III Pathology	X	0.6278	$34.08	$17.04	$6.82
0345	Level I Transfusion Laboratory Procedures	X	0.2589	$14.06	$3.10	$2.81
0346	Level II Transfusion Laboratory Procedures	X	0.3877	$21.05	$5.31	$4.21
0347	Level III Transfusion Laboratory Procedures	X	0.9646	$52.37	$13.19	$10.47
0348	Fertility Laboratory Procedures	X	1.2207	$66.27	.....	$13.25
0352	Level I Injections	X	0.1076	$5.84	.....	$1.17
0353	Level II Allergy Injections	X	0.4106	$22.29	.....	$4.46
0355	Level III Immunizations	K	0.2667	$14.48	.....	$2.90
0356	Level IV Immunizations	K	0.4353	$23.63	.....	$4.73
0359	Level II Injections	X	0.8794	$47.74	.....	$9.55
0360	Level I Alimentary Tests	X	1.7088	$92.77	$42.45	$18.55
0361	Level II Alimentary Tests	X	3.5574	$193.13	$83.23	$38.63
0362	Level III Otorhinolaryngologic Function Tests	X	2.5384	$137.81	.....	$27.56
0363	Level I Otorhinolaryngologic Function Tests	X	0.8536	$46.34	$17.15	$9.27
0364	Level I Audiometry	X	0.4415	$23.97	$9.06	$4.79
0365	Level II Audiometry	X	1.1915	$64.69	$18.95	$12.94
0367	Level I Pulmonary Test	X	0.5828	$31.64	$15.16	$6.33
0368	Level II Pulmonary Tests	X	0.9321	$50.60	$25.30	$10.12
0369	Level III Pulmonary Tests	X	2.5282	$137.25	$44.18	$27.45
0370	Allergy Tests	X	0.8858	$48.09	$11.58	$9.62
0371	Level I Allergy Injections	X	0.4084	$22.17	$4.44	$4.43
0372	Therapeutic Phlebotomy	X	0.5529	$30.02	$10.09	$6.00
0373	Neuropsychological Testing	X	2.1165	$114.90	$22.98	$22.98
0374	Monitoring Psychiatric Drugs	X	1.1062	$60.05	.....	$12.01
0375	Ancillary Outpatient Services when Patient Expires	T	.....	$1,150.00	.....	$230.00
0376	Pkgd cancer chemo, other	S	2.1479	$116.61	.....	$23.32
0377	Sep cancer chemo, other	S	0.6673	$36.23	.....	$7.25
0378	Infusion of pkgd cancer	S	4.3955	$238.63	.....	$47.73
0379	Infusion, separate cancer	S	2.4298	$131.91	.....	$26.38
0380	Pkgd cancer chemo, both	S	5.1857	$281.53	.....	$56.31
0381	Sep cancer chemo, both	S	2.1596	$117.24	.....	$23.45
0382	Infusion, pkgd noncancer	S	4.6839	$254.28	.....	$50.86
0383	Infusion, separate noncancer	S	1.8419	$99.99	.....	$20.00
0384	GI Procedures with Stents	T	36.0040	$1,954.62	$424.53	$390.92
0385	Level I Prosthetic Urological Procedures	T	66.4829	$3,609.29	.....	$721.86
0386	Level II Prosthetic Urological Procedures	T	118.8122	$6,450.20	.....	$1,290.04
0387	Level II Hysteroscopy	T	28.5174	$1,548.18	$660.84	$309.64
0388	Discography	S	11.7450	$637.62	$304.54	$127.52
0389	Non-imaging Nuclear Medicine	S	1.6475	$89.44	$44.72	$17.89
0390	Level I Thyroid Imaging	S	2.8434	$154.37	$77.18	$30.87
0391	Level II Thyroid Imaging	S	3.7174	$201.81	$100.91	$40.36
0392	Adrenal Imaging	S	6.7081	$364.18	$182.09	$72.84
0393	Red Cell/Plasma Studies	S	4.0720	$221.06	$110.53	$44.21
0394	Hepatobiliary Imaging	S	4.4370	$240.88	$120.44	$48.18
0395	GI Tract and B12 Studies	S	3.9372	$213.75	$106.87	$42.75
0396	Bone Imaging	S	4.2445	$230.43	$115.21	$46.09
0397	Vascular Imaging	S	2.4737	$134.29	$67.15	$26.86
0398	Cardiac Imaging	S	6.6521	$361.14	$180.57	$72.23

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0399	Cardiac Add-on Imaging	S	1.6033	$87.04	$43.52	$17.41
0400	Hematopoietic Imaging	S	3.8691	$210.05	$105.02	$42.01
0401	Pulmonary Imaging	S	4.9130	$266.72	$133.36	$53.34
0402	Brain Imaging	S	5.4818	$297.60	$148.80	$59.52
0403	CSF Imaging	S	3.9265	$213.17	$106.58	$42.63
0404	Renal Imaging	S	5.1538	$279.79	$139.90	$55.96
0405	Non-renal GU Studies	S	0.7739	$42.01	$21.01	$8.40
0406	Tumor/Infection Imaging	S	4.7542	$258.10	.....	$51.62
0407	Thyroid Radionucliide treatment	S	4.2797	$232.34	$116.17	$46.47
0408	Non-thyroid Radionucliide treatment	S	4.0000	$217.16	.....	$43.43
0409	Red Blood Cell Tests	X	0.1385	$7.52	$2.31	$1.50
0410	Mammogram Add On	S	0.1473	$8.00	.....	$1.60
0411	Respiratory Procedures	S	0.4207	$22.84	.....	$4.57
0412	IMRT Treatment Delivery	S	5.2832	$286.82	.....	$57.36
0413	IMRT Treatment Plan	S	6.0369	$327.74	.....	$65.55
0414	Reconstruction CT Angiography of Aorta	S	4.8012	$260.65	.....	$52.13
0415	Level II Endoscopy Lower Airway	T	20.9920	$1,139.63	$463.30	$227.93
0600	Low Level Clinic Visits	V	0.9376	$50.90	.....	$10.18
0601	Mid Level Clinic Visits	V	1.0031	$54.46	.....	$10.89
0602	High Level Clinic Visits	V	1.5603	$84.71	.....	$16.94
0610	Low Level Emergency Visits	V	1.4146	$76.80	$19.57	$15.36
0611	Mid Level Emergency Visits	V	2.4881	$135.08	$36.47	$27.02
0612	High Level Emergency Visits	V	4.3235	$234.72	$54.14	$46.94
0620	Critical Care	S	9.2657	$503.03	$145.78	$100.61
0648	Breast Reconstruction with Prosthesis	T	55.5345	$3,014.91	.....	$602.98
0649	Prostate Brachytherapy Palladium Seeds	T	119.0281	$6,461.92	.....	$1,292.38
0651	Complex Interstitial Radiation Source Application	S	10.0459	$545.38	$109.08	$109.08
0652	Insertion of Intraperitoneal Catheters	T	28.0692	$1,523.85	.....	$304.77
0653	Vascular Reconstruction/Fistula Repair with Device	T	32.4880	$1,763.74	.....	$352.75
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	103.8544	$5,638.15	.....	$1,127.63
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	142.2244	$7,721.22	.....	$1,544.24
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	101.3662	$5,503.07	.....	$1,100.61
0657	Placement of Tissue Clips	S	1.5630	$84.85	.....	$16.97
0658	Percutaneous Breast Biopsies	T	5.6035	$304.21	.....	$60.84
0659	Hyperbaric Oxygen	S	3.2220	$174.92	.....	$34.98
0660	Level II Otorhinolaryngologic Function Tests	X	1.7330	$94.08	$30.66	$18.82
0661	Level IV Pathology	X	3.3215	$180.32	$90.16	$36.06
0662	CT Angiography	S	5.8751	$318.95	$156.47	$63.79
0664	Proton Beam Radiation Therapy	S	9.6828	$525.67	.....	$105.13
0665	Bone Density:AppendicularSkeleton	S	0.7225	$39.22	.....	$7.84
0668	Level I Angiography and Venography except Extremity	S	10.4896	$569.47	$237.76	$113.89
0669	Digital Mammography	S	0.9111	$49.46	.....	$9.89
0670	Intravenous and Intracardiac Ultrasound	S	26.5472	$1,441.22	$521.95	$288.24
0671	Level II Echocardiogram Except Transesophageal	S	1.6392	$88.99	$44.50	$17.80
0672	Level IV Posterior Segment Procedures	T	39.1363	$2,124.67	$988.43	$424.93
0673	Level IV Anterior Segment Eye Procedures	T	26.7626	$1,452.91	$649.56	$290.58
0674	Prostate Cryoablation	T	101.1198	$5,489.69	.....	$1,097.94
0675	Prostatic Thermotherapy	T	49.3613	$2,679.78	.....	$535.96
0676	Level II Transcatheter Thrombolysis	T	3.7505	$203.61	$55.06	$40.72
0677	Level I Transcatheter Thrombolysis	T	3.0769	$167.04	.....	$33.41
0678	External Counterpulsation	T	2.0622	$111.95	.....	$22.39
0679	Level II Resuscitation and Cardioversion	S	5.4862	$297.84	$95.30	$59.57
0680	Insertion of Patient Activated Event Recorders	S	61.4222	$3,334.55	.....	$666.91
0681	Knee Arthroplasty	T	96.7483	$5,252.37	$2,090.21	$1,050.47
0682	Level V Debridement & Destruction	T	7.6815	$417.02	$174.57	$83.40
0683	Level II Photochemotherapy	S	1.7915	$97.26	$35.01	$19.45
0684	Prostate Brachytherapy Iodine Seeds	T	104.7194	$5,685.11	.....	$1,137.02
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	4.8912	$265.54	$116.83	$53.11
0686	Level III Skin Repair	T	17.0868	$927.63	$341.70	$185.53
0687	Revision/Removal of Neurostimulator Electrodes	T	19.9913	$1,085.31	$499.24	$217.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	42.5880	$2,312.06	$1,132.91	$462.41
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5427	$29.46	.....	$5.89
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3986	$21.64	$10.35	$4.33
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.9894	$162.29	$81.15	$32.46
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	0.9625	$52.25	$26.13	$10.45
0693	Level II Breast Reconstruction	T	38.6469	$2,098.10	$798.17	$419.62

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0694	Mohs Surgery	T	3.3272	$180.63	$72.25	$36.13
0695	Level VII Debridement & Destruction	T	19.1377	$1,038.97	$266.59	$207.79
0697	Level I Echocardiogram Except Transesophageal	S	1.4621	$79.38	$39.69	$15.88
0698	Level II Eye Tests & Treatments	S	0.9355	$50.79	$18.72	$10.16
0699	Level IV Eye Tests & Treatments	T	2.2211	$120.58	$54.26	$24.12
0700	Antepartum Manipulation	T	2.4359	$132.24	$37.03	$26.45
0701	SR 89 chloride, per mCi	K	7.4586	$404.92		$80.98
0702	SM 153 lexidronam, 50 mCi	K	16.1415	$876.31		$175.26
0704	IN 111 Satumomab pendetide per dose	K	2.9212	$158.59		$31.72
0726	Dexrazoxane hcl injection, 250 mg	K	1.9860	$107.82		$21.56
0728	Filgrastim 300 mcg injection	K	2.2544	$122.39		$24.48
0730	Pamidronate disodium , 30 mg	K	1.5359	$83.38		$16.68
0732	Mesna injection 200 mg	K	0.4908	$26.65		$5.33
0733	Non esrd epoetin alpha inj, 1000 u	K	0.1782	$9.67		$1.93
0734	Injection, darbepoetin alfa (for non-ESRD use), pre 1 mcg	K	0.0463	$2.51		$.50
0800	Leuprolide acetate, 3.75 mg	K	3.3020	$179.26		$35.85
0802	Etoposide oral 50 mg	K	0.4830	$26.22		$5.24
0807	Aldesleukin/single use vial	K	7.0936	$385.10		$77.02
0810	Goserelin acetate implant 3.6 mg	K	4.9549	$269.00		$53.80
0811	Carboplatin injection 50 mg	K	1.5475	$84.01		$16.80
0812	Carmustine, 100 mg	K	0.9972	$54.14		$10.83
0813	Cisplatin 10 mg injection	K	0.3594	$19.51		$3.90
0820	Daunorubicin 10 mg	K	0.60	$32.86		$6.57
0821	Daunorubicin citrate liposom 10 mg	K	2.9697	$161.22		$32.24
0822	Diethylstilbestrol injection 250 mg	K	1.3274	$72.06		$14.41
0823	Docetaxel, 20 mg	K	4.0041	$217.38		$43.48
0827	Floxuridine injection 500 mg	K	2.1836	$118.55		$23.71
0828	Gemcitabine HCL 200 mg	K	1.4523	$78.84		$15.77
0830	Irinotecan injection 20 mg	K	1.8626	$101.12		$20.22
0831	Ifosfomide injection 1 gm	K	1.1616	$63.06		$12.61
0832	Idarubicin hcl injection 5 mg	K	3.2438	$176.10		$35.22
0836	Interferon alfa-2b inj recombinant, 1 million	K	0.2000	$10.86		$2.17
0838	Interferon gamma 1-b inj, 3 million u	K	2.4742	$134.32		$26.86
0840	Melphalan hydrochl 50 mg	K	4.4072	$239.26		$47.85
0842	Fludarabine phosphate inj 50 mg	K	3.6854	$200.08		$40.02
0843	Pegaspargase, singl dose vial	K	5.7621	$312.82		$62.56
0844	Pentostatin injection, 10 mg	K	17.4201	$945.72		$189.14
0849	Rituximab, 100 mg	K	5.5636	$302.04		$60.41
0850	Streptozocin injection, 1 gm	K	1.3942	$75.69		$15.14
0852	Topotecan, 4 mg	K	7.9075	$429.29		$85.86
0855	Vinorelbine tartrate, 10 mg	K	1.1683	$63.43		$12.69
0856	Porfimer sodium, 75 mg	K	25.3788	$1,377.79		$275.56
0857	Bleomycin sulfate injection 15 u	K	2.2352	$121.35		$24.27
0858	Cladribine, 1mg	K	0.7031	$38.17		$7.63
0861	Leuprolide acetate injection 1 mg	K	0.8223	$44.64		$8.93
0862	Mitomycin 5 mg inj	K	0.9557	$51.88		$10.38
0863	Paclitaxel injection, 30 mg	K	1.2674	$68.81		$13.76
0864	Mitoxantrone hcl, 5 mg	K	3.1513	$171.08		$34.22
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K	1.5823	$85.90		$17.18
0884	Rho d immune globulin inj, 1 dose pkg	K	0.2312	$12.55		$2.51
0888	Cyclosporine oral 100 mg	K	0.0482	$2.62		$.52
0890	Lymphocyte immune globulin 250 mg	K	2.1958	$119.21		$23.84
0891	Tacrolimus oral per 1 mg	K	0.0236	$1.28		$.26
0900	Alglucerase injection, per 10 u	K	0.5473	$29.71		$5.94
0901	Alpha 1 proteinase inhibitor, 10 mg	K	0.0214	$1.16		$.23
0902	Botulinum toxin a, per unit	K	0.0460	$2.50		$.50
0903	Cytomegalovirus imm IV/vial	K	5.0754	$275.54		$55.11
0905	Immune globulin, 1g	K	0.8103	$43.99		$8.80
0906	RSV-ivig, 50 mg	K	6.0142	$326.50		$65.30
0909	Interferon beta-1a, 33 mcg	K	2.8010	$152.06		$30.41
0910	Interferon beta-1b /0.25 mg	K	1.9843	$107.73		$21.55
0911	Streptokinase per 250,000 iu	K	1.6055	$87.16		$17.43
0916	Imiglucerase injection/unit	K	0.0531	$2.88		$.58
0917	Inj, Adenosine, 90 mg	K	2.3474	$127.44		$25.49
0925	Factor viii per iu	K	0.0085	$.46		$.09
0926	Factor VIII (porcine) per iu	K	0.0253	$1.37		$.27
0927	Factor viii recombinant per iu	K	0.0168	$.91		$.18
0928	Factor ix complex per iu	K	0.0085	$.46		$.09
0929	Anti-inhibitor per iu	K	0.0168	$.91		$.18

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0930	Antithrombin iii injection per iu	K	0.0117	$.64		$.13
0931	Factor IX non-recombinant, per iu	K	0.0104	$.56		$.11
0932	Factor IX recombinant, per iu	K	0.0168	$.91		$.18
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.0608	$111.88		$22.38
0950	Blood (Whole) For Transfusion	K	1.4575	$79.13		$15.83
0952	Cryoprecipitate	K	0.4860	$26.38		$5.28
0954	RBC leukocytes reduced	K	1.9770	$107.33		$21.47
0955	Plasma, Fresh Frozen	K	1.5750	$85.51		$17.10
0956	Plasma Protein Fraction	K	1.5414	$83.68		$16.74
0957	Platelet Concentrate	K	0.6870	$37.30		$7.46
0958	Platelet Rich Plasma	K	1.1296	$61.32		$12.26
0959	Red Blood Cells	K	1.4326	$77.77		$15.55
0960	Washed Red Blood Cells	K	2.6638	$144.62		$28.92
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.7319	$39.73		$7.95
0963	Albumin (human), 5%, 250 ml	K	3.4713	$188.45		$37.69
0964	Albumin (human), 25%, 20 ml	K	0.7911	$42.95		$8.59
0965	Albumin (human), 25%, 50ml	K	1.9432	$105.49		$21.10
0966	Plasmaprotein fract,5%,250ml	K	7.7071	$418.41		$83.68
1009	Cryoprecip reduced plasma	K	0.9447	$51.29		$10.26
1010	Blood, L/R, CMV-neg	K	2.1361	$115.97		$23.19
1011	Platelets, HLA-m, L/R, unit	K	8.2851	$449.79		$89.96
1013	Platelet concentrate, L/R, unit	K	0.9101	$49.41		$9.88
1016	Blood, L/R, froz/deglycerol/washed	K	5.0012	$271.51		$54.30
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	6.5175	$353.83		$70.77
1018	Blood, L/R, irradiated	K	2.1950	$119.16		$23.83
1019	Platelets, aph/pher, L/R, irradiated, unit	K	6.7353	$365.65		$73.13
1020	Pit, pher,L/R,CMV,irrad	K	9.6266	$522.62		$104.52
1021	RBC, frz/deg/wsh, L/R, irrad	K	6.5287	$354.44		$70.89
1022	RBC, L/R, CMV neg, irrad	K	3.9139	$212.48		$42.50
1045	Iobenguane sulfate I-131per 0.5 mCi	K	2.9293	$159.03		$31.81
1064	I-131 sodium iodide capsule	K	0.1007	$5.47		$1.09
1065	I-131 sodium iodide solution	K	0.0002	$.01		$.00
1084	Denileukin diftitox, 300 MCG	K	15.0913	$819.29		$163.86
1086	Temozolomide,oral 5 mg	K	0.0643	$3.49		$.70
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.0535	$220.06		$44.01
1092	IN 111 Pentetate, per 0.5 mCi	K	4.0824	$221.63		$44.33
1095	Technetium TC 99M Depreotide	K	3.7042	$201.10		$40.22
1096	TC 99M Exametazime, per dose	K	3.8103	$206.86		$41.37
1122	TC 99M arcitumomab, per vial	K	9.6556	$524.19		$104.84
1167	Epirubicin hcl, 2 mg	K	0.3597	$19.53		$3.91
1178	Busulfan IV, 6 mg	K	6.0245	$327.06		$65.41
1203	Verteporfin for injection	K	16.1946	$879.19		$175.84
1207	Octreotide injection, depot	K	1.1849	$64.33		$12.87
1305	Apligraf	K	11.2075	$608.44		$121.69
1409	Factor viia recombinant, per 1.2 mg	K	17.9693	$975.54		$195.11
1501	New Technology - Level I ($0 - $50)	S		$25.00		$5.00
1502	New Technology - Level II ($50 - $100)	S		$75.00		$15.00
1503	New Technology - Level III ($100 - $200)	S		$150.00		$30.00
1504	New Technology - Level IV ($200 - $300)	S		$250.00		$50.00
1505	New Technology - Level V ($300 - $400)	S		$350.00		$70.00
1506	New Technology - Level VI ($400 - $500)	S		$450.00		$90.00
1507	New Technology - Level VII ($500 - $600)	S		$550.00		$110.00
1508	New Technology - Level VIII ($600 - $700)	S		$650.00		$130.00
1509	New Technology - Level IX ($700 - $800)	S		$750.00		$150.00
1510	New Technology - Level X ($800 - $900)	S		$850.00		$170.00
1511	New Technology - Level XI ($900 - $1000)	S		$950.00		$190.00
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00		$210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00		$230.00
1514	New Technology - Level XIV ($1200 - $1300)	S		$1,250.00		$250.00
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00		$270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00		$290.00
1517	New Technology - Level XX ($1500-$1600)	S		$1,550.00		$310.00
1518	New Technology - Level XX ($1600-$1700)	S		$1,650.00		$330.00
1519	New Technology - Level XX ($1700-$1800)	S		$1,750.00		$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00		$370.00
1521	New Technology - Level XX ($1900-$2000)	S		$1,950.00		$390.00
1522	New Technology - Level XX ($2000-$2500)	S		$2,250.00		$450.00
1523	New Technology - Level XX ($2500-$3000)	S		$2,750.00		$550.00
1524	New Technology - Level XX ($3000-$3500)	S		$3,250.00		$650.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1525	New Technology - Level XX ($3500-$4000)	S		$3,750.00		$750.00
1526	New Technology - Level XX ($4000-$4500)	S		$4,250.00		$850.00
1527	New Technology - Level XX ($4500-$5000)	S		$4,750.00		$950.00
1528	New Technology - Level XX ($5000-$5500)	S		$5,250.00		$1,050.00
1529	New Technology - Level XX ($5500-$6000)	S		$5,750.00		$1,150.00
1530	New Technology - Level XX ($6000-$6500)	S		$6,250.00		$1,250.00
1531	New Technology - Level XX ($6500-$7000)	S		$6,750.00		$1,350.00
1532	New Technology - Level XX ($7000-$7500)	S		$7,250.00		$1,450.00
1533	New Technology - Level XX ($7500-$8000)	S		$7,750.00		$1,550.00
1534	New Technology - Level XX ($8000-$8500)	S		$8,250.00		$1,650.00
1535	New Technology - Level XX ($8500-$9000)	S		$8,750.00		$1,750.00
1536	New Technology - Level XX ($9000-$9500)	S		$9,250.00		$1,850.00
1537	New Technology - Level XX ($9500-$10000)	S		$9,750.00		$1,950.00
1538	New Technology - Level I ($0 - $50)	T		$25.00		$5.00
1539	New Technology - Level II ($50 - $100)	T		$75.00		$15.00
1540	New Technology - Level III ($100 - $200)	T		$150.00		$30.00
1541	New Technology - Level IV ($200 - $300)	T		$250.00		$50.00
1542	New Technology - Level V ($300 - $400)	T		$350.00		$70.00
1543	New Technology - Level VI ($400 - $500)	T		$450.00		$90.00
1544	New Technology - Level VII ($500 - $600)	T		$550.00		$110.00
1545	New Technology - Level VIII ($600 - $700)	T		$650.00		$130.00
1546	New Technology - Level IX ($700 - $800)	T		$750.00		$150.00
1547	New Technology - Level X ($800 - $900)	T		$850.00		$170.00
1548	New Technology - Level XI ($900 - $1000)	T		$950.00		$190.00
1549	New Technology - Level XII ($1000 - $1100)	T		$1,050.00		$210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		$1,150.00		$230.00
1551	New Technology - Level XIV ($1200 - $1300)	T		$1,250.00		$250.00
1552	New Technology - Level XV ($1300 - $1400)	T		$1,350.00		$270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		$1,450.00		$290.00
1554	New Technology - Level XX ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology - Level XX ($1600-$1700)	T		$1,650.00		$330.00
1556	New Technology - Level XX ($1700-$1800)	T		$1,750.00		$350.00
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00		$370.00
1558	New Technology - Level XX ($1900-$2000)	T		$1,950.00		$390.00
1559	New Technology - Level XX ($2000-$2500)	T		$2,250.00		$450.00
1560	New Technology - Level XX ($2500-$3000)	T		$2,750.00		$550.00
1561	New Technology - Level XX ($3000-$3500)	T		$3,250.00		$650.00
1562	New Technology - Level XX ($3500-$4000)	T		$3,750.00		$750.00
1563	New Technology - Level XX ($4000-$4500)	T		$4,250.00		$850.00
1564	New Technology - Level XX ($4500-$5000)	T		$4,750.00		$950.00
1565	New Technology - Level XX ($5000-$5500)	T		$5,250.00		$1,050.00
1566	New Technology - Level XX ($5500-$6000)	T		$5,750.00		$1,150.00
1567	New Technology - Level XX ($6000-$6500)	T		$6,250.00		$1,250.00
1568	New Technology - Level XX ($6500-$7000)	T		$6,750.00		$1,350.00
1569	New Technology - Level XX ($7000-$7500)	T		$7,250.00		$1,450.00
1570	New Technology - Level XX ($7500-$8000)	T		$7,750.00		$1,550.00
1571	New Technology - Level XX ($8000-$8500)	T		$8,250.00		$1,650.00
1572	New Technology - Level XX ($8500-$9000)	T		$8,750.00		$1,750.00
1573	New Technology - Level XX ($9000-$9500)	T		$9,250.00		$1,850.00
1574	New Technology - Level XX ($9500-$10000)	T		$9,750.00		$1,950.00
1604	IN 111 capromab pendetide, per dose	K	12.4029	$673.34		$134.67
1605	Abciximab injection, 10 mg	K	5.2806	$286.68		$57.34
1606	Anistreplase, 30 u	K	25.3116	$1,374.14		$274.83
1607	Eptifibatide injection, 5mg	K	0.1426	$7.74		$1.55
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.1863	$10.11		$2.02
1611	Hylan G-F 20 injection, 16 mg	K	2.1566	$117.08		$23.42
1612	Daclizumab, parenteral, 25 mg	K	3.7304	$202.52		$40.50
1613	Trastuzumab, 10 mg	K	0.7384	$40.09		$8.02
1614	Valrubicin, 200 mg	K	9.6183	$522.17		$104.43
1615	Basiliximab, 20 mg	K	11.2007	$608.07		$121.61
1618	Vonwillebrandfactrcmplx, per iu	K	0.0168	$.91		$.18
1620	Technetium tc99m bicisate	K	3.3106	$179.73		$35.95
1625	Indium 111-in pentetreotide	K	6.8170	$370.09		$74.02
1628	Chromic phosphate p32	K	2.0103	$109.14		$21.83
1716	Brachytx source, Gold 198	K	1.3399	$72.74		$14.55
1718	Brachytx source, Iodine 125	K	0.6695	$36.35		$7.27
1719	Brachytx source, Non-HDR Ir-192	K	0.3053	$16.57		$3.31
1720	Brachytx source, Palladium 103	K	0.8104	$44.00		$8.80
1775	FDG, per dose (4-40 mCi/ml)	K	5.8606	$318.17		$63.63

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1783	Ocular implant, aqueous drain device	H				
1814	Retinal Tamp, silicone oil	H				
1818	Integrated keratoprosthesis	H				
1900	Lead coronary venous	H				
2614	Probe, percutaneous lumbar disc	H				
2616	Brachytx source, Yttrium-90	K	163.4011	$8,870.88		$1,774.18
2632	Brachytx sol, I-125, per mCi	H				
7000	Amifostine, 500 mg	K	3.9932	$216.79		$43.36
7011	Oprelvekin injection, 5 mg	K	2.7246	$147.92		$29.58
7015	Busulfan, oral, 2 mg	K	0.0263	$1.43		$.29
7024	Corticorelin ovine triflutat	K	3.4880	$189.36		$37.87
7025	Digoxin immune FAB (ovine)	K	4.4789	$243.16		$48.63
7027	Fomepizole, 15mg	K	0.2215	$12.03		$2.41
7030	Hemin, per 1 mg	K	0.0119	$.65		$.13
7031	Octreotide acetate injection	K	1.0339	$56.13		$11.23
7034	Somatropin injection	K	0.9206	$49.98		$10.00
7035	Teniposide, 50 mg	K	1.5530	$84.31		$16.86
7036	Urokinase 250,000 iu inj	K	5.1032	$277.05		$55.41
7037	Urofollitropin, 75 iu	K	1.1321	$61.46		$12.29
7038	Muromonab-CD3, 5 mg	K	5.8452	$317.33		$63.47
7041	Tirofiban hydrochloride 12.5 mg	K	4.2976	$233.31		$46.66
7042	Capecitabine, oral, 150 mg	K	0.0290	$1.57		$.31
7043	Infliximab injection 10 mg	K	0.6841	$37.14		$7.43
7045	Trimetrexate glucoronate	K	1.2099	$65.68		$13.14
7046	Doxorubicin hcl liposome inj 10 mg	K	4.6362	$251.69		$50.34
7049	Filgrastim 480 mcg injection	K	3.1998	$173.71		$34.74
7051	Leuprolide acetate implant, 65 mg	K	68.9392	$3,742.64		$748.53
9000	Na chromate Cr51, per 0.25mCi	K	1.2631	$68.57		$13.71
9002	Tenecteplase, 50mg/vial	K	23.2303	$1,261.15		$252.23
9003	Palivizumab, per 50mg	K	6.3850	$346.64		$69.33
9004	Gemtuzumab ozogamicin inj,5mg	K	17.5020	$950.17		$190.03
9005	Reteplase injection	K	10.1332	$550.12		$110.02
9009	Baclofen refill kit - per 2000 mcg	K	0.7478	$40.60		$8.12
9010	Baclofen refill kit - per 4000 mcg	K	0.7340	$39.85		$7.97
9012	Arsenic Trioxide	K	0.4837	$26.26		$5.25
9015	Mycophenolate mofetil oral 250 mg	K	0.0373	$2.02		$.40
9018	Botulinum toxin B, per 100 u	K	0.1272	$6.91		$1.38
9019	Caspofungin acetate, 5 mg	K	0.5334	$28.96		$5.79
9020	Sirolimus tablet, oral 1 mg	K	0.0520	$2.82		$.56
9021	Immune globulin 10 mg	K	0.0080	$.43		$.09
9022	IM inj interferon beta 1-a	K	0.9417	$51.12		$10.22
9023	Rho d immune globulin 50 mcg	K	0.0523	$2.84		$.57
9024	Amphotericin b lipid complex	K	0.4174	$22.66		$4.53
9025	Rubidium-Rb-82	K	2.5939	$140.82		$28.16
9100	Iodinated I-131albumin, per 5 uci	K	0.0071	$.39		$.08
9104	Anti-thymocyte globulin rabbit	K	2.9801	$161.79		$32.36
9105	Hep B imm glob, per 1 ml	K	1.5621	$84.80		$16.96
9108	Thyrotropin alfa, per 1.1 mg	K	6.6059	$358.63		$71.73
9109	Tirofiban hcl, per 6.25 mg	K	2.2328	$121.22		$24.24
9110	Alemtuzumab, per 10 mg	K	7.6422	$414.89		$82.98
9111	Inj, bivalirudin, per 250 mg vial	G		$397.81		$59.46
9112	Perflutren lipid micro, per 2ml	G		$148.20		$22.15
9113	Inj, pantoprazole sodium, vial	G		$22.80		$3.41
9114	Nesiritide, per 0.5 mg vial	G		$144.40		$21.58
9115	Inj, zoledronic acid, per 1 mg	G		$203.40		$30.40
9116	Inj, Ertapenem sodium, per 1 gm vial	G		$45.31		$6.77
9117	Y-90 ibritumomab tiuxetan	K	332.7763	$18,066.09		$3,613.22
9118	IN-111 ibritumomab tiuxetan	K	38.3972	$2,084.55		$416.91
9119	Pegfilgrastim, per 1 mg	G		$467.09		$69.82
9120	Inj, Fulvestrant, per 50 mg	G		$175.16		$26.18
9121	Inj, Argatroban, per 5 mg	G		$14.25		$2.13
9122	Inj, Triptorelin pamoate, per 3.75 mg	G		$415.24		$62.07
9200	Orcel, per 36 cm2	G		$1,135.25		$169.69
9201	Dermagraft, per 37.5 sq cm	K	7.9288	$430.45		$86.09
9202	Octafluoropropane	K	2.1253	$115.38		$23.08
9203	Perflexane lipid micro	G		$142.50		$21.30
9204	Ziprasidone mesylate	G		$41.56		$6.21
9205	Oxaliplatin	G		$94.46		$14.12
9217	Leuprolide acetate suspnsion, 7.5 mg	K	5.5128	$299.28		$59.86

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9500	Platelets, irradiated	K	1.2398	$67.31		$13.46
9501	Platelets, pheresis	K	6.7772	$367.93		$73.59
9502	Platelet pheresis irradiated	K	7.3552	$399.31		$79.86
9503	Fresh frozen plasma, ea unit	K	1.1560	$62.76		$12.55
9504	RBC deglycerolized	K	3.9764	$215.87		$43.17
9505	RBC irradiated	K	1.8011	$97.78		$19.56
9506	Granulocytes, pheresis	K	20.7004	$1,123.80		$224.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004

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	1501		$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	1557		$1,850.00		$370.00
00100	N		Anesth, salivary gland					
00102	N		Anesth, repair of cleft lip					
00103	N		Anesth, blepharoplasty					
00104	N		Anesth, electroshock					
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	27.2538	$1,479.58		$295.92
0013T	T		Osteochondral knee allograft	0041	27.2538	$1,479.58		$295.92
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					
00144	N		Anesth, corneal transplant					
00145	N		Anesth, vitreoretinal surg					
00147	N		Anesth, iridectomy					
00148	N		Anesth, eye exam					
0014T	T		Meniscal transplant, knee	0041	27.2538	$1,479.58		$295.92
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	T		Thermotx choroid vasc lesion	0235	4.9900	$270.90	$72.04	$54.18
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	0.6390	$34.69	$15.76	$6.94
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	E		Extracorp shock wave tx, ms					
0020T	A		Extracorp shock wave tx, ft					
00210	N		Anesth, open head surgery					
00212	N		Anesth, skull drainage					
00214	C		Anesth, skull drainage					
00215	C		Anesth, skull repair/fract					
00216	N		Anesth, head vessel surgery					
00218	N		Anesth, special head surgery					
0021T	C		Fetal oximetry, 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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0025T	S		Ultrasonic pachymetry	0230	0.7379	$40.06	$14.97	$8.01
0026T	A		Measure remnant lipoproteins					
0027T	T		Endoscopic epidural lysis	1547		$850.00		$170.00
0028T	N		Dexa body composition study					
0029T	N		Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A		Antiprothrombin antibody					
0031T	N		Speculoscopy					
00320	N		Anesth, neck organ surgery					
00322	N		Anesth, biopsy of thyroid					
00326	N		Anesth, larynx/trach, < 1 yr					
0032T	N		Speculoscopy w/direct sample					
0033T	C		Endovasc taa repr incl subcl					
0034T	C		Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C		Insert endovasc prosth, taa					
0036T	C		Endovasc prosth, taa, add-on					
0037T	C		Artery transpose/endovas taa					
0038T	C		Rad endovasc taa rpr w/cover					
0039T	C		Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					
00404	C		Anesth, surgery of breast					
00406	C		Anesth, surgery of breast					
0040T	C		Rad s/i, endovasc taa prosth					
00410	N		Anesth, correct heart rhythm					
0041T	A		Detect ur infect agnt w/cpas					
0042T	N		Ct perfusion w/contrast, cbf					
0043T	A		Co expired gas analysis					
0044T	N		Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
00470	N		Anesth, removal of rib					
00472	N		Anesth, chest wall repair					
00474	C		Anesth, surgery of rib(s)					
00500	N		Anesth, esophageal surgery					
00520	N		Anesth, chest procedure					
00522	N		Anesth, chest lining biopsy					
00524	C		Anesth, chest drainage					
00528	N		Anesth, chest partition view					
00530	N		Anesth, pacemaker insertion					
00532	N		Anesth, vascular access					
00534	N		Anesth, cardioverter/defib					
00537	N		Anesth, cardiac electrophys					
00539	N		Anesth, trach-bronch reconst					
00540	C		Anesth, chest surgery					
00541	N		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00635	N		Anesth, lumbar puncture					
00640	N		Anesth, spine manipulation					
00670	C		Anesth, spine, cord surgery					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
00730	N		Anesth, abdominal wall surg					
00740	N		Anesth, upper gi visualize					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
00770	N		Anesth, blood vessel repair					
00790	N		Anesth, surg upper abdomen					
00792	C		Anesth, hemorr/excise liver					
00794	C		Anesth, pancreas removal					
00796	C		Anesth, for liver transplant					
00797	N		Anesth, surgery for obesity					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
00810	N		Anesth, low intestine scope					
00820	N		Anesth, abdominal wall surg					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N		Anesth, hernia repair< 1 yr					
00836	N		Anesth hernia repair preemie					
00840	N		Anesth, surg lower abdomen					
00842	N		Anesth, amniocentesis					
00844	C		Anesth, pelvis surgery					
00846	C		Anesth, hysterectomy					
00848	C		Anesth, pelvic organ surg					
00851	N		Anesth, tubal ligation					
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
00902	N		Anesth, anorectal surgery					
00904	C		Anesth, perineal surgery					
00906	N		Anesth, removal of vulva					
00908	C		Anesth, removal of prostate					
00910	N		Anesth, bladder surgery					
00912	N		Anesth, bladder tumor surg					
00914	N		Anesth, removal of prostate					
00916	N		Anesth, bleeding control					
00918	N		Anesth, stone removal					
00920	N		Anesth, genitalia surgery					
00921	N		Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	C		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		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					
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		Anesth, nerve block/inj					
01992	N		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	1.0937	$59.38		$11.88
10022	T		Fna w/image	0002	1.0937	$59.38		$11.88
10040	T		Acne surgery	0010	0.6806	$36.95	$10.08	$7.39
10060	T		Drainage of skin abscess	0006	1.7487	$94.94	$24.12	$18.99
10061	T		Drainage of skin abscess	0006	1.7487	$94.94	$24.12	$18.99
10080	T		Drainage of pilonidal cyst	0006	1.7487	$94.94	$24.12	$18.99

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
10081	T		Drainage of pilonidal cyst	0007	11.4943	$624.01		$124.80
10120	T		Remove foreign body	0006	1.7487	$94.94	$24.12	$18.99
10121	T		Remove foreign body	0021	14.5749	$791.26	$219.48	$158.25
10140	T		Drainage of hematoma/fluid	0007	11.4943	$624.01		$124.80
10160	T		Puncture drainage of lesion	0018	0.9567	$51.94	$16.04	$10.39
10180	T		Complex drainage, wound	0007	11.4943	$624.01		$124.80
11000	T		Debride infected skin	0015	1.5832	$85.95	$20.35	$17.19
11001	T		Debride infected skin add-on	0012	0.8203	$44.53	$11.18	$8.91
11010	T		Debride skin, fx	0022	18.6725	$1,013.71	$354.45	$202.74
11011	T		Debride skin/muscle, fx	0022	18.6725	$1,013.71	$354.45	$202.74
11012	T		Debride skin/muscle/bone, fx	0022	18.6725	$1,013.71	$354.45	$202.74
11040	T		Debride skin, partial	0015	1.5832	$85.95	$20.35	$17.19
11041	T		Debride skin, full	0015	1.5832	$85.95	$20.35	$17.19
11042	T		Debride skin/tissue	0016	2.7343	$148.44	$57.31	$29.69
11043	T		Debride tissue/muscle	0016	2.7343	$148.44	$57.31	$29.69
11044	T		Debride tissue/muscle/bone	0682	7.6815	$417.02	$174.57	$83.40
11055	T		Trim skin lesion	0012	0.8203	$44.53	$11.18	$8.91
11056	T		Trim skin lesions, 2 to 4	0012	0.8203	$44.53	$11.18	$8.91
11057	T		Trim skin lesions, over 4	0012	0.8203	$44.53	$11.18	$8.91
11100	T		Biopsy of skin lesion	0018	0.9567	$51.94	$16.04	$10.39
11101	T		Biopsy, skin add-on	0018	0.9567	$51.94	$16.04	$10.39
11200	T		Removal of skin tags	0013	1.1420	$62.00	$14.20	$12.40
11201	T		Remove skin tags add-on	0015	1.5832	$85.95	$20.35	$17.19
11300	T		Shave skin lesion	0012	0.8203	$44.53	$11.18	$8.91
11301	T		Shave skin lesion	0012	0.8203	$44.53	$11.18	$8.91
11302	T		Shave skin lesion	0012	0.8203	$44.53	$11.18	$8.91
11303	T		Shave skin lesion	0015	1.5832	$85.95	$20.35	$17.19
11305	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11306	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11307	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11308	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11310	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11311	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11312	T		Shave skin lesion	0013	1.1420	$62.00	$14.20	$12.40
11313	T		Shave skin lesion	0016	2.7343	$148.44	$57.31	$29.69
11400	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11401	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11402	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11403	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11404	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11406	T		Removal of skin lesion	0021	14.5749	$791.26	$219.48	$158.25
11420	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11421	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11422	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11423	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11424	T		Removal of skin lesion	0021	14.5749	$791.26	$219.48	$158.25
11426	T		Removal of skin lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11440	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11441	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11442	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11443	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11444	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11446	T		Removal of skin lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11450	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11451	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11462	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11463	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11470	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11471	T		Removal, sweat gland lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11600	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11601	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11602	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11603	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11604	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11606	T		Removal of skin lesion	0021	14.5749	$791.26	$219.48	$158.25
11620	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11621	T		Removal of skin lesion	0019	3.9807	$216.11	$71.87	$43.22
11622	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11623	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11624	T		Removal of skin lesion	0021	14.5749	$791.26	$219.48	$158.25
11626	T		Removal of skin lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11640	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11641	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11642	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11643	T		Removal of skin lesion	0020	7.3105	$396.88	$113.25	$79.38
11644	T		Removal of skin lesion	0021	14.5749	$791.26	$219.48	$158.25
11646	T		Removal of skin lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11719	T		Trim nail(s)	0009	0.6597	$35.81	$8.34	$7.16
11720	T		Debride nail, 1-5	0009	0.6597	$35.81	$8.34	$7.16
11721	T		Debride nail, 6 or more	0009	0.6597	$35.81	$8.34	$7.16
11730	T		Removal of nail plate	0013	1.1420	$62.00	$14.20	$12.40
11732	T		Remove nail plate, add-on	0012	0.8203	$44.53	$11.18	$8.91
11740	T		Drain blood from under nail	0009	0.6597	$35.81	$8.34	$7.16
11750	T		Removal of nail bed	0019	3.9807	$216.11	$71.87	$43.22
11752	T		Remove nail bed/finger tip	0022	18.6725	$1,013.71	$354.45	$202.74
11755	T		Biopsy, nail unit	0019	3.9807	$216.11	$71.87	$43.22
11760	T		Repair of nail bed	0024	1.7847	$96.89	$34.75	$19.38
11762	T		Reconstruction of nail bed	0024	1.7847	$96.89	$34.75	$19.38
11765	T		Excision of nail fold, toe	0015	1.5832	$85.95	$20.35	$17.19
11770	T		Removal of pilonidal lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11771	T		Removal of pilonidal lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11772	T		Removal of pilonidal lesion	0022	18.6725	$1,013.71	$354.45	$202.74
11900	T		Injection into skin lesions	0012	0.8203	$44.53	$11.18	$8.91
11901	T		Added skin lesions injection	0012	0.8203	$44.53	$11.18	$8.91
11920	T		Correct skin color defects	0024	1.7847	$96.89	$34.75	$19.38
11921	T		Correct skin color defects	0024	1.7847	$96.89	$34.75	$19.38
11922	T		Correct skin color defects	0024	1.7847	$96.89	$34.75	$19.38
11950	T		Therapy for contour defects	0024	1.7847	$96.89	$34.75	$19.38
11951	T		Therapy for contour defects	0024	1.7847	$96.89	$34.75	$19.38
11952	T		Therapy for contour defects	0024	1.7847	$96.89	$34.75	$19.38
11954	T		Therapy for contour defects	0024	1.7847	$96.89	$34.75	$19.38
11960	T		Insert tissue expander(s)	0027	15.8319	$859.50	$329.72	$171.90
11970	T		Replace tissue expander	0027	15.8319	$859.50	$329.72	$171.90
11971	T		Remove tissue expander(s)	0022	18.6725	$1,013.71	$354.45	$202.74
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	3.9807	$216.11	$71.87	$43.22
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6232	$33.83		$6.77
11981	X		Insert drug implant device	0340	0.6232	$33.83		$6.77
11982	X		Remove drug implant device	0340	0.6232	$33.83		$6.77
11983	X		Remove/insert drug implant	0340	0.6232	$33.83		$6.77
12001	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12002	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12004	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12005	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12006	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12007	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12011	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12013	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12014	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12015	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12016	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12017	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12018	T		Repair superficial wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12020	T		Closure of split wound	0024	1.7847	$96.89	$34.75	$19.38
12021	T		Closure of split wound	0024	1.7847	$96.89	$34.75	$19.38
12031	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12032	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12034	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12035	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12036	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12037	T		Layer closure of wound(s)	0025	6.2703	$340.41	$115.49	$68.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12041	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12042	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12044	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12045	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12046	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12047	T		Layer closure of wound(s)	0025	6.2703	$340.41	$115.49	$68.08
12051	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12052	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12053	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12054	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12055	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12056	T		Layer closure of wound(s)	0024	1.7847	$96.89	$34.75	$19.38
12057	T		Layer closure of wound(s)	0025	6.2703	$340.41	$115.49	$68.08
13100	T		Repair of wound or lesion	0025	6.2703	$340.41	$115.49	$68.08
13101	T		Repair of wound or lesion	0025	6.2703	$340.41	$115.49	$68.08
13102	T		Repair wound/lesion add-on	0024	1.7847	$96.89	$34.75	$19.38
13120	T		Repair of wound or lesion	0024	1.7847	$96.89	$34.75	$19.38
13121	T		Repair of wound or lesion	0024	1.7847	$96.89	$34.75	$19.38
13122	T		Repair wound/lesion add-on	0024	1.7847	$96.89	$34.75	$19.38
13131	T		Repair of wound or lesion	0024	1.7847	$96.89	$34.75	$19.38
13132	T		Repair of wound or lesion	0024	1.7847	$96.89	$34.75	$19.38
13133	T		Repair wound/lesion add-on	0024	1.7847	$96.89	$34.75	$19.38
13150	T		Repair of wound or lesion	0025	6.2703	$340.41	$115.49	$68.08
13151	T		Repair of wound or lesion	0024	1.7847	$96.89	$34.75	$19.38
13152	T		Repair of wound or lesion	0025	6.2703	$340.41	$115.49	$68.08
13153	T		Repair wound/lesion add-on	0024	1.7847	$96.89	$34.75	$19.38
13160	T		Late closure of wound	0027	15.8319	$859.50	$329.72	$171.90
14000	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14001	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14020	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14021	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14040	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14041	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14060	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14061	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14300	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
14350	T		Skin tissue rearrangement	0027	15.8319	$859.50	$329.72	$171.90
15000	T		Skin graft	0025	6.2703	$340.41	$115.49	$68.08
15001	T		Skin graft add-on	0025	6.2703	$340.41	$115.49	$68.08
15050	T		Skin pinch graft	0025	6.2703	$340.41	$115.49	$68.08
15100	T		Skin split graft	0027	15.8319	$859.50	$329.72	$171.90
15101	T		Skin split graft add-on	0027	15.8319	$859.50	$329.72	$171.90
15120	T		Skin split graft	0027	15.8319	$859.50	$329.72	$171.90
15121	T		Skin split graft add-on	0027	15.8319	$859.50	$329.72	$171.90
15200	T		Skin full graft	0027	15.8319	$859.50	$329.72	$171.90
15201	T		Skin full graft add-on	0025	6.2703	$340.41	$115.49	$68.08
15220	T		Skin full graft	0027	15.8319	$859.50	$329.72	$171.90
15221	T		Skin full graft add-on	0025	6.2703	$340.41	$115.49	$68.08
15240	T		Skin full graft	0027	15.8319	$859.50	$329.72	$171.90
15241	T		Skin full graft add-on	0025	6.2703	$340.41	$115.49	$68.08
15260	T		Skin full graft	0027	15.8319	$859.50	$329.72	$171.90
15261	T		Skin full graft add-on	0025	6.2703	$340.41	$115.49	$68.08
15342	T		Cultured skin graft, 25 cm	0024	1.7847	$96.89	$34.75	$19.38
15343	T		Culture skn graft addl 25 cm	0024	1.7847	$96.89	$34.75	$19.38
15350	T		Skin homograft	0686	17.0868	$927.63	$341.70	$185.53
15351	T		Skin homograft add-on	0027	15.8319	$859.50	$329.72	$171.90
15400	T		Skin heterograft	0025	6.2703	$340.41	$115.49	$68.08
15401	T		Skin heterograft add-on	0025	6.2703	$340.41	$115.49	$68.08
15570	T		Form skin pedicle flap	0027	15.8319	$859.50	$329.72	$171.90
15572	T		Form skin pedicle flap	0027	15.8319	$859.50	$329.72	$171.90
15574	T		Form skin pedicle flap	0027	15.8319	$859.50	$329.72	$171.90
15576	T		Form skin pedicle flap	0027	15.8319	$859.50	$329.72	$171.90
15600	T		Skin graft	0027	15.8319	$859.50	$329.72	$171.90
15610	T		Skin graft	0027	15.8319	$859.50	$329.72	$171.90
15620	T		Skin graft	0027	15.8319	$859.50	$329.72	$171.90
15630	T		Skin graft	0027	15.8319	$859.50	$329.72	$171.90

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15650	T		Transfer skin pedicle flap	0027	15.8319	$859.50	$329.72	$171.90
15732	T		Muscle-skin graft, head/neck	0027	15.8319	$859.50	$329.72	$171.90
15734	T		Muscle-skin graft, trunk	0027	15.8319	$859.50	$329.72	$171.90
15736	T		Muscle-skin graft, arm	0027	15.8319	$859.50	$329.72	$171.90
15738	T		Muscle-skin graft, leg	0027	15.8319	$859.50	$329.72	$171.90
15740	T		Island pedicle flap graft	0027	15.8319	$859.50	$329.72	$171.90
15750	T		Neurovascular pedicle graft	0027	15.8319	$859.50	$329.72	$171.90
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	15.8319	$859.50	$329.72	$171.90
15770	T		Derma-fat-fascia graft	0027	15.8319	$859.50	$329.72	$171.90
15775	T		Hair transplant punch grafts	0025	6.2703	$340.41	$115.49	$68.08
15776	T		Hair transplant punch grafts	0025	6.2703	$340.41	$115.49	$68.08
15780	T		Abrasion treatment of skin	0022	18.6725	$1,013.71	$354.45	$202.74
15781	T		Abrasion treatment of skin	0022	18.6725	$1,013.71	$354.45	$202.74
15782	T		Abrasion treatment of skin	0022	18.6725	$1,013.71	$354.45	$202.74
15783	T		Abrasion treatment of skin	0016	2.7343	$148.44	$57.31	$29.69
15786	T		Abrasion, lesion, single	0012	0.8203	$44.53	$11.18	$8.91
15787	T		Abrasion, lesions, add-on	0013	1.1420	$62.00	$14.20	$12.40
15788	T		Chemical peel, face, epiderm	0012	0.8203	$44.53	$11.18	$8.91
15789	T		Chemical peel, face, dermal	0015	1.5832	$85.95	$20.35	$17.19
15792	T		Chemical peel, nonfacial	0012	0.8203	$44.53	$11.18	$8.91
15793	T		Chemical peel, nonfacial	0012	0.8203	$44.53	$11.18	$8.91
15810	T		Salabrasion	0016	2.7343	$148.44	$57.31	$29.69
15811	T		Salabrasion	0016	2.7343	$148.44	$57.31	$29.69
15819	T		Plastic surgery, neck	0025	6.2703	$340.41	$115.49	$68.08
15820	T		Revision of lower eyelid	0027	15.8319	$859.50	$329.72	$171.90
15821	T		Revision of lower eyelid	0027	15.8319	$859.50	$329.72	$171.90
15822	T		Revision of upper eyelid	0027	15.8319	$859.50	$329.72	$171.90
15823	T		Revision of upper eyelid	0027	15.8319	$859.50	$329.72	$171.90
15824	T		Removal of forehead wrinkles	0027	15.8319	$859.50	$329.72	$171.90
15825	T		Removal of neck wrinkles	0027	15.8319	$859.50	$329.72	$171.90
15826	T		Removal of brow wrinkles	0027	15.8319	$859.50	$329.72	$171.90
15828	T		Removal of face wrinkles	0027	15.8319	$859.50	$329.72	$171.90
15829	T		Removal of skin wrinkles	0027	15.8319	$859.50	$329.72	$171.90
15831	T		Excise excessive skin tissue	0022	18.6725	$1,013.71	$354.45	$202.74
15832	T		Excise excessive skin tissue	0022	18.6725	$1,013.71	$354.45	$202.74
15833	T		Excise excessive skin tissue	0022	18.6725	$1,013.71	$354.45	$202.74
15834	T		Excise excessive skin tissue	0022	18.6725	$1,013.71	$354.45	$202.74
15835	T		Excise excessive skin tissue	0025	6.2703	$340.41	$115.49	$68.08
15836	T		Excise excessive skin tissue	0020	7.3105	$396.88	$113.25	$79.38
15837	T		Excise excessive skin tissue	0020	7.3105	$396.88	$113.25	$79.38
15838	T		Excise excessive skin tissue	0020	7.3105	$396.88	$113.25	$79.38
15839	T		Excise excessive skin tissue	0020	7.3105	$396.88	$113.25	$79.38
15840	T		Graft for face nerve palsy	0027	15.8319	$859.50	$329.72	$171.90
15841	T		Graft for face nerve palsy	0027	15.8319	$859.50	$329.72	$171.90
15842	T		Flap for face nerve palsy	0027	15.8319	$859.50	$329.72	$171.90
15845	T		Skin and muscle repair, face	0027	15.8319	$859.50	$329.72	$171.90
15850	T		Removal of sutures	0016	2.7343	$148.44	$57.31	$29.69
15851	T		Removal of sutures	0012	0.8203	$44.53	$11.18	$8.91
15852	X		Dressing change,not for burn	0340	0.6232	$33.83		$6.77
15860	S		Test for blood flow in graft	1501		$25.00		$5.00
15876	T		Suction assisted lipectomy	0027	15.8319	$859.50	$329.72	$171.90
15877	T		Suction assisted lipectomy	0027	15.8319	$859.50	$329.72	$171.90
15878	T		Suction assisted lipectomy	0027	15.8319	$859.50	$329.72	$171.90
15879	T		Suction assisted lipectomy	0027	15.8319	$859.50	$329.72	$171.90
15920	T		Removal of tail bone ulcer	0022	18.6725	$1,013.71	$354.45	$202.74
15922	T		Removal of tail bone ulcer	0027	15.8319	$859.50	$329.72	$171.90
15931	T		Remove sacrum pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
15933	T		Remove sacrum pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
15934	T		Remove sacrum pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15935	T		Remove sacrum pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15936	T		Remove sacrum pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15937	T		Remove sacrum pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15940	T		Remove hip pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15941	T		Remove hip pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
15944	T		Remove hip pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15945	T		Remove hip pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15946	T		Remove hip pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15950	T		Remove thigh pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
15951	T		Remove thigh pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
15952	T		Remove thigh pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15953	T		Remove thigh pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15956	T		Remove thigh pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15958	T		Remove thigh pressure sore	0027	15.8319	$859.50	$329.72	$171.90
15999	T		Removal of pressure sore	0022	18.6725	$1,013.71	$354.45	$202.74
16000	T		Initial treatment of burn(s)	0012	0.8203	$44.53	$11.18	$8.91
16010	T		Treatment of burn(s)	0016	2.7343	$148.44	$57.31	$29.69
16015	T		Treatment of burn(s)	0017	16.7332	$908.43	$227.84	$181.69
16020	T		Treatment of burn(s)	0013	1.1420	$62.00	$14.20	$12.40
16025	T		Treatment of burn(s)	0012	0.8203	$44.53	$11.18	$8.91
16030	T		Treatment of burn(s)	0015	1.5832	$85.95	$20.35	$17.19
16035	C		Incision of burn scab, initi					
16036	C		Incise burn scab, addl incis					
17000	T		Destroy benign/premlg lesion	0010	0.6806	$36.95	$10.08	$7.39
17003	T		Destroy lesions, 2-14	0010	0.6806	$36.95	$10.08	$7.39
17004	T		Destroy lesions, 15 or more	0011	2.1800	$118.35	$27.88	$23.67
17106	T		Destruction of skin lesions	0011	2.1800	$118.35	$27.88	$23.67
17107	T		Destruction of skin lesions	0011	2.1800	$118.35	$27.88	$23.67
17108	T		Destruction of skin lesions	0011	2.1800	$118.35	$27.88	$23.67
17110	T		Destruct lesion, 1-14	0010	0.6806	$36.95	$10.08	$7.39
17111	T		Destruct lesion, 15 or more	0011	2.1800	$118.35	$27.88	$23.67
17250	T		Chemical cautery, tissue	0013	1.1420	$62.00	$14.20	$12.40
17260	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17261	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17262	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17263	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17264	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17266	T		Destruction of skin lesions	0016	2.7343	$148.44	$57.31	$29.69
17270	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17271	T		Destruction of skin lesions	0013	1.1420	$62.00	$14.20	$12.40
17272	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17273	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17274	T		Destruction of skin lesions	0016	2.7343	$148.44	$57.31	$29.69
17276	T		Destruction of skin lesions	0016	2.7343	$148.44	$57.31	$29.69
17280	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17281	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17282	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17283	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17284	T		Destruction of skin lesions	0016	2.7343	$148.44	$57.31	$29.69
17286	T		Destruction of skin lesions	0015	1.5832	$85.95	$20.35	$17.19
17304	T		Chemosurgery of skin lesion	0694	3.3272	$180.63	$72.25	$36.13
17305	T		2 stage mohs, up to 5 spec	0694	3.3272	$180.63	$72.25	$36.13
17306	T		3 stage mohs, up to 5 spec	0694	3.3272	$180.63	$72.25	$36.13
17307	T		Mohs addl stage up to 5 spec	0694	3.3272	$180.63	$72.25	$36.13
17310	T		Extensive skin chemosurgery	0694	3.3272	$180.63	$72.25	$36.13
17340	T		Cryotherapy of skin	0012	0.8203	$44.53	$11.18	$8.91
17360	T		Skin peel therapy	0012	0.8203	$44.53	$11.18	$8.91
17380	T		Hair removal by electrolysis	0012	0.8203	$44.53	$11.18	$8.91
17999	T		Skin tissue procedure	0006	1.7487	$94.94	$24.12	$18.99
19000	T		Drainage of breast lesion	0004	1.5774	$85.64	$22.10	$17.13
19001	T		Drain breast lesion add-on	0004	1.5774	$85.64	$22.10	$17.13
19020	T		Incision of breast lesion	0008	16.8303	$913.70		$182.74
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.3675	$182.82	$71.59	$36.56
19101	T		Biopsy of breast, open	0028	17.7459	$963.41	$303.74	$192.68
19102	T		Bx breast percut w/image	0005	3.3675	$182.82	$71.59	$36.56
19103	T		Bx breast percut w/device	0658	5.6035	$304.21		$60.84
19110	T		Nipple exploration	0028	17.7459	$963.41	$303.74	$192.68
19112	T		Excise breast duct fistula	0028	17.7459	$963.41	$303.74	$192.68
19120	T		Removal of breast lesion	0028	17.7459	$963.41	$303.74	$192.68

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19125	T		Excision, breast lesion	0028	17.7459	$963.41	$303.74	$192.68
19126	T		Excision, addl breast lesion	0028	17.7459	$963.41	$303.74	$192.68
19140	T		Removal of breast tissue	0028	17.7459	$963.41	$303.74	$192.68
19160	T		Removal of breast tissue	0028	17.7459	$963.41	$303.74	$192.68
19162	T		Remove breast tissue, nodes	0693	38.6469	$2,098.10	$798.17	$419.62
19180	T		Removal of breast	0029	29.2783	$1,589.49	$632.64	$317.90
19182	T		Removal of breast	0029	29.2783	$1,589.49	$632.64	$317.90
19200	C		Removal of breast					
19220	C		Removal of breast					
19240	T		Removal of breast	0030	37.2809	$2,023.94	$763.55	$404.79
19260	T		Removal of chest wall lesion	0021	14.5749	$791.26	$219.48	$158.25
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	1.5630	$84.85		$16.97
19316	T		Suspension of breast	0029	29.2783	$1,589.49	$632.64	$317.90
19318	T		Reduction of large breast	0693	38.6469	$2,098.10	$798.17	$419.62
19324	T		Enlarge breast	0693	38.6469	$2,098.10	$798.17	$419.62
19325	T		Enlarge breast with implant	0648	55.5345	$3,014.91		$602.98
19328	T		Removal of breast implant	0029	29.2783	$1,589.49	$632.64	$317.90
19330	T		Removal of implant material	0029	29.2783	$1,589.49	$632.64	$317.90
19340	T		Immediate breast prosthesis	0030	37.2809	$2,023.94	$763.55	$404.79
19342	T		Delayed breast prosthesis	0648	55.5345	$3,014.91		$602.98
19350	T		Breast reconstruction	0029	29.2783	$1,589.49	$632.64	$317.90
19355	T		Correct inverted nipple(s)	0029	29.2783	$1,589.49	$632.64	$317.90
19357	T		Breast reconstruction	0648	55.5345	$3,014.91		$602.98
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	29.2783	$1,589.49	$632.64	$317.90
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	29.2783	$1,589.49	$632.64	$317.90
19371	T		Removal of breast capsule	0029	29.2783	$1,589.49	$632.64	$317.90
19380	T		Revise breast reconstruction	0030	37.2809	$2,023.94	$763.55	$404.79
19396	T		Design custom breast implant	0029	29.2783	$1,589.49	$632.64	$317.90
19499	T		Breast surgery procedure	0028	17.7459	$963.41	$303.74	$192.68
20000	T		Incision of abscess	0006	1.7487	$94.94	$24.12	$18.99
20005	T		Incision of deep abscess	0049	19.9376	$1,082.39		$216.48
20100	T		Explore wound, neck	0023	3.1587	$171.48	$40.37	$34.30
20101	T		Explore wound, chest	0027	15.8319	$859.50	$329.72	$171.90
20102	T		Explore wound, abdomen	0027	15.8319	$859.50	$329.72	$171.90
20103	T		Explore wound, extremity	0023	3.1587	$171.48	$40.37	$34.30
20150	T		Excise epiphyseal bar	0051	34.9381	$1,896.75		$379.35
20200	T		Muscle biopsy	0021	14.5749	$791.26	$219.48	$158.25
20205	T		Deep muscle biopsy	0021	14.5749	$791.26	$219.48	$158.25
20206	T		Needle biopsy, muscle	0005	3.3675	$182.82	$71.59	$36.56
20220	T		Bone biopsy, trocar/needle	0019	3.9807	$216.11	$71.87	$43.22
20225	T		Bone biopsy, trocar/needle	0020	7.3105	$396.88	$113.25	$79.38
20240	T		Bone biopsy, excisional	0022	18.6725	$1,013.71	$354.45	$202.74
20245	T		Bone biopsy, excisional	0022	18.6725	$1,013.71	$354.45	$202.74
20250	T		Open bone biopsy	0049	19.9376	$1,082.39		$216.48
20251	T		Open bone biopsy	0049	19.9376	$1,082.39		$216.48
20500	T		Injection of sinus tract	0251	1.8643	$101.21		$20.24
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	3.9807	$216.11	$71.87	$43.22
20525	T		Removal of foreign body	0022	18.6725	$1,013.71	$354.45	$202.74
20526	T		Ther injection, carp tunnel	0204	2.2209	$120.57	$40.13	$24.11
20550	T		Inject tendon/ligament/cyst	0204	2.2209	$120.57	$40.13	$24.11
20551	T		Inject tendon origin/insert	0204	2.2209	$120.57	$40.13	$24.11
20552	T		Inject trigger point, 1 or 2	0204	2.2209	$120.57	$40.13	$24.11
20553	T		Inject trigger points, > 3	0204	2.2209	$120.57	$40.13	$24.11
20600	T		Drain/inject, joint/bursa	0204	2.2209	$120.57	$40.13	$24.11
20605	T		Drain/inject, joint/bursa	0204	2.2209	$120.57	$40.13	$24.11
20610	T		Drain/inject, joint/bursa	0204	2.2209	$120.57	$40.13	$24.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20612	T		Aspirate/inj ganglion cyst	0204	2.2209	$120.57	$40.13	$24.11
20615	T		Treatment of bone cyst	0004	1.5774	$85.64	$22.10	$17.13
20650	T		Insert and remove bone pin	0049	19.9376	$1,082.39		$216.48
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	0.6232	$33.83		$6.77
20670	T		Removal of support implant	0021	14.5749	$791.26	$219.48	$158.25
20680	T		Removal of support implant	0022	18.6725	$1,013.71	$354.45	$202.74
20690	T		Apply bone fixation device	0050	25.1166	$1,363.56		$272.71
20692	T		Apply bone fixation device	0050	25.1166	$1,363.56		$272.71
20693	T		Adjust bone fixation device	0049	19.9376	$1,082.39		$216.48
20694	T		Remove bone fixation device	0049	19.9376	$1,082.39		$216.48
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	25.1166	$1,363.56		$272.71
20902	T		Removal of bone for graft	0050	25.1166	$1,363.56		$272.71
20910	T		Remove cartilage for graft	0027	15.8319	$859.50	$329.72	$171.90
20912	T		Remove cartilage for graft	0027	15.8319	$859.50	$329.72	$171.90
20920	T		Removal of fascia for graft	0027	15.8319	$859.50	$329.72	$171.90
20922	T		Removal of fascia for graft	0027	15.8319	$859.50	$329.72	$171.90
20924	T		Removal of tendon for graft	0050	25.1166	$1,363.56		$272.71
20926	T		Removal of tissue for graft	0027	15.8319	$859.50	$329.72	$171.90
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	1.7487	$94.94	$24.12	$18.99
20955	C		Fibula bone graft, microvasc					
20956	C		Iliac bone graft, microvasc					
20957	C		Mt bone graft, microvasc					
20962	C		Other bone graft, microvasc					
20969	C		Bone/skin graft, microvasc					
20970	C		Bone/skin graft, iliac crest					
20972	C		Bone/skin graft, metatarsal					
20973	C		Bone/skin graft, great toe					
20974	A		Electrical bone stimulation					
20975	T		Electrical bone stimulation	0049	19.9376	$1,082.39		$216.48
20979	A		Us bone stimulation					
20999	T		Musculoskeletal surgery	0049	19.9376	$1,082.39		$216.48
21010	T		Incision of jaw joint	0254	21.4368	$1,163.78	$321.35	$232.76
21015	T		Resection of facial tumor	0253	15.1698	$823.55	$282.29	$164.71
21025	T		Excision of bone, lower jaw	0256	35.0866	$1,904.82		$380.96
21026	T		Excision of facial bone(s)	0256	35.0866	$1,904.82		$380.96
21029	T		Contour of face bone lesion	0256	35.0866	$1,904.82		$380.96
21030	T		Removal of face bone lesion	0254	21.4368	$1,163.78	$321.35	$232.76
21031	T		Remove exostosis, mandible	0254	21.4368	$1,163.78	$321.35	$232.76
21032	T		Remove exostosis, maxilla	0254	21.4368	$1,163.78	$321.35	$232.76
21034	T		Removal of face bone lesion	0256	35.0866	$1,904.82		$380.96
21040	T		Removal of jaw bone lesion	0254	21.4368	$1,163.78	$321.35	$232.76
21044	T		Removal of jaw bone lesion	0256	35.0866	$1,904.82		$380.96
21045	C		Extensive jaw surgery					
21046	T		Remove mandible cyst complex	0256	35.0866	$1,904.82		$380.96
21047	T		Excise lwr jaw cyst w/repair	0256	35.0866	$1,904.82		$380.96
21048	T		Remove maxilla cyst complex	0256	35.0866	$1,904.82		$380.96
21049	T		Excis uppr jaw cyst w/repair	0256	35.0866	$1,904.82		$380.96
21050	T		Removal of jaw joint	0256	35.0866	$1,904.82		$380.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21060	T		Remove jaw joint cartilage	0256	35.0866	$1,904.82		$380.96
21070	T		Remove coronoid process	0256	35.0866	$1,904.82		$380.96
21076	T		Prepare face/oral prosthesis	0254	21.4368	$1,163.78	$321.35	$232.76
21077	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21079	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21080	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21081	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21082	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21083	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21084	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21085	T		Prepare face/oral prosthesis	0253	15.1698	$823.55	$282.29	$164.71
21086	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21087	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21088	T		Prepare face/oral prosthesis	0256	35.0866	$1,904.82		$380.96
21089	T		Prepare face/oral prosthesis	0253	15.1698	$823.55	$282.29	$164.71
21100	T		Maxillofacial fixation	0256	35.0866	$1,904.82		$380.96
21110	T		Interdental fixation	0252	6.5416	$355.14	$113.41	$71.03
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	21.4368	$1,163.78	$321.35	$232.76
21121	T		Reconstruction of chin	0254	21.4368	$1,163.78	$321.35	$232.76
21122	T		Reconstruction of chin	0254	21.4368	$1,163.78	$321.35	$232.76
21123	T		Reconstruction of chin	0254	21.4368	$1,163.78	$321.35	$232.76
21125	T		Augmentation, lower jaw bone	0254	21.4368	$1,163.78	$321.35	$232.76
21127	T		Augmentation, lower jaw bone	0256	35.0866	$1,904.82		$380.96
21137	T		Reduction of forehead	0254	21.4368	$1,163.78	$321.35	$232.76
21138	T		Reduction of forehead	0256	35.0866	$1,904.82		$380.96
21139	T		Reduction of forehead	0256	35.0866	$1,904.82		$380.96
21141	C		Reconstruct midface, lefort					
21142	C		Reconstruct midface, lefort					
21143	C		Reconstruct midface, lefort					
21145	C		Reconstruct midface, lefort					
21146	C		Reconstruct midface, lefort					
21147	C		Reconstruct midface, lefort					
21150	C		Reconstruct midface, lefort					
21151	C		Reconstruct midface, lefort					
21154	C		Reconstruct midface, lefort					
21155	C		Reconstruct midface, lefort					
21159	C		Reconstruct midface, lefort					
21160	C		Reconstruct midface, lefort					
21172	C		Reconstruct orbit/forehead					
21175	C		Reconstruct orbit/forehead					
21179	C		Reconstruct entire forehead					
21180	C		Reconstruct entire forehead					
21181	T		Contour cranial bone lesion	0254	21.4368	$1,163.78	$321.35	$232.76
21182	C		Reconstruct cranial bone					
21183	C		Reconstruct cranial bone					
21184	C		Reconstruct cranial bone					
21188	C		Reconstruction of midface					
21193	C		Reconst lwr jaw w/o graft					
21194	C		Reconst lwr jaw w/graft					
21195	C		Reconst lwr jaw w/o fixation					
21196	C		Reconst lwr jaw w/fixation					
21198	T		Reconstr lwr jaw segment	0256	35.0866	$1,904.82		$380.96
21199	T		Reconstr lwr jaw w/advance	0256	35.0866	$1,904.82		$380.96
21206	T		Reconstruct upper jaw bone	0256	35.0866	$1,904.82		$380.96
21208	T		Augmentation of facial bones	0256	35.0866	$1,904.82		$380.96
21209	T		Reduction of facial bones	0256	35.0866	$1,904.82		$380.96
21210	T		Face bone graft	0256	35.0866	$1,904.82		$380.96
21215	T		Lower jaw bone graft	0256	35.0866	$1,904.82		$380.96
21230	T		Rib cartilage graft	0256	35.0866	$1,904.82		$380.96
21235	T		Ear cartilage graft	0254	21.4368	$1,163.78	$321.35	$232.76
21240	T		Reconstruction of jaw joint	0256	35.0866	$1,904.82		$380.96
21242	T		Reconstruction of jaw joint	0256	35.0866	$1,904.82		$380.96
21243	T		Reconstruction of jaw joint	0256	35.0866	$1,904.82		$380.96
21244	T		Reconstruction of lower jaw	0256	35.0866	$1,904.82		$380.96
21245	T		Reconstruction of jaw	0256	35.0866	$1,904.82		$380.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21246	T		Reconstruction of jaw	0256	35.0866	$1,904.82		$380.96
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	35.0866	$1,904.82		$380.96
21249	T		Reconstruction of jaw	0256	35.0866	$1,904.82		$380.96
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	35.0866	$1,904.82		$380.96
21261	T		Revise eye sockets	0256	35.0866	$1,904.82		$380.96
21263	T		Revise eye sockets	0256	35.0866	$1,904.82		$380.96
21267	T		Revise eye sockets	0256	35.0866	$1,904.82		$380.96
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	35.0866	$1,904.82		$380.96
21275	T		Revision, orbitofacial bones	0256	35.0866	$1,904.82		$380.96
21280	T		Revision of eyelid	0256	35.0866	$1,904.82		$380.96
21282	T		Revision of eyelid	0253	15.1698	$823.55	$282.29	$164.71
21295	T		Revision of jaw muscle/bone	0252	6.5416	$355.14	$113.41	$71.03
21296	T		Revision of jaw muscle/bone	0254	21.4368	$1,163.78	$321.35	$232.76
21299	T		Cranio/maxillofacial surgery	0253	15.1698	$823.55	$282.29	$164.71
21300	T		Treatment of skull fracture	0253	15.1698	$823.55	$282.29	$164.71
21310	X		Treatment of nose fracture	0340	0.6232	$33.83		$6.77
21315	X		Treatment of nose fracture	0340	0.6232	$33.83		$6.77
21320	X		Treatment of nose fracture	0340	0.6232	$33.83		$6.77
21325	T		Treatment of nose fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21330	T		Treatment of nose fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21335	T		Treatment of nose fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21336	T		Treat nasal septal fracture	0046	31.9719	$1,735.72	$535.76	$347.14
21337	T		Treat nasal septal fracture	0253	15.1698	$823.55	$282.29	$164.71
21338	T		Treat nasoethmoid fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21339	T		Treat nasoethmoid fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21340	T		Treatment of nose fracture	0256	35.0866	$1,904.82		$380.96
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	21.4368	$1,163.78	$321.35	$232.76
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	35.0866	$1,904.82		$380.96
21356	C		Treat cheek bone fracture					
21360	C		Treat cheek bone fracture					
21365	C		Treat cheek bone fracture					
21366	C		Treat cheek bone fracture					
21385	C		Treat eye socket fracture					
21386	C		Treat eye socket fracture					
21387	C		Treat eye socket fracture					
21390	T		Treat eye socket fracture	0256	35.0866	$1,904.82		$380.96
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	6.5416	$355.14	$113.41	$71.03
21401	T		Treat eye socket fracture	0253	15.1698	$823.55	$282.29	$164.71
21406	T		Treat eye socket fracture	0256	35.0866	$1,904.82		$380.96
21407	T		Treat eye socket fracture	0256	35.0866	$1,904.82		$380.96
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21422	C		Treat mouth roof fracture					
21423	C		Treat mouth roof fracture					
21431	C		Treat craniofacial fracture					
21432	C		Treat craniofacial fracture					
21433	C		Treat craniofacial fracture					
21435	C		Treat craniofacial fracture					
21436	C		Treat craniofacial fracture					
21440	T		Treat dental ridge fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21445	T		Treat dental ridge fracture	0254	21.4368	$1,163.78	$321.35	$232.76
21450	T		Treat lower jaw fracture	0251	1.8643	$101.21		$20.24
21451	T		Treat lower jaw fracture	0252	6.5416	$355.14	$113.41	$71.03
21452	T		Treat lower jaw fracture	0253	15.1698	$823.55	$282.29	$164.71
21453	T		Treat lower jaw fracture	0256	35.0866	$1,904.82		$380.96
21454	T		Treat lower jaw fracture	0254	21.4368	$1,163.78	$321.35	$232.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21461	T		Treat lower jaw fracture	0256	35.0866	$1,904.82		$380.96
21462	T		Treat lower jaw fracture	0256	35.0866	$1,904.82		$380.96
21465	T		Treat lower jaw fracture	0256	35.0866	$1,904.82		$380.96
21470	T		Treat lower jaw fracture	0256	35.0866	$1,904.82		$380.96
21480	T		Reset dislocated jaw	0251	1.8643	$101.21		$20.24
21485	T		Reset dislocated jaw	0253	15.1698	$823.55	$282.29	$164.71
21490	T		Repair dislocated jaw	0256	35.0866	$1,904.82		$380.96
21493	T		Treat hyoid bone fracture	0252	6.5416	$355.14	$113.41	$71.03
21494	T		Treat hyoid bone fracture	0252	6.5416	$355.14	$113.41	$71.03
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	15.1698	$823.55	$282.29	$164.71
21499	T		Head surgery procedure	0253	15.1698	$823.55	$282.29	$164.71
21501	T		Drain neck/chest lesion	0008	16.8303	$913.70		$182.74
21502	T		Drain chest lesion	0049	19.9376	$1,082.39		$216.48
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	14.5749	$791.26	$219.48	$158.25
21555	T		Remove lesion, neck/chest	0022	18.6725	$1,013.71	$354.45	$202.74
21556	T		Remove lesion, neck/chest	0022	18.6725	$1,013.71	$354.45	$202.74
21557	C		Remove tumor, neck/chest					
21600	T		Partial removal of rib	0050	25.1166	$1,363.56		$272.71
21610	T		Partial removal of rib	0050	25.1166	$1,363.56		$272.71
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	19.9376	$1,082.39		$216.48
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	19.9376	$1,082.39		$216.48
21725	T		Revision of neck muscle	0006	1.7487	$94.94	$24.12	$18.99
21740	C		Reconstruction of sternum					
21742	T		Repair stern/nuss w/o scope	0051	34.9381	$1,896.75		$379.35
21743	T		Repair sternum/nuss w/scope	0051	34.9381	$1,896.75		$379.35
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	1.9233	$104.41		$20.88
21805	T		Treatment of rib fracture	0046	31.9719	$1,735.72	$535.76	$347.14
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	1.9233	$104.41		$20.88
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0252	6.5416	$355.14	$113.41	$71.03
21920	T		Biopsy soft tissue of back	0020	7.3105	$396.88	$113.25	$79.38
21925	T		Biopsy soft tissue of back	0022	18.6725	$1,013.71	$354.45	$202.74
21930	T		Remove lesion, back or flank	0022	18.6725	$1,013.71	$354.45	$202.74
21935	T		Remove tumor, back	0022	18.6725	$1,013.71	$354.45	$202.74
22100	T		Remove part of neck vertebra	0208	40.6521	$2,206.96		$441.39
22101	T		Remove part, thorax vertebra	0208	40.6521	$2,206.96		$441.39
22102	T		Remove part, lumbar vertebra	0208	40.6521	$2,206.96		$441.39
22103	T		Remove extra spine segment	0208	40.6521	$2,206.96		$441.39
22110	C		Remove part of neck vertebra					
22112	C		Remove part, thorax vertebra					
22114	C		Remove part, lumbar vertebra					
22116	C		Remove extra spine segment					
22210	C		Revision of neck spine					
22212	C		Revision of thorax spine					
22214	C		Revision of lumbar spine					
22216	C		Revise, extra spine segment					
22220	C		Revision of neck spine					
22222	C		Revision of thorax spine					
22224	C		Revision of lumbar spine					
22226	C		Revise, extra spine segment					
22305	T		Treat spine process fracture	0043	1.9233	$104.41		$20.88
22310	T		Treat spine fracture	0043	1.9233	$104.41		$20.88
22315	T		Treat spine fracture	0043	1.9233	$104.41		$20.88
22318	C		Treat odontoid fx w/o graft					
22319	C		Treat odontoid fx w/graft					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22325	C		Treat spine fracture					
22326	C		Treat neck spine fracture					
22327	C		Treat thorax spine fracture					
22328	C		Treat each add spine fx					
22505	T		Manipulation of spine	0045	13.5546	$735.87	$268.47	$147.17
22520	T		Percut vertebroplasty thor	0050	25.1166	$1,363.56		$272.71
22521	T		Percut vertebroplasty lumb	0050	25.1166	$1,363.56		$272.71
22522	T		Percut vertebroplasty addl	0050	25.1166	$1,363.56		$272.71
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	40.6521	$2,206.96		$441.39
22614	T		Spine fusion, extra segment	0208	40.6521	$2,206.96		$441.39
22630	C		Lumbar spine fusion					
22632	C		Spine fusion, extra segment					
22800	C		Fusion of spine					
22802	C		Fusion of spine					
22804	C		Fusion of spine					
22808	C		Fusion of spine					
22810	C		Fusion of spine					
22812	C		Fusion of spine					
22818	C		Kyphectomy, 1-2 segments					
22819	C		Kyphectomy, 3 or more					
22830	C		Exploration of spinal fusion					
22840	C		Insert spine fixation device					
22841	C		Insert spine fixation device					
22842	C		Insert spine fixation device					
22843	C		Insert spine fixation device					
22844	C		Insert spine fixation device					
22845	C		Insert spine fixation device					
22846	C		Insert spine fixation device					
22847	C		Insert spine fixation device					
22848	C		Insert pelv fixation device					
22849	C		Reinsert spinal fixation					
22850	C		Remove spine fixation device					
22851	C		Apply spine prosth device					
22852	C		Remove spine fixation device					
22855	C		Remove spine fixation device					
22899	T		Spine surgery procedure	0043	1.9233	$104.41		$20.88
22900	T		Remove abdominal wall lesion	0022	18.6725	$1,013.71	$354.45	$202.74
22999	T		Abdomen surgery procedure	0022	18.6725	$1,013.71	$354.45	$202.74
23000	T		Removal of calcium deposits	0021	14.5749	$791.26	$219.48	$158.25
23020	T		Release shoulder joint	0051	34.9381	$1,896.75		$379.35
23030	T		Drain shoulder lesion	0008	16.8303	$913.70		$182.74
23031	T		Drain shoulder bursa	0008	16.8303	$913.70		$182.74
23035	T		Drain shoulder bone lesion	0049	19.9376	$1,082.39		$216.48
23040	T		Exploratory shoulder surgery	0050	25.1166	$1,363.56		$272.71
23044	T		Exploratory shoulder surgery	0050	25.1166	$1,363.56		$272.71
23065	T		Biopsy shoulder tissues	0021	14.5749	$791.26	$219.48	$158.25
23066	T		Biopsy shoulder tissues	0022	18.6725	$1,013.71	$354.45	$202.74
23075	T		Removal of shoulder lesion	0021	14.5749	$791.26	$219.48	$158.25
23076	T		Removal of shoulder lesion	0022	18.6725	$1,013.71	$354.45	$202.74
23077	T		Remove tumor of shoulder	0022	18.6725	$1,013.71	$354.45	$202.74
23100	T		Biopsy of shoulder joint	0049	19.9376	$1,082.39		$216.48
23101	T		Shoulder joint surgery	0050	25.1166	$1,363.56		$272.71
23105	T		Remove shoulder joint lining	0050	25.1166	$1,363.56		$272.71
23106	T		Incision of collarbone joint	0050	25.1166	$1,363.56		$272.71
23107	T		Explore treat shoulder joint	0050	25.1166	$1,363.56		$272.71
23120	T		Partial removal, collar bone	0051	34.9381	$1,896.75		$379.35
23125	T		Removal of collar bone	0051	34.9381	$1,896.75		$379.35

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23130	T		Remove shoulder bone, part	0051	34.9381	$1,896.75		$379.35
23140	T		Removal of bone lesion	0049	19.9376	$1,082.39		$216.48
23145	T		Removal of bone lesion	0050	25.1166	$1,363.56		$272.71
23146	T		Removal of bone lesion	0050	25.1166	$1,363.56		$272.71
23150	T		Removal of humerus lesion	0050	25.1166	$1,363.56		$272.71
23155	T		Removal of humerus lesion	0050	25.1166	$1,363.56		$272.71
23156	T		Removal of humerus lesion	0050	25.1166	$1,363.56		$272.71
23170	T		Remove collar bone lesion	0050	25.1166	$1,363.56		$272.71
23172	T		Remove shoulder blade lesion	0050	25.1166	$1,363.56		$272.71
23174	T		Remove humerus lesion	0050	25.1166	$1,363.56		$272.71
23180	T		Remove collar bone lesion	0050	25.1166	$1,363.56		$272.71
23182	T		Remove shoulder blade lesion	0050	25.1166	$1,363.56		$272.71
23184	T		Remove humerus lesion	0050	25.1166	$1,363.56		$272.71
23190	T		Partial removal of scapula	0050	25.1166	$1,363.56		$272.71
23195	T		Removal of head of humerus	0050	25.1166	$1,363.56		$272.71
23200	C		Removal of collar bone					
23210	C		Removal of shoulder blade					
23220	C		Partial removal of humerus					
23221	C		Partial removal of humerus					
23222	C		Partial removal of humerus					
23330	T		Remove shoulder foreign body	0020	7.3105	$396.88	$113.25	$79.38
23331	T		Remove shoulder foreign body	0022	18.6725	$1,013.71	$354.45	$202.74
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	34.9381	$1,896.75		$379.35
23397	T		Muscle transfers	0052	42.6430	$2,315.05		$463.01
23400	T		Fixation of shoulder blade	0050	25.1166	$1,363.56		$272.71
23405	T		Incision of tendon & muscle	0050	25.1166	$1,363.56		$272.71
23406	T		Incise tendon(s) & muscle(s)	0050	25.1166	$1,363.56		$272.71
23410	T		Repair of tendon(s)	0052	42.6430	$2,315.05		$463.01
23412	T		Repair rotator cuff, chronic	0052	42.6430	$2,315.05		$463.01
23415	T		Release of shoulder ligament	0051	34.9381	$1,896.75		$379.35
23420	T		Repair of shoulder	0052	42.6430	$2,315.05		$463.01
23430	T		Repair biceps tendon	0052	42.6430	$2,315.05		$463.01
23440	T		Remove/transplant tendon	0052	42.6430	$2,315.05		$463.01
23450	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23455	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23460	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23462	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23465	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23466	T		Repair shoulder capsule	0052	42.6430	$2,315.05		$463.01
23470	T		Reconstruct shoulder joint	0048	47.4707	$2,577.14	$695.60	$515.43
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	34.9381	$1,896.75		$379.35
23485	T		Revision of collar bone	0051	34.9381	$1,896.75		$379.35
23490	T		Reinforce clavicle	0051	34.9381	$1,896.75		$379.35
23491	T		Reinforce shoulder bones	0051	34.9381	$1,896.75		$379.35
23500	T		Treat clavicle fracture	0043	1.9233	$104.41		$20.88
23505	T		Treat clavicle fracture	0043	1.9233	$104.41		$20.88
23515	T		Treat clavicle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23520	T		Treat clavicle dislocation	0043	1.9233	$104.41		$20.88
23525	T		Treat clavicle dislocation	0043	1.9233	$104.41		$20.88
23530	T		Treat clavicle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
23532	T		Treat clavicle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
23540	T		Treat clavicle dislocation	0043	1.9233	$104.41		$20.88
23545	T		Treat clavicle dislocation	0043	1.9233	$104.41		$20.88
23550	T		Treat clavicle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
23552	T		Treat clavicle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
23570	T		Treat shoulder blade fx	0043	1.9233	$104.41		$20.88
23575	T		Treat shoulder blade fx	0043	1.9233	$104.41		$20.88
23585	T		Treat scapula fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23600	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
23605	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
23615	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23616	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23620	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23625	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
23630	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23650	T		Treat shoulder dislocation	0043	1.9233	$104.41		$20.88
23655	T		Treat shoulder dislocation	0045	13.5546	$735.87	$268.47	$147.17
23660	T		Treat shoulder dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
23665	T		Treat dislocation/fracture	0043	1.9233	$104.41		$20.88
23670	T		Treat dislocation/fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23675	T		Treat dislocation/fracture	0043	1.9233	$104.41		$20.88
23680	T		Treat dislocation/fracture	0046	31.9719	$1,735.72	$535.76	$347.14
23700	T		Fixation of shoulder	0045	13.5546	$735.87	$268.47	$147.17
23800	T		Fusion of shoulder joint	0051	34.9381	$1,896.75		$379.35
23802	T		Fusion of shoulder joint	0051	34.9381	$1,896.75		$379.35
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	6.2703	$340.41	$115.49	$68.08
23929	T		Shoulder surgery procedure	0043	1.9233	$104.41		$20.88
23930	T		Drainage of arm lesion	0008	16.8303	$913.70		$182.74
23931	T		Drainage of arm bursa	0006	1.7487	$94.94	$24.12	$18.99
23935	T		Drain arm/elbow bone lesion	0049	19.9376	$1,082.39		$216.48
24000	T		Exploratory elbow surgery	0050	25.1166	$1,363.56		$272.71
24006	T		Release elbow joint	0050	25.1166	$1,363.56		$272.71
24065	T		Biopsy arm/elbow soft tissue	0021	14.5749	$791.26	$219.48	$158.25
24066	T		Biopsy arm/elbow soft tissue	0021	14.5749	$791.26	$219.48	$158.25
24075	T		Remove arm/elbow lesion	0021	14.5749	$791.26	$219.48	$158.25
24076	T		Remove arm/elbow lesion	0022	18.6725	$1,013.71	$354.45	$202.74
24077	T		Remove tumor of arm/elbow	0022	18.6725	$1,013.71	$354.45	$202.74
24100	T		Biopsy elbow joint lining	0049	19.9376	$1,082.39		$216.48
24101	T		Explore/treat elbow joint	0050	25.1166	$1,363.56		$272.71
24102	T		Remove elbow joint lining	0050	25.1166	$1,363.56		$272.71
24105	T		Removal of elbow bursa	0049	19.9376	$1,082.39		$216.48
24110	T		Remove humerus lesion	0049	19.9376	$1,082.39		$216.48
24115	T		Remove/graft bone lesion	0050	25.1166	$1,363.56		$272.71
24116	T		Remove/graft bone lesion	0050	25.1166	$1,363.56		$272.71
24120	T		Remove elbow lesion	0049	19.9376	$1,082.39		$216.48
24125	T		Remove/graft bone lesion	0050	25.1166	$1,363.56		$272.71
24126	T		Remove/graft bone lesion	0050	25.1166	$1,363.56		$272.71
24130	T		Removal of head of radius	0050	25.1166	$1,363.56		$272.71
24134	T		Removal of arm bone lesion	0050	25.1166	$1,363.56		$272.71
24136	T		Remove radius bone lesion	0050	25.1166	$1,363.56		$272.71
24138	T		Remove elbow bone lesion	0050	25.1166	$1,363.56		$272.71
24140	T		Partial removal of arm bone	0050	25.1166	$1,363.56		$272.71
24145	T		Partial removal of radius	0050	25.1166	$1,363.56		$272.71
24147	T		Partial removal of elbow	0050	25.1166	$1,363.56		$272.71
24149	C		Radical resection of elbow					
24150	T		Extensive humerus surgery	0052	42.6430	$2,315.05		$463.01
24151	T		Extensive humerus surgery	0052	42.6430	$2,315.05		$463.01
24152	T		Extensive radius surgery	0052	42.6430	$2,315.05		$463.01
24153	T		Extensive radius surgery	0052	42.6430	$2,315.05		$463.01
24155	T		Removal of elbow joint	0051	34.9381	$1,896.75		$379.35
24160	T		Remove elbow joint implant	0050	25.1166	$1,363.56		$272.71
24164	T		Remove radius head implant	0050	25.1166	$1,363.56		$272.71
24200	T		Removal of arm foreign body	0019	3.9807	$216.11	$71.87	$43.22
24201	T		Removal of arm foreign body	0021	14.5749	$791.26	$219.48	$158.25
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	13.5546	$735.87	$268.47	$147.17
24301	T		Muscle/tendon transfer	0050	25.1166	$1,363.56		$272.71
24305	T		Arm tendon lengthening	0050	25.1166	$1,363.56		$272.71
24310	T		Revision of arm tendon	0049	19.9376	$1,082.39		$216.48
24320	T		Repair of arm tendon	0051	34.9381	$1,896.75		$379.35
24330	T		Revision of arm muscles	0051	34.9381	$1,896.75		$379.35
24331	T		Revision of arm muscles	0051	34.9381	$1,896.75		$379.35
24332	T		Tenolysis, triceps	0049	19.9376	$1,082.39		$216.48
24340	T		Repair of biceps tendon	0051	34.9381	$1,896.75		$379.35
24341	T		Repair arm tendon/muscle	0051	34.9381	$1,896.75		$379.35
24342	T		Repair of ruptured tendon	0051	34.9381	$1,896.75		$379.35
24343	T		Repr elbow lat ligmnt w/tiss	0050	25.1166	$1,363.56		$272.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24344	T		Reconstruct elbow lat ligmnt	0051	34.9381	$1,896.75		$379.35
24345	T		Repr elbw med ligmnt w/tissu	0050	25.1166	$1,363.56		$272.71
24346	T		Reconstruct elbow med ligmnt	0051	34.9381	$1,896.75		$379.35
24350	T		Repair of tennis elbow	0050	25.1166	$1,363.56		$272.71
24351	T		Repair of tennis elbow	0050	25.1166	$1,363.56		$272.71
24352	T		Repair of tennis elbow	0050	25.1166	$1,363.56		$272.71
24354	T		Repair of tennis elbow	0050	25.1166	$1,363.56		$272.71
24356	T		Revision of tennis elbow	0050	25.1166	$1,363.56		$272.71
24360	T		Reconstruct elbow joint	0047	30.3786	$1,649.22	$537.03	$329.84
24361	T		Reconstruct elbow joint	0048	47.4707	$2,577.14	$695.60	$515.43
24362	T		Reconstruct elbow joint	0048	47.4707	$2,577.14	$695.60	$515.43
24363	T		Replace elbow joint	0048	47.4707	$2,577.14	$695.60	$515.43
24365	T		Reconstruct head of radius	0047	30.3786	$1,649.22	$537.03	$329.84
24366	T		Reconstruct head of radius	0048	47.4707	$2,577.14	$695.60	$515.43
24400	T		Revision of humerus	0050	25.1166	$1,363.56		$272.71
24410	T		Revision of humerus	0050	25.1166	$1,363.56		$272.71
24420	T		Revision of humerus	0051	34.9381	$1,896.75		$379.35
24430	T		Repair of humerus	0051	34.9381	$1,896.75		$379.35
24435	T		Repair humerus with graft	0051	34.9381	$1,896.75		$379.35
24470	T		Revision of elbow joint	0051	34.9381	$1,896.75		$379.35
24495	T		Decompression of forearm	0050	25.1166	$1,363.56		$272.71
24498	T		Reinforce humerus	0051	34.9381	$1,896.75		$379.35
24500	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24505	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24515	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24516	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24530	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24535	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24538	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24545	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24546	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24560	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24565	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24566	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24575	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24576	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24577	T		Treat humerus fracture	0043	1.9233	$104.41		$20.88
24579	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24582	T		Treat humerus fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24586	T		Treat elbow fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24587	T		Treat elbow fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24600	T		Treat elbow dislocation	0043	1.9233	$104.41		$20.88
24605	T		Treat elbow dislocation	0045	13.5546	$735.87	$268.47	$147.17
24615	T		Treat elbow dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
24620	T		Treat elbow fracture	0043	1.9233	$104.41		$20.88
24635	T		Treat elbow fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24640	T		Treat elbow dislocation	0043	1.9233	$104.41		$20.88
24650	T		Treat radius fracture	0043	1.9233	$104.41		$20.88
24655	T		Treat radius fracture	0043	1.9233	$104.41		$20.88
24665	T		Treat radius fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24666	T		Treat radius fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24670	T		Treat ulnar fracture	0043	1.9233	$104.41		$20.88
24675	T		Treat ulnar fracture	0043	1.9233	$104.41		$20.88
24685	T		Treat ulnar fracture	0046	31.9719	$1,735.72	$535.76	$347.14
24800	T		Fusion of elbow joint	0051	34.9381	$1,896.75		$379.35
24802	T		Fusion/graft of elbow joint	0051	34.9381	$1,896.75		$379.35
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	19.9376	$1,082.39		$216.48
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	42.6430	$2,315.05		$463.01
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	1.9233	$104.41		$20.88
25000	T		Incision of tendon sheath	0049	19.9376	$1,082.39		$216.48
25001	T		Incise flexor carpi radialis	0049	19.9376	$1,082.39		$216.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25020	T		Decompress forearm 1 space	0049	19.9376	$1,082.39		$216.48
25023	T		Decompress forearm 1 space	0050	25.1166	$1,363.56		$272.71
25024	T		Decompress forearm 2 spaces	0050	25.1166	$1,363.56		$272.71
25025	T		Decompress forarm 2 spaces	0050	25.1166	$1,363.56		$272.71
25028	T		Drainage of forearm lesion	0049	19.9376	$1,082.39		$216.48
25031	T		Drainage of forearm bursa	0049	19.9376	$1,082.39		$216.48
25035	T		Treat forearm bone lesion	0049	19.9376	$1,082.39		$216.48
25040	T		Explore/treat wrist joint	0050	25.1166	$1,363.56		$272.71
25065	T		Biopsy forearm soft tissues	0021	14.5749	$791.26	$219.48	$158.25
25066	T		Biopsy forearm soft tissues	0022	18.6725	$1,013.71	$354.45	$202.74
25075	T		Removel forearm lesion subcu	0021	14.5749	$791.26	$219.48	$158.25
25076	T		Removel forearm lesion deep	0022	18.6725	$1,013.71	$354.45	$202.74
25077	T		Remove tumor, forearm/wrist	0022	18.6725	$1,013.71	$354.45	$202.74
25085	T		Incision of wrist capsule	0049	19.9376	$1,082.39		$216.48
25100	T		Biopsy of wrist joint	0049	19.9376	$1,082.39		$216.48
25101	T		Explore/treat wrist joint	0050	25.1166	$1,363.56		$272.71
25105	T		Remove wrist joint lining	0050	25.1166	$1,363.56		$272.71
25107	T		Remove wrist joint cartilage	0050	25.1166	$1,363.56		$272.71
25110	T		Remove wrist tendon lesion	0049	19.9376	$1,082.39		$216.48
25111	T		Remove wrist tendon lesion	0053	14.8188	$804.50	$253.49	$160.90
25112	T		Reremove wrist tendon lesion	0053	14.8188	$804.50	$253.49	$160.90
25115	T		Remove wrist/forearm lesion	0049	19.9376	$1,082.39		$216.48
25116	T		Remove wrist/forearm lesion	0049	19.9376	$1,082.39		$216.48
25118	T		Excise wrist tendon sheath	0050	25.1166	$1,363.56		$272.71
25119	T		Partial removal of ulna	0050	25.1166	$1,363.56		$272.71
25120	T		Removal of forearm lesion	0050	25.1166	$1,363.56		$272.71
25125	T		Remove/graft forearm lesion	0050	25.1166	$1,363.56		$272.71
25126	T		Remove/graft forearm lesion	0050	25.1166	$1,363.56		$272.71
25130	T		Removal of wrist lesion	0050	25.1166	$1,363.56		$272.71
25135	T		Remove & graft wrist lesion	0050	25.1166	$1,363.56		$272.71
25136	T		Remove & graft wrist lesion	0050	25.1166	$1,363.56		$272.71
25145	T		Remove forearm bone lesion	0050	25.1166	$1,363.56		$272.71
25150	T		Partial removal of ulna	0050	25.1166	$1,363.56		$272.71
25151	T		Partial removal of radius	0050	25.1166	$1,363.56		$272.71
25170	T		Extensive forearm surgery	0052	42.6430	$2,315.05		$463.01
25210	T		Removal of wrist bone	0054	24.2685	$1,317.51		$263.50
25215	T		Removal of wrist bones	0054	24.2685	$1,317.51		$263.50
25230	T		Partial removal of radius	0050	25.1166	$1,363.56		$272.71
25240	T		Partial removal of ulna	0050	25.1166	$1,363.56		$272.71
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	19.9376	$1,082.39		$216.48
25250	T		Removal of wrist prosthesis	0050	25.1166	$1,363.56		$272.71
25251	T		Removal of wrist prosthesis	0050	25.1166	$1,363.56		$272.71
25259	T		Manipulate wrist w/anesthes	0043	1.9233	$104.41		$20.88
25260	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25263	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25265	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25270	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25272	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25274	T		Repair forearm tendon/muscle	0050	25.1166	$1,363.56		$272.71
25275	T		Repair forearm tendon sheath	0050	25.1166	$1,363.56		$272.71
25280	T		Revise wrist/forearm tendon	0050	25.1166	$1,363.56		$272.71
25290	T		Incise wrist/forearm tendon	0050	25.1166	$1,363.56		$272.71
25295	T		Release wrist/forearm tendon	0049	19.9376	$1,082.39		$216.48
25300	T		Fusion of tendons at wrist	0050	25.1166	$1,363.56		$272.71
25301	T		Fusion of tendons at wrist	0050	25.1166	$1,363.56		$272.71
25310	T		Transplant forearm tendon	0051	34.9381	$1,896.75		$379.35
25312	T		Transplant forearm tendon	0051	34.9381	$1,896.75		$379.35
25315	T		Revise palsy hand tendon(s)	0051	34.9381	$1,896.75		$379.35
25316	T		Revise palsy hand tendon(s)	0051	34.9381	$1,896.75		$379.35
25320	T		Repair/revise wrist joint	0051	34.9381	$1,896.75		$379.35
25332	T		Revise wrist joint	0047	30.3786	$1,649.22	$537.03	$329.84
25335	T		Realignment of hand	0051	34.9381	$1,896.75		$379.35
25337	T		Reconstruct ulna/radioulnar	0051	34.9381	$1,896.75		$379.35
25350	T		Revision of radius	0051	34.9381	$1,896.75		$379.35
25355	T		Revision of radius	0051	34.9381	$1,896.75		$379.35

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25360	T		Revision of ulna	0050	25.1166	$1,363.56		$272.71
25365	T		Revise radius & ulna	0050	25.1166	$1,363.56		$272.71
25370	T		Revise radius or ulna	0051	34.9381	$1,896.75		$379.35
25375	T		Revise radius & ulna	0051	34.9381	$1,896.75		$379.35
25390	T		Shorten radius or ulna	0050	25.1166	$1,363.56		$272.71
25391	T		Lengthen radius or ulna	0051	34.9381	$1,896.75		$379.35
25392	T		Shorten radius & ulna	0050	25.1166	$1,363.56		$272.71
25393	T		Lengthen radius & ulna	0051	34.9381	$1,896.75		$379.35
25394	T		Repair carpal bone, shorten	0053	14.8188	$804.50	$253.49	$160.90
25400	T		Repair radius or ulna	0050	25.1166	$1,363.56		$272.71
25405	T		Repair/graft radius or ulna	0050	25.1166	$1,363.56		$272.71
25415	T		Repair radius & ulna	0050	25.1166	$1,363.56		$272.71
25420	T		Repair/graft radius & ulna	0051	34.9381	$1,896.75		$379.35
25425	T		Repair/graft radius or ulna	0051	34.9381	$1,896.75		$379.35
25426	T		Repair/graft radius & ulna	0051	34.9381	$1,896.75		$379.35
25430	T		Vasc graft into carpal bone	0054	24.2685	$1,317.51		$263.50
25431	T		Repair nonunion carpal bone	0054	24.2685	$1,317.51		$263.50
25440	T		Repair/graft wrist bone	0051	34.9381	$1,896.75		$379.35
25441	T		Reconstruct wrist joint	0048	47.4707	$2,577.14	$695.60	$515.43
25442	T		Reconstruct wrist joint	0048	47.4707	$2,577.14	$695.60	$515.43
25443	T		Reconstruct wrist joint	0048	47.4707	$2,577.14	$695.60	$515.43
25444	T		Reconstruct wrist joint	0048	47.4707	$2,577.14	$695.60	$515.43
25445	T		Reconstruct wrist joint	0048	47.4707	$2,577.14	$695.60	$515.43
25446	T		Wrist replacement	0048	47.4707	$2,577.14	$695.60	$515.43
25447	T		Repair wrist joint(s)	0047	30.3786	$1,649.22	$537.03	$329.84
25449	T		Remove wrist joint implant	0047	30.3786	$1,649.22	$537.03	$329.84
25450	T		Revision of wrist joint	0051	34.9381	$1,896.75		$379.35
25455	T		Revision of wrist joint	0051	34.9381	$1,896.75		$379.35
25490	T		Reinforce radius	0051	34.9381	$1,896.75		$379.35
25491	T		Reinforce ulna	0051	34.9381	$1,896.75		$379.35
25492	T		Reinforce radius and ulna	0051	34.9381	$1,896.75		$379.35
25500	T		Treat fracture of radius	0043	1.9233	$104.41		$20.88
25505	T		Treat fracture of radius	0043	1.9233	$104.41		$20.88
25515	T		Treat fracture of radius	0046	31.9719	$1,735.72	$535.76	$347.14
25520	T		Treat fracture of radius	0043	1.9233	$104.41		$20.88
25525	T		Treat fracture of radius	0046	31.9719	$1,735.72	$535.76	$347.14
25526	T		Treat fracture of radius	0046	31.9719	$1,735.72	$535.76	$347.14
25530	T		Treat fracture of ulna	0043	1.9233	$104.41		$20.88
25535	T		Treat fracture of ulna	0043	1.9233	$104.41		$20.88
25545	T		Treat fracture of ulna	0046	31.9719	$1,735.72	$535.76	$347.14
25560	T		Treat fracture radius & ulna	0043	1.9233	$104.41		$20.88
25565	T		Treat fracture radius & ulna	0043	1.9233	$104.41		$20.88
25574	T		Treat fracture radius & ulna	0046	31.9719	$1,735.72	$535.76	$347.14
25575	T		Treat fracture radius/ulna	0046	31.9719	$1,735.72	$535.76	$347.14
25600	T		Treat fracture radius/ulna	0043	1.9233	$104.41		$20.88
25605	T		Treat fracture radius/ulna	0043	1.9233	$104.41		$20.88
25611	T		Treat fracture radius/ulna	0046	31.9719	$1,735.72	$535.76	$347.14
25620	T		Treat fracture radius/ulna	0046	31.9719	$1,735.72	$535.76	$347.14
25622	T		Treat wrist bone fracture	0043	1.9233	$104.41		$20.88
25624	T		Treat wrist bone fracture	0043	1.9233	$104.41		$20.88
25628	T		Treat wrist bone fracture	0046	31.9719	$1,735.72	$535.76	$347.14
25630	T		Treat wrist bone fracture	0043	1.9233	$104.41		$20.88
25635	T		Treat wrist bone fracture	0043	1.9233	$104.41		$20.88
25645	T		Treat wrist bone fracture	0046	31.9719	$1,735.72	$535.76	$347.14
25650	T		Treat wrist bone fracture	0043	1.9233	$104.41		$20.88
25651	T		Pin ulnar styloid fracture	0046	31.9719	$1,735.72	$535.76	$347.14
25652	T		Treat fracture ulnar styloid	0046	31.9719	$1,735.72	$535.76	$347.14
25660	T		Treat wrist dislocation	0043	1.9233	$104.41		$20.88
25670	T		Treat wrist dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
25671	T		Pin radioulnar dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
25675	T		Treat wrist dislocation	0043	1.9233	$104.41		$20.88
25676	T		Treat wrist dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
25680	T		Treat wrist fracture	0043	1.9233	$104.41		$20.88
25685	T		Treat wrist fracture	0046	31.9719	$1,735.72	$535.76	$347.14
25690	T		Treat wrist dislocation	0043	1.9233	$104.41		$20.88
25695	T		Treat wrist dislocation	0046	31.9719	$1,735.72	$535.76	$347.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25800	T		Fusion of wrist joint	0051	34.9381	$1,896.75		$379.35
25805	T		Fusion/graft of wrist joint	0051	34.9381	$1,896.75		$379.35
25810	T		Fusion/graft of wrist joint	0051	34.9381	$1,896.75		$379.35
25820	T		Fusion of hand bones	0053	14.8188	$804.50	$253.49	$160.90
25825	T		Fuse hand bones with graft	0054	24.2685	$1,317.51		$263.50
25830	T		Fusion, radioulnar jnt/ulna	0051	34.9381	$1,896.75		$379.35
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	19.9376	$1,082.39		$216.48
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	19.9376	$1,082.39		$216.48
25924	C		Amputation follow-up surgery					
25927	C		Amputation of hand					
25929	T		Amputation follow-up surgery	0027	15.8319	$859.50	$329.72	$171.90
25931	C		Amputation follow-up surgery					
25999	T		Forearm or wrist surgery	0043	1.9233	$104.41		$20.88
26010	T		Drainage of finger abscess	0006	1.7487	$94.94	$24.12	$18.99
26011	T		Drainage of finger abscess	0007	11.4943	$624.01		$124.80
26020	T		Drain hand tendon sheath	0053	14.8188	$804.50	$253.49	$160.90
26025	T		Drainage of palm bursa	0053	14.8188	$804.50	$253.49	$160.90
26030	T		Drainage of palm bursa(s)	0053	14.8188	$804.50	$253.49	$160.90
26034	T		Treat hand bone lesion	0053	14.8188	$804.50	$253.49	$160.90
26035	T		Decompress fingers/hand	0053	14.8188	$804.50	$253.49	$160.90
26037	T		Decompress fingers/hand	0053	14.8188	$804.50	$253.49	$160.90
26040	T		Release palm contracture	0054	24.2685	$1,317.51		$263.50
26045	T		Release palm contracture	0054	24.2685	$1,317.51		$263.50
26055	T		Incise finger tendon sheath	0053	14.8188	$804.50	$253.49	$160.90
26060	T		Incision of finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26070	T		Explore/treat hand joint	0053	14.8188	$804.50	$253.49	$160.90
26075	T		Explore/treat finger joint	0053	14.8188	$804.50	$253.49	$160.90
26080	T		Explore/treat finger joint	0053	14.8188	$804.50	$253.49	$160.90
26100	T		Biopsy hand joint lining	0053	14.8188	$804.50	$253.49	$160.90
26105	T		Biopsy finger joint lining	0053	14.8188	$804.50	$253.49	$160.90
26110	T		Biopsy finger joint lining	0053	14.8188	$804.50	$253.49	$160.90
26115	T		Removel hand lesion subcut	0022	18.6725	$1,013.71	$354.45	$202.74
26116	T		Removel hand lesion, deep	0022	18.6725	$1,013.71	$354.45	$202.74
26117	T		Remove tumor, hand/finger	0022	18.6725	$1,013.71	$354.45	$202.74
26121	T		Release palm contracture	0054	24.2685	$1,317.51		$263.50
26123	T		Release palm contracture	0054	24.2685	$1,317.51		$263.50
26125	T		Release palm contracture	0054	24.2685	$1,317.51		$263.50
26130	T		Remove wrist joint lining	0053	14.8188	$804.50	$253.49	$160.90
26135	T		Revise finger joint, each	0054	24.2685	$1,317.51		$263.50
26140	T		Revise finger joint, each	0053	14.8188	$804.50	$253.49	$160.90
26145	T		Tendon excision, palm/finger	0053	14.8188	$804.50	$253.49	$160.90
26160	T		Remove tendon sheath lesion	0053	14.8188	$804.50	$253.49	$160.90
26170	T		Removal of palm tendon, each	0053	14.8188	$804.50	$253.49	$160.90
26180	T		Removal of finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26185	T		Remove finger bone	0053	14.8188	$804.50	$253.49	$160.90
26200	T		Remove hand bone lesion	0053	14.8188	$804.50	$253.49	$160.90
26205	T		Remove/graft bone lesion	0054	24.2685	$1,317.51		$263.50
26210	T		Removal of finger lesion	0053	14.8188	$804.50	$253.49	$160.90
26215	T		Remove/graft finger lesion	0053	14.8188	$804.50	$253.49	$160.90
26230	T		Partial removal of hand bone	0053	14.8188	$804.50	$253.49	$160.90
26235	T		Partial removal, finger bone	0053	14.8188	$804.50	$253.49	$160.90
26236	T		Partial removal, finger bone	0053	14.8188	$804.50	$253.49	$160.90
26250	T		Extensive hand surgery	0053	14.8188	$804.50	$253.49	$160.90
26255	T		Extensive hand surgery	0054	24.2685	$1,317.51		$263.50
26260	T		Extensive finger surgery	0053	14.8188	$804.50	$253.49	$160.90
26261	T		Extensive finger surgery	0053	14.8188	$804.50	$253.49	$160.90
26262	T		Partial removal of finger	0053	14.8188	$804.50	$253.49	$160.90
26320	T		Removal of implant from hand	0021	14.5749	$791.26	$219.48	$158.25
26340	T		Manipulate finger w/anesth	0043	1.9233	$104.41		$20.88
26350	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26352	T		Repair/graft hand tendon	0054	24.2685	$1,317.51		$263.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26356	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26357	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26358	T		Repair/graft hand tendon	0054	24.2685	$1,317.51		$263.50
26370	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26372	T		Repair/graft hand tendon	0054	24.2685	$1,317.51		$263.50
26373	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26390	T		Revise hand/finger tendon	0054	24.2685	$1,317.51		$263.50
26392	T		Repair/graft hand tendon	0054	24.2685	$1,317.51		$263.50
26410	T		Repair hand tendon	0053	14.8188	$804.50	$253.49	$160.90
26412	T		Repair/graft hand tendon	0054	24.2685	$1,317.51		$263.50
26415	T		Excision, hand/finger tendon	0054	24.2685	$1,317.51		$263.50
26416	T		Graft hand or finger tendon	0054	24.2685	$1,317.51		$263.50
26418	T		Repair finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26420	T		Repair/graft finger tendon	0054	24.2685	$1,317.51		$263.50
26426	T		Repair finger/hand tendon	0054	24.2685	$1,317.51		$263.50
26428	T		Repair/graft finger tendon	0054	24.2685	$1,317.51		$263.50
26432	T		Repair finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26433	T		Repair finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26434	T		Repair/graft finger tendon	0054	24.2685	$1,317.51		$263.50
26437	T		Realignment of tendons	0053	14.8188	$804.50	$253.49	$160.90
26440	T		Release palm/finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26442	T		Release palm & finger tendon	0054	24.2685	$1,317.51		$263.50
26445	T		Release hand/finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26449	T		Release forearm/hand tendon	0054	24.2685	$1,317.51		$263.50
26450	T		Incision of palm tendon	0053	14.8188	$804.50	$253.49	$160.90
26455	T		Incision of finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26460	T		Incise hand/finger tendon	0053	14.8188	$804.50	$253.49	$160.90
26471	T		Fusion of finger tendons	0053	14.8188	$804.50	$253.49	$160.90
26474	T		Fusion of finger tendons	0053	14.8188	$804.50	$253.49	$160.90
26476	T		Tendon lengthening	0053	14.8188	$804.50	$253.49	$160.90
26477	T		Tendon shortening	0053	14.8188	$804.50	$253.49	$160.90
26478	T		Lengthening of hand tendon	0053	14.8188	$804.50	$253.49	$160.90
26479	T		Shortening of hand tendon	0053	14.8188	$804.50	$253.49	$160.90
26480	T		Transplant hand tendon	0054	24.2685	$1,317.51		$263.50
26483	T		Transplant/graft hand tendon	0054	24.2685	$1,317.51		$263.50
26485	T		Transplant palm tendon	0054	24.2685	$1,317.51		$263.50
26489	T		Transplant/graft palm tendon	0054	24.2685	$1,317.51		$263.50
26490	T		Revise thumb tendon	0054	24.2685	$1,317.51		$263.50
26492	T		Tendon transfer with graft	0054	24.2685	$1,317.51		$263.50
26494	T		Hand tendon/muscle transfer	0054	24.2685	$1,317.51		$263.50
26496	T		Revise thumb tendon	0054	24.2685	$1,317.51		$263.50
26497	T		Finger tendon transfer	0054	24.2685	$1,317.51		$263.50
26498	T		Finger tendon transfer	0054	24.2685	$1,317.51		$263.50
26499	T		Revision of finger	0054	24.2685	$1,317.51		$263.50
26500	T		Hand tendon reconstruction	0053	14.8188	$804.50	$253.49	$160.90
26502	T		Hand tendon reconstruction	0054	24.2685	$1,317.51		$263.50
26504	T		Hand tendon reconstruction	0054	24.2685	$1,317.51		$263.50
26508	T		Release thumb contracture	0053	14.8188	$804.50	$253.49	$160.90
26510	T		Thumb tendon transfer	0054	24.2685	$1,317.51		$263.50
26516	T		Fusion of knuckle joint	0054	24.2685	$1,317.51		$263.50
26517	T		Fusion of knuckle joints	0054	24.2685	$1,317.51		$263.50
26518	T		Fusion of knuckle joints	0054	24.2685	$1,317.51		$263.50
26520	T		Release knuckle contracture	0053	14.8188	$804.50	$253.49	$160.90
26525	T		Release finger contracture	0053	14.8188	$804.50	$253.49	$160.90
26530	T		Revise knuckle joint	0047	30.3786	$1,649.22	$537.03	$329.84
26531	T		Revise knuckle with implant	0048	47.4707	$2,577.14	$695.60	$515.43
26535	T		Revise finger joint	0047	30.3786	$1,649.22	$537.03	$329.84
26536	T		Revise/implant finger joint	0048	47.4707	$2,577.14	$695.60	$515.43
26540	T		Repair hand joint	0053	14.8188	$804.50	$253.49	$160.90
26541	T		Repair hand joint with graft	0054	24.2685	$1,317.51		$263.50
26542	T		Repair hand joint with graft	0053	14.8188	$804.50	$253.49	$160.90
26545	T		Reconstruct finger joint	0054	24.2685	$1,317.51		$263.50
26546	T		Repair nonunion hand	0054	24.2685	$1,317.51		$263.50
26548	T		Reconstruct finger joint	0054	24.2685	$1,317.51		$263.50
26550	T		Construct thumb replacement	0054	24.2685	$1,317.51		$263.50
26551	C		Great toe-hand transfer					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26553	C		Single transfer, toe-hand					
26554	C		Double transfer, toe-hand					
26555	T		Positional change of finger	0054	24.2685	$1,317.51		$263.50
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	14.8188	$804.50	$253.49	$160.90
26561	T		Repair of web finger	0054	24.2685	$1,317.51		$263.50
26562	T		Repair of web finger	0054	24.2685	$1,317.51		$263.50
26565	T		Correct metacarpal flaw	0054	24.2685	$1,317.51		$263.50
26567	T		Correct finger deformity	0054	24.2685	$1,317.51		$263.50
26568	T		Lengthen metacarpal/finger	0054	24.2685	$1,317.51		$263.50
26580	T		Repair hand deformity	0054	24.2685	$1,317.51		$263.50
26587	T		Reconstruct extra finger	0053	14.8188	$804.50	$253.49	$160.90
26590	T		Repair finger deformity	0054	24.2685	$1,317.51		$263.50
26591	T		Repair muscles of hand	0054	24.2685	$1,317.51		$263.50
26593	T		Release muscles of hand	0053	14.8188	$804.50	$253.49	$160.90
26596	T		Excision constricting tissue	0054	24.2685	$1,317.51		$263.50
26600	T		Treat metacarpal fracture	0043	1.9233	$104.41		$20.88
26605	T		Treat metacarpal fracture	0043	1.9233	$104.41		$20.88
26607	T		Treat metacarpal fracture	0043	1.9233	$104.41		$20.88
26608	T		Treat metacarpal fracture	0046	31.9719	$1,735.72	$535.76	$347.14
26615	T		Treat metacarpal fracture	0046	31.9719	$1,735.72	$535.76	$347.14
26641	T		Treat thumb dislocation	0043	1.9233	$104.41		$20.88
26645	T		Treat thumb fracture	0043	1.9233	$104.41		$20.88
26650	T		Treat thumb fracture	0046	31.9719	$1,735.72	$535.76	$347.14
26665	T		Treat thumb fracture	0046	31.9719	$1,735.72	$535.76	$347.14
26670	T		Treat hand dislocation	0043	1.9233	$104.41		$20.88
26675	T		Treat hand dislocation	0043	1.9233	$104.41		$20.88
26676	T		Pin hand dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26685	T		Treat hand dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26686	T		Treat hand dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26700	T		Treat knuckle dislocation	0043	1.9233	$104.41		$20.88
26705	T		Treat knuckle dislocation	0043	1.9233	$104.41		$20.88
26706	T		Pin knuckle dislocation	0043	1.9233	$104.41		$20.88
26715	T		Treat knuckle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26720	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26725	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26727	T		Treat finger fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
26735	T		Treat finger fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
26740	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26742	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26746	T		Treat finger fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
26750	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26755	T		Treat finger fracture, each	0043	1.9233	$104.41		$20.88
26756	T		Pin finger fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
26765	T		Treat finger fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
26770	T		Treat finger dislocation	0043	1.9233	$104.41		$20.88
26775	T		Treat finger dislocation	0045	13.5546	$735.87	$268.47	$147.17
26776	T		Pin finger dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26785	T		Treat finger dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
26820	T		Thumb fusion with graft	0054	24.2685	$1,317.51		$263.50
26841	T		Fusion of thumb	0054	24.2685	$1,317.51		$263.50
26842	T		Thumb fusion with graft	0054	24.2685	$1,317.51		$263.50
26843	T		Fusion of hand joint	0054	24.2685	$1,317.51		$263.50
26844	T		Fusion/graft of hand joint	0054	24.2685	$1,317.51		$263.50
26850	T		Fusion of knuckle	0054	24.2685	$1,317.51		$263.50
26852	T		Fusion of knuckle with graft	0054	24.2685	$1,317.51		$263.50
26860	T		Fusion of finger joint	0054	24.2685	$1,317.51		$263.50
26861	T		Fusion of finger jnt, add-on	0054	24.2685	$1,317.51		$263.50
26862	T		Fusion/graft of finger joint	0054	24.2685	$1,317.51		$263.50
26863	T		Fuse/graft added joint	0054	24.2685	$1,317.51		$263.50
26910	T		Amputate metacarpal bone	0054	24.2685	$1,317.51		$263.50
26951	T		Amputation of finger/thumb	0053	14.8188	$804.50	$253.49	$160.90
26952	T		Amputation of finger/thumb	0053	14.8188	$804.50	$253.49	$160.90
26989	T		Hand/finger surgery	0043	1.9233	$104.41		$20.88
26990	T		Drainage of pelvis lesion	0049	19.9376	$1,082.39		$216.48
26991	T		Drainage of pelvis bursa	0049	19.9376	$1,082.39		$216.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	19.9376	$1,082.39		$216.48
27001	T		Incision of hip tendon	0050	25.1166	$1,363.56		$272.71
27003	T		Incision of hip tendon	0050	25.1166	$1,363.56		$272.71
27005	C		Incision of hip tendon					
27006	C		Incision of hip tendons					
27025	C		Incision of hip/thigh fascia					
27030	C		Drainage of hip joint					
27033	T		Exploration of hip joint	0051	34.9381	$1,896.75		$379.35
27035	T		Denervation of hip joint	0052	42.6430	$2,315.05		$463.01
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0021	14.5749	$791.26	$219.48	$158.25
27041	T		Biopsy of soft tissues	0022	18.6725	$1,013.71	$354.45	$202.74
27047	T		Remove hip/pelvis lesion	0022	18.6725	$1,013.71	$354.45	$202.74
27048	T		Remove hip/pelvis lesion	0022	18.6725	$1,013.71	$354.45	$202.74
27049	T		Remove tumor, hip/pelvis	0022	18.6725	$1,013.71	$354.45	$202.74
27050	T		Biopsy of sacroiliac joint	0049	19.9376	$1,082.39		$216.48
27052	T		Biopsy of hip joint	0049	19.9376	$1,082.39		$216.48
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	19.9376	$1,082.39		$216.48
27062	T		Remove femur lesion/bursa	0049	19.9376	$1,082.39		$216.48
27065	T		Removal of hip bone lesion	0049	19.9376	$1,082.39		$216.48
27066	T		Removal of hip bone lesion	0050	25.1166	$1,363.56		$272.71
27067	T		Remove/graft hip bone lesion	0050	25.1166	$1,363.56		$272.71
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	25.1166	$1,363.56		$272.71
27086	T		Remove hip foreign body	0020	7.3105	$396.88	$113.25	$79.38
27087	T		Remove hip foreign body	0049	19.9376	$1,082.39		$216.48
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	E		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	25.1166	$1,363.56		$272.71
27098	T		Transfer tendon to pelvis	0050	25.1166	$1,363.56		$272.71
27100	T		Transfer of abdominal muscle	0051	34.9381	$1,896.75		$379.35
27105	T		Transfer of spinal muscle	0051	34.9381	$1,896.75		$379.35
27110	T		Transfer of iliopsoas muscle	0051	34.9381	$1,896.75		$379.35
27111	T		Transfer of iliopsoas muscle	0051	34.9381	$1,896.75		$379.35
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27179	C		Revise head/neck of femur					
27181	C		Treat slipped epiphysis					
27185	C		Revision of femur epiphysis					
27187	C		Reinforce hip bones					
27193	T		Treat pelvic ring fracture	0043	1.9233	$104.41		$20.88
27194	T		Treat pelvic ring fracture	0045	13.5546	$735.87	$268.47	$147.17
27200	T		Treat tail bone fracture	0043	1.9233	$104.41		$20.88
27202	T		Treat tail bone fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	25.1166	$1,363.56		$272.71
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.9233	$104.41		$20.88
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	1.9233	$104.41		$20.88
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	25.1166	$1,363.56		$272.71
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.9233	$104.41		$20.88
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.9233	$104.41		$20.88
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.9233	$104.41		$20.88
27252	T		Treat hip dislocation	0045	13.5546	$735.87	$268.47	$147.17
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.9233	$104.41		$20.88
27257	T		Treat hip dislocation	0045	13.5546	$735.87	$268.47	$147.17
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.9233	$104.41		$20.88
27266	T		Treat hip dislocation	0045	13.5546	$735.87	$268.47	$147.17
27275	T		Manipulation of hip joint	0045	13.5546	$735.87	$268.47	$147.17
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	1.9233	$104.41		$20.88
27301	T		Drain thigh/knee lesion	0008	16.8303	$913.70		$182.74
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	19.9376	$1,082.39		$216.48
27306	T		Incision of thigh tendon	0049	19.9376	$1,082.39		$216.48
27307	T		Incision of thigh tendons	0049	19.9376	$1,082.39		$216.48
27310	T		Exploration of knee joint	0050	25.1166	$1,363.56		$272.71
27315	T		Partial removal, thigh nerve	0220	16.5293	$897.36		$179.47
27320	T		Partial removal, thigh nerve	0220	16.5293	$897.36		$179.47
27323	T		Biopsy, thigh soft tissues	0021	14.5749	$791.26	$219.48	$158.25
27324	T		Biopsy, thigh soft tissues	0022	18.6725	$1,013.71	$354.45	$202.74
27327	T		Removal of thigh lesion	0022	18.6725	$1,013.71	$354.45	$202.74
27328	T		Removal of thigh lesion	0022	18.6725	$1,013.71	$354.45	$202.74
27329	T		Remove tumor, thigh/knee	0022	18.6725	$1,013.71	$354.45	$202.74
27330	T		Biopsy, knee joint lining	0050	25.1166	$1,363.56		$272.71
27331	T		Explore/treat knee joint	0050	25.1166	$1,363.56		$272.71
27332	T		Removal of knee cartilage	0050	25.1166	$1,363.56		$272.71
27333	T		Removal of knee cartilage	0050	25.1166	$1,363.56		$272.71
27334	T		Remove knee joint lining	0050	25.1166	$1,363.56		$272.71
27335	T		Remove knee joint lining	0050	25.1166	$1,363.56		$272.71
27340	T		Removal of kneecap bursa	0049	19.9376	$1,082.39		$216.48
27345	T		Removal of knee cyst	0049	19.9376	$1,082.39		$216.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27347	T		Remove knee cyst	0049	19.9376	$1,082.39		$216.48
27350	T		Removal of kneecap	0050	25.1166	$1,363.56		$272.71
27355	T		Remove femur lesion	0050	25.1166	$1,363.56		$272.71
27356	T		Remove femur lesion/graft	0050	25.1166	$1,363.56		$272.71
27357	T		Remove femur lesion/graft	0050	25.1166	$1,363.56		$272.71
27358	T		Remove femur lesion/fixation	0050	25.1166	$1,363.56		$272.71
27360	T		Partial removal, leg bone(s)	0050	25.1166	$1,363.56		$272.71
27365	C		Extensive leg surgery					
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	18.6725	$1,013.71	$354.45	$202.74
27380	T		Repair of kneecap tendon	0049	19.9376	$1,082.39		$216.48
27381	T		Repair/graft kneecap tendon	0049	19.9376	$1,082.39		$216.48
27385	T		Repair of thigh muscle	0049	19.9376	$1,082.39		$216.48
27386	T		Repair/graft of thigh muscle	0049	19.9376	$1,082.39		$216.48
27390	T		Incision of thigh tendon	0049	19.9376	$1,082.39		$216.48
27391	T		Incision of thigh tendons	0049	19.9376	$1,082.39		$216.48
27392	T		Incision of thigh tendons	0049	19.9376	$1,082.39		$216.48
27393	T		Lengthening of thigh tendon	0050	25.1166	$1,363.56		$272.71
27394	T		Lengthening of thigh tendons	0050	25.1166	$1,363.56		$272.71
27395	T		Lengthening of thigh tendons	0051	34.9381	$1,896.75		$379.35
27396	T		Transplant of thigh tendon	0050	25.1166	$1,363.56		$272.71
27397	T		Transplants of thigh tendons	0051	34.9381	$1,896.75		$379.35
27400	T		Revise thigh muscles/tendons	0051	34.9381	$1,896.75		$379.35
27403	T		Repair of knee cartilage	0050	25.1166	$1,363.56		$272.71
27405	T		Repair of knee ligament	0051	34.9381	$1,896.75		$379.35
27407	T		Repair of knee ligament	0051	34.9381	$1,896.75		$379.35
27409	T		Repair of knee ligaments	0051	34.9381	$1,896.75		$379.35
27418	T		Repair degenerated kneecap	0051	34.9381	$1,896.75		$379.35
27420	T		Revision of unstable kneecap	0051	34.9381	$1,896.75		$379.35
27422	T		Revision of unstable kneecap	0051	34.9381	$1,896.75		$379.35
27424	T		Revision/removal of kneecap	0051	34.9381	$1,896.75		$379.35
27425	T		Lateral retinacular release	0050	25.1166	$1,363.56		$272.71
27427	T		Reconstruction, knee	0052	42.6430	$2,315.05		$463.01
27428	T		Reconstruction, knee	0052	42.6430	$2,315.05		$463.01
27429	T		Reconstruction, knee	0052	42.6430	$2,315.05		$463.01
27430	T		Revision of thigh muscles	0051	34.9381	$1,896.75		$379.35
27435	T		Incision of knee joint	0051	34.9381	$1,896.75		$379.35
27437	T		Revise kneecap	0047	30.3786	$1,649.22	$537.03	$329.84
27438	T		Revise kneecap with implant	0048	47.4707	$2,577.14	$695.60	$515.43
27440	T		Revision of knee joint	0047	30.3786	$1,649.22	$537.03	$329.84
27441	T		Revision of knee joint	0047	30.3786	$1,649.22	$537.03	$329.84
27442	T		Revision of knee joint	0047	30.3786	$1,649.22	$537.03	$329.84
27443	T		Revision of knee joint	0047	30.3786	$1,649.22	$537.03	$329.84
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	96.7483	$5,252.37	$2,090.21	$1,050.47
27447	C		Total knee arthroplasty					
27448	C		Incision of thigh					
27450	C		Incision of thigh					
27454	C		Realignment of thigh bone					
27455	C		Realignment of knee					
27457	C		Realignment of knee					
27465	C		Shortening of thigh bone					
27466	C		Lengthening of thigh bone					
27468	C		Shorten/lengthen thighs					
27470	C		Repair of thigh					
27472	C		Repair/graft of thigh					
27475	C		Surgery to stop leg growth					
27477	C		Surgery to stop leg growth					
27479	C		Surgery to stop leg growth					
27485	C		Surgery to stop leg growth					
27486	C		Revise/replace knee joint					
27487	C		Revise/replace knee joint					
27488	C		Removal of knee prosthesis					
27495	C		Reinforce thigh					
27496	T		Decompression of thigh/knee	0049	19.9376	$1,082.39		$216.48
27497	T		Decompression of thigh/knee	0049	19.9376	$1,082.39		$216.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27498	T		Decompression of thigh/knee	0049	19.9376	$1,082.39		$216.48
27499	T		Decompression of thigh/knee	0049	19.9376	$1,082.39		$216.48
27500	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27501	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27502	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27503	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27506	C		Treatment of thigh fracture					
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27509	T		Treatment of thigh fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27510	T		Treatment of thigh fracture	0043	1.9233	$104.41		$20.88
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	1.9233	$104.41		$20.88
27517	T		Treat thigh fx growth plate	0043	1.9233	$104.41		$20.88
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	1.9233	$104.41		$20.88
27524	T		Treat kneecap fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27530	T		Treat knee fracture	0043	1.9233	$104.41		$20.88
27532	T		Treat knee fracture	0043	1.9233	$104.41		$20.88
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	1.9233	$104.41		$20.88
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	1.9233	$104.41		$20.88
27552	T		Treat knee dislocation	0045	13.5546	$735.87	$268.47	$147.17
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	1.9233	$104.41		$20.88
27562	T		Treat kneecap dislocation	0045	13.5546	$735.87	$268.47	$147.17
27566	T		Treat kneecap dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
27570	T		Fixation of knee joint	0045	13.5546	$735.87	$268.47	$147.17
27580	C		Fusion of knee					
27590	C		Amputate leg at thigh					
27591	C		Amputate leg at thigh					
27592	C		Amputate leg at thigh					
27594	T		Amputation follow-up surgery	0049	19.9376	$1,082.39		$216.48
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	1.9233	$104.41		$20.88
27600	T		Decompression of lower leg	0049	19.9376	$1,082.39		$216.48
27601	T		Decompression of lower leg	0049	19.9376	$1,082.39		$216.48
27602	T		Decompression of lower leg	0049	19.9376	$1,082.39		$216.48
27603	T		Drain lower leg lesion	0008	16.8303	$913.70		$182.74
27604	T		Drain lower leg bursa	0049	19.9376	$1,082.39		$216.48
27605	T		Incision of achilles tendon	0055	18.8851	$1,025.25	$355.34	$205.05
27606	T		Incision of achilles tendon	0049	19.9376	$1,082.39		$216.48
27607	T		Treat lower leg bone lesion	0049	19.9376	$1,082.39		$216.48
27610	T		Explore/treat ankle joint	0050	25.1166	$1,363.56		$272.71
27612	T		Exploration of ankle joint	0050	25.1166	$1,363.56		$272.71
27613	T		Biopsy lower leg soft tissue	0020	7.3105	$396.88	$113.25	$79.38
27614	T		Biopsy lower leg soft tissue	0022	18.6725	$1,013.71	$354.45	$202.74
27615	T		Remove tumor, lower leg	0046	31.9719	$1,735.72	$535.76	$347.14
27618	T		Remove lower leg lesion	0021	14.5749	$791.26	$219.48	$158.25
27619	T		Remove lower leg lesion	0022	18.6725	$1,013.71	$354.45	$202.74
27620	T		Explore/treat ankle joint	0050	25.1166	$1,363.56		$272.71
27625	T		Remove ankle joint lining	0050	25.1166	$1,363.56		$272.71
27626	T		Remove ankle joint lining	0050	25.1166	$1,363.56		$272.71
27630	T		Removal of tendon lesion	0049	19.9376	$1,082.39		$216.48
27635	T		Remove lower leg bone lesion	0050	25.1166	$1,363.56		$272.71
27637	T		Remove/graft leg bone lesion	0050	25.1166	$1,363.56		$272.71
27638	T		Remove/graft leg bone lesion	0050	25.1166	$1,363.56		$272.71
27640	T		Partial removal of tibia	0051	34.9381	$1,896.75		$379.35
27641	T		Partial removal of fibula	0050	25.1166	$1,363.56		$272.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	34.9381	$1,896.75		$379.35
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	34.9381	$1,896.75		$379.35
27652	T		Repair/graft achilles tendon	0051	34.9381	$1,896.75		$379.35
27654	T		Repair of achilles tendon	0051	34.9381	$1,896.75		$379.35
27656	T		Repair leg fascia defect	0049	19.9376	$1,082.39		$216.48
27658	T		Repair of leg tendon, each	0049	19.9376	$1,082.39		$216.48
27659	T		Repair of leg tendon, each	0049	19.9376	$1,082.39		$216.48
27664	T		Repair of leg tendon, each	0049	19.9376	$1,082.39		$216.48
27665	T		Repair of leg tendon, each	0050	25.1166	$1,363.56		$272.71
27675	T		Repair lower leg tendons	0049	19.9376	$1,082.39		$216.48
27676	T		Repair lower leg tendons	0050	25.1166	$1,363.56		$272.71
27680	T		Release of lower leg tendon	0050	25.1166	$1,363.56		$272.71
27681	T		Release of lower leg tendons	0050	25.1166	$1,363.56		$272.71
27685	T		Revision of lower leg tendon	0050	25.1166	$1,363.56		$272.71
27686	T		Revise lower leg tendons	0050	25.1166	$1,363.56		$272.71
27687	T		Revision of calf tendon	0050	25.1166	$1,363.56		$272.71
27690	T		Revise lower leg tendon	0051	34.9381	$1,896.75		$379.35
27691	T		Revise lower leg tendon	0051	34.9381	$1,896.75		$379.35
27692	T		Revise additional leg tendon	0051	34.9381	$1,896.75		$379.35
27695	T		Repair of ankle ligament	0050	25.1166	$1,363.56		$272.71
27696	T		Repair of ankle ligaments	0050	25.1166	$1,363.56		$272.71
27698	T		Repair of ankle ligament	0050	25.1166	$1,363.56		$272.71
27700	T		Revision of ankle joint	0047	30.3786	$1,649.22	$537.03	$329.84
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	19.9376	$1,082.39		$216.48
27705	T		Incision of tibia	0051	34.9381	$1,896.75		$379.35
27707	T		Incision of fibula	0049	19.9376	$1,082.39		$216.48
27709	T		Incision of tibia & fibula	0050	25.1166	$1,363.56		$272.71
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	25.1166	$1,363.56		$272.71
27732	T		Repair of fibula epiphysis	0050	25.1166	$1,363.56		$272.71
27734	T		Repair lower leg epiphyses	0050	25.1166	$1,363.56		$272.71
27740	T		Repair of leg epiphyses	0050	25.1166	$1,363.56		$272.71
27742	T		Repair of leg epiphyses	0051	34.9381	$1,896.75		$379.35
27745	T		Reinforce tibia	0051	34.9381	$1,896.75		$379.35
27750	T		Treatment of tibia fracture	0043	1.9233	$104.41		$20.88
27752	T		Treatment of tibia fracture	0043	1.9233	$104.41		$20.88
27756	T		Treatment of tibia fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27758	T		Treatment of tibia fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27759	T		Treatment of tibia fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27760	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27762	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27766	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27780	T		Treatment of fibula fracture	0043	1.9233	$104.41		$20.88
27781	T		Treatment of fibula fracture	0043	1.9233	$104.41		$20.88
27784	T		Treatment of fibula fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27786	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27788	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27792	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27808	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27810	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27814	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27816	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27818	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
27822	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27823	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27824	T		Treat lower leg fracture	0043	1.9233	$104.41		$20.88
27825	T		Treat lower leg fracture	0043	1.9233	$104.41		$20.88
27826	T		Treat lower leg fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27827	T		Treat lower leg fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27828	T		Treat lower leg fracture	0046	31.9719	$1,735.72	$535.76	$347.14
27829	T		Treat lower leg joint	0046	31.9719	$1,735.72	$535.76	$347.14
27830	T		Treat lower leg dislocation	0043	1.9233	$104.41		$20.88
27831	T		Treat lower leg dislocation	0043	1.9233	$104.41		$20.88
27832	T		Treat lower leg dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
27840	T		Treat ankle dislocation	0043	1.9233	$104.41		$20.88
27842	T		Treat ankle dislocation	0045	13.5546	$735.87	$268.47	$147.17
27846	T		Treat ankle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
27848	T		Treat ankle dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
27860	T		Fixation of ankle joint	0045	13.5546	$735.87	$268.47	$147.17
27870	T		Fusion of ankle joint	0051	34.9381	$1,896.75		$379.35
27871	T		Fusion of tibiofibular joint	0051	34.9381	$1,896.75		$379.35
27880	C		Amputation of lower leg					
27881	C		Amputation of lower leg					
27882	C		Amputation of lower leg					
27884	T		Amputation follow-up surgery	0049	19.9376	$1,082.39		$216.48
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	25.1166	$1,363.56		$272.71
27892	T		Decompression of leg	0049	19.9376	$1,082.39		$216.48
27893	T		Decompression of leg	0049	19.9376	$1,082.39		$216.48
27894	T		Decompression of leg	0049	19.9376	$1,082.39		$216.48
27899	T		Leg/ankle surgery procedure	0043	1.9233	$104.41		$20.88
28001	T		Drainage of bursa of foot	0008	16.8303	$913.70		$182.74
28002	T		Treatment of foot infection	0049	19.9376	$1,082.39		$216.48
28003	T		Treatment of foot infection	0049	19.9376	$1,082.39		$216.48
28005	T		Treat foot bone lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28008	T		Incision of foot fascia	0055	18.8851	$1,025.25	$355.34	$205.05
28010	T		Incision of toe tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28011	T		Incision of toe tendons	0055	18.8851	$1,025.25	$355.34	$205.05
28020	T		Exploration of foot joint	0055	18.8851	$1,025.25	$355.34	$205.05
28022	T		Exploration of foot joint	0055	18.8851	$1,025.25	$355.34	$205.05
28024	T		Exploration of toe joint	0055	18.8851	$1,025.25	$355.34	$205.05
28030	T		Removal of foot nerve	0220	16.5293	$897.36		$179.47
28035	T		Decompression of tibia nerve	0220	16.5293	$897.36		$179.47
28043	T		Excision of foot lesion	0021	14.5749	$791.26	$219.48	$158.25
28045	T		Excision of foot lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28046	T		Resection of tumor, foot	0055	18.8851	$1,025.25	$355.34	$205.05
28050	T		Biopsy of foot joint lining	0055	18.8851	$1,025.25	$355.34	$205.05
28052	T		Biopsy of foot joint lining	0055	18.8851	$1,025.25	$355.34	$205.05
28054	T		Biopsy of toe joint lining	0055	18.8851	$1,025.25	$355.34	$205.05
28060	T		Partial removal, foot fascia	0056	25.1591	$1,365.86	$405.81	$273.17
28062	T		Removal of foot fascia	0056	25.1591	$1,365.86	$405.81	$273.17
28070	T		Removal of foot joint lining	0056	25.1591	$1,365.86	$405.81	$273.17
28072	T		Removal of foot joint lining	0056	25.1591	$1,365.86	$405.81	$273.17
28080	T		Removal of foot lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28086	T		Excise foot tendon sheath	0055	18.8851	$1,025.25	$355.34	$205.05
28088	T		Excise foot tendon sheath	0055	18.8851	$1,025.25	$355.34	$205.05
28090	T		Removal of foot lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28092	T		Removal of toe lesions	0055	18.8851	$1,025.25	$355.34	$205.05
28100	T		Removal of ankle/heel lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28102	T		Remove/graft foot lesion	0056	25.1591	$1,365.86	$405.81	$273.17
28103	T		Remove/graft foot lesion	0056	25.1591	$1,365.86	$405.81	$273.17
28104	T		Removal of foot lesion	0055	18.8851	$1,025.25	$355.34	$205.05
28106	T		Remove/graft foot lesion	0056	25.1591	$1,365.86	$405.81	$273.17
28107	T		Remove/graft foot lesion	0056	25.1591	$1,365.86	$405.81	$273.17
28108	T		Removal of toe lesions	0055	18.8851	$1,025.25	$355.34	$205.05
28110	T		Part removal of metatarsal	0056	25.1591	$1,365.86	$405.81	$273.17
28111	T		Part removal of metatarsal	0055	18.8851	$1,025.25	$355.34	$205.05
28112	T		Part removal of metatarsal	0055	18.8851	$1,025.25	$355.34	$205.05
28113	T		Part removal of metatarsal	0055	18.8851	$1,025.25	$355.34	$205.05
28114	T		Removal of metatarsal heads	0055	18.8851	$1,025.25	$355.34	$205.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28116	T		Revision of foot	0055	18.8851	$1,025.25	$355.34	$205.05
28118	T		Removal of heel bone	0055	18.8851	$1,025.25	$355.34	$205.05
28119	T		Removal of heel spur	0055	18.8851	$1,025.25	$355.34	$205.05
28120	T		Part removal of ankle/heel	0055	18.8851	$1,025.25	$355.34	$205.05
28122	T		Partial removal of foot bone	0055	18.8851	$1,025.25	$355.34	$205.05
28124	T		Partial removal of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28126	T		Partial removal of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28130	T		Removal of ankle bone	0055	18.8851	$1,025.25	$355.34	$205.05
28140	T		Removal of metatarsal	0055	18.8851	$1,025.25	$355.34	$205.05
28150	T		Removal of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28153	T		Partial removal of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28160	T		Partial removal of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28171	T		Extensive foot surgery	0055	18.8851	$1,025.25	$355.34	$205.05
28173	T		Extensive foot surgery	0055	18.8851	$1,025.25	$355.34	$205.05
28175	T		Extensive foot surgery	0055	18.8851	$1,025.25	$355.34	$205.05
28190	T		Removal of foot foreign body	0019	3.9807	$216.11	$71.87	$43.22
28192	T		Removal of foot foreign body	0021	14.5749	$791.26	$219.48	$158.25
28193	T		Removal of foot foreign body	0021	14.5749	$791.26	$219.48	$158.25
28200	T		Repair of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28202	T		Repair/graft of foot tendon	0056	25.1591	$1,365.86	$405.81	$273.17
28208	T		Repair of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28210	T		Repair/graft of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28220	T		Release of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28222	T		Release of foot tendons	0055	18.8851	$1,025.25	$355.34	$205.05
28225	T		Release of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28226	T		Release of foot tendons	0055	18.8851	$1,025.25	$355.34	$205.05
28230	T		Incision of foot tendon(s)	0055	18.8851	$1,025.25	$355.34	$205.05
28232	T		Incision of toe tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28234	T		Incision of foot tendon	0055	18.8851	$1,025.25	$355.34	$205.05
28238	T		Revision of foot tendon	0056	25.1591	$1,365.86	$405.81	$273.17
28240	T		Release of big toe	0055	18.8851	$1,025.25	$355.34	$205.05
28250	T		Revision of foot fascia	0056	25.1591	$1,365.86	$405.81	$273.17
28260	T		Release of midfoot joint	0056	25.1591	$1,365.86	$405.81	$273.17
28261	T		Revision of foot tendon	0056	25.1591	$1,365.86	$405.81	$273.17
28262	T		Revision of foot and ankle	0056	25.1591	$1,365.86	$405.81	$273.17
28264	T		Release of midfoot joint	0056	25.1591	$1,365.86	$405.81	$273.17
28270	T		Release of foot contracture	0055	18.8851	$1,025.25	$355.34	$205.05
28272	T		Release of toe joint, each	0055	18.8851	$1,025.25	$355.34	$205.05
28280	T		Fusion of toes	0055	18.8851	$1,025.25	$355.34	$205.05
28285	T		Repair of hammertoe	0055	18.8851	$1,025.25	$355.34	$205.05
28286	T		Repair of hammertoe	0055	18.8851	$1,025.25	$355.34	$205.05
28288	T		Partial removal of foot bone	0056	25.1591	$1,365.86	$405.81	$273.17
28289	T		Repair hallux rigidus	0056	25.1591	$1,365.86	$405.81	$273.17
28290	T		Correction of bunion	0056	25.1591	$1,365.86	$405.81	$273.17
28292	T		Correction of bunion	0057	25.4248	$1,380.29	$475.91	$276.06
28293	T		Correction of bunion	0057	25.4248	$1,380.29	$475.91	$276.06
28294	T		Correction of bunion	0056	25.1591	$1,365.86	$405.81	$273.17
28296	T		Correction of bunion	0056	25.1591	$1,365.86	$405.81	$273.17
28297	T		Correction of bunion	0057	25.4248	$1,380.29	$475.91	$276.06
28298	T		Correction of bunion	0056	25.1591	$1,365.86	$405.81	$273.17
28299	T		Correction of bunion	0057	25.4248	$1,380.29	$475.91	$276.06
28300	T		Incision of heel bone	0056	25.1591	$1,365.86	$405.81	$273.17
28302	T		Incision of ankle bone	0056	25.1591	$1,365.86	$405.81	$273.17
28304	T		Incision of midfoot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28305	T		Incise/graft midfoot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28306	T		Incision of metatarsal	0056	25.1591	$1,365.86	$405.81	$273.17
28307	T		Incision of metatarsal	0056	25.1591	$1,365.86	$405.81	$273.17
28308	T		Incision of metatarsal	0056	25.1591	$1,365.86	$405.81	$273.17
28309	T		Incision of metatarsals	0056	25.1591	$1,365.86	$405.81	$273.17
28310	T		Revision of big toe	0055	18.8851	$1,025.25	$355.34	$205.05
28312	T		Revision of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28313	T		Repair deformity of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28315	T		Removal of sesamoid bone	0055	18.8851	$1,025.25	$355.34	$205.05
28320	T		Repair of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28322	T		Repair of metatarsals	0056	25.1591	$1,365.86	$405.81	$273.17
28340	T		Resect enlarged toe tissue	0055	18.8851	$1,025.25	$355.34	$205.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28341	T		Resect enlarged toe	0055	18.8851	$1,025.25	$355.34	$205.05
28344	T		Repair extra toe(s)	0056	25.1591	$1,365.86	$405.81	$273.17
28345	T		Repair webbed toe(s)	0056	25.1591	$1,365.86	$405.81	$273.17
28360	T		Reconstruct cleft foot	0056	25.1591	$1,365.86	$405.81	$273.17
28400	T		Treatment of heel fracture	0043	1.9233	$104.41		$20.88
28405	T		Treatment of heel fracture	0043	1.9233	$104.41		$20.88
28406	T		Treatment of heel fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28415	T		Treat heel fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28420	T		Treat/graft heel fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28430	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
28435	T		Treatment of ankle fracture	0043	1.9233	$104.41		$20.88
28436	T		Treatment of ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28445	T		Treat ankle fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28450	T		Treat midfoot fracture, each	0043	1.9233	$104.41		$20.88
28455	T		Treat midfoot fracture, each	0043	1.9233	$104.41		$20.88
28456	T		Treat midfoot fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28465	T		Treat midfoot fracture, each	0046	31.9719	$1,735.72	$535.76	$347.14
28470	T		Treat metatarsal fracture	0043	1.9233	$104.41		$20.88
28475	T		Treat metatarsal fracture	0043	1.9233	$104.41		$20.88
28476	T		Treat metatarsal fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28485	T		Treat metatarsal fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28490	T		Treat big toe fracture	0043	1.9233	$104.41		$20.88
28495	T		Treat big toe fracture	0043	1.9233	$104.41		$20.88
28496	T		Treat big toe fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28505	T		Treat big toe fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28510	T		Treatment of toe fracture	0043	1.9233	$104.41		$20.88
28515	T		Treatment of toe fracture	0043	1.9233	$104.41		$20.88
28525	T		Treat toe fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28530	T		Treat sesamoid bone fracture	0043	1.9233	$104.41		$20.88
28531	T		Treat sesamoid bone fracture	0046	31.9719	$1,735.72	$535.76	$347.14
28540	T		Treat foot dislocation	0043	1.9233	$104.41		$20.88
28545	T		Treat foot dislocation	0045	13.5546	$735.87	$268.47	$147.17
28546	T		Treat foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28555	T		Repair foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28570	T		Treat foot dislocation	0043	1.9233	$104.41		$20.88
28575	T		Treat foot dislocation	0043	1.9233	$104.41		$20.88
28576	T		Treat foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28585	T		Repair foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28600	T		Treat foot dislocation	0043	1.9233	$104.41		$20.88
28605	T		Treat foot dislocation	0043	1.9233	$104.41		$20.88
28606	T		Treat foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28615	T		Repair foot dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28630	T		Treat toe dislocation	0043	1.9233	$104.41		$20.88
28635	T		Treat toe dislocation	0045	13.5546	$735.87	$268.47	$147.17
28636	T		Treat toe dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28645	T		Repair toe dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28660	T		Treat toe dislocation	0043	1.9233	$104.41		$20.88
28665	T		Treat toe dislocation	0045	13.5546	$735.87	$268.47	$147.17
28666	T		Treat toe dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28675	T		Repair of toe dislocation	0046	31.9719	$1,735.72	$535.76	$347.14
28705	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28715	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28725	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28730	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28735	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28737	T		Revision of foot bones	0055	18.8851	$1,025.25	$355.34	$205.05
28740	T		Fusion of foot bones	0056	25.1591	$1,365.86	$405.81	$273.17
28750	T		Fusion of big toe joint	0055	18.8851	$1,025.25	$355.34	$205.05
28755	T		Fusion of big toe joint	0055	18.8851	$1,025.25	$355.34	$205.05
28760	T		Fusion of big toe joint	0056	25.1591	$1,365.86	$405.81	$273.17
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	18.8851	$1,025.25	$355.34	$205.05
28820	T		Amputation of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28825	T		Partial amputation of toe	0055	18.8851	$1,025.25	$355.34	$205.05
28899	T		Foot/toes surgery procedure	0043	1.9233	$104.41		$20.88

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29000	S		Application of body cast	0058	1.0785	$58.55		$11.71
29010	S		Application of body cast	0058	1.0785	$58.55		$11.71
29015	S		Application of body cast	0058	1.0785	$58.55		$11.71
29020	S		Application of body cast	0058	1.0785	$58.55		$11.71
29025	S		Application of body cast	0058	1.0785	$58.55		$11.71
29035	S		Application of body cast	0058	1.0785	$58.55		$11.71
29040	S		Application of body cast	0058	1.0785	$58.55		$11.71
29044	S		Application of body cast	0058	1.0785	$58.55		$11.71
29046	S		Application of body cast	0058	1.0785	$58.55		$11.71
29049	S		Application of figure eight	0058	1.0785	$58.55		$11.71
29055	S		Application of shoulder cast	0058	1.0785	$58.55		$11.71
29058	S		Application of shoulder cast	0058	1.0785	$58.55		$11.71
29065	S		Application of long arm cast	0058	1.0785	$58.55		$11.71
29075	S		Application of forearm cast	0058	1.0785	$58.55		$11.71
29085	S		Apply hand/wrist cast	0058	1.0785	$58.55		$11.71
29086	S		Apply finger cast	0058	1.0785	$58.55		$11.71
29105	S		Apply long arm splint	0058	1.0785	$58.55		$11.71
29125	S		Apply forearm splint	0058	1.0785	$58.55		$11.71
29126	S		Apply forearm splint	0058	1.0785	$58.55		$11.71
29130	S		Application of finger splint	0058	1.0785	$58.55		$11.71
29131	S		Application of finger splint	0058	1.0785	$58.55		$11.71
29200	S		Strapping of chest	0058	1.0785	$58.55		$11.71
29220	S		Strapping of low back	0058	1.0785	$58.55		$11.71
29240	S		Strapping of shoulder	0058	1.0785	$58.55		$11.71
29260	S		Strapping of elbow or wrist	0058	1.0785	$58.55		$11.71
29280	S		Strapping of hand or finger	0058	1.0785	$58.55		$11.71
29305	S		Application of hip cast	0058	1.0785	$58.55		$11.71
29325	S		Application of hip casts	0058	1.0785	$58.55		$11.71
29345	S		Application of long leg cast	0058	1.0785	$58.55		$11.71
29355	S		Application of long leg cast	0058	1.0785	$58.55		$11.71
29358	S		Apply long leg cast brace	0058	1.0785	$58.55		$11.71
29365	S		Application of long leg cast	0058	1.0785	$58.55		$11.71
29405	S		Apply short leg cast	0058	1.0785	$58.55		$11.71
29425	S		Apply short leg cast	0058	1.0785	$58.55		$11.71
29435	S		Apply short leg cast	0058	1.0785	$58.55		$11.71
29440	S		Addition of walker to cast	0058	1.0785	$58.55		$11.71
29445	S		Apply rigid leg cast	0058	1.0785	$58.55		$11.71
29450	S		Application of leg cast	0058	1.0785	$58.55		$11.71
29505	S		Application, long leg splint	0058	1.0785	$58.55		$11.71
29515	S		Application lower leg splint	0058	1.0785	$58.55		$11.71
29520	S		Strapping of hip	0058	1.0785	$58.55		$11.71
29530	S		Strapping of knee	0058	1.0785	$58.55		$11.71
29540	S		Strapping of ankle	0058	1.0785	$58.55		$11.71
29550	S		Strapping of toes	0058	1.0785	$58.55		$11.71
29580	S		Application of paste boot	0058	1.0785	$58.55		$11.71
29590	S		Application of foot splint	0058	1.0785	$58.55		$11.71
29700	S		Removal/revision of cast	0058	1.0785	$58.55		$11.71
29705	S		Removal/revision of cast	0058	1.0785	$58.55		$11.71
29710	S		Removal/revision of cast	0058	1.0785	$58.55		$11.71
29715	S		Removal/revision of cast	0058	1.0785	$58.55		$11.71
29720	S		Repair of body cast	0058	1.0785	$58.55		$11.71
29730	S		Windowing of cast	0058	1.0785	$58.55		$11.71
29740	S		Wedging of cast	0058	1.0785	$58.55		$11.71
29750	S		Wedging of clubfoot cast	0058	1.0785	$58.55		$11.71
29799	S		Casting/strapping procedure	0058	1.0785	$58.55		$11.71
29800	T		Jaw arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29804	T		Jaw arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29805	T		Shoulder arthroscopy, dx	0041	27.2538	$1,479.58		$295.92
29806	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29807	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29819	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29820	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29821	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29822	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29823	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29824	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29825	T		Shoulder arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29826	T		Shoulder arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29827	T		Arthroscop rotator cuff repr	0041	27.2538	$1,479.58		$295.92
29830	T		Elbow arthroscopy	0041	27.2538	$1,479.58		$295.92
29834	T		Elbow arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29835	T		Elbow arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29836	T		Elbow arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29837	T		Elbow arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29838	T		Elbow arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29840	T		Wrist arthroscopy	0041	27.2538	$1,479.58		$295.92
29843	T		Wrist arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29844	T		Wrist arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29845	T		Wrist arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29846	T		Wrist arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29847	T		Wrist arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29848	T		Wrist endoscopy/surgery	0041	27.2538	$1,479.58		$295.92
29850	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29851	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29855	T		Tibial arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29856	T		Tibial arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29860	T		Hip arthroscopy, dx	0041	27.2538	$1,479.58		$295.92
29861	T		Hip arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29862	T		Hip arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29863	T		Hip arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29870	T		Knee arthroscopy, dx	0041	27.2538	$1,479.58		$295.92
29871	T		Knee arthroscopy/drainage	0041	27.2538	$1,479.58		$295.92
29873	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29874	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29875	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29876	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29877	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29879	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29880	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29881	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29882	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29883	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29884	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29885	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29886	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29887	T		Knee arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29888	T		Knee arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29889	T		Knee arthroscopy/surgery	0042	42.8551	$2,326.56	$804.74	$465.31
29891	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29892	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29893	T		Scope, plantar fasciotomy	0055	18.8851	$1,025.25	$355.34	$205.05
29894	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29895	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29897	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29898	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29899	T		Ankle arthroscopy/surgery	0041	27.2538	$1,479.58		$295.92
29900	T		Mcp joint arthroscopy, dx	0053	14.8188	$804.50	$253.49	$160.90
29901	T		Mcp joint arthroscopy, surg	0053	14.8188	$804.50	$253.49	$160.90
29902	T		Mcp joint arthroscopy, surg	0053	14.8188	$804.50	$253.49	$160.90
29999	T		Arthroscopy of joint	0041	27.2538	$1,479.58		$295.92
30000	T		Drainage of nose lesion	0251	1.8643	$101.21		$20.24
30020	T		Drainage of nose lesion	0251	1.8643	$101.21		$20.24
30100	T		Intranasal biopsy	0252	6.5416	$355.14	$113.41	$71.03
30110	T		Removal of nose polyp(s)	0253	15.1698	$823.55	$282.29	$164.71
30115	T		Removal of nose polyp(s)	0253	15.1698	$823.55	$282.29	$164.71
30117	T		Removal of intranasal lesion	0253	15.1698	$823.55	$282.29	$164.71
30118	T		Removal of intranasal lesion	0254	21.4368	$1,163.78	$321.35	$232.76
30120	T		Revision of nose	0253	15.1698	$823.55	$282.29	$164.71
30124	T		Removal of nose lesion	0252	6.5416	$355.14	$113.41	$71.03
30125	T		Removal of nose lesion	0256	35.0866	$1,904.82		$380.96
30130	T		Removal of turbinate bones	0253	15.1698	$823.55	$282.29	$164.71
30140	T		Removal of turbinate bones	0254	21.4368	$1,163.78	$321.35	$232.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30150	T		Partial removal of nose	0256	35.0866	$1,904.82		$380.96
30160	T		Removal of nose	0256	35.0866	$1,904.82		$380.96
30200	T		Injection treatment of nose	0253	15.1698	$823.55	$282.29	$164.71
30210	T		Nasal sinus therapy	0252	6.5416	$355.14	$113.41	$71.03
30220	T		Insert nasal septal button	0252	6.5416	$355.14	$113.41	$71.03
30300	X		Remove nasal foreign body	0340	0.6232	$33.83		$6.77
30310	T		Remove nasal foreign body	0253	15.1698	$823.55	$282.29	$164.71
30320	T		Remove nasal foreign body	0253	15.1698	$823.55	$282.29	$164.71
30400	T		Reconstruction of nose	0256	35.0866	$1,904.82		$380.96
30410	T		Reconstruction of nose	0256	35.0866	$1,904.82		$380.96
30420	T		Reconstruction of nose	0256	35.0866	$1,904.82		$380.96
30430	T		Revision of nose	0254	21.4368	$1,163.78	$321.35	$232.76
30435	T		Revision of nose	0256	35.0866	$1,904.82		$380.96
30450	T		Revision of nose	0256	35.0866	$1,904.82		$380.96
30460	T		Revision of nose	0256	35.0866	$1,904.82		$380.96
30462	T		Revision of nose	0256	35.0866	$1,904.82		$380.96
30465	T		Repair nasal stenosis	0256	35.0866	$1,904.82		$380.96
30520	T		Repair of nasal septum	0254	21.4368	$1,163.78	$321.35	$232.76
30540	T		Repair nasal defect	0256	35.0866	$1,904.82		$380.96
30545	T		Repair nasal defect	0256	35.0866	$1,904.82		$380.96
30560	T		Release of nasal adhesions	0251	1.8643	$101.21		$20.24
30580	T		Repair upper jaw fistula	0256	35.0866	$1,904.82		$380.96
30600	T		Repair mouth/nose fistula	0256	35.0866	$1,904.82		$380.96
30620	T		Intranasal reconstruction	0256	35.0866	$1,904.82		$380.96
30630	T		Repair nasal septum defect	0254	21.4368	$1,163.78	$321.35	$232.76
30801	T		Cauterization, inner nose	0252	6.5416	$355.14	$113.41	$71.03
30802	T		Cauterization, inner nose	0253	15.1698	$823.55	$282.29	$164.71
30901	T		Control of nosebleed	0250	1.5381	$83.50	$29.23	$16.70
30903	T		Control of nosebleed	0250	1.5381	$83.50	$29.23	$16.70
30905	T		Control of nosebleed	0250	1.5381	$83.50	$29.23	$16.70
30906	T		Repeat control of nosebleed	0250	1.5381	$83.50	$29.23	$16.70
30915	T		Ligation, nasal sinus artery	0091	28.5187	$1,548.25	$348.23	$309.65
30920	T		Ligation, upper jaw artery	0092	25.1347	$1,364.54	$505.37	$272.91
30930	T		Therapy, fracture of nose	0253	15.1698	$823.55	$282.29	$164.71
30999	T		Nasal surgery procedure	0251	1.8643	$101.21		$20.24
31000	T		Irrigation, maxillary sinus	0251	1.8643	$101.21		$20.24
31002	T		Irrigation, sphenoid sinus	0252	6.5416	$355.14	$113.41	$71.03
31020	T		Exploration, maxillary sinus	0254	21.4368	$1,163.78	$321.35	$232.76
31030	T		Exploration, maxillary sinus	0256	35.0866	$1,904.82		$380.96
31032	T		Explore sinus, remove polyps	0256	35.0866	$1,904.82		$380.96
31040	T		Exploration behind upper jaw	0254	21.4368	$1,163.78	$321.35	$232.76
31050	T		Exploration, sphenoid sinus	0256	35.0866	$1,904.82		$380.96
31051	T		Sphenoid sinus surgery	0256	35.0866	$1,904.82		$380.96
31070	T		Exploration of frontal sinus	0254	21.4368	$1,163.78	$321.35	$232.76
31075	T		Exploration of frontal sinus	0256	35.0866	$1,904.82		$380.96
31080	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31081	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31084	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31085	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31086	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31087	T		Removal of frontal sinus	0256	35.0866	$1,904.82		$380.96
31090	T		Exploration of sinuses	0256	35.0866	$1,904.82		$380.96
31200	T		Removal of ethmoid sinus	0256	35.0866	$1,904.82		$380.96
31201	T		Removal of ethmoid sinus	0256	35.0866	$1,904.82		$380.96
31205	T		Removal of ethmoid sinus	0256	35.0866	$1,904.82		$380.96
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0071	0.9012	$48.93	$12.89	$9.79
31233	T		Nasal/sinus endoscopy, dx	0073	3.4396	$186.73	$73.38	$37.35
31235	T		Nasal/sinus endoscopy, dx	0074	14.4952	$786.93	$295.70	$157.39
31237	T		Nasal/sinus endoscopy, surg	0075	20.4113	$1,108.11	$445.92	$221.62
31238	T		Nasal/sinus endoscopy, surg	0074	14.4952	$786.93	$295.70	$157.39
31239	T		Nasal/sinus endoscopy, surg	0075	20.4113	$1,108.11	$445.92	$221.62
31240	T		Nasal/sinus endoscopy, surg	0074	14.4952	$786.93	$295.70	$157.39
31254	T		Revision of ethmoid sinus	0075	20.4113	$1,108.11	$445.92	$221.62
31255	T		Removal of ethmoid sinus	0075	20.4113	$1,108.11	$445.92	$221.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31256	T		Exploration maxillary sinus	0075	20.4113	$1,108.11	$445.92	$221.62
31267	T		Endoscopy, maxillary sinus	0075	20.4113	$1,108.11	$445.92	$221.62
31276	T		Sinus endoscopy, surgical	0075	20.4113	$1,108.11	$445.92	$221.62
31287	T		Nasal/sinus endoscopy, surg	0075	20.4113	$1,108.11	$445.92	$221.62
31288	T		Nasal/sinus endoscopy, surg	0075	20.4113	$1,108.11	$445.92	$221.62
31290	C		Nasal/sinus endoscopy, surg					
31291	C		Nasal/sinus endoscopy, surg					
31292	C		Nasal/sinus endoscopy, surg					
31293	C		Nasal/sinus endoscopy, surg					
31294	C		Nasal/sinus endoscopy, surg					
31299	T		Sinus surgery procedure	0252	6.5416	$355.14	$113.41	$71.03
31300	T		Removal of larynx lesion	0254	21.4368	$1,163.78	$321.35	$232.76
31320	T		Diagnostic incision, larynx	0256	35.0866	$1,904.82		$380.96
31360	C		Removal of larynx					
31365	C		Removal of larynx					
31367	C		Partial removal of larynx					
31368	C		Partial removal of larynx					
31370	C		Partial removal of larynx					
31375	C		Partial removal of larynx					
31380	C		Partial removal of larynx					
31382	C		Partial removal of larynx					
31390	C		Removal of larynx & pharynx					
31395	C		Reconstruct larynx & pharynx					
31400	T		Revision of larynx	0256	35.0866	$1,904.82		$380.96
31420	T		Removal of epiglottis	0256	35.0866	$1,904.82		$380.96
31500	S		Insert emergency airway	0094	2.6412	$143.39	$48.46	$28.68
31502	T		Change of windpipe airway	0121	2.2058	$119.75	$43.80	$23.95
31505	T		Diagnostic laryngoscopy	0071	0.9012	$48.93	$12.89	$9.79
31510	T		Laryngoscopy with biopsy	0074	14.4952	$786.93	$295.70	$157.39
31511	T		Remove foreign body, larynx	0072	1.6987	$92.22	$26.68	$18.44
31512	T		Removal of larynx lesion	0074	14.4952	$786.93	$295.70	$157.39
31513	T		Injection into vocal cord	0072	1.6987	$92.22	$26.68	$18.44
31515	T		Laryngoscopy for aspiration	0074	14.4952	$786.93	$295.70	$157.39
31520	T		Diagnostic laryngoscopy	0072	1.6987	$92.22	$26.68	$18.44
31525	T		Diagnostic laryngoscopy	0074	14.4952	$786.93	$295.70	$157.39
31526	T		Diagnostic laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31527	T		Laryngoscopy for treatment	0075	20.4113	$1,108.11	$445.92	$221.62
31528	T		Laryngoscopy and dilation	0074	14.4952	$786.93	$295.70	$157.39
31529	T		Laryngoscopy and dilation	0074	14.4952	$786.93	$295.70	$157.39
31530	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31531	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31535	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31536	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31540	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31541	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31560	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31561	T		Operative laryngoscopy	0075	20.4113	$1,108.11	$445.92	$221.62
31570	T		Laryngoscopy with injection	0074	14.4952	$786.93	$295.70	$157.39
31571	T		Laryngoscopy with injection	0075	20.4113	$1,108.11	$445.92	$221.62
31575	T		Diagnostic laryngoscopy	0072	1.6987	$92.22	$26.68	$18.44
31576	T		Laryngoscopy with biopsy	0075	20.4113	$1,108.11	$445.92	$221.62
31577	T		Remove foreign body, larynx	0073	3.4396	$186.73	$73.38	$37.35
31578	T		Removal of larynx lesion	0075	20.4113	$1,108.11	$445.92	$221.62
31579	T		Diagnostic laryngoscopy	0073	3.4396	$186.73	$73.38	$37.35
31580	T		Revision of larynx	0256	35.0866	$1,904.82		$380.96
31582	T		Revision of larynx	0256	35.0866	$1,904.82		$380.96
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	15.1698	$823.55	$282.29	$164.71
31586	T		Treat larynx fracture	0256	35.0866	$1,904.82		$380.96
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	35.0866	$1,904.82		$380.96
31590	T		Reinnervate larynx	0256	35.0866	$1,904.82		$380.96
31595	T		Larynx nerve surgery	0256	35.0866	$1,904.82		$380.96
31599	T		Larynx surgery procedure	0254	21.4368	$1,163.78	$321.35	$232.76
31600	T		Incision of windpipe	0254	21.4368	$1,163.78	$321.35	$232.76
31601	T		Incision of windpipe	0254	21.4368	$1,163.78	$321.35	$232.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31603	T		Incision of windpipe	0252	6.5416	$355.14	$113.41	$71.03
31605	T		Incision of windpipe	0253	15.1698	$823.55	$282.29	$164.71
31610	T		Incision of windpipe	0254	21.4368	$1,163.78	$321.35	$232.76
31611	T		Surgery/speech prosthesis	0254	21.4368	$1,163.78	$321.35	$232.76
31612	T		Puncture/clear windpipe	0254	21.4368	$1,163.78	$321.35	$232.76
31613	T		Repair windpipe opening	0254	21.4368	$1,163.78	$321.35	$232.76
31614	T		Repair windpipe opening	0256	35.0866	$1,904.82		$380.96
31615	T		Visualization of windpipe	0076	9.3560	$507.93	$189.82	$101.59
31622	T		Dx bronchoscope/wash	0076	9.3560	$507.93	$189.82	$101.59
31623	T		Dx bronchoscope/brush	0076	9.3560	$507.93	$189.82	$101.59
31624	T		Dx bronchoscope/lavage	0076	9.3560	$507.93	$189.82	$101.59
31625	T		Bronchoscopy w/biopsy(s)	0076	9.3560	$507.93	$189.82	$101.59
31628	T		Bronchoscopy/lung bx, each	0076	9.3560	$507.93	$189.82	$101.59
31629	T		Bronchoscopy/needle bx, each	0076	9.3560	$507.93	$189.82	$101.59
31630	T		Bronchoscopy dilate/fx repr	0415	20.9920	$1,139.63	$463.30	$227.93
31631	T		Bronchoscopy, dilate w/stent	0415	20.9920	$1,139.63	$463.30	$227.93
31635	T		Bronchoscopy w/fb removal	0076	9.3560	$507.93	$189.82	$101.59
31640	T		Bronchoscopy w/tumor excise	0415	20.9920	$1,139.63	$463.30	$227.93
31641	T		Bronchoscopy, treat blockage	0415	20.9920	$1,139.63	$463.30	$227.93
31643	T		Diag bronchoscope/catheter	0076	9.3560	$507.93	$189.82	$101.59
31645	T		Bronchoscopy, clear airways	0076	9.3560	$507.93	$189.82	$101.59
31646	T		Bronchoscopy, reclear airway	0076	9.3560	$507.93	$189.82	$101.59
31656	T		Bronchoscopy, inj for x-ray	0076	9.3560	$507.93	$189.82	$101.59
31700	T		Insertion of airway catheter	0072	1.6987	$92.22	$26.68	$18.44
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	3.4396	$186.73	$73.38	$37.35
31720	T		Clearance of airways	0072	1.6987	$92.22	$26.68	$18.44
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	3.4396	$186.73	$73.38	$37.35
31750	T		Repair of windpipe	0256	35.0866	$1,904.82		$380.96
31755	T		Repair of windpipe	0256	35.0866	$1,904.82		$380.96
31760	C		Repair of windpipe					
31766	C		Reconstruction of windpipe					
31770	C		Repair/graft of bronchus					
31775	C		Reconstruct bronchus					
31780	C		Reconstruct windpipe					
31781	C		Reconstruct windpipe					
31785	T		Remove windpipe lesion	0254	21.4368	$1,163.78	$321.35	$232.76
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	15.1698	$823.55	$282.29	$164.71
31825	T		Repair of windpipe defect	0254	21.4368	$1,163.78	$321.35	$232.76
31830	T		Revise windpipe scar	0254	21.4368	$1,163.78	$321.35	$232.76
31899	T		Airways surgical procedure	0076	9.3560	$507.93	$189.82	$101.59
32000	T		Drainage of chest	0070	3.1393	$170.43		$34.09
32002	T		Treatment of collapsed lung	0070	3.1393	$170.43		$34.09
32005	T		Treat lung lining chemically	0070	3.1393	$170.43		$34.09
32020	T		Insertion of chest tube	0070	3.1393	$170.43		$34.09
32035	C		Exploration of chest					
32036	C		Exploration of chest					
32095	C		Biopsy through chest wall					
32100	C		Exploration/biopsy of chest					
32110	C		Explore/repair chest					
32120	C		Re-exploration of chest					
32124	C		Explore chest free adhesions					
32140	C		Removal of lung lesion(s)					
32141	C		Remove/treat lung lesions					
32150	C		Removal of lung lesion(s)					
32151	C		Remove lung foreign body					
32160	C		Open chest heart massage					
32200	C		Drain, open, lung lesion					
32201	T		Drain, percut, lung lesion	0070	3.1393	$170.43		$34.09
32215	C		Treat chest lining					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32220	C		Release of lung					
32225	C		Partial release of lung					
32310	C		Removal of chest lining					
32320	C		Free/remove chest lining					
32400	T		Needle biopsy chest lining	0005	3.3675	$182.82	$71.59	$36.56
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	4.8912	$265.54	$116.83	$53.11
32420	T		Puncture/clear lung	0070	3.1393	$170.43		$34.09
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	28.6334	$1,554.48	$591.64	$310.90
32602	T		Thoracoscopy, diagnostic	0069	28.6334	$1,554.48	$591.64	$310.90
32603	T		Thoracoscopy, diagnostic	0069	28.6334	$1,554.48	$591.64	$310.90
32604	T		Thoracoscopy, diagnostic	0069	28.6334	$1,554.48	$591.64	$310.90
32605	T		Thoracoscopy, diagnostic	0069	28.6334	$1,554.48	$591.64	$310.90
32606	T		Thoracoscopy, diagnostic	0069	28.6334	$1,554.48	$591.64	$310.90
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	3.1393	$170.43		$34.09
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.1393	$170.43		$34.09
33010	T		Drainage of heart sac	0070	3.1393	$170.43		$34.09
33011	T		Repeat drainage of heart sac	0070	3.1393	$170.43		$34.09
33015	C		Incision of heart sac					
33020	C		Incision of heart sac					
33025	C		Incision of heart sac					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	116.1611	$6,306.27	$1,722.59	$1,261.25
33207	T		Insertion of heart pacemaker	0089	116.1611	$6,306.27	$1,722.59	$1,261.25
33208	T		Insertion of heart pacemaker	0655	142.2244	$7,721.22		$1,544.24
33210	T		Insertion of heart electrode	0106	49.9534	$2,711.92	$542.39	$542.38
33211	T		Insertion of heart electrode	0106	49.9534	$2,711.92	$542.39	$542.38
33212	T		Insertion of pulse generator	0090	87.2850	$4,738.62	$1,705.90	$947.72
33213	T		Insertion of pulse generator	0654	103.8544	$5,638.15		$1,127.63
33214	T		Upgrade of pacemaker system	0655	142.2244	$7,721.22		$1,544.24
33215	T		Reposition pacing-defib lead	0105	18.9084	$1,026.52	$370.40	$205.30
33216	T		Revise eltrd pacing-defib	0106	49.9534	$2,711.92	$542.39	$542.38
33217	T		Insert lead pace-defib, dual	0106	49.9534	$2,711.92	$542.39	$542.38
33218	T		Repair lead pace-defib, one	0106	49.9534	$2,711.92	$542.39	$542.38
33220	T		Repair lead pace-defib, dual	0106	49.9534	$2,711.92	$542.39	$542.38
33222	T		Revise pocket, pacemaker	0027	15.8319	$859.50	$329.72	$171.90
33223	T		Revise pocket, pacing-defib	0027	15.8319	$859.50	$329.72	$171.90
33224	T		Insert pacing lead & connect	1547		$850.00		$170.00
33225	T		L ventric pacing lead add-on	1550		$1,150.00		$230.00
33226	T		Reposition l ventric lead	0105	18.9084	$1,026.52	$370.40	$205.30
33233	T		Removal of pacemaker system	0105	18.9084	$1,026.52	$370.40	$205.30
33234	T		Removal of pacemaker system	0105	18.9084	$1,026.52	$370.40	$205.30
33235	T		Removal pacemaker electrode	0105	18.9084	$1,026.52	$370.40	$205.30
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	T		Insert pulse generator	0107	290.5429	$15,773.28	$3,429.62	$3,154.66
33241	T		Remove pulse generator	0105	18.9084	$1,026.52	$370.40	$205.30
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	18.9084	$1,026.52	$370.40	$205.30
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	T		Eltrd/insert pace-defib	0108	489.5275	$26,575.96		$5,315.19
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	61.4222	$3,334.55		$666.91
33284	T		Remove pat-active ht record	0109	7.7075	$418.43	$131.49	$83.69
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33414	C		Repair of aortic valve					
33415	C		Revision, subvalvular tissue					
33416	C		Revise ventricle muscle					
33417	C		Repair of aortic valve					
33420	C		Revision of mitral valve					
33422	C		Revision of mitral valve					
33425	C		Repair of mitral valve					
33426	C		Repair of mitral valve					
33427	C		Repair of mitral valve					
33430	C		Replacement of mitral valve					
33460	C		Revision of tricuspid valve					
33463	C		Valvuloplasty, tricuspid					
33464	C		Valvuloplasty, tricuspid					
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N		Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	3.1393	$170.43		$34.09
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	34.6065	$1,878.75	$655.22	$375.75
34111	T		Removal of arm artery clot	0088	34.6065	$1,878.75	$655.22	$375.75
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	34.6065	$1,878.75	$655.22	$375.75
34203	T		Removal of leg artery clot	0088	34.6065	$1,878.75	$655.22	$375.75
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	34.6065	$1,878.75	$655.22	$375.75
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	34.6065	$1,878.75	$655.22	$375.75
34490	T		Removal of vein clot	0088	34.6065	$1,878.75	$655.22	$375.75
34501	T		Repair valve, femoral vein	0088	34.6065	$1,878.75	$655.22	$375.75
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	34.6065	$1,878.75	$655.22	$375.75
34520	T		Cross-over vein graft	0088	34.6065	$1,878.75	$655.22	$375.75
34530	T		Leg vein fusion	0088	34.6065	$1,878.75	$655.22	$375.75
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		Xpose for endoprosth, iliac					
34834	C		Xpose, endoprosth, brachial					
34900	C		Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	32.4880	$1,763.74		$352.75
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	20.6662	$1,121.95	$277.34	$224.39
35182	C		Repair blood vessel lesion					
35184	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
35188	T		Repair blood vessel lesion	0088	34.6065	$1,878.75	$655.22	$375.75
35189	C		Repair blood vessel lesion					
35190	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
35201	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
35206	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
35207	T		Repair blood vessel lesion	0088	34.6065	$1,878.75	$655.22	$375.75
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	20.6662	$1,121.95	$277.34	$224.39
35231	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
35236	T		Repair blood vessel lesion	0093	20.6662	$1,121.95	$277.34	$224.39
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	20.6662	$1,121.95	$277.34	$224.39
35261	T		Repair blood vessel lesion	0653	32.4880	$1,763.74		$352.75
35266	T		Repair blood vessel lesion	0653	32.4880	$1,763.74		$352.75
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	32.4880	$1,763.74		$352.75
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	20.6662	$1,121.95	$277.34	$224.39
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	34.8355	$1,891.18		$378.24
35459	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35460	T		Repair venous blockage	0081	34.8355	$1,891.18		$378.24
35470	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35471	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35472	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35473	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35474	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35475	T		Repair arterial blockage	0081	34.8355	$1,891.18		$378.24
35476	T		Repair venous blockage	0081	34.8355	$1,891.18		$378.24
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	34.8355	$1,891.18		$378.24

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35485	T		Atherectomy, open	0081	34.8355	$1,891.18		$378.24
35490	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35491	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35492	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35493	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35494	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35495	T		Atherectomy, percutaneous	0081	34.8355	$1,891.18		$378.24
35500	T		Harvest vein for bypass	0081	34.8355	$1,891.18		$378.24
35501	C		Artery bypass graft					
35506	C		Artery bypass graft					
35507	C		Artery bypass graft					
35508	C		Artery bypass graft					
35509	C		Artery bypass graft					
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		Harvest femoropopliteal vein					
35582	C		Vein bypass graft					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					
35612	C		Artery bypass graft					
35616	C		Artery bypass graft					
35621	C		Artery bypass graft					
35623	C		Bypass graft, not vein					
35626	C		Artery bypass graft					
35631	C		Artery bypass graft					
35636	C		Artery bypass graft					
35641	C		Artery bypass graft					
35642	C		Artery bypass graft					
35645	C		Artery bypass graft					
35646	C		Artery bypass graft					
35647	C		Artery bypass graft					
35650	C		Artery bypass graft					
35651	C		Artery bypass graft					
35654	C		Artery bypass graft					
35656	C		Artery bypass graft					
35661	C		Artery bypass graft					
35663	C		Artery bypass graft					
35665	C		Artery bypass graft					
35666	C		Artery bypass graft					
35671	C		Artery bypass graft					
35681	C		Composite bypass graft					
35682	C		Composite bypass graft					
35683	C		Composite bypass graft					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35685	T		Bypass graft patency/patch	0093	20.6662	$1,121.95	$277.34	$224.39
35686	T		Bypass graft/av fist patency	0093	20.6662	$1,121.95	$277.34	$224.39
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	25.6233	$1,391.06	$459.35	$278.21
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	20.6662	$1,121.95	$277.34	$224.39
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	34.6065	$1,878.75	$655.22	$375.75
35876	T		Removal of clot in graft	0088	34.6065	$1,878.75	$655.22	$375.75
35879	T		Revise graft w/vein	0088	34.6065	$1,878.75	$655.22	$375.75
35881	T		Revise graft w/vein	0088	34.6065	$1,878.75	$655.22	$375.75
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	25.6233	$1,391.06	$459.35	$278.21
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4805	$134.66	$65.52	$26.93
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	129.8988	$7,052.08		$1,410.42
36261	T		Revision of infusion pump	0124	27.4545	$1,490.48	$298.10	$298.10
36262	T		Removal of infusion pump	0109	7.7075	$418.43	$131.49	$83.69
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					
36415	E		Drawing blood					
36416	E		Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.2236	$12.14	$3.51	$2.43
36425	T		Vein access cutdown > 1 yr	0035	0.2236	$12.14	$3.51	$2.43
36430	S		Blood transfusion service	0110	3.7128	$201.56		$40.31
36440	S		Bl push transfuse, 2 yr or <	0110	3.7128	$201.56		$40.31
36450	S		Bl exchange/transfuse, nb	0110	3.7128	$201.56		$40.31
36455	S		Bl exchange/transfuse non-nb	0110	3.7128	$201.56		$40.31
36460	S		Transfusion service, fetal	0110	3.7128	$201.56		$40.31
36468	T		Injection(s), spider veins	0098	1.1630	$63.14	$15.17	$12.63
36469	T		Injection(s), spider veins	0098	1.1630	$63.14	$15.17	$12.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36470	T		Injection therapy of vein	0098	1.1630	$63.14	$15.17	$12.63
36471	T		Injection therapy of veins	0098	1.1630	$63.14	$15.17	$12.63
36481	N		Insertion of catheter, vein					
36488	T		Insertion of catheter, vein	0032	11.5584	$627.49		$125.50
36489	T		Insertion of catheter, vein	0032	11.5584	$627.49		$125.50
36490	T		Insertion of catheter, vein	0032	11.5584	$627.49		$125.50
36491	T		Insertion of catheter, vein	0032	11.5584	$627.49		$125.50
36493	X		Repositioning of cvc	0187	4.4274	$240.36	$90.71	$48.07
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S		Apheresis wbc	0111	14.0169	$760.96	$211.96	$152.19
36512	S		Apheresis rbc	0111	14.0169	$760.96	$211.96	$152.19
36513	S		Apheresis platelets	0111	14.0169	$760.96	$211.96	$152.19
36514	S		Apheresis plasma	0111	14.0169	$760.96	$211.96	$152.19
36515	S		Apheresis, adsorp/reinfuse	0112	34.8318	$1,890.98	$609.71	$378.20
36516	S		Apheresis, selective	0112	34.8318	$1,890.98	$609.71	$378.20
36522	S		Photopheresis	0112	34.8318	$1,890.98	$609.71	$378.20
36530	T		Insertion of infusion pump	0119	129.8988	$7,052.08		$1,410.42
36531	T		Revision of infusion pump	0124	27.4545	$1,490.48	$298.10	$298.10
36532	T		Removal of infusion pump	0109	7.7075	$418.43	$131.49	$83.69
36533	T		Insertion of access device	0115	25.6233	$1,391.06	$459.35	$278.21
36534	T		Revision of access device	0109	7.7075	$418.43	$131.49	$83.69
36535	T		Removal of access device	0109	7.7075	$418.43	$131.49	$83.69
36536	T		Remove cva device obstruct	1541		$250.00		$50.00
36537	T		Remove cva lumen obstruct	1541		$250.00		$50.00
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	3.0769	$167.04		$33.41
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	11.5584	$627.49		$125.50
36660	C		Insertion catheter, artery					
36680	X		Insert needle, bone cavity	0340	0.6232	$33.83		$6.77
36800	T		Insertion of cannula	0115	25.6233	$1,391.06	$459.35	$278.21
36810	T		Insertion of cannula	0115	25.6233	$1,391.06	$459.35	$278.21
36815	T		Insertion of cannula	0115	25.6233	$1,391.06	$459.35	$278.21
36819	T		Av fusion/uppr arm vein	0088	34.6065	$1,878.75	$655.22	$375.75
36820	T		Av fusion/forearm vein	0088	34.6065	$1,878.75	$655.22	$375.75
36821	T		Av fusion direct any site	0088	34.6065	$1,878.75	$655.22	$375.75
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	34.6065	$1,878.75	$655.22	$375.75
36830	T		Artery-vein graft	0088	34.6065	$1,878.75	$655.22	$375.75
36831	T		Open thrombect av fistula	0088	34.6065	$1,878.75	$655.22	$375.75
36832	T		Av fistula revision, open	0088	34.6065	$1,878.75	$655.22	$375.75
36833	T		Av fistula revision	0088	34.6065	$1,878.75	$655.22	$375.75
36834	T		Repair A-V aneurysm	0088	34.6065	$1,878.75	$655.22	$375.75
36835	T		Artery to vein shunt	0115	25.6233	$1,391.06	$459.35	$278.21
36860	T		External cannula declotting	0103	12.1256	$658.29	$223.63	$131.66
36861	T		Cannula declotting	0115	25.6233	$1,391.06	$459.35	$278.21
36870	T		Percut thrombect av fistula	0653	32.4880	$1,763.74		$352.75
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					
37200	T		Transcatheter biopsy	0685	4.8912	$265.54	$116.83	$53.11
37201	T		Transcatheter therapy infuse	0676	3.7505	$203.61	$55.06	$40.72
37202	T		Transcatheter therapy infuse	0677	3.0769	$167.04		$33.41
37203	T		Transcatheter retrieval	0103	12.1256	$658.29	$223.63	$131.66
37204	T		Transcatheter occlusion	0115	25.6233	$1,391.06	$459.35	$278.21
37205	T		Transcatheter stent	0229	59.4977	$3,230.07	$771.23	$646.01
37206	T		Transcatheter stent add-on	0229	59.4977	$3,230.07	$771.23	$646.01

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37207	T		Transcatheter stent	0229	59.4977	$3,230.07	$771.23	$646.01
37208	T		Transcatheter stent add-on	0229	59.4977	$3,230.07	$771.23	$646.01
37209	T		Exchange arterial catheter	0103	12.1256	$658.29	$223.63	$131.66
37250	S		Iv us first vessel add-on	0670	26.5472	$1,441.22	$521.95	$288.24
37251	S		Iv us each add vessel add-on	0670	26.5472	$1,441.22	$521.95	$288.24
37500	T		Endoscopy ligate perf veins	0092	25.1347	$1,364.54	$505.37	$272.91
37501	T		Vascular endoscopy procedure	0092	25.1347	$1,364.54	$505.37	$272.91
37565	T		Ligation of neck vein	0093	20.6662	$1,121.95	$277.34	$224.39
37600	T		Ligation of neck artery	0093	20.6662	$1,121.95	$277.34	$224.39
37605	T		Ligation of neck artery	0091	28.5187	$1,548.25	$348.23	$309.65
37606	T		Ligation of neck artery	0091	28.5187	$1,548.25	$348.23	$309.65
37607	T		Ligation of a-v fistula	0092	25.1347	$1,364.54	$505.37	$272.91
37609	T		Temporal artery procedure	0021	14.5749	$791.26	$219.48	$158.25
37615	T		Ligation of neck artery	0091	28.5187	$1,548.25	$348.23	$309.65
37616	C		Ligation of chest artery					
37617	C		Ligation of abdomen artery					
37618	C		Ligation of extremity artery					
37620	T		Revision of major vein	0091	28.5187	$1,548.25	$348.23	$309.65
37650	T		Revision of major vein	0091	28.5187	$1,548.25	$348.23	$309.65
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	28.5187	$1,548.25	$348.23	$309.65
37720	T		Removal of leg vein	0092	25.1347	$1,364.54	$505.37	$272.91
37730	T		Removal of leg veins	0092	25.1347	$1,364.54	$505.37	$272.91
37735	T		Removal of leg veins/lesion	0092	25.1347	$1,364.54	$505.37	$272.91
37760	T		Revision of leg veins	0091	28.5187	$1,548.25	$348.23	$309.65
37780	T		Revision of leg vein	0091	28.5187	$1,548.25	$348.23	$309.65
37785	T		Revise secondary varicosity	0091	28.5187	$1,548.25	$348.23	$309.65
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	29.0094	$1,574.89	$621.82	$314.98
37799	T		Vascular surgery procedure	0035	0.2236	$12.14	$3.51	$2.43
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	40.8955	$2,220.18	$1,001.89	$444.04
38129	T		Laparoscope proc, spleen	0130	32.5959	$1,769.60	$659.53	$353.92
38200	N		Injection for spleen x-ray					
38204	E		Bl donor search management					
38205	S		Harvest allogenic stem cells	0111	14.0169	$760.96	$211.96	$152.19
38206	S		Harvest auto stem cells	0111	14.0169	$760.96	$211.96	$152.19
38207	E		Cryopreserve stem cells					
38208	E		Thaw preserved stem cells					
38209	E		Wash harvest stem cells					
38210	E		T-cell depletion of harvest					
38211	E		Tumor cell deplete of harvst					
38212	E		Rbc depletion of harvest					
38213	E		Platelet deplete of harvest					
38214	E		Volume deplete of harvest					
38215	E		Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	2.2627	$122.84		$24.57
38221	T		Bone marrow biopsy	0003	2.2627	$122.84		$24.57
38230	S		Bone marrow collection	0123	4.0076	$217.57		$43.51
38240	S		Bone marrow/stem transplant	0123	4.0076	$217.57		$43.51
38241	S		Bone marrow/stem transplant	0123	4.0076	$217.57		$43.51
38242	S		Lymphocyte infuse transplant	0111	14.0169	$760.96	$211.96	$152.19
38300	T		Drainage, lymph node lesion	0008	16.8303	$913.70		$182.74
38305	T		Drainage, lymph node lesion	0008	16.8303	$913.70		$182.74
38308	T		Incision of lymph channels	0113	19.9529	$1,083.22		$216.64
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	19.9529	$1,083.22		$216.64
38505	T		Needle biopsy, lymph nodes	0005	3.3675	$182.82	$71.59	$36.56
38510	T		Biopsy/removal, lymph nodes	0113	19.9529	$1,083.22		$216.64
38520	T		Biopsy/removal, lymph nodes	0113	19.9529	$1,083.22		$216.64
38525	T		Biopsy/removal, lymph nodes	0113	19.9529	$1,083.22		$216.64

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38530	T		Biopsy/removal, lymph nodes	0113	19.9529	$1,083.22		$216.64
38542	T		Explore deep node(s), neck	0114	37.3583	$2,028.14	$485.91	$405.63
38550	T		Removal, neck/armpit lesion	0113	19.9529	$1,083.22		$216.64
38555	T		Removal, neck/armpit lesion	0113	19.9529	$1,083.22		$216.64
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	40.8955	$2,220.18	$1,001.89	$444.04
38571	T		Laparoscopy, lymphadenectomy	0132	56.6318	$3,074.48	$1,239.22	$614.90
38572	T		Laparoscopy, lymphadenectomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
38589	T		Laparoscope proc, lymphatic	0130	32.5959	$1,769.60	$659.53	$353.92
38700	T		Removal of lymph nodes, neck	0113	19.9529	$1,083.22		$216.64
38720	T		Removal of lymph nodes, neck	0113	19.9529	$1,083.22		$216.64
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	37.3583	$2,028.14	$485.91	$405.63
38745	T		Remove armpit lymph nodes	0114	37.3583	$2,028.14	$485.91	$405.63
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	19.9529	$1,083.22		$216.64
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	3.7128	$201.56		$40.31
39000	C		Exploration of chest					
39010	C		Exploration of chest					
39200	C		Removal chest lesion					
39220	C		Removal chest lesion					
39400	T		Visualization of chest	0069	28.6334	$1,554.48	$591.64	$310.90
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	1.8643	$101.21		$20.24
40500	T		Partial excision of lip	0253	15.1698	$823.55	$282.29	$164.71
40510	T		Partial excision of lip	0254	21.4368	$1,163.78	$321.35	$232.76
40520	T		Partial excision of lip	0253	15.1698	$823.55	$282.29	$164.71
40525	T		Reconstruct lip with flap	0254	21.4368	$1,163.78	$321.35	$232.76
40527	T		Reconstruct lip with flap	0254	21.4368	$1,163.78	$321.35	$232.76
40530	T		Partial removal of lip	0254	21.4368	$1,163.78	$321.35	$232.76
40650	T		Repair lip	0252	6.5416	$355.14	$113.41	$71.03
40652	T		Repair lip	0252	6.5416	$355.14	$113.41	$71.03
40654	T		Repair lip	0252	6.5416	$355.14	$113.41	$71.03
40700	T		Repair cleft lip/nasal	0256	35.0866	$1,904.82		$380.96
40701	T		Repair cleft lip/nasal	0256	35.0866	$1,904.82		$380.96
40702	T		Repair cleft lip/nasal	0256	35.0866	$1,904.82		$380.96
40720	T		Repair cleft lip/nasal	0256	35.0866	$1,904.82		$380.96
40761	T		Repair cleft lip/nasal	0256	35.0866	$1,904.82		$380.96
40799	T		Lip surgery procedure	0253	15.1698	$823.55	$282.29	$164.71
40800	T		Drainage of mouth lesion	0251	1.8643	$101.21		$20.24
40801	T		Drainage of mouth lesion	0252	6.5416	$355.14	$113.41	$71.03
40804	X		Removal, foreign body, mouth	0340	0.6232	$33.83		$6.77
40805	T		Removal, foreign body, mouth	0252	6.5416	$355.14	$113.41	$71.03
40806	T		Incision of lip fold	0251	1.8643	$101.21		$20.24
40808	T		Biopsy of mouth lesion	0251	1.8643	$101.21		$20.24
40810	T		Excision of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40812	T		Excise/repair mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
40814	T		Excise/repair mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
40816	T		Excision of mouth lesion	0254	21.4368	$1,163.78	$321.35	$232.76
40818	T		Excise oral mucosa for graft	0251	1.8643	$101.21		$20.24
40819	T		Excise lip or cheek fold	0252	6.5416	$355.14	$113.41	$71.03
40820	T		Treatment of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
40830	T		Repair mouth laceration	0251	1.8643	$101.21		$20.24
40831	T		Repair mouth laceration	0252	6.5416	$355.14	$113.41	$71.03
40840	T		Reconstruction of mouth	0254	21.4368	$1,163.78	$321.35	$232.76
40842	T		Reconstruction of mouth	0254	21.4368	$1,163.78	$321.35	$232.76
40843	T		Reconstruction of mouth	0254	21.4368	$1,163.78	$321.35	$232.76
40844	T		Reconstruction of mouth	0256	35.0866	$1,904.82		$380.96
40845	T		Reconstruction of mouth	0256	35.0866	$1,904.82		$380.96
40899	T		Mouth surgery procedure	0252	6.5416	$355.14	$113.41	$71.03
41000	T		Drainage of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
41005	T		Drainage of mouth lesion	0251	1.8643	$101.21		$20.24
41006	T		Drainage of mouth lesion	0254	21.4368	$1,163.78	$321.35	$232.76
41007	T		Drainage of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
41008	T		Drainage of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
41009	T		Drainage of mouth lesion	0251	1.8643	$101.21		$20.24
41010	T		Incision of tongue fold	0253	15.1698	$823.55	$282.29	$164.71
41015	T		Drainage of mouth lesion	0251	1.8643	$101.21		$20.24
41016	T		Drainage of mouth lesion	0252	6.5416	$355.14	$113.41	$71.03
41017	T		Drainage of mouth lesion	0252	6.5416	$355.14	$113.41	$71.03
41018	T		Drainage of mouth lesion	0252	6.5416	$355.14	$113.41	$71.03
41100	T		Biopsy of tongue	0252	6.5416	$355.14	$113.41	$71.03
41105	T		Biopsy of tongue	0253	15.1698	$823.55	$282.29	$164.71
41108	T		Biopsy of floor of mouth	0252	6.5416	$355.14	$113.41	$71.03
41110	T		Excision of tongue lesion	0253	15.1698	$823.55	$282.29	$164.71
41112	T		Excision of tongue lesion	0253	15.1698	$823.55	$282.29	$164.71
41113	T		Excision of tongue lesion	0253	15.1698	$823.55	$282.29	$164.71
41114	T		Excision of tongue lesion	0254	21.4368	$1,163.78	$321.35	$232.76
41115	T		Excision of tongue fold	0252	6.5416	$355.14	$113.41	$71.03
41116	T		Excision of mouth lesion	0253	15.1698	$823.55	$282.29	$164.71
41120	T		Partial removal of tongue	0254	21.4368	$1,163.78	$321.35	$232.76
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	1.8643	$101.21		$20.24
41251	T		Repair tongue laceration	0252	6.5416	$355.14	$113.41	$71.03
41252	T		Repair tongue laceration	0252	6.5416	$355.14	$113.41	$71.03
41500	T		Fixation of tongue	0254	21.4368	$1,163.78	$321.35	$232.76
41510	T		Tongue to lip surgery	0253	15.1698	$823.55	$282.29	$164.71
41520	T		Reconstruction, tongue fold	0252	6.5416	$355.14	$113.41	$71.03
41599	T		Tongue and mouth surgery	0251	1.8643	$101.21		$20.24
41800	T		Drainage of gum lesion	0251	1.8643	$101.21		$20.24
41805	T		Removal foreign body, gum	0254	21.4368	$1,163.78	$321.35	$232.76
41806	T		Removal foreign body,jawbone	0253	15.1698	$823.55	$282.29	$164.71
41820	T		Excision, gum, each quadrant	0252	6.5416	$355.14	$113.41	$71.03
41821	T		Excision of gum flap	0252	6.5416	$355.14	$113.41	$71.03
41822	T		Excision of gum lesion	0253	15.1698	$823.55	$282.29	$164.71
41823	T		Excision of gum lesion	0254	21.4368	$1,163.78	$321.35	$232.76
41825	T		Excision of gum lesion	0253	15.1698	$823.55	$282.29	$164.71
41826	T		Excision of gum lesion	0253	15.1698	$823.55	$282.29	$164.71
41827	T		Excision of gum lesion	0254	21.4368	$1,163.78	$321.35	$232.76
41828	T		Excision of gum lesion	0253	15.1698	$823.55	$282.29	$164.71
41830	T		Removal of gum tissue	0253	15.1698	$823.55	$282.29	$164.71
41850	T		Treatment of gum lesion	0253	15.1698	$823.55	$282.29	$164.71
41870	T		Gum graft	0254	21.4368	$1,163.78	$321.35	$232.76
41872	T		Repair gum	0253	15.1698	$823.55	$282.29	$164.71
41874	T		Repair tooth socket	0254	21.4368	$1,163.78	$321.35	$232.76
41899	T		Dental surgery procedure	0253	15.1698	$823.55	$282.29	$164.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42000	T		Drainage mouth roof lesion	0251	1.8643	$101.21		$20.24
42100	T		Biopsy roof of mouth	0252	6.5416	$355.14	$113.41	$71.03
42104	T		Excision lesion, mouth roof	0253	15.1698	$823.55	$282.29	$164.71
42106	T		Excision lesion, mouth roof	0253	15.1698	$823.55	$282.29	$164.71
42107	T		Excision lesion, mouth roof	0254	21.4368	$1,163.78	$321.35	$232.76
42120	T		Remove palate/lesion	0256	35.0866	$1,904.82		$380.96
42140	T		Excision of uvula	0252	6.5416	$355.14	$113.41	$71.03
42145	T		Repair palate, pharynx/uvula	0254	21.4368	$1,163.78	$321.35	$232.76
42160	T		Treatment mouth roof lesion	0253	15.1698	$823.55	$282.29	$164.71
42180	T		Repair palate	0251	1.8643	$101.21		$20.24
42182	T		Repair palate	0256	35.0866	$1,904.82		$380.96
42200	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42205	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42210	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42215	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42220	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42225	T		Reconstruct cleft palate	0256	35.0866	$1,904.82		$380.96
42226	T		Lengthening of palate	0256	35.0866	$1,904.82		$380.96
42227	T		Lengthening of palate	0256	35.0866	$1,904.82		$380.96
42235	T		Repair palate	0253	15.1698	$823.55	$282.29	$164.71
42260	T		Repair nose to lip fistula	0254	21.4368	$1,163.78	$321.35	$232.76
42280	T		Preparation, palate mold	0251	1.8643	$101.21		$20.24
42281	T		Insertion, palate prosthesis	0253	15.1698	$823.55	$282.29	$164.71
42299	T		Palate/uvula surgery	0251	1.8643	$101.21		$20.24
42300	T		Drainage of salivary gland	0253	15.1698	$823.55	$282.29	$164.71
42305	T		Drainage of salivary gland	0253	15.1698	$823.55	$282.29	$164.71
42310	T		Drainage of salivary gland	0251	1.8643	$101.21		$20.24
42320	T		Drainage of salivary gland	0251	1.8643	$101.21		$20.24
42325	T		Create salivary cyst drain	0251	1.8643	$101.21		$20.24
42326	T		Create salivary cyst drain	0252	6.5416	$355.14	$113.41	$71.03
42330	T		Removal of salivary stone	0253	15.1698	$823.55	$282.29	$164.71
42335	T		Removal of salivary stone	0253	15.1698	$823.55	$282.29	$164.71
42340	T		Removal of salivary stone	0253	15.1698	$823.55	$282.29	$164.71
42400	T		Biopsy of salivary gland	0005	3.3675	$182.82	$71.59	$36.56
42405	T		Biopsy of salivary gland	0253	15.1698	$823.55	$282.29	$164.71
42408	T		Excision of salivary cyst	0253	15.1698	$823.55	$282.29	$164.71
42409	T		Drainage of salivary cyst	0253	15.1698	$823.55	$282.29	$164.71
42410	T		Excise parotid gland/lesion	0256	35.0866	$1,904.82		$380.96
42415	T		Excise parotid gland/lesion	0256	35.0866	$1,904.82		$380.96
42420	T		Excise parotid gland/lesion	0256	35.0866	$1,904.82		$380.96
42425	T		Excise parotid gland/lesion	0256	35.0866	$1,904.82		$380.96
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	35.0866	$1,904.82		$380.96
42450	T		Excise sublingual gland	0254	21.4368	$1,163.78	$321.35	$232.76
42500	T		Repair salivary duct	0254	21.4368	$1,163.78	$321.35	$232.76
42505	T		Repair salivary duct	0256	35.0866	$1,904.82		$380.96
42507	T		Parotid duct diversion	0256	35.0866	$1,904.82		$380.96
42508	T		Parotid duct diversion	0256	35.0866	$1,904.82		$380.96
42509	T		Parotid duct diversion	0256	35.0866	$1,904.82		$380.96
42510	T		Parotid duct diversion	0256	35.0866	$1,904.82		$380.96
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	15.1698	$823.55	$282.29	$164.71
42650	T		Dilation of salivary duct	0252	6.5416	$355.14	$113.41	$71.03
42660	T		Dilation of salivary duct	0252	6.5416	$355.14	$113.41	$71.03
42665	T		Ligation of salivary duct	0254	21.4368	$1,163.78	$321.35	$232.76
42699	T		Salivary surgery procedure	0253	15.1698	$823.55	$282.29	$164.71
42700	T		Drainage of tonsil abscess	0251	1.8643	$101.21		$20.24
42720	T		Drainage of throat abscess	0253	15.1698	$823.55	$282.29	$164.71
42725	T		Drainage of throat abscess	0256	35.0866	$1,904.82		$380.96
42800	T		Biopsy of throat	0253	15.1698	$823.55	$282.29	$164.71
42802	T		Biopsy of throat	0253	15.1698	$823.55	$282.29	$164.71
42804	T		Biopsy of upper nose/throat	0253	15.1698	$823.55	$282.29	$164.71
42806	T		Biopsy of upper nose/throat	0254	21.4368	$1,163.78	$321.35	$232.76
42808	T		Excise pharynx lesion	0253	15.1698	$823.55	$282.29	$164.71
42809	X		Remove pharynx foreign body	0340	0.6232	$33.83		$6.77
42810	T		Excision of neck cyst	0254	21.4368	$1,163.78	$321.35	$232.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42815	T		Excision of neck cyst	0256	35.0866	$1,904.82		$380.96
42820	T		Remove tonsils and adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42821	T		Remove tonsils and adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42825	T		Removal of tonsils	0258	21.0273	$1,141.55	$437.25	$228.31
42826	T		Removal of tonsils	0258	21.0273	$1,141.55	$437.25	$228.31
42830	T		Removal of adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42831	T		Removal of adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42835	T		Removal of adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42836	T		Removal of adenoids	0258	21.0273	$1,141.55	$437.25	$228.31
42842	T		Extensive surgery of throat	0254	21.4368	$1,163.78	$321.35	$232.76
42844	T		Extensive surgery of throat	0256	35.0866	$1,904.82		$380.96
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	21.0273	$1,141.55	$437.25	$228.31
42870	T		Excision of lingual tonsil	0258	21.0273	$1,141.55	$437.25	$228.31
42890	T		Partial removal of pharynx	0256	35.0866	$1,904.82		$380.96
42892	T		Revision of pharyngeal walls	0256	35.0866	$1,904.82		$380.96
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	6.5416	$355.14	$113.41	$71.03
42950	T		Reconstruction of throat	0254	21.4368	$1,163.78	$321.35	$232.76
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	21.4368	$1,163.78	$321.35	$232.76
42960	T		Control throat bleeding	0250	1.5381	$83.50	$29.23	$16.70
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	35.0866	$1,904.82		$380.96
42970	T		Control nose/throat bleeding	0250	1.5381	$83.50	$29.23	$16.70
42971	C		Control nose/throat bleeding					
42972	T		Control nose/throat bleeding	0253	15.1698	$823.55	$282.29	$164.71
42999	T		Throat surgery procedure	0252	6.5416	$355.14	$113.41	$71.03
43020	T		Incision of esophagus	0252	6.5416	$355.14	$113.41	$71.03
43030	T		Throat muscle surgery	0253	15.1698	$823.55	$282.29	$164.71
43045	C		Incision of esophagus					
43100	C		Excision of esophagus lesion					
43101	C		Excision of esophagus lesion					
43107	C		Removal of esophagus					
43108	C		Removal of esophagus					
43112	C		Removal of esophagus					
43113	C		Removal of esophagus					
43116	C		Partial removal of esophagus					
43117	C		Partial removal of esophagus					
43118	C		Partial removal of esophagus					
43121	C		Partial removal of esophagus					
43122	C		Partial removal of esophagus					
43123	C		Partial removal of esophagus					
43124	C		Removal of esophagus					
43130	T		Removal of esophagus pouch	0254	21.4368	$1,163.78	$321.35	$232.76
43135	C		Removal of esophagus pouch					
43200	T		Esophagus endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43201	T		Esoph scope w/submucous inj	0141	7.8542	$426.40	$143.38	$85.28
43202	T		Esophagus endoscopy, biopsy	0141	7.8542	$426.40	$143.38	$85.28
43204	T		Esoph scope w/sclerosis inj	0141	7.8542	$426.40	$143.38	$85.28
43205	T		Esophagus endoscopy/ligation	0141	7.8542	$426.40	$143.38	$85.28
43215	T		Esophagus endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43216	T		Esophagus endoscopy/lesion	0141	7.8542	$426.40	$143.38	$85.28
43217	T		Esophagus endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43219	T		Esophagus endoscopy	0384	36.0040	$1,954.62	$424.53	$390.92
43220	T		Esoph endoscopy, dilation	0141	7.8542	$426.40	$143.38	$85.28
43226	T		Esoph endoscopy, dilation	0141	7.8542	$426.40	$143.38	$85.28
43227	T		Esoph endoscopy, repair	0141	7.8542	$426.40	$143.38	$85.28
43228	T		Esoph endoscopy, ablation	0141	7.8542	$426.40	$143.38	$85.28
43231	T		Esoph endoscopy w/us exam	0141	7.8542	$426.40	$143.38	$85.28
43232	T		Esoph endoscopy w/us fn bx	0141	7.8542	$426.40	$143.38	$85.28
43234	T		Upper GI endoscopy, exam	0141	7.8542	$426.40	$143.38	$85.28
43235	T		Uppr gi endoscopy, diagnosis	0141	7.8542	$426.40	$143.38	$85.28
43236	T		Uppr gi scope w/submuc inj	0141	7.8542	$426.40	$143.38	$85.28
43239	T		Upper GI endoscopy, biopsy	0141	7.8542	$426.40	$143.38	$85.28
43240	T		Esoph endoscope w/drain cyst	0141	7.8542	$426.40	$143.38	$85.28

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43241	T		Upper GI endoscopy with tube	0141	7.8542	$426.40	$143.38	$85.28
43242	T		Uppr gi endoscopy w/us fn bx	0141	7.8542	$426.40	$143.38	$85.28
43243	T		Upper gi endoscopy & inject	0141	7.8542	$426.40	$143.38	$85.28
43244	T		Upper GI endoscopy/ligation	0141	7.8542	$426.40	$143.38	$85.28
43245	T		Uppr gi scope dilate strictr	0141	7.8542	$426.40	$143.38	$85.28
43246	T		Place gastrostomy tube	0141	7.8542	$426.40	$143.38	$85.28
43247	T		Operative upper GI endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43248	T		Uppr gi endoscopy/guide wire	0141	7.8542	$426.40	$143.38	$85.28
43249	T		Esoph endoscopy, dilation	0141	7.8542	$426.40	$143.38	$85.28
43250	T		Upper GI endoscopy/tumor	0141	7.8542	$426.40	$143.38	$85.28
43251	T		Operative upper GI endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43255	T		Operative upper GI endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43256	T		Uppr gi endoscopy w stent	0384	36.0040	$1,954.62	$424.53	$390.92
43258	T		Operative upper GI endoscopy	0141	7.8542	$426.40	$143.38	$85.28
43259	T		Endoscopic ultrasound exam	0141	7.8542	$426.40	$143.38	$85.28
43260	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43261	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43262	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43263	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43264	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43265	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43267	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43268	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43269	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43271	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43272	T		Endo cholangiopancreatograph	0151	18.8763	$1,024.78	$245.46	$204.96
43280	T		Laparoscopy, fundoplasty	0132	56.6318	$3,074.48	$1,239.22	$614.90
43289	T		Laparoscope proc, esoph	0130	32.5959	$1,769.60	$659.53	$353.92
43300	C		Repair of esophagus					
43305	C		Repair esophagus and fistula					
43310	C		Repair of esophagus					
43312	C		Repair esophagus and fistula					
43313	C		Esophagoplasty congenital					
43314	C		Tracheo-esophagoplasty cong					
43320	C		Fuse esophagus & stomach					
43324	C		Revise esophagus & stomach					
43325	C		Revise esophagus & stomach					
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					
43331	C		Repair of esophagus					
43340	C		Fuse esophagus & intestine					
43341	C		Fuse esophagus & intestine					
43350	C		Surgical opening, esophagus					
43351	C		Surgical opening, esophagus					
43352	C		Surgical opening, esophagus					
43360	C		Gastrointestinal repair					
43361	C		Gastrointestinal repair					
43400	C		Ligate esophagus veins					
43401	C		Esophagus surgery for veins					
43405	C		Ligate/staple esophagus					
43410	C		Repair esophagus wound					
43415	C		Repair esophagus wound					
43420	C		Repair esophagus opening					
43425	C		Repair esophagus opening					
43450	T		Dilate esophagus	0140	6.3480	$344.63	$107.24	$68.93
43453	T		Dilate esophagus	0140	6.3480	$344.63	$107.24	$68.93
43456	T		Dilate esophagus	0140	6.3480	$344.63	$107.24	$68.93
43458	T		Dilate esophagus	0140	6.3480	$344.63	$107.24	$68.93
43460	C		Pressure treatment esophagus					
43496	C		Free jejunum flap, microvasc					
43499	T		Esophagus surgery procedure	0141	7.8542	$426.40	$143.38	$85.28
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43600	T		Biopsy of stomach	0141	7.8542	$426.40	$143.38	$85.28
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	56.6318	$3,074.48	$1,239.22	$614.90
43652	T		Laparoscopy, vagus nerve	0132	56.6318	$3,074.48	$1,239.22	$614.90
43653	T		Laparoscopy, gastrostomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
43659	T		Laparoscope proc, stom	0130	32.5959	$1,769.60	$659.53	$353.92
43750	T		Place gastrostomy tube	0141	7.8542	$426.40	$143.38	$85.28
43752	E		Nasal/orogastric w/stent					
43760	T		Change gastrostomy tube	0121	2.2058	$119.75	$43.80	$23.95
43761	T		Reposition gastrostomy tube	0121	2.2058	$119.75	$43.80	$23.95
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	7.8542	$426.40	$143.38	$85.28
43831	T		Place gastrostomy tube	0141	7.8542	$426.40	$143.38	$85.28
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	7.8542	$426.40	$143.38	$85.28
43880	C		Repair stomach-bowel fistula					
43999	T		Stomach surgery procedure	0141	7.8542	$426.40	$143.38	$85.28
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	7.8542	$426.40	$143.38	$85.28
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	40.8955	$2,220.18	$1,001.89	$444.04
44201	T		Laparoscopy, jejunostomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T		Lap part colectomy w/stoma	0132	56.6318	$3,074.48	$1,239.22	$614.90
44207	T		L colectomy/coloproctostomy	0132	56.6318	$3,074.48	$1,239.22	$614.90
44208	T		L colectomy/coloproctostomy	0132	56.6318	$3,074.48	$1,239.22	$614.90
44210	C		Laparo total proctocolectomy					
44211	C		Laparo total proctocolectomy					
44212	C		Laparo total proctocolectomy					
44238	T		Laparoscope proc, intestine	0130	32.5959	$1,769.60	$659.53	$353.92
44239	T		Laparoscope proc, rectum	0130	32.5959	$1,769.60	$659.53	$353.92
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	15.8319	$859.50	$329.72	$171.90
44314	C		Revision of ileostomy					
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	15.8319	$859.50	$329.72	$171.90
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44361	T		Small bowel endoscopy/biopsy	0142	9.0138	$489.35	$152.78	$97.87
44363	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44364	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44365	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44366	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44369	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44370	T		Small bowel endoscopy/stent	0384	36.0040	$1,954.62	$424.53	$390.92
44372	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44373	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44376	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44377	T		Small bowel endoscopy/biopsy	0142	9.0138	$489.35	$152.78	$97.87
44378	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44379	T		S bowel endoscope w/stent	0384	36.0040	$1,954.62	$424.53	$390.92
44380	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44382	T		Small bowel endoscopy	0142	9.0138	$489.35	$152.78	$97.87
44383	T		Ileoscopy w/stent	0384	36.0040	$1,954.62	$424.53	$390.92
44385	T		Endoscopy of bowel pouch	0143	8.3227	$451.83	$186.06	$90.37
44386	T		Endoscopy, bowel pouch/biop	0143	8.3227	$451.83	$186.06	$90.37
44388	T		Colon endoscopy	0143	8.3227	$451.83	$186.06	$90.37
44389	T		Colonoscopy with biopsy	0143	8.3227	$451.83	$186.06	$90.37
44390	T		Colonoscopy for foreign body	0143	8.3227	$451.83	$186.06	$90.37
44391	T		Colonoscopy for bleeding	0143	8.3227	$451.83	$186.06	$90.37
44392	T		Colonoscopy & polypectomy	0143	8.3227	$451.83	$186.06	$90.37
44393	T		Colonoscopy, lesion removal	0143	8.3227	$451.83	$186.06	$90.37
44394	T		Colonoscopy w/snare	0143	8.3227	$451.83	$186.06	$90.37
44397	T		Colonoscopy w/stent	0384	36.0040	$1,954.62	$424.53	$390.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44500	T		Intro, gastrointestinal tube	0121	2.2058	$119.75	$43.80	$23.95
44602	C		Suture, small intestine					
44603	C		Suture, small intestine					
44604	C		Suture, large intestine					
44605	C		Repair of bowel lesion					
44615	C		Intestinal stricturoplasty					
44620	C		Repair bowel opening					
44625	C		Repair bowel opening					
44626	C		Repair bowel opening					
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N		Intraop colon lavage add-on					
44799	T		Intestine surgery procedure	0142	9.0138	$489.35	$152.78	$97.87
44800	C		Excision of bowel pouch					
44820	C		Excision of mesentery lesion					
44850	C		Repair of mesentery					
44899	C		Bowel surgery procedure					
44900	C		Drain app abscess, open					
44901	C		Drain app abscess, percut					
44950	C		Appendectomy					
44955	C		Appendectomy add-on					
44960	C		Appendectomy					
44970	T		Laparoscopy, appendectomy	0130	32.5959	$1,769.60	$659.53	$353.92
44979	T		Laparoscope proc, app	0130	32.5959	$1,769.60	$659.53	$353.92
45000	T		Drainage of pelvic abscess	0149	16.8557	$915.08	$293.06	$183.02
45005	T		Drainage of rectal abscess	0148	4.1171	$223.51	$63.38	$44.70
45020	T		Drainage of rectal abscess	0149	16.8557	$915.08	$293.06	$183.02
45100	T		Biopsy of rectum	0149	16.8557	$915.08	$293.06	$183.02
45108	T		Removal of anorectal lesion	0150	22.2565	$1,208.28	$437.12	$241.66
45110	C		Removal of rectum					
45111	C		Partial removal of rectum					
45112	C		Removal of rectum					
45113	C		Partial proctectomy					
45114	C		Partial removal of rectum					
45116	C		Partial removal of rectum					
45119	C		Remove rectum w/reservoir					
45120	C		Removal of rectum					
45121	C		Removal of rectum and colon					
45123	C		Partial proctectomy					
45126	C		Pelvic exenteration					
45130	C		Excision of rectal prolapse					
45135	C		Excision of rectal prolapse					
45136	C		Excise ileoanal reservior					
45150	T		Excision of rectal stricture	0150	22.2565	$1,208.28	$437.12	$241.66
45160	T		Excision of rectal lesion	0150	22.2565	$1,208.28	$437.12	$241.66
45170	T		Excision of rectal lesion	0150	22.2565	$1,208.28	$437.12	$241.66
45190	T		Destruction, rectal tumor	0150	22.2565	$1,208.28	$437.12	$241.66
45300	T		Proctosigmoidoscopy dx	0146	3.9986	$217.08	$64.40	$43.42
45303	T		Proctosigmoidoscopy dilate	0146	3.9986	$217.08	$64.40	$43.42
45305	T		Proctosigmoidoscopy w/bx	0146	3.9986	$217.08	$64.40	$43.42
45307	T		Proctosigmoidoscopy fb	0146	3.9986	$217.08	$64.40	$43.42
45308	T		Proctosigmoidoscopy removal	0147	7.5876	$411.92		$82.38
45309	T		Proctosigmoidoscopy removal	0147	7.5876	$411.92		$82.38
45315	T		Proctosigmoidoscopy removal	0147	7.5876	$411.92		$82.38
45317	T		Proctosigmoidoscopy bleed	0146	3.9986	$217.08	$64.40	$43.42
45320	T		Proctosigmoidoscopy ablate	0147	7.5876	$411.92		$82.38
45321	T		Proctosigmoidoscopy volvul	0147	7.5876	$411.92		$82.38
45327	T		Proctosigmoidoscopy w/stent	0384	36.0040	$1,954.62	$424.53	$390.92
45330	T		Diagnostic sigmoidoscopy	0146	3.9986	$217.08	$64.40	$43.42
45331	T		Sigmoidoscopy and biopsy	0146	3.9986	$217.08	$64.40	$43.42
45332	T		Sigmoidoscopy w/fb removal	0146	3.9986	$217.08	$64.40	$43.42
45333	T		Sigmoidoscopy & polypectomy	0147	7.5876	$411.92		$82.38

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45334	T		Sigmoidoscopy for bleeding	0147	7.5876	$411.92		$82.38
45335	T		Sigmoidoscope w/submuc inj	0147	7.5876	$411.92		$82.38
45337	T		Sigmoidoscopy & decompress	0147	7.5876	$411.92		$82.38
45338	T		Sigmoidoscpy w/tumr remove	0147	7.5876	$411.92		$82.38
45339	T		Sigmoidoscopy w/ablate tumr	0147	7.5876	$411.92		$82.38
45340	T		Sig w/balloon dilation	0147	7.5876	$411.92		$82.38
45341	T		Sigmoidoscopy w/ultrasound	0147	7.5876	$411.92		$82.38
45342	T		Sigmoidoscopy w/us guide bx	0147	7.5876	$411.92		$82.38
45345	T		Sigmoidoscopy w/stent	0384	36.0040	$1,954.62	$424.53	$390.92
45355	T		Surgical colonoscopy	0143	8.3227	$451.83	$186.06	$90.37
45378	T		Diagnostic colonoscopy	0143	8.3227	$451.83	$186.06	$90.37
45379	T		Colonoscopy w/fb removal	0143	8.3227	$451.83	$186.06	$90.37
45380	T		Colonoscopy and biopsy	0143	8.3227	$451.83	$186.06	$90.37
45381	T		Colonoscope, submucous inj	0143	8.3227	$451.83	$186.06	$90.37
45382	T		Colonoscopy/control bleeding	0143	8.3227	$451.83	$186.06	$90.37
45383	T		Lesion removal colonoscopy	0143	8.3227	$451.83	$186.06	$90.37
45384	T		Lesion remove colonoscopy	0143	8.3227	$451.83	$186.06	$90.37
45385	T		Lesion removal colonoscopy	0143	8.3227	$451.83	$186.06	$90.37
45386	T		Colonoscope dilate stricture	0143	8.3227	$451.83	$186.06	$90.37
45387	T		Colonoscopy w/stent	0384	36.0040	$1,954.62	$424.53	$390.92
45500	T		Repair of rectum	0150	22.2565	$1,208.28	$437.12	$241.66
45505	T		Repair of rectum	0150	22.2565	$1,208.28	$437.12	$241.66
45520	T		Treatment of rectal prolapse	0098	1.1630	$63.14	$15.17	$12.63
45540	C		Correct rectal prolapse					
45541	C		Correct rectal prolapse					
45550	C		Repair rectum/remove sigmoid					
45560	T		Repair of rectocele	0150	22.2565	$1,208.28	$437.12	$241.66
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	4.1171	$223.51	$63.38	$44.70
45905	T		Dilation of anal sphincter	0149	16.8557	$915.08	$293.06	$183.02
45910	T		Dilation of rectal narrowing	0149	16.8557	$915.08	$293.06	$183.02
45915	T		Remove rectal obstruction	0148	4.1171	$223.51	$63.38	$44.70
45999	T		Rectum surgery procedure	0148	4.1171	$223.51	$63.38	$44.70
46020	T		Placement of seton	0148	4.1171	$223.51	$63.38	$44.70
46030	T		Removal of rectal marker	0148	4.1171	$223.51	$63.38	$44.70
46040	T		Incision of rectal abscess	0149	16.8557	$915.08	$293.06	$183.02
46045	T		Incision of rectal abscess	0150	22.2565	$1,208.28	$437.12	$241.66
46050	T		Incision of anal abscess	0148	4.1171	$223.51	$63.38	$44.70
46060	T		Incision of rectal abscess	0150	22.2565	$1,208.28	$437.12	$241.66
46070	T		Incision of anal septum	0155	9.9148	$538.26	$188.89	$107.65
46080	T		Incision of anal sphincter	0149	16.8557	$915.08	$293.06	$183.02
46083	T		Incise external hemorrhoid	0148	4.1171	$223.51	$63.38	$44.70
46200	T		Removal of anal fissure	0150	22.2565	$1,208.28	$437.12	$241.66
46210	T		Removal of anal crypt	0149	16.8557	$915.08	$293.06	$183.02
46211	T		Removal of anal crypts	0150	22.2565	$1,208.28	$437.12	$241.66
46220	T		Removal of anal tag	0149	16.8557	$915.08	$293.06	$183.02
46221	T		Ligation of hemorrhoid(s)	0148	4.1171	$223.51	$63.38	$44.70
46230	T		Removal of anal tags	0149	16.8557	$915.08	$293.06	$183.02
46250	T		Hemorrhoidectomy	0150	22.2565	$1,208.28	$437.12	$241.66
46255	T		Hemorrhoidectomy	0150	22.2565	$1,208.28	$437.12	$241.66
46257	T		Remove hemorrhoids & fissure	0150	22.2565	$1,208.28	$437.12	$241.66
46258	T		Remove hemorrhoids & fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46260	T		Hemorrhoidectomy	0150	22.2565	$1,208.28	$437.12	$241.66
46261	T		Remove hemorrhoids & fissure	0150	22.2565	$1,208.28	$437.12	$241.66
46262	T		Remove hemorrhoids & fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46270	T		Removal of anal fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46275	T		Removal of anal fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46280	T		Removal of anal fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46285	T		Removal of anal fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46288	T		Repair anal fistula	0150	22.2565	$1,208.28	$437.12	$241.66
46320	T		Removal of hemorrhoid clot	0148	4.1171	$223.51	$63.38	$44.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46500	T		Injection into hemorrhoid(s)	0155	9.9148	$538.26	$188.89	$107.65
46600	X		Diagnostic anoscopy	0340	0.6232	$33.83		$6.77
46604	T		Anoscopy and dilation	0147	7.5876	$411.92		$82.38
46606	T		Anoscopy and biopsy	0147	7.5876	$411.92		$82.38
46608	T		Anoscopy, remove for body	0147	7.5876	$411.92		$82.38
46610	T		Anoscopy, remove lesion	0147	7.5876	$411.92		$82.38
46611	T		Anoscopy	0147	7.5876	$411.92		$82.38
46612	T		Anoscopy, remove lesions	0147	7.5876	$411.92		$82.38
46614	T		Anoscopy, control bleeding	0147	7.5876	$411.92		$82.38
46615	T		Anoscopy	0147	7.5876	$411.92		$82.38
46700	T		Repair of anal stricture	0150	22.2565	$1,208.28	$437.12	$241.66
46705	C		Repair of anal stricture					
46706	T		Repr of anal fistula w/glue	0148	4.1171	$223.51	$63.38	$44.70
46715	C		Repair of anovaginal fistula					
46716	C		Repair of anovaginal fistula					
46730	C		Construction of absent anus					
46735	C		Construction of absent anus					
46740	C		Construction of absent anus					
46742	C		Repair of imperforated anus					
46744	C		Repair of cloacal anomaly					
46746	C		Repair of cloacal anomaly					
46748	C		Repair of cloacal anomaly					
46750	T		Repair of anal sphincter	0150	22.2565	$1,208.28	$437.12	$241.66
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	22.2565	$1,208.28	$437.12	$241.66
46754	T		Removal of suture from anus	0149	16.8557	$915.08	$293.06	$183.02
46760	T		Repair of anal sphincter	0150	22.2565	$1,208.28	$437.12	$241.66
46761	T		Repair of anal sphincter	0150	22.2565	$1,208.28	$437.12	$241.66
46762	T		Implant artificial sphincter	0150	22.2565	$1,208.28	$437.12	$241.66
46900	T		Destruction, anal lesion(s)	0016	2.7343	$148.44	$57.31	$29.69
46910	T		Destruction, anal lesion(s)	0017	16.7332	$908.43	$227.84	$181.69
46916	T		Cryosurgery, anal lesion(s)	0013	1.1420	$62.00	$14.20	$12.40
46917	T		Laser surgery, anal lesions	0695	19.1377	$1,038.97	$266.59	$207.79
46922	T		Excision of anal lesion(s)	0695	19.1377	$1,038.97	$266.59	$207.79
46924	T		Destruction, anal lesion(s)	0695	19.1377	$1,038.97	$266.59	$207.79
46934	T		Destruction of hemorrhoids	0155	9.9148	$538.26	$188.89	$107.65
46935	T		Destruction of hemorrhoids	0155	9.9148	$538.26	$188.89	$107.65
46936	T		Destruction of hemorrhoids	0149	16.8557	$915.08	$293.06	$183.02
46937	T		Cryotherapy of rectal lesion	0149	16.8557	$915.08	$293.06	$183.02
46938	T		Cryotherapy of rectal lesion	0150	22.2565	$1,208.28	$437.12	$241.66
46940	T		Treatment of anal fissure	0149	16.8557	$915.08	$293.06	$183.02
46942	T		Treatment of anal fissure	0148	4.1171	$223.51	$63.38	$44.70
46945	T		Ligation of hemorrhoids	0155	9.9148	$538.26	$188.89	$107.65
46946	T		Ligation of hemorrhoids	0155	9.9148	$538.26	$188.89	$107.65
46999	T		Anus surgery procedure	0148	4.1171	$223.51	$63.38	$44.70
47000	T		Needle biopsy of liver	0685	4.8912	$265.54	$116.83	$53.11
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0005	3.3675	$182.82	$71.59	$36.56
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	32.5959	$1,769.60	$659.53	$353.92
47371	T		Laparo ablate liver cryosurg	0130	32.5959	$1,769.60	$659.53	$353.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47379	T		Laparoscope procedure, liver	0130	32.5959	$1,769.60	$659.53	$353.92
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	1557		$1,850.00		$370.00
47399	T		Liver surgery procedure	0005	3.3675	$182.82	$71.59	$36.56
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	8.2940	$450.27	$113.02	$90.05
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	8.2940	$450.27	$113.02	$90.05
47511	T		Insert bile duct drain	0152	8.2940	$450.27	$113.02	$90.05
47525	T		Change bile duct catheter	0122	8.4398	$458.19	$93.97	$91.64
47530	T		Revise/reinsert bile tube	0122	8.4398	$458.19	$93.97	$91.64
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	8.2940	$450.27	$113.02	$90.05
47553	T		Biliary endoscopy thru skin	0152	8.2940	$450.27	$113.02	$90.05
47554	T		Biliary endoscopy thru skin	0152	8.2940	$450.27	$113.02	$90.05
47555	T		Biliary endoscopy thru skin	0152	8.2940	$450.27	$113.02	$90.05
47556	T		Biliary endoscopy thru skin	0152	8.2940	$450.27	$113.02	$90.05
47560	T		Laparoscopy w/cholangio	0130	32.5959	$1,769.60	$659.53	$353.92
47561	T		Laparo w/cholangio/biopsy	0130	32.5959	$1,769.60	$659.53	$353.92
47562	T		Laparoscopic cholecystectomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
47563	T		Laparo cholecystectomy/graph	0131	40.8955	$2,220.18	$1,001.89	$444.04
47564	T		Laparo cholecystectomy/explr	0131	40.8955	$2,220.18	$1,001.89	$444.04
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	32.5959	$1,769.60	$659.53	$353.92
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	8.2940	$450.27	$113.02	$90.05
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					
47711	C		Excision of bile duct tumor					
47712	C		Excision of bile duct tumor					
47715	C		Excision of bile duct cyst					
47716	C		Fusion of bile duct cyst					
47720	C		Fuse gallbladder & bowel					
47721	C		Fuse upper gi structures					
47740	C		Fuse gallbladder & bowel					
47741	C		Fuse gallbladder & bowel					
47760	C		Fuse bile ducts and bowel					
47765	C		Fuse liver ducts & bowel					
47780	C		Fuse bile ducts and bowel					
47785	C		Fuse bile ducts and bowel					
47800	C		Reconstruction of bile ducts					
47801	C		Placement, bile duct support					
47802	C		Fuse liver duct & intestine					
47900	C		Suture bile duct injury					
47999	T		Bile tract surgery procedure	0152	8.2940	$450.27	$113.02	$90.05
48000	C		Drainage of abdomen					
48001	C		Placement of drain, pancreas					
48005	C		Resect/debride pancreas					
48020	C		Removal of pancreatic stone					
48100	C		Biopsy of pancreas, open					
48102	T		Needle biopsy, pancreas	0685	4.8912	$265.54	$116.83	$53.11
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	3.3675	$182.82	$71.59	$36.56
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	3.3675	$182.82	$71.59	$36.56
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	3.1393	$170.43		$34.09
49081	T		Removal of abdominal fluid	0070	3.1393	$170.43		$34.09
49085	T		Remove abdomen foreign body	0153	21.2745	$1,154.97	$410.87	$230.99
49180	T		Biopsy, abdominal mass	0685	4.8912	$265.54	$116.83	$53.11
49200	T		Removal of abdominal lesion	0130	32.5959	$1,769.60	$659.53	$353.92
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					
49250	T		Excision of umbilicus	0153	21.2745	$1,154.97	$410.87	$230.99
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	32.5959	$1,769.60	$659.53	$353.92
49321	T		Laparoscopy, biopsy	0130	32.5959	$1,769.60	$659.53	$353.92
49322	T		Laparoscopy, aspiration	0130	32.5959	$1,769.60	$659.53	$353.92
49323	T		Laparo drain lymphocele	0130	32.5959	$1,769.60	$659.53	$353.92
49329	T		Laparo proc, abdm/per/oment	0130	32.5959	$1,769.60	$659.53	$353.92
49400	N		Air injection into abdomen					
49419	T		Insrt abdom cath for chemotx	0119	129.8988	$7,052.08		$1,410.42
49420	T		Insert abdom drain, temp	0652	28.0692	$1,523.85		$304.77
49421	T		Insert abdom drain, perm	0652	28.0692	$1,523.85		$304.77
49422	T		Remove perm cannula/catheter	0105	18.9084	$1,026.52	$370.40	$205.30
49423	T		Exchange drainage catheter	0152	8.2940	$450.27	$113.02	$90.05
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	21.2745	$1,154.97	$410.87	$230.99
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	18.9084	$1,026.52	$370.40	$205.30
49491	T		Rpr hern preemie reduc	0154	26.8861	$1,459.62	$464.85	$291.92
49492	T		Rpr ing hern premie, blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49495	T		Rpr ing hernia baby, reduc	0154	26.8861	$1,459.62	$464.85	$291.92
49496	T		Rpr ing hernia baby, blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49500	T		Rpr ing hernia, init, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49501	T		Rpr ing hernia, init blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49505	T		Prp i/hern init reduc>5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49507	T		Prp i/hern init block>5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49520	T		Rerepair ing hernia, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49521	T		Rerepair ing hernia, blocked	0154	26.8861	$1,459.62	$464.85	$291.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49525	T		Repair ing hernia, sliding	0154	26.8861	$1,459.62	$464.85	$291.92
49540	T		Repair lumbar hernia	0154	26.8861	$1,459.62	$464.85	$291.92
49550	T		Rpr rem hernia, init, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49553	T		Rpr fem hernia, init blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49555	T		Rerepair fem hernia, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49557	T		Rerepair fem hernia, blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49560	T		Rpr ventral hern init, reduc	0154	26.8861	$1,459.62	$464.85	$291.92
49561	T		Rpr ventral hern init, block	0154	26.8861	$1,459.62	$464.85	$291.92
49565	T		Rerepair ventrl hern, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49566	T		Rerepair ventrl hern, block	0154	26.8861	$1,459.62	$464.85	$291.92
49568	T		Hernia repair w/mesh	0154	26.8861	$1,459.62	$464.85	$291.92
49570	T		Rpr epigastric hern, reduce	0154	26.8861	$1,459.62	$464.85	$291.92
49572	T		Rpr epigastric hern, blocked	0154	26.8861	$1,459.62	$464.85	$291.92
49580	T		Rpr umbil hern, reduc < 5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49582	T		Rpr umbil hern, block < 5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49585	T		Rpr umbil hern, reduc > 5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49587	T		Rpr umbil hern, block > 5 yr	0154	26.8861	$1,459.62	$464.85	$291.92
49590	T		Repair spigilian hernia	0154	26.8861	$1,459.62	$464.85	$291.92
49600	T		Repair umbilical lesion	0154	26.8861	$1,459.62	$464.85	$291.92
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	40.8955	$2,220.18	$1,001.89	$444.04
49651	T		Laparo hernia repair recur	0131	40.8955	$2,220.18	$1,001.89	$444.04
49659	T		Laparo proc, hernia repair	0131	40.8955	$2,220.18	$1,001.89	$444.04
49900	C		Repair of abdominal wall					
49904	C		Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	21.2745	$1,154.97	$410.87	$230.99
50010	C		Exploration of kidney					
50020	C		Renal abscess, open drain					
50021	T		Renal abscess, percut drain	0005	3.3675	$182.82	$71.59	$36.56
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					
50060	C		Removal of kidney stone					
50065	C		Incision of kidney					
50070	C		Incision of kidney					
50075	C		Removal of kidney stone					
50080	T		Removal of kidney stone	0163	33.6435	$1,826.47		$365.29
50081	T		Removal of kidney stone	0163	33.6435	$1,826.47		$365.29
50100	C		Revise kidney blood vessels					
50120	C		Exploration of kidney					
50125	C		Explore and drain kidney					
50130	C		Removal of kidney stone					
50135	C		Exploration of kidney					
50200	T		Biopsy of kidney	0685	4.8912	$265.54	$116.83	$53.11
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					
50230	C		Removal kidney open, radical					
50234	C		Removal of kidney & ureter					
50236	C		Removal of kidney & ureter					
50240	C		Partial removal of kidney					
50280	C		Removal of kidney lesion					
50290	C		Removal of kidney lesion					
50300	C		Removal of donor kidney					
50320	C		Removal of donor kidney					
50340	C		Removal of kidney					
50360	C		Transplantation of kidney					
50365	C		Transplantation of kidney					
50370	C		Remove transplanted kidney					
50380	C		Reimplantation of kidney					
50390	T		Drainage of kidney lesion	0685	4.8912	$265.54	$116.83	$53.11
50392	T		Insert kidney drain	0161	16.5822	$900.23	$249.36	$180.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50393	T		Insert ureteral tube	0161	16.5822	$900.23	$249.36	$180.05
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	16.5822	$900.23	$249.36	$180.05
50396	T		Measure kidney pressure	0164	1.2115	$65.77	$17.59	$13.15
50398	T		Change kidney tube	0122	8.4398	$458.19	$93.97	$91.64
50400	C		Revision of kidney/ureter					
50405	C		Revision of kidney/ureter					
50500	C		Repair of kidney wound					
50520	C		Close kidney-skin fistula					
50525	C		Repair renal-abdomen fistula					
50526	C		Repair renal-abdomen fistula					
50540	C		Revision of horseshoe kidney					
50541	T		Laparo ablate renal cyst	0130	32.5959	$1,769.60	$659.53	$353.92
50542	T		Laparo ablate renal mass	0131	40.8955	$2,220.18	$1,001.89	$444.04
50543	T		Laparo partial nephrectomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
50544	T		Laparoscopy, pyeloplasty	0130	32.5959	$1,769.60	$659.53	$353.92
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	32.5959	$1,769.60	$659.53	$353.92
50551	T		Kidney endoscopy	0160	6.8152	$369.99	$105.06	$74.00
50553	T		Kidney endoscopy	0161	16.5822	$900.23	$249.36	$180.05
50555	T		Kidney endoscopy & biopsy	0160	6.8152	$369.99	$105.06	$74.00
50557	T		Kidney endoscopy & treatment	0162	21.8578	$1,186.64		$237.33
50559	T		Renal endoscopy/radiotracer	0160	6.8152	$369.99	$105.06	$74.00
50561	T		Kidney endoscopy & treatment	0161	16.5822	$900.23	$249.36	$180.05
50562	T		Renal scope w/tumor resect	0160	6.8152	$369.99	$105.06	$74.00
50570	C		Kidney endoscopy					
50572	C		Kidney endoscopy					
50574	C		Kidney endoscopy & biopsy					
50575	C		Kidney endoscopy					
50576	C		Kidney endoscopy & treatment					
50578	C		Renal endoscopy/radiotracer					
50580	C		Kidney endoscopy & treatment					
50590	T		Fragmenting of kidney stone	0169	44.5329	$2,417.65	$1,115.69	$483.53
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	1.2115	$65.77	$17.59	$13.15
50688	T		Change of ureter tube	0122	8.4398	$458.19	$93.97	$91.64
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	40.8955	$2,220.18	$1,001.89	$444.04
50947	T		Laparo new ureter/bladder	0131	40.8955	$2,220.18	$1,001.89	$444.04
50948	T		Laparo new ureter/bladder	0131	40.8955	$2,220.18	$1,001.89	$444.04
50949	T		Laparoscope proc, ureter	0130	32.5959	$1,769.60	$659.53	$353.92
50951	T		Endoscopy of ureter	0160	6.8152	$369.99	$105.06	$74.00
50953	T		Endoscopy of ureter	0160	6.8152	$369.99	$105.06	$74.00
50955	T		Ureter endoscopy & biopsy	0161	16.5822	$900.23	$249.36	$180.05
50957	T		Ureter endoscopy & treatment	0161	16.5822	$900.23	$249.36	$180.05
50959	T		Ureter endoscopy & tracer	0161	16.5822	$900.23	$249.36	$180.05
50961	T		Ureter endoscopy & treatment	0161	16.5822	$900.23	$249.36	$180.05
50970	T		Ureter endoscopy	0160	6.8152	$369.99	$105.06	$74.00
50972	T		Ureter endoscopy & catheter	0160	6.8152	$369.99	$105.06	$74.00
50974	T		Ureter endoscopy & biopsy	0161	16.5822	$900.23	$249.36	$180.05
50976	T		Ureter endoscopy & treatment	0161	16.5822	$900.23	$249.36	$180.05
50978	T		Ureter endoscopy & tracer	0161	16.5822	$900.23	$249.36	$180.05
50980	T		Ureter endoscopy & treatment	0161	16.5822	$900.23	$249.36	$180.05
51000	T		Drainage of bladder	0165	14.0780	$764.28		$152.86
51005	T		Drainage of bladder	0164	1.2115	$65.77	$17.59	$13.15
51010	T		Drainage of bladder	0165	14.0780	$764.28		$152.86
51020	T		Incise & treat bladder	0162	21.8578	$1,186.64		$237.33
51030	T		Incise & treat bladder	0162	21.8578	$1,186.64		$237.33
51040	T		Incise & drain bladder	0162	21.8578	$1,186.64		$237.33
51045	T		Incise bladder/drain ureter	0160	6.8152	$369.99	$105.06	$74.00
51050	T		Removal of bladder stone	0162	21.8578	$1,186.64		$237.33
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	21.8578	$1,186.64		$237.33
51080	T		Drainage of bladder abscess	0007	11.4943	$624.01		$124.80
51500	T		Removal of bladder cyst	0154	26.8861	$1,459.62	$464.85	$291.92
51520	T		Removal of bladder lesion	0162	21.8578	$1,186.64		$237.33
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	1.2115	$65.77	$17.59	$13.15
51701	N		Insert bladder catheter					
51702	N		Insert temp bladder cath					
51703	N		Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.2058	$119.75	$43.80	$23.95
51710	T		Change of bladder tube	0122	8.4398	$458.19	$93.97	$91.64
51715	T		Endoscopic injection/implant	0167	30.1066	$1,634.46	$555.84	$326.89
51720	T		Treatment of bladder lesion	0156	3.1438	$170.67	$46.55	$34.13
51725	T		Simple cystometrogram	0156	3.1438	$170.67	$46.55	$34.13
51726	T		Complex cystometrogram	0156	3.1438	$170.67	$46.55	$34.13
51736	T		Urine flow measurement	0164	1.2115	$65.77	$17.59	$13.15
51741	T		Electro-uroflowmetry, first	0164	1.2115	$65.77	$17.59	$13.15

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51772	T		Urethra pressure profile	0164	1.2115	$65.77	$17.59	$13.15
51784	T		Anal/urinary muscle study	0164	1.2115	$65.77	$17.59	$13.15
51785	T		Anal/urinary muscle study	0164	1.2115	$65.77	$17.59	$13.15
51792	T		Urinary reflex study	0164	1.2115	$65.77	$17.59	$13.15
51795	T		Urine voiding pressure study	0164	1.2115	$65.77	$17.59	$13.15
51797	T		Intraabdominal pressure test	0164	1.2115	$65.77	$17.59	$13.15
51798	X		Us urine capacity measure	0340	0.6232	$33.83		$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	21.8578	$1,186.64		$237.33
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	40.8955	$2,220.18	$1,001.89	$444.04
51992	T		Laparo sling operation	0132	56.6318	$3,074.48	$1,239.22	$614.90
52000	T		Cystoscopy	0160	6.8152	$369.99	$105.06	$74.00
52001	T		Cystoscopy, removal of clots	0160	6.8152	$369.99	$105.06	$74.00
52005	T		Cystoscopy & ureter catheter	0161	16.5822	$900.23	$249.36	$180.05
52007	T		Cystoscopy and biopsy	0161	16.5822	$900.23	$249.36	$180.05
52010	T		Cystoscopy & duct catheter	0160	6.8152	$369.99	$105.06	$74.00
52204	T		Cystoscopy	0161	16.5822	$900.23	$249.36	$180.05
52214	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52224	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52234	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52235	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52240	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52250	T		Cystoscopy and radiotracer	0162	21.8578	$1,186.64		$237.33
52260	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52265	T		Cystoscopy and treatment	0160	6.8152	$369.99	$105.06	$74.00
52270	T		Cystoscopy & revise urethra	0161	16.5822	$900.23	$249.36	$180.05
52275	T		Cystoscopy & revise urethra	0161	16.5822	$900.23	$249.36	$180.05
52276	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52277	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52281	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52282	T		Cystoscopy, implant stent	0385	66.4829	$3,609.29		$721.86
52283	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52285	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52290	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52300	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52301	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52305	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52310	T		Cystoscopy and treatment	0160	6.8152	$369.99	$105.06	$74.00
52315	T		Cystoscopy and treatment	0161	16.5822	$900.23	$249.36	$180.05
52317	T		Remove bladder stone	0162	21.8578	$1,186.64		$237.33
52318	T		Remove bladder stone	0162	21.8578	$1,186.64		$237.33
52320	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52325	T		Cystoscopy, stone removal	0162	21.8578	$1,186.64		$237.33
52327	T		Cystoscopy, inject material	0162	21.8578	$1,186.64		$237.33
52330	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52332	T		Cystoscopy and treatment	0162	21.8578	$1,186.64		$237.33
52334	T		Create passage to kidney	0162	21.8578	$1,186.64		$237.33
52341	T		Cysto w/ureter stricture tx	0162	21.8578	$1,186.64		$237.33
52342	T		Cysto w/up stricture tx	0162	21.8578	$1,186.64		$237.33
52343	T		Cysto w/renal stricture tx	0162	21.8578	$1,186.64		$237.33
52344	T		Cysto/uretero, stone remove	0162	21.8578	$1,186.64		$237.33
52345	T		Cysto/uretero w/up stricture	0162	21.8578	$1,186.64		$237.33
52346	T		Cystouretero w/renal strict	0162	21.8578	$1,186.64		$237.33
52347	T		Cystoscopy, resect ducts	0160	6.8152	$369.99	$105.06	$74.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52351	T		Cystouretero & or pyeloscope	0160	6.8152	$369.99	$105.06	$74.00
52352	T		Cystouretero w/stone remove	0162	21.8578	$1,186.64		$237.33
52353	T		Cystouretero w/lithotripsy	0163	33.6435	$1,826.47		$365.29
52354	T		Cystouretero w/biopsy	0162	21.8578	$1,186.64		$237.33
52355	T		Cystouretero w/excise tumor	0162	21.8578	$1,186.64		$237.33
52400	T		Cystouretero w/congen repr	0162	21.8578	$1,186.64		$237.33
52450	T		Incision of prostate	0162	21.8578	$1,186.64		$237.33
52500	T		Revision of bladder neck	0162	21.8578	$1,186.64		$237.33
52510	T		Dilation prostatic urethra	0161	16.5822	$900.23	$249.36	$180.05
52601	T		Prostatectomy (TURP)	0163	33.6435	$1,826.47		$365.29
52606	T		Control postop bleeding	0162	21.8578	$1,186.64		$237.33
52612	T		Prostatectomy, first stage	0163	33.6435	$1,826.47		$365.29
52614	T		Prostatectomy, second stage	0163	33.6435	$1,826.47		$365.29
52620	T		Remove residual prostate	0163	33.6435	$1,826.47		$365.29
52630	T		Remove prostate regrowth	0163	33.6435	$1,826.47		$365.29
52640	T		Relieve bladder contracture	0162	21.8578	$1,186.64		$237.33
52647	T		Laser surgery of prostate	0163	33.6435	$1,826.47		$365.29
52648	T		Laser surgery of prostate	0163	33.6435	$1,826.47		$365.29
52700	T		Drainage of prostate abscess	0162	21.8578	$1,186.64		$237.33
53000	T		Incision of urethra	0166	16.8401	$914.23	$218.73	$182.85
53010	T		Incision of urethra	0166	16.8401	$914.23	$218.73	$182.85
53020	T		Incision of urethra	0166	16.8401	$914.23	$218.73	$182.85
53025	T		Incision of urethra	0166	16.8401	$914.23	$218.73	$182.85
53040	T		Drainage of urethra abscess	0166	16.8401	$914.23	$218.73	$182.85
53060	T		Drainage of urethra abscess	0166	16.8401	$914.23	$218.73	$182.85
53080	T		Drainage of urinary leakage	0166	16.8401	$914.23	$218.73	$182.85
53085	C		Drainage of urinary leakage					
53200	T		Biopsy of urethra	0166	16.8401	$914.23	$218.73	$182.85
53210	T		Removal of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53215	T		Removal of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53220	T		Treatment of urethra lesion	0168	30.3485	$1,647.59	$405.60	$329.52
53230	T		Removal of urethra lesion	0168	30.3485	$1,647.59	$405.60	$329.52
53235	T		Removal of urethra lesion	0168	30.3485	$1,647.59	$405.60	$329.52
53240	T		Surgery for urethra pouch	0168	30.3485	$1,647.59	$405.60	$329.52
53250	T		Removal of urethra gland	0166	16.8401	$914.23	$218.73	$182.85
53260	T		Treatment of urethra lesion	0166	16.8401	$914.23	$218.73	$182.85
53265	T		Treatment of urethra lesion	0166	16.8401	$914.23	$218.73	$182.85
53270	T		Removal of urethra gland	0167	30.1066	$1,634.46	$555.84	$326.89
53275	T		Repair of urethra defect	0166	16.8401	$914.23	$218.73	$182.85
53400	T		Revise urethra, stage 1	0168	30.3485	$1,647.59	$405.60	$329.52
53405	T		Revise urethra, stage 2	0168	30.3485	$1,647.59	$405.60	$329.52
53410	T		Reconstruction of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	30.3485	$1,647.59	$405.60	$329.52
53425	T		Reconstruct urethra, stage 2	0168	30.3485	$1,647.59	$405.60	$329.52
53430	T		Reconstruction of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53431	T		Reconstruct urethra/bladder	0168	30.3485	$1,647.59	$405.60	$329.52
53440	T		Correct bladder function	0385	66.4829	$3,609.29		$721.86
53442	T		Remove perineal prosthesis	0166	16.8401	$914.23	$218.73	$182.85
53444	T		Insert tandem cuff	0385	66.4829	$3,609.29		$721.86
53445	T		Insert uro/ves nck sphincter	0386	118.8122	$6,450.20		$1,290.04
53446	T		Remove uro sphincter	0168	30.3485	$1,647.59	$405.60	$329.52
53447	T		Remove/replace ur sphincter	0386	118.8122	$6,450.20		$1,290.014
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	30.3485	$1,647.59	$405.60	$329.52
53450	T		Revision of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53460	T		Revision of urethra	0168	30.3485	$1,647.59	$405.60	$329.52
53502	T		Repair of urethra injury	0166	16.8401	$914.23	$218.73	$182.85
53505	T		Repair of urethra injury	0167	30.1066	$1,634.46	$555.84	$326.89
53510	T		Repair of urethra injury	0166	16.8401	$914.23	$218.73	$182.85
53515	T		Repair of urethra injury	0168	30.3485	$1,647.59	$405.60	$329.52
53520	T		Repair of urethra defect	0168	30.3485	$1,647.59	$405.60	$329.52
53600	T		Dilate urethra stricture	0156	3.1438	$170.67	$46.55	$34.13
53601	T		Dilate urethra stricture	0164	1.2115	$65.77	$17.59	$13.15
53605	T		Dilate urethra stricture	0161	16.5822	$900.23	$249.36	$180.05
53620	T		Dilate urethra stricture	0165	14.0780	$764.28		$152.86

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53621	T		Dilate urethra stricture	0164	1.2115	$65.77	$17.59	$13.15
53660	T		Dilation of urethra	0164	1.2115	$65.77	$17.59	$13.15
53661	T		Dilation of urethra	0164	1.2115	$65.77	$17.59	$13.15
53665	T		Dilation of urethra	0166	16.8401	$914.23	$218.73	$182.85
53850	T		Prostatic microwave thermotx	0675	49.3613	$2,679.78		$535.96
53852	T		Prostatic rf thermotx	0675	49.3613	$2,679.78		$535.96
53853	T		Prostatic water thermother	1550		$1,150.00		$230.00
53899	T		Urology surgery procedure	0164	1.2115	$65.77	$17.59	$13.15
54000	T		Slitting of prepuce	0166	16.8401	$914.23	$218.73	$182.85
54001	T		Slitting of prepuce	0166	16.8401	$914.23	$218.73	$182.85
54015	T		Drain penis lesion	0007	11.4943	$624.01		$124.80
54050	T		Destruction, penis lesion(s)	0013	1.1420	$62.00	$14.20	$12.40
54055	T		Destruction, penis lesion(s)	0017	16.7332	$908.43	$227.84	$181.69
54056	T		Cryosurgery, penis lesion(s)	0012	0.8203	$44.53	$11.18	$8.91
54057	T		Laser surg, penis lesion(s)	0017	16.7332	$908.43	$227.84	$181.69
54060	T		Excision of penis lesion(s)	0017	16.7332	$908.43	$227.84	$181.69
54065	T		Destruction, penis lesion(s)	0695	19.1377	$1,038.97	$266.59	$207.79
54100	T		Biopsy of penis	0021	14.5749	$791.26	$219.48	$158.25
54105	T		Biopsy of penis	0022	18.6725	$1,013.71	$354.45	$202.74
54110	T		Treatment of penis lesion	0181	29.0094	$1,574.89	$621.82	$314.98
54111	T		Treat penis lesion, graft	0181	29.0094	$1,574.89	$621.82	$314.98
54112	T		Treat penis lesion, graft	0181	29.0094	$1,574.89	$621.82	$314.98
54115	T		Treatment of penis lesion	0008	16.8303	$913.70		$182.74
54120	T		Partial removal of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	18.4967	$1,004.17	$304.87	$200.83
54152	T		Circumcision	0180	18.4967	$1,004.17	$304.87	$200.83
54160	T		Circumcision	0180	18.4967	$1,004.17	$304.87	$200.83
54161	T		Circumcision	0180	18.4967	$1,004.17	$304.87	$200.83
54162	T		Lysis penil circumic lesion	0180	18.4967	$1,004.17	$304.87	$200.83
54163	T		Repair of circumcision	0180	18.4967	$1,004.17	$304.87	$200.83
54164	T		Frenulotomy of penis	0180	18.4967	$1,004.17	$304.87	$200.83
54200	T		Treatment of penis lesion	0156	3.1438	$170.67	$46.55	$34.13
54205	T		Treatment of penis lesion	0181	29.0094	$1,574.89	$621.82	$314.98
54220	T		Treatment of penis lesion	0156	3.1438	$170.67	$46.55	$34.13
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	14.0780	$764.28		$152.86
54235	T		Penile injection	0164	1.2115	$65.77	$17.59	$13.15
54240	T		Penis study	0164	1.2115	$65.77	$17.59	$13.15
54250	T		Penis study	0165	14.0780	$764.28		$152.86
54300	T		Revision of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54304	T		Revision of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54308	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54312	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54316	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54318	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54322	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54324	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54326	T		Reconstruction of urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54328	T		Revise penis/urethra	0181	29.0094	$1,574.89	$621.82	$314.98
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	29.0094	$1,574.89	$621.82	$314.98
54344	T		Secondary urethral surgery	0181	29.0094	$1,574.89	$621.82	$314.98
54348	T		Secondary urethral surgery	0181	29.0094	$1,574.89	$621.82	$314.98
54352	T		Reconstruct urethra/penis	0181	29.0094	$1,574.89	$621.82	$314.98
54360	T		Penis plastic surgery	0181	29.0094	$1,574.89	$621.82	$314.98
54380	T		Repair penis	0181	29.0094	$1,574.89	$621.82	$314.98
54385	T		Repair penis	0181	29.0094	$1,574.89	$621.82	$314.98
54390	C		Repair penis and bladder					
54400	T		Insert semi-rigid prosthesis	0385	66.4829	$3,609.29		$721.86
54401	T		Insert self-contd prosthesis	0386	118.8122	$6,450.20		$1,240.04
54405	T		Insert multi-comp penis pros	0386	118.8122	$6,450.20		$1,240.04
54406	T		Remove muti-comp penis pros	0181	29.0094	$1,574.89	$621.82	$314.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54408	T		Repair multi-comp penis pros	0181	29.0094	$1,574.89	$621.82	$314.98
54410	T		Remove/replace penis prosth	0386	118.8122	$6,450.20		$1,290.04
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	29.0094	$1,574.89	$621.82	$314.98
54416	T		Remv/repl penis contain pros	0385	66.4829	$3,609.29		$721.86
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54430	C		Revision of penis					
54435	T		Revision of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54440	T		Repair of penis	0181	29.0094	$1,574.89	$621.82	$314.98
54450	T		Preputial stretching	0156	3.1438	$170.67	$46.55	$34.13
54500	T		Biopsy of testis	0005	3.3675	$182.82	$71.59	$36.56
54505	T		Biopsy of testis	0183	21.7612	$1,181.39		$236.28
54512	T		Excise lesion testis	0183	21.7612	$1,181.39		$236.28
54520	T		Removal of testis	0183	21.7612	$1,181.39		$236.28
54522	T		Orchiectomy, partial	0183	21.7612	$1,181.39		$236.28
54530	T		Removal of testis	0154	26.8861	$1,459.62	$464.85	$291.92
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	26.8861	$1,459.62	$464.85	$291.92
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	21.7612	$1,181.39		$236.28
54620	T		Suspension of testis	0183	21.7612	$1,181.39		$236.28
54640	T		Suspension of testis	0154	26.8861	$1,459.62	$464.85	$291.92
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	21.7612	$1,181.39		$236.28
54670	T		Repair testis injury	0183	21.7612	$1,181.39		$236.28
54680	T		Relocation of testis(es)	0183	21.7612	$1,181.39		$236.28
54690	T		Laparoscopy, orchiectomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
54692	T		Laparoscopy, orchiopexy	0132	56.6318	$3,074.48	$1,239.22	$614.90
54699	T		Laparoscope proc, testis	0130	32.5959	$1,769.60	$659.53	$353.92
54700	T		Drainage of scrotum	0183	21.7612	$1,181.39		$236.28
54800	T		Biopsy of epididymis	0004	1.5774	$85.64	$22.10	$17.13
54820	T		Exploration of epididymis	0183	21.7612	$1,181.39		$236.28
54830	T		Remove epididymis lesion	0183	21.7612	$1,181.39		$236.28
54840	T		Remove epididymis lesion	0183	21.7612	$1,181.39		$236.28
54860	T		Removal of epididymis	0183	21.7612	$1,181.39		$236.28
54861	T		Removal of epididymis	0183	21.7612	$1,181.39		$236.28
54900	T		Fusion of spermatic ducts	0183	21.7612	$1,181.39		$236.28
54901	T		Fusion of spermatic ducts	0183	21.7612	$1,181.39		$236.28
55000	T		Drainage of hydrocele	0004	1.5774	$85.64	$22.10	$17.13
55040	T		Removal of hydrocele	0154	26.8861	$1,459.62	$464.85	$291.92
55041	T		Removal of hydroceles	0154	26.8861	$1,459.62	$464.85	$291.92
55060	T		Repair of hydrocele	0183	21.7612	$1,181.39		$236.28
55100	T		Drainage of scrotum abscess	0007	11.4943	$624.01		$124.80
55110	T		Explore scrotum	0183	21.7612	$1,181.39		$236.28
55120	T		Removal of scrotum lesion	0183	21.7612	$1,181.39		$236.28
55150	T		Removal of scrotum	0183	21.7612	$1,181.39		$236.28
55175	T		Revision of scrotum	0183	21.7612	$1,181.39		$236.28
55180	T		Revision of scrotum	0183	21.7612	$1,181.39		$236.28
55200	T		Incision of sperm duct	0183	21.7612	$1,181.39		$236.28
55250	T		Removal of sperm duct(s)	0183	21.7612	$1,181.39		$236.28
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	21.7612	$1,181.39		$236.28
55450	T		Ligation of sperm duct	0183	21.7612	$1,181.39		$236.28
55500	T		Removal of hydrocele	0183	21.7612	$1,181.39		$236.28
55520	T		Removal of sperm cord lesion	0183	21.7612	$1,181.39		$236.28
55530	T		Revise spermatic cord veins	0183	21.7612	$1,181.39		$236.28
55535	T		Revise spermatic cord veins	0154	26.8861	$1,459.62	$464.85	$291.92
55540	T		Revise hernia & sperm veins	0154	26.8861	$1,459.62	$464.85	$291.92
55550	T		Laparo ligate spermatic vein	0131	40.8955	$2,220.18	$1,001.89	$444.04
55559	T		Laparo proc, spermatic cord	0130	32.5959	$1,769.60	$659.53	$353.92
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	21.7612	$1,181.39		$236.28
55700	T		Biopsy of prostate	0184	3.8073	$206.69	$96.27	$41.34

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55705	T		Biopsy of prostate	0184	3.8073	$206.69	$96.27	$41.34
55720	T		Drainage of prostate abscess	0162	21.8578	$1,186.64		$237.33
55725	T		Drainage of prostate abscess	0162	21.8578	$1,186.64		$237.33
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	33.6435	$1,826.47		$365.29
55860	T		Surgical exposure, prostate	0165	14.0780	$764.28		$152.86
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C		Laparo radical prostatectomy					
55870	T		Vag hyst w/enterocele repair	0197	5.1958	$282.07		$56.41
55873	T		Cryoablate prostate	0674	101.1198	$5,489.69		$1,097.94
55899	T		Genital surgery procedure	0164	1.2115	$65.77	$17.59	$13.15
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	2.6966	$146.40	$39.11	$29.28
56420	T		Drainage of gland abscess	0192	2.6966	$146.40	$39.11	$29.28
56440	T		Surgery for vulva lesion	0194	18.8194	$1,021.69	$397.84	$204.34
56441	T		Lysis of labial lesion(s)	0193	15.7365	$854.32	$171.13	$170.86
56501	T		Destroy, vulva lesions, sim	0017	16.7332	$908.43	$227.84	$181.69
56515	T		Destroy vulva lesion/s compl	0695	19.1377	$1,038.97	$266.59	$207.79
56605	T		Biopsy of vulva/perineum	0019	3.9807	$216.11	$71.87	$43.22
56606	T		Biopsy of vulva/perineum	0019	3.9807	$216.11	$71.87	$43.22
56620	T		Partial removal of vulva	0195	25.3207	$1,374.64	$483.80	$274.93
56625	T		Complete removal of vulva	0195	25.3207	$1,374.64	$483.80	$274.93
56630	C		Extensive vulva surgery					
56631	C		Extensive vulva surgery					
56632	C		Extensive vulva surgery					
56633	C		Extensive vulva surgery					
56634	C		Extensive vulva surgery					
56637	C		Extensive vulva surgery					
56640	C		Extensive vulva surgery					
56700	T		Partial removal of hymen	0194	18.8194	$1,021.69	$397.84	$204.34
56720	T		Incision of hymen	0193	15.7365	$854.32	$171.13	$170.86
56740	T		Remove vagina gland lesion	0194	18.8194	$1,021.69	$397.84	$204.34
56800	T		Repair of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
56805	T		Repair clitoris	0194	18.8194	$1,021.69	$397.84	$204.34
56810	T		Repair of perineum	0194	18.8194	$1,021.69	$397.84	$204.34
56820	T		Exam of vulva w/scope	0188	1.1079	$60.15		$12.03
56821	T		Exam/biopsy of vulva w/scope	0189	1.3207	$71.70	$16.70	$14.34
57000	T		Exploration of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
57010	T		Drainage of pelvic abscess	0194	18.8194	$1,021.69	$397.84	$204.34
57020	T		Drainage of pelvic fluid	0192	2.6966	$146.40	$39.11	$29.28
57022	T		I & d vaginal hematoma, pp	0007	11.4943	$624.01		$124.80
57023	T		I & d vag hematoma, non-ob	0007	11.4943	$624.01		$124.80
57061	T		Destroy vag lesions, simple	0194	18.8194	$1,021.69	$397.84	$204.34
57065	T		Destroy vag lesions, complex	0194	18.8194	$1,021.69	$397.84	$204.34
57100	T		Biopsy of vagina	0192	2.6966	$146.40	$39.11	$29.28
57105	T		Biopsy of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
57106	T		Remove vagina wall, partial	0194	18.8194	$1,021.69	$397.84	$204.34
57107	T		Remove vagina tissue, part	0195	25.3207	$1,374.64	$483.80	$274.93
57109	T		Vaginectomy partial w/nodes	0195	25.3207	$1,374.64	$483.80	$274.93
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
57130	T		Remove vagina lesion	0194	18.8194	$1,021.69	$397.84	$204.34
57135	T		Remove vagina lesion	0194	18.8194	$1,021.69	$397.84	$204.34
57150	T		Treat vagina infection	0191	0.1679	$9.12	$2.65	$1.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57155	T		Insert uteri tandems/ovoids	0193	15.7365	$854.32	$171.13	$170.86
57160	T		Insert pessary/other device	0188	1.1079	$60.15		$12.03
57170	T		Fitting of diaphragm/cap	0191	0.1679	$9.12	$2.65	$1.82
57180	T		Treat vaginal bleeding	0192	2.6966	$146.40	$39.11	$29.28
57200	T		Repair of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
57210	T		Repair vagina/perineum	0194	18.8194	$1,021.69	$397.84	$204.34
57220	T		Revision of urethra	0195	25.3207	$1,374.64	$483.80	$274.93
57230	T		Repair of urethral lesion	0194	18.8194	$1,021.69	$397.84	$204.34
57240	T		Repair bladder & vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57250	T		Repair rectum & vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57260	T		Repair of vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57265	T		Extensive repair of vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57268	T		Repair of bowel bulge	0195	25.3207	$1,374.64	$483.80	$274.93
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57284	T		Repair paravaginal defect	0195	25.3207	$1,374.64	$483.80	$274.93
57287	T		Revise/remove sling repair	0202	38.8053	$2,106.70	$1,032.28	$421.34
57288	T		Repair bladder defect	0202	38.8053	$2,106.70	$1,032.28	$421.34
57289	T		Repair bladder & vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57291	T		Construction of vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	25.3207	$1,374.64	$483.80	$274.93
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					
57310	T		Repair urethrovaginal lesion	0195	25.3207	$1,374.64	$483.80	$274.93
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	25.3207	$1,374.64	$483.80	$274.93
57330	T		Repair bladder-vagina lesion	0195	25.3207	$1,374.64	$483.80	$274.93
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	18.8194	$1,021.69	$397.84	$204.34
57410	T		Pelvic examination	0194	18.8194	$1,021.69	$397.84	$204.34
57415	T		Remove vaginal foreign body	0194	18.8194	$1,021.69	$397.84	$204.34
57420	T		Exam of vagina w/scope	0192	2.6966	$146.40	$39.11	$29.28
57421	T		Exam/biopsy of vag w/scope	0192	2.6966	$146.40	$39.11	$29.28
57452	T		Examination of vagina	0189	1.3207	$71.70	$16.70	$14.34
57454	T		Vagina examination & biopsy	0192	2.6966	$146.40	$39.11	$29.28
57455	T		Biopsy of cervix w/scope	0192	2.6966	$146.40	$39.11	$29.28
57456	T		Endocerv curettage w/scope	0192	2.6966	$146.40	$39.11	$29.28
57460	T		Cervix excision	0193	15.7365	$854.32	$171.13	$170.86
57461	T		Conz of cervix w/scope, leep	0194	18.8194	$1,021.69	$397.84	$204.34
57500	T		Biopsy of cervix	0192	2.6966	$146.40	$39.11	$29.28
57505	T		Endocervical curettage	0192	2.6966	$146.40	$39.11	$29.28
57510	T		Cauterization of cervix	0193	15.7365	$854.32	$171.13	$170.86
57511	T		Cryocautery of cervix	0189	1.3207	$71.70	$16.70	$14.34
57513	T		Laser surgery of cervix	0193	15.7365	$854.32	$171.13	$170.86
57520	T		Conization of cervix	0194	18.8194	$1,021.69	$397.84	$204.34
57522	T		Conization of cervix	0195	25.3207	$1,374.64	$483.80	$274.93
57530	T		Removal of cervix	0195	25.3207	$1,374.64	$483.80	$274.93
57531	C		Removal of cervix, radical					
57540	C		Removal of residual cervix					
57545	C		Remove cervix/repair pelvis					
57550	T		Removal of residual cervix	0195	25.3207	$1,374.64	$483.80	$274.93
57555	T		Remove cervix/repair vagina	0195	25.3207	$1,374.64	$483.80	$274.93
57556	T		Remove cervix, repair bowel	0195	25.3207	$1,374.64	$483.80	$274.93
57700	T		Revision of cervix	0194	18.8194	$1,021.69	$397.84	$204.34
57720	T		Revision of cervix	0194	18.8194	$1,021.69	$397.84	$204.34
57800	T		Dilation of cervical canal	0193	15.7365	$854.32	$171.13	$170.86
57820	T		D & c of residual cervix	0196	16.1823	$878.52	$338.23	$175.70
58100	T		Biopsy of uterus lining	0188	1.1079	$60.15		$12.03
58120	T		Dilation and curettage	0196	16.1823	$878.52	$338.23	$175.70
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	25.3207	$1,374.64	$483.80	$274.93
58146	C		Myomectomy abdom complex					
58150	C		Total hysterectomy					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C		Vag hyst complex					
58291	C		Vag hyst incl t/o, complex					
58292	C		Vag hyst t/o & repair, compl					
58293	C		Vag hyst w/uro repair, compl					
58294	C		Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	1.3207	$71.70	$16.70	$14.34
58321	T		Artificial insemination	0197	5.1958	$282.07		$56.41
58322	T		Artificial insemination	0197	5.1958	$282.07		$56.41
58323	T		Sperm washing	0197	5.1958	$282.07		$56.41
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	18.8194	$1,021.69	$397.84	$204.34
58346	T		Insert heyman uteri capsule	0193	15.7365	$854.32	$171.13	$170.86
58350	T		Reopen fallopian tube	0194	18.8194	$1,021.69	$397.84	$204.34
58353	T		Endometr ablate, thermal	0195	25.3207	$1,374.64	$483.80	$274.93
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					
58540	C		Revision of uterus					
58545	T		Laparoscopic myomectomy	0130	32.5959	$1,769.60	$659.53	$353.92
58546	T		Laparo-myomectomy, complex	0131	40.8955	$2,220.18	$1,001.89	$444.04
58550	T		Laparo-asst vag hysterectomy	0132	56.6318	$3,074.48	$1,239.22	$614.90
58552	T		Laparo-vag hyst incl t/o	0131	40.8955	$2,220.18	$1,001.89	$444.04
58553	T		Laparo-vag hyst, complex	0131	40.8955	$2,220.18	$1,001.89	$444.04
58554	T		Laparo-vag hyst w/t/o, compl	0131	40.8955	$2,220.18	$1,001.89	$444.04
58555	T		Hysteroscopy, dx, sep proc	0190	19.8088	$1,075.40	$424.28	$215.08
58558	T		Hysteroscopy, biopsy	0190	19.8088	$1,075.40	$424.28	$215.08
58559	T		Hysteroscopy, lysis	0190	19.8088	$1,075.40	$424.28	$215.08
58560	T		Hysteroscopy, resect septum	0387	28.5174	$1,548.18	$660.84	$309.64
58561	T		Hysteroscopy, remove myoma	0387	28.5174	$1,548.18	$660.84	$309.64
58562	T		Hysteroscopy, remove fb	0190	19.8088	$1,075.40	$424.28	$215.08
58563	T		Hysteroscopy, ablation	0387	28.5174	$1,548.18	$660.84	$309.64
58578	T		Laparo proc, uterus	0130	32.5959	$1,769.60	$659.53	$353.92
58579	T		Hysteroscope procedure	0190	19.8088	$1,075.40	$424.28	$215.08
58600	T		Division of fallopian tube	0194	18.8194	$1,021.69	$397.84	$204.34
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	18.8194	$1,021.69	$397.84	$204.34
58660	T		Laparoscopy, lysis	0131	40.8955	$2,220.18	$1,001.89	$444.04
58661	T		Laparoscopy, remove adnexa	0131	40.8955	$2,220.18	$1,001.89	$444.04
58662	T		Laparoscopy, excise lesions	0131	40.8955	$2,220.18	$1,001.89	$444.04
58670	T		Laparoscopy, tubal cautery	0131	40.8955	$2,220.18	$1,001.89	$444.04
58671	T		Laparoscopy, tubal block	0131	40.8955	$2,220.18	$1,001.89	$444.04
58672	T		Laparoscopy, fimbrioplasty	0131	40.8955	$2,220.18	$1,001.89	$444.04
58673	T		Laparoscopy, salpingostomy	0131	40.8955	$2,220.18	$1,001.89	$444.04
58679	T		Laparo proc, oviduct-ovary	0130	32.5959	$1,769.60	$659.53	$353.92
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58800	T		Drainage of ovarian cyst(s)	0195	25.3207	$1,374.64	$483.80	$274.93
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	25.3207	$1,374.64	$483.80	$274.93
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	15.7365	$854.32	$171.13	$170.86
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0195	25.3207	$1,374.64	$483.80	$274.93
58920	T		Partial removal of ovary(s)	0195	25.3207	$1,374.64	$483.80	$274.93
58925	T		Removal of ovarian cyst(s)	0195	25.3207	$1,374.64	$483.80	$274.93
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	18.8194	$1,021.69	$397.84	$204.34
58974	T		Transfer of embryo	0197	5.1958	$282.07		$56.41
58976	T		Transfer of embryo	0197	5.1958	$282.07		$56.41
58999	T		Genital surgery procedure	0191	0.1679	$9.12	$2.65	$1.82
59000	T		Amniocentesis, diagnostic	0198	1.3718	$74.47	$32.19	$14.89
59001	T		Amniocentesis, therapeutic	0198	1.3718	$74.47	$32.19	$14.89
59012	T		Fetal cord puncture,prenatal	0198	1.3718	$74.47	$32.19	$14.89
59015	T		Chorion biopsy	0198	1.3718	$74.47	$32.19	$14.89
59020	T		Fetal contract stress test	0198	1.3718	$74.47	$32.19	$14.89
59025	T		Fetal non-stress test	0198	1.3718	$74.47	$32.19	$14.89
59030	T		Fetal scalp blood sample	0198	1.3718	$74.47	$32.19	$14.89
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	40.8955	$2,220.18	$1,001.89	$444.04
59151	T		Treat ectopic pregnancy	0131	40.8955	$2,220.18	$1,001.89	$444.04
59160	T		D & c after delivery	0196	16.1823	$878.52	$338.23	$175.70
59200	T		Insert cervical dilator	0189	1.3207	$71.70	$16.70	$14.34
59300	T		Episiotomy or vaginal repair	0193	15.7365	$854.32	$171.13	$170.86
59320	T		Revision of cervix	0194	18.8194	$1,021.69	$397.84	$204.34
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	E		Obstetrical care					
59409	T		Obstetrical care	0199	16.8630	$915.48		$183.10
59410	E		Obstetrical care					
59412	T		Antepartum manipulation	0700	2.4359	$132.24	$37.03	$26.45
59414	T		Deliver placenta	0199	16.8630	$915.48		$183.10
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	16.8630	$915.48		$183.10
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	17.2803	$938.13	$329.65	$187.63
59820	T		Care of miscarriage	0201	17.2803	$938.13	$329.65	$187.63
59821	T		Treatment of miscarriage	0201	17.2803	$938.13	$329.65	$187.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59830	C		Treat uterus infection					
59840	T		Abortion	0200	18.3633	$996.93	$307.83	$199.39
59841	T		Abortion	0200	18.3633	$996.93	$307.83	$199.39
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.3718	$74.47	$32.19	$14.89
59870	T		Evacuate mole of uterus	0201	17.2803	$938.13	$329.65	$187.63
59871	T		Remove cerclage suture	0194	18.8194	$1,021.69	$397.84	$204.34
59898	T		Laparo proc, ob care/deliver	0130	32.5959	$1,769.60	$659.53	$353.92
59899	T		Maternity care procedure	0198	1.3718	$74.47	$32.19	$14.89
60000	T		Drain thyroid/tongue cyst	0252	6.5416	$355.14	$113.41	$71.03
60001	T		Aspirate/inject thyriod cyst	0004	1.5774	$85.64	$22.10	$17.13
60100	T		Biopsy of thyroid	0004	1.5774	$85.64	$22.10	$17.13
60200	T		Remove thyroid lesion	0114	37.3583	$2,028.14	$485.91	$405.63
60210	T		Partial thyroid excision	0114	37.3583	$2,028.14	$485.91	$405.63
60212	T		Partial thyroid excision	0114	37.3583	$2,028.14	$485.91	$405.63
60220	T		Partial removal of thyroid	0114	37.3583	$2,028.14	$485.91	$405.63
60225	T		Partial removal of thyroid	0114	37.3583	$2,028.14	$485.91	$405.63
60240	T		Removal of thyroid	0114	37.3583	$2,028.14	$485.91	$405.63
60252	T		Removal of thyroid	0256	35.0866	$1,904.82		$380.96
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	35.0866	$1,904.82		$380.96
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	37.3583	$2,028.14	$485.91	$405.63
60281	T		Remove thyroid duct lesion	0114	37.3583	$2,028.14	$485.91	$405.63
60500	T		Explore parathyroid glands	0256	35.0866	$1,904.82		$380.96
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	18.6725	$1,013.71	$354.45	$202.74
60520	C		Removal of thymus gland					
60521	C		Removal of thymus gland					
60522	C		Removal of thymus gland					
60540	C		Explore adrenal gland					
60545	C		Explore adrenal gland					
60600	C		Remove carotid body lesion					
60605	C		Remove carotid body lesion					
60650	C		Laparoscopy adrenalectomy					
60659	T		Laparo proc, endocrine	0130	32.5959	$1,769.60	$659.53	$353.92
60699	T		Endocrine surgery procedure	0114	37.3583	$2,028.14	$485.91	$405.63
61000	T		Remove cranial cavity fluid	0212	2.9989	$162.81	$74.92	$32.56
61001	T		Remove cranial cavity fluid	0212	2.9989	$162.81	$74.92	$32.56
61020	T		Remove brain cavity fluid	0212	2.9989	$162.81	$74.92	$32.56
61026	T		Injection into brain canal	0212	2.9989	$162.81	$74.92	$32.56
61050	T		Remove brain canal fluid	0212	2.9989	$162.81	$74.92	$32.56
61055	T		Injection into brain canal	0212	2.9989	$162.81	$74.92	$32.56
61070	T		Brain canal shunt procedure	0212	2.9989	$162.81	$74.92	$32.56
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	34.0161	$1,846.70	$453.41	$369.34
61250	C		Pierce skull & explore					
61253	C		Pierce skull & explore					
61304	C		Open skull for exploration					
61305	C		Open skull for exploration					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C		Decompressive craniotomy					
61323	C		Decompressive lobectomy					
61330	T		Decompress eye socket	0256	35.0866	$1,904.82		$380.96
61332	C		Explore/biopsy eye socket					
61333	C		Explore orbit/remove lesion					
61334	C		Explore orbit/remove object					
61340	C		Relieve cranial pressure					
61343	C		Incise skull (press relief)					
61345	C		Relieve cranial pressure					
61440	C		Incise skull for surgery					
61450	C		Incise skull for surgery					
61458	C		Incise skull for brain wound					
61460	C		Incise skull for surgery					
61470	C		Incise skull for surgery					
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	N		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61582	C		Craniofacial approach, skull					
61583	C		Craniofacial approach, skull					
61584	C		Orbitocranial approach/skull					
61585	C		Orbitocranial approach/skull					
61586	C		Resect nasopharynx, skull					
61590	C		Infratemporal approach/skull					
61591	C		Infratemporal approach/skull					
61592	C		Orbitocranial approach/skull					
61595	C		Transtemporal approach/skull					
61596	C		Transcochlear approach/skull					
61597	C		Transcondylar approach/skull					
61598	C		Transpetrosal approach/skull					
61600	C		Resect/excise cranial lesion					
61601	C		Resect/excise cranial lesion					
61605	C		Resect/excise cranial lesion					
61606	C		Resect/excise cranial lesion					
61607	C		Resect/excise cranial lesion					
61608	C		Resect/excise cranial lesion					
61609	C		Transect artery, sinus					
61610	C		Transect artery, sinus					
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T		Endovasc tempory vessel occl	1555		$1,650.00		$330.00
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	34.8355	$1,891.18		$378.24
61680	C		Intracranial vessel surgery					
61682	C		Intracranial vessel surgery					
61684	C		Intracranial vessel surgery					
61686	C		Intracranial vessel surgery					
61690	C		Intracranial vessel surgery					
61692	C		Intracranial vessel surgery					
61697	C		Brain aneurysm repr, complx					
61698	C		Brain aneurysm repr, complx					
61700	C		Brain aneurysm repr, simple					
61702	C		Inner skull vessel surgery					
61703	C		Clamp neck artery					
61705	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	16.5293	$897.36		$179.47
61791	T		Treat trigeminal tract	0204	2.2209	$120.57	$40.13	$24.11
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	6.1992	$336.55	$127.49	$67.31
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	19.9913	$1,085.31	$499.24	$217.06
61885	T		Implant neurostim one array	0222	188.7735	$10,248.32		$2,049.66
61886	T		Implant neurostim arrays	0222	188.7735	$10,248.32		$2,049.66
61888	T		Revise/remove neuroreceiver	0688	42.5880	$2,312.06	$1,132.91	$462.41
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		Retr bone flap to fix skull					
62160	N		Neuroendoscopy add-on					
62161	C		Dissect brain w/scope					
62162	C		Remove colloid cyst w/scope					
62163	C		Neuroendoscopy w/fb removal					
62164	C		Remove brain tumor w/scope					
62165	C		Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.2058	$119.75	$43.80	$23.95
62200	C		Establish brain cavity shunt					
62201	C		Establish brain cavity shunt					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0122	8.4398	$458.19	$93.97	$91.64
62230	T		Replace/revise brain shunt	0224	34.0161	$1,846.70	$453.41	$369.34
62252	S		Csf shunt reprogram	0691	2.9894	$162.29	$81.14	$32.46
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	11.8511	$643.38	$276.76	$128.68
62264	T		Epidural lysis on single day	0203	11.8511	$643.38	$276.76	$128.68
62268	T		Drain spinal cord cyst	0212	2.9989	$162.81	$74.92	$32.56
62269	T		Needle biopsy, spinal cord	0005	3.3675	$182.82	$71.59	$36.56
62270	T		Spinal fluid tap, diagnostic	0206	5.2584	$285.47	$75.55	$57.09
62272	T		Drain cerebro spinal fluid	0206	5.2584	$285.47	$75.55	$57.09
62273	T		Treat epidural spine lesion	0206	5.2584	$285.47	$75.55	$57.09
62280	T		Treat spinal cord lesion	0207	6.5998	$358.30	$123.69	$71.66
62281	T		Treat spinal cord lesion	0207	6.5998	$358.30	$123.69	$71.66
62282	T		Treat spinal canal lesion	0207	6.5998	$358.30	$123.69	$71.66
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0220	16.5293	$897.36		$179.47
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	2.9989	$162.81	$74.92	$32.56
62294	T		Injection into spinal artery	0212	2.9989	$162.81	$74.92	$32.56
62310	T		Inject spine c/t	0206	5.2584	$285.47	$75.55	$57.09
62311	T		Inject spine l/s (cd)	0206	5.2584	$285.47	$75.55	$57.09
62318	T		Inject spine w/cath, c/t	0206	5.2584	$285.47	$75.55	$57.09
62319	T		Inject spine w/cath l/s (cd)	0206	5.2584	$285.47	$75.55	$57.09
62350	T		Implant spinal canal cath	0223	26.0352	$1,413.42		$282.68
62351	T		Implant spinal canal cath	0208	40.6521	$2,206.96		$441.39
62355	T		Remove spinal canal catheter	0203	11.8511	$643.38	$276.76	$128.68
62360	T		Insert spine infusion device	0226	159.6795	$8,668.84		$1,733.77
62361	T		Implant spine infusion pump	0227	163.6124	$8,882.35		$1,776.47
62362	T		Implant spine infusion pump	0227	163.6124	$8,882.35		$1,776.47
62365	T		Remove spine infusion device	0203	11.8511	$643.38	$276.76	$128.68
62367	S		Analyze spine infusion pump	0691	2.9894	$162.29	$81.14	$32.46
62368	S		Analyze spine infusion pump	0691	2.9894	$162.29	$81.14	$32.46
63001	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63003	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63005	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63011	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63012	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63015	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63016	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63017	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63020	T		Neck spine disk surgery	0208	40.6521	$2,206.96		$441.39
63030	T		Low back disk surgery	0208	40.6521	$2,206.96		$441.39
63035	T		Spinal disk surgery add-on	0208	40.6521	$2,206.96		$441.39
63040	T		Laminotomy, single cervical	0208	40.6521	$2,206.96		$441.39
63042	T		Laminotomy, single lumbar	0208	40.6521	$2,206.96		$441.39
63043	C		Laminotomy, addl cervical					
63044	C		Laminotomy, addl lumbar					
63045	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63046	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63047	T		Removal of spinal lamina	0208	40.6521	$2,206.96		$441.39
63048	T		Remove spinal lamina add-on	0208	40.6521	$2,206.96		$441.39
63055	T		Decompress spinal cord	0208	40.6521	$2,206.96		$441.39
63056	T		Decompress spinal cord	0208	40.6521	$2,206.96		$441.39
63057	T		Decompress spine cord add-on	0208	40.6521	$2,206.96		$441.39
63064	T		Decompress spinal cord	0208	40.6521	$2,206.96		$441.39
63066	T		Decompress spine cord add-on	0208	40.6521	$2,206.96		$441.39
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	16.5293	$897.36		$179.47
63610	T		Stimulation of spinal cord	0220	16.5293	$897.36		$179.47
63615	T		Remove lesion of spinal cord	0220	16.5293	$897.36		$179.47
63650	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
63655	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
63660	T		Revise/remove neuroelectrode	0687	19.9913	$1,085.31	$499.24	$217.06
63685	T		Implant neuroreceiver	0222	188.7735	$10,248.32		$2,049.66
63688	T		Revise/remove neuroreceiver	0688	42.5880	$2,312.06	$1,132.91	$462.41
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	51.1329	$2,775.95	$621.80	$555.19
63744	T		Revision of spinal shunt	0228	51.1329	$2,775.95	$621.80	$555.19
63746	T		Removal of spinal shunt	0109	7.7075	$418.43	$131.49	$83.69
64400	T		N block inj, trigeminal	0204	2.2209	$120.57	$40.13	$24.11
64402	T		N block inj, facial	0204	2.2209	$120.57	$40.13	$24.11
64405	T		N block inj, occipital	0204	2.2209	$120.57	$40.13	$24.11
64408	T		N block inj, vagus	0204	2.2209	$120.57	$40.13	$24.11
64410	T		N block inj, phrenic	0204	2.2209	$120.57	$40.13	$24.11
64412	T		N block inj, spinal accessor	0204	2.2209	$120.57	$40.13	$24.11
64413	T		N block inj, cervical plexus	0204	2.2209	$120.57	$40.13	$24.11
64415	T		Injection for nerve block	0204	2.2209	$120.57	$40.13	$24.11
64416	T		N block cont infuse, b plex	0204	2.2209	$120.57	$40.13	$24.11
64417	T		N block inj, axillary	0204	2.2209	$120.57	$40.13	$24.11
64418	T		N block inj, suprascapular	0204	2.2209	$120.57	$40.13	$24.11
64420	T		N block inj, intercost, sng	0207	6.5998	$358.30	$123.69	$71.66
64421	T		N block inj, intercost, mlt	0207	6.5998	$358.30	$123.69	$71.66
64425	T		N block inj ilio-ing/hypogi	0204	2.2209	$120.57	$40.13	$24.11
64430	T		N block inj, pudendal	0204	2.2209	$120.57	$40.13	$24.11
64435	T		N block inj, paracervical	0204	2.2209	$120.57	$40.13	$24.11
64445	T		Injection for nerve block	0204	2.2209	$120.57	$40.13	$24.11
64446	T		N blk inj, sciatic, cont inf	0204	2.2209	$120.57	$40.13	$24.11
64447	T		N block inj fem, single	0204	2.2209	$120.57	$40.13	$24.11
64448	T		N block inj fem, cont inf	0204	2.2209	$120.57	$40.13	$24.11
64450	T		N block, other peripheral	0204	2.2209	$120.57	$40.13	$24.11
64470	T		Inj paravertebral c/t	0207	6.5998	$358.30	$123.69	$71.66
64472	T		Inj paravertebral c/t add-on	0207	6.5998	$358.30	$123.69	$71.66
64475	T		Inj paravertebral l/s	0207	6.5998	$358.30	$123.69	$71.66
64476	T		Inj paravertebral l/s add-on	0207	6.5998	$358.30	$123.69	$71.66
64479	T		Inj foramen epidural c/t	0207	6.5998	$358.30	$123.69	$71.66
64480	T		Inj foramen epidural add-on	0207	6.5998	$358.30	$123.69	$71.66
64483	T		Inj foramen epidural l/s	0207	6.5998	$358.30	$123.69	$71.66
64484	T		Inj foramen epidural add-on	0207	6.5998	$358.30	$123.69	$71.66
64505	T		N block, spenopalatine gangl	0204	2.2209	$120.57	$40.13	$24.11
64508	T		N block, carotid sinus s/p	0204	2.2209	$120.57	$40.13	$24.11
64510	T		N block, stellate ganglion	0207	6.5998	$358.30	$123.69	$71.66
64520	T		N block, lumbar/thoracic	0207	6.5998	$358.30	$123.69	$71.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64530	T		N block inj, celiac pelus	0207	6.5998	$358.30	$123.69	$71.66
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64555	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64560	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64561	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64565	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64573	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64575	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64577	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64580	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64581	S		Implant neuroelectrodes	0225	56.0375	$3,042.22		$608.44
64585	T		Revise/remove neuroelectrode	0687	19.9913	$1,085.31	$499.24	$217.06
64590	T		Implant neuroreceiver	0222	188.7735	$10,248.32		$2,049.66
64595	T		Revise/remove neuroreceiver	0688	42.5880	$2,312.06	$1,132.91	$462.41
64600	T		Injection treatment of nerve	0203	11.8511	$643.38	$276.76	$128.68
64605	T		Injection treatment of nerve	0203	11.8511	$643.38	$276.76	$128.68
64610	T		Injection treatment of nerve	0203	11.8511	$643.38	$276.76	$128.68
64612	T		Destroy nerve, face muscle	0204	2.2209	$120.57	$40.13	$24.11
64613	T		Destroy nerve, spine muscle	0204	2.2209	$120.57	$40.13	$24.11
64614	T		Destroy nerve, extrem musc	0204	2.2209	$120.57	$40.13	$24.11
64620	T		Injection treatment of nerve	0203	11.8511	$643.38	$276.76	$128.68
64622	T		Destr paravertebrl nerve l/s	0203	11.8511	$643.38	$276.76	$128.68
64623	T		Destr paravertebral n add-on	0203	11.8511	$643.38	$276.76	$128.68
64626	T		Destr paravertebrl nerve c/t	0203	11.8511	$643.38	$276.76	$128.68
64627	T		Destr paravertebral n add-on	0203	11.8511	$643.38	$276.76	$128.68
64630	T		Injection treatment of nerve	0207	6.5998	$358.30	$123.69	$71.66
64640	T		Injection treatment of nerve	0207	6.5998	$358.30	$123.69	$71.66
64680	T		Injection treatment of nerve	0203	11.8511	$643.38	$276.76	$128.68
64702	T		Revise finger/toe nerve	0220	16.5293	$897.36		$179.47
64704	T		Revise hand/foot nerve	0220	16.5293	$897.36		$179.47
64708	T		Revise arm/leg nerve	0220	16.5293	$897.36		$179.47
64712	T		Revision of sciatic nerve	0220	16.5293	$897.36		$179.47
64713	T		Revision of arm nerve(s)	0220	16.5293	$897.36		$179.47
64714	T		Revise low back nerve(s)	0220	16.5293	$897.36		$179.47
64716	T		Revision of cranial nerve	0220	16.5293	$897.36		$179.47
64718	T		Revise ulnar nerve at elbow	0220	16.5293	$897.36		$179.47
64719	T		Revise ulnar nerve at wrist	0220	16.5293	$897.36		$179.47
64721	T		Carpal tunnel surgery	0220	16.5293	$897.36		$179.47
64722	T		Relieve pressure on nerve(s)	0220	16.5293	$897.36		$179.47
64726	T		Release foot/toe nerve	0220	16.5293	$897.36		$179.47
64727	T		Internal nerve revision	0220	16.5293	$897.36		$179.47
64732	T		Incision of brow nerve	0220	16.5293	$897.36		$179.47
64734	T		Incision of cheek nerve	0220	16.5293	$897.36		$179.47
64736	T		Incision of chin nerve	0220	16.5293	$897.36		$179.47
64738	T		Incision of jaw nerve	0220	16.5293	$897.36		$179.47
64740	T		Incision of tongue nerve	0220	16.5293	$897.36		$179.47
64742	T		Incision of facial nerve	0220	16.5293	$897.36		$179.47
64744	T		Incise nerve, back of head	0220	16.5293	$897.36		$179.47
64746	T		Incise diaphragm nerve	0220	16.5293	$897.36		$179.47
64752	C		Incision of vagus nerve					
64755	C		Incision of stomach nerves					
64760	C		Incision of vagus nerve					
64761	T		Incision of pelvis nerve	0220	16.5293	$897.36		$179.47
64763	C		Incise hip/thigh nerve					
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	16.5293	$897.36		$179.47
64772	T		Incision of spinal nerve	0220	16.5293	$897.36		$179.47
64774	T		Remove skin nerve lesion	0220	16.5293	$897.36		$179.47
64776	T		Remove digit nerve lesion	0220	16.5293	$897.36		$179.47
64778	T		Digit nerve surgery add-on	0220	16.5293	$897.36		$179.47
64782	T		Remove limb nerve lesion	0220	16.5293	$897.36		$179.47
64783	T		Limb nerve surgery add-on	0220	16.5293	$897.36		$179.47
64784	T		Remove nerve lesion	0220	16.5293	$897.36		$179.47
64786	T		Remove sciatic nerve lesion	0221	25.8194	$1,401.71	$463.62	$280.34
64787	T		Implant nerve end	0220	16.5293	$897.36		$179.47

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64788	T		Remove skin nerve lesion	0220	16.5293	$897.36		$179.47
64790	T		Removal of nerve lesion	0220	16.5293	$897.36		$179.47
64792	T		Removal of nerve lesion	0221	25.8194	$1,401.71	$463.62	$280.34
64795	T		Biopsy of nerve	0220	16.5293	$897.36		$179.47
64802	T		Remove sympathetic nerves	0220	16.5293	$897.36		$179.47
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	16.5293	$897.36		$179.47
64821	T		Remove sympathestic nerves	0054	24.2685	$1,317.51		$263.50
64822	T		Remove sympathetic nerves	0054	24.2685	$1,317.51		$263.50
64823	T		Remove sympathetic nerves	0054	24.2685	$1,317.51		$263.50
64831	T		Repair of digit nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64832	T		Repair nerve add-on	0221	25.8194	$1,401.71	$463.62	$280.34
64834	T		Repair of hand or foot nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64835	T		Repair of hand or foot nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64836	T		Repair of hand or foot nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64837	T		Repair nerve add-on	0221	25.8194	$1,401.71	$463.62	$280.34
64840	T		Repair of leg nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64856	T		Repair/transpose nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64857	T		Repair arm/leg nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64858	T		Repair sciatic nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64859	T		Nerve surgery	0221	25.8194	$1,401.71	$463.62	$280.34
64861	T		Repair of arm nerves	0221	25.8194	$1,401.71	$463.62	$280.34
64862	T		Repair of low back nerves	0221	25.8194	$1,401.71	$463.62	$280.34
64864	T		Repair of facial nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64865	T		Repair of facial nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64872	T		Subsequent repair of nerve	0221	25.8194	$1,401.71	$463.62	$280.34
64874	T		Repair & revise nerve add-on	0221	25.8194	$1,401.71	$463.62	$280.34
64876	T		Repair nerve/shorten bone	0221	25.8194	$1,401.71	$463.62	$280.34
64885	T		Nerve graft, head or neck	0221	25.8194	$1,401.71	$463.62	$280.34
64886	T		Nerve graft, head or neck	0221	25.8194	$1,401.71	$463.62	$280.34
64890	T		Nerve graft, hand or foot	0221	25.8194	$1,401.71	$463.62	$280.34
64891	T		Nerve graft, hand or foot	0221	25.8194	$1,401.71	$463.62	$280.34
64892	T		Nerve graft, arm or leg	0221	25.8194	$1,401.71	$463.62	$280.34
64893	T		Nerve graft, arm or leg	0221	25.8194	$1,401.71	$463.62	$280.34
64895	T		Nerve graft, hand or foot	0221	25.8194	$1,401.71	$463.62	$280.34
64896	T		Nerve graft, hand or foot	0221	25.8194	$1,401.71	$463.62	$280.34
64897	T		Nerve graft, arm or leg	0221	25.8194	$1,401.71	$463.62	$280.34
64898	T		Nerve graft, arm or leg	0221	25.8194	$1,401.71	$463.62	$280.34
64901	T		Nerve graft add-on	0221	25.8194	$1,401.71	$463.62	$280.34
64902	T		Nerve graft add-on	0221	25.8194	$1,401.71	$463.62	$280.34
64905	T		Nerve pedicle transfer	0221	25.8194	$1,401.71	$463.62	$280.34
64907	T		Nerve pedicle transfer	0221	25.8194	$1,401.71	$463.62	$280.34
64999	T		Nervous system surgery	0204	2.2209	$120.57	$40.13	$24.11
65091	T		Revise eye	0242	29.2193	$1,586.29	$597.36	$317.26
65093	T		Revise eye with implant	0241	21.9830	$1,193.44	$384.47	$238.69
65101	T		Removal of eye	0242	29.2193	$1,586.29	$597.36	$317.26
65103	T		Remove eye/insert implant	0242	29.2193	$1,586.29	$597.36	$317.26
65105	T		Remove eye/attach implant	0242	29.2193	$1,586.29	$597.36	$317.26
65110	T		Removal of eye	0242	29.2193	$1,586.29	$597.36	$317.26
65112	T		Remove eye/revise socket	0242	29.2193	$1,586.29	$597.36	$317.26
65114	T		Remove eye/revise socket	0242	29.2193	$1,586.29	$597.36	$317.26
65125	T		Revise ocular implant	0240	17.3397	$941.35	$315.31	$188.27
65130	T		Insert ocular implant	0241	21.9830	$1,193.44	$384.47	$238.69
65135	T		Insert ocular implant	0241	21.9830	$1,193.44	$384.47	$238.69
65140	T		Attach ocular implant	0242	29.2193	$1,586.29	$597.36	$317.26
65150	T		Revise ocular implant	0241	21.9830	$1,193.44	$384.47	$238.69
65155	T		Reinsert ocular implant	0242	29.2193	$1,586.29	$597.36	$317.26
65175	T		Removal of ocular implant	0240	17.3397	$941.35	$315.31	$188.27
65205	S		Remove foreign body from eye	0698	0.9355	$50.79	$18.72	$10.16
65210	S		Remove foreign body from eye	0231	2.0880	$113.36	$50.94	$22.67
65220	S		Remove foreign body from eye	0231	2.0880	$113.36	$50.94	$22.67

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65222	S		Remove foreign body from eye	0231	2.0880	$113.36	$50.94	$22.67
65235	T		Remove foreign body from eye	0233	14.5435	$789.55	$266.33	$157.91
65260	T		Remove foreign body from eye	0236	19.6866	$1,068.77		$213.75
65265	T		Remove foreign body from eye	0236	19.6866	$1,068.77		$213.75
65270	T		Repair of eye wound	0240	17.3397	$941.35	$315.31	$188.27
65272	T		Repair of eye wound	0233	14.5435	$789.55	$266.33	$157.91
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0233	14.5435	$789.55	$266.33	$157.91
65280	T		Repair of eye wound	0234	21.5482	$1,169.83	$511.31	$233.97
65285	T		Repair of eye wound	0234	21.5482	$1,169.83	$511.31	$233.97
65286	T		Repair of eye wound	0233	14.5435	$789.55	$266.33	$157.91
65290	T		Repair of eye socket wound	0243	21.1035	$1,145.69	$431.39	$229.14
65400	T		Removal of eye lesion	0233	14.5435	$789.55	$266.33	$157.91
65410	T		Biopsy of cornea	0233	14.5435	$789.55	$266.33	$157.91
65420	T		Removal of eye lesion	0233	14.5435	$789.55	$266.33	$157.91
65426	T		Removal of eye lesion	0234	21.5482	$1,169.83	$511.31	$233.97
65430	S		Corneal smear	0230	0.7379	$40.06	$14.97	$8.01
65435	T		Curette/treat cornea	0239	6.2432	$338.94	$110.62	$67.79
65436	T		Curette/treat cornea	0233	14.5435	$789.55	$266.33	$157.91
65450	S		Treatment of corneal lesion	0231	2.0880	$113.36	$50.94	$22.67
65600	T		Revision of cornea	0240	17.3397	$941.35	$315.31	$188.27
65710	T		Corneal transplant	0244	37.4885	$2,035.21	$803.26	$407.04
65730	T		Corneal transplant	0244	37.4885	$2,035.21	$803.26	$407.04
65750	T		Corneal transplant	0244	37.4885	$2,035.21	$803.26	$407.04
65755	T		Corneal transplant	0244	37.4885	$2,035.21	$803.26	$407.04
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	37.4885	$2,035.21	$803.26	$407.04
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.5435	$789.55	$266.33	$157.91
65775	T		Correction of astigmatism	0233	14.5435	$789.55	$266.33	$157.91
65800	T		Drainage of eye	0233	14.5435	$789.55	$266.33	$157.91
65805	T		Drainage of eye	0233	14.5435	$789.55	$266.33	$157.91
65810	T		Drainage of eye	0234	21.5482	$1,169.83	$511.31	$233.97
65815	T		Drainage of eye	0234	21.5482	$1,169.83	$511.31	$233.97
65820	T		Relieve inner eye pressure	0232	4.9739	$270.03	$103.17	$54.01
65850	T		Incision of eye	0234	21.5482	$1,169.83	$511.31	$233.97
65855	T		Laser surgery of eye	0247	5.0192	$272.49	$104.31	$54.50
65860	T		Incise inner eye adhesions	0247	5.0192	$272.49	$104.31	$54.50
65865	T		Incise inner eye adhesions	0233	14.5435	$789.55	$266.33	$157.91
65870	T		Incise inner eye adhesions	0234	21.5482	$1,169.83	$511.31	$233.97
65875	T		Incise inner eye adhesions	0234	21.5482	$1,169.83	$511.31	$233.97
65880	T		Incise inner eye adhesions	0233	14.5435	$789.55	$266.33	$157.91
65900	T		Remove eye lesion	0233	14.5435	$789.55	$266.33	$157.91
65920	T		Remove implant of eye	0233	14.5435	$789.55	$266.33	$157.91
65930	T		Remove blood clot from eye	0234	21.5482	$1,169.83	$511.31	$233.97
66020	T		Injection treatment of eye	0233	14.5435	$789.55	$266.33	$157.91
66030	T		Injection treatment of eye	0233	14.5435	$789.55	$266.33	$157.91
66130	T		Remove eye lesion	0234	21.5482	$1,169.83	$511.31	$233.97
66150	T		Glaucoma surgery	0233	14.5435	$789.55	$266.33	$157.91
66155	T		Glaucoma surgery	0234	21.5482	$1,169.83	$511.31	$233.97
66160	T		Glaucoma surgery	0234	21.5482	$1,169.83	$511.31	$233.97
66165	T		Glaucoma surgery	0234	21.5482	$1,169.83	$511.31	$233.97
66170	T		Glaucoma surgery	0234	21.5482	$1,169.83	$511.31	$233.97
66172	T		Incision of eye	0673	26.7626	$1,452.91	$649.56	$290.58
66180	T		Implant eye shunt	0673	26.7626	$1,452.91	$649.56	$290.58
66185	T		Revise eye shunt	0673	26.7626	$1,452.91	$649.56	$290.58
66220	T		Repair eye lesion	0236	19.6866	$1,068.77		$213.75
66225	T		Repair/graft eye lesion	0673	26.7626	$1,452.91	$649.56	$290.58
66250	T		Follow-up surgery of eye	0233	14.5435	$789.55	$266.33	$157.91
66500	T		Incision of iris	0232	4.9739	$270.03	$103.17	$54.01
66505	T		Incision of iris	0232	4.9739	$270.03	$103.17	$54.01
66600	T		Remove iris and lesion	0233	14.5435	$789.55	$266.33	$157.91
66605	T		Removal of iris	0234	21.5482	$1,169.83	$511.31	$233.97
66625	T		Removal of iris	0233	14.5435	$789.55	$266.33	$157.91

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66630	T		Removal of iris	0233	14.5435	$789.55	$266.33	$157.91
66635	T		Removal of iris	0234	21.5482	$1,169.83	$511.31	$233.97
66680	T		Repair iris & ciliary body	0234	21.5482	$1,169.83	$511.31	$233.97
66682	T		Repair iris & ciliary body	0234	21.5482	$1,169.83	$511.31	$233.97
66700	T		Destruction, ciliary body	0233	14.5435	$789.55	$266.33	$157.91
66710	T		Destruction, ciliary body	0233	14.5435	$789.55	$266.33	$157.91
66720	T		Destruction, ciliary body	0233	14.5435	$789.55	$266.33	$157.91
66740	T		Destruction, ciliary body	0233	14.5435	$789.55	$266.33	$157.91
66761	T		Revision of iris	0247	5.0192	$272.49	$104.31	$54.50
66762	T		Revision of iris	0247	5.0192	$272.49	$104.31	$54.50
66770	T		Removal of inner eye lesion	0247	5.0192	$272.49	$104.31	$54.50
66820	T		Incision, secondary cataract	0232	4.9739	$270.03	$103.17	$54.01
66821	T		After cataract laser surgery	0247	5.0192	$272.49	$104.31	$54.50
66825	T		Reposition intraocular lens	0234	21.5482	$1,169.83	$511.31	$233.97
66830	T		Removal of lens lesion	0232	4.9739	$270.03	$103.17	$54.01
66840	T		Removal of lens material	0245	12.5751	$682.69	$226.11	$136.54
66850	T		Removal of lens material	0249	28.3307	$1,538.05	$524.67	$307.61
66852	T		Removal of lens material	0249	28.3307	$1,538.05	$524.67	$307.61
66920	T		Extraction of lens	0249	28.3307	$1,538.05	$524.67	$307.61
66930	T		Extraction of lens	0249	28.3307	$1,538.05	$524.67	$307.61
66940	T		Extraction of lens	0245	12.5751	$682.69	$226.11	$136.54
66982	T		Cataract surgery, complex	0246	22.8428	$1,240.11	$495.96	$248.02
66983	T		Cataract surg w/iol, 1 stage	0246	22.8428	$1,240.11	$495.96	$248.02
66984	T		Cataract surg w/iol, 1 stage	0246	22.8428	$1,240.11	$495.96	$248.02
66985	T		Insert lens prosthesis	0246	22.8428	$1,240.11	$495.96	$248.02
66986	T		Exchange lens prosthesis	0246	22.8428	$1,240.11	$495.96	$248.02
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	4.9739	$270.03	$103.17	$54.01
67005	T		Partial removal of eye fluid	0237	34.0324	$1,847.58	$818.54	$369.52
67010	T		Partial removal of eye fluid	0237	34.0324	$1,847.58	$818.54	$369.52
67015	T		Release of eye fluid	0237	34.0324	$1,847.58	$818.54	$369.52
67025	T		Replace eye fluid	0236	19.6866	$1,068.77		$213.75
67027	T		Implant eye drug system	0237	34.0324	$1,847.58	$818.54	$369.52
67028	T		Injection eye drug	0235	4.9900	$270.90	$72.04	$54.18
67030	T		Incise inner eye strands	0236	19.6866	$1,068.77		$213.75
67031	T		Laser surgery, eye strands	0247	5.0192	$272.49	$104.31	$54.50
67036	T		Removal of inner eye fluid	0237	34.0324	$1,847.58	$818.54	$369.52
67038	T		Strip retinal membrane	0237	34.0324	$1,847.58	$818.54	$369.52
67039	T		Laser treatment of retina	0237	34.0324	$1,847.58	$818.54	$369.52
67040	T		Laser treatment of retina	0672	39.1363	$2,124.67	$988.43	$424.93
67101	T		Repair detached retina	0235	4.9900	$270.90	$72.04	$54.18
67105	T		Repair detached retina	0248	4.7544	$258.11	$95.08	$51.62
67107	T		Repair detached retina	0672	39.1363	$2,124.67	$988.43	$424.93
67108	T		Repair detached retina	0672	39.1363	$2,124.67	$988.43	$424.93
67110	T		Repair detached retina	0236	19.6866	$1,068.77		$213.75
67112	T		Rerepair detached retina	0672	39.1363	$2,124.67	$988.43	$424.93
67115	T		Release encircling material	0236	19.6866	$1,068.77		$213.75
67120	T		Remove eye implant material	0236	19.6866	$1,068.77		$213.75
67121	T		Remove eye implant material	0237	34.0324	$1,847.58	$818.54	$369.52
67141	T		Treatment of retina	0235	4.9900	$270.90	$72.04	$54.18
67145	T		Treatment of retina	0248	4.7544	$258.11	$95.08	$51.62
67208	T		Treatment of retinal lesion	0235	4.9900	$270.90	$72.04	$54.18
67210	T		Treatment of retinal lesion	0248	4.7544	$258.11	$95.08	$51.62
67218	T		Treatment of retinal lesion	0236	19.6866	$1,068.77		$213.75
67220	T		Treatment of choroid lesion	0235	4.9900	$270.90	$72.04	$54.18
67221	T		Ocular photodynamic ther	0235	4.9900	$270.90	$72.04	$54.18
67225	T		Eye photodynamic ther add-on	0235	4.9900	$270.90	$72.04	$54.18
67227	T		Treatment of retinal lesion	0235	4.9900	$270.90	$72.04	$54.18
67228	T		Treatment of retinal lesion	0248	4.7544	$258.11	$95.08	$51.62
67250	T		Reinforce eye wall	0240	17.3397	$941.35	$315.31	$188.27
67255	T		Reinforce/graft eye wall	0237	34.0324	$1,847.58	$818.54	$369.52
67299	T		Eye surgery procedure	0235	4.9900	$270.90	$72.04	$54.18
67311	T		Revise eye muscle	0243	21.1035	$1,145.69	$431.39	$229.14
67312	T		Revise two eye muscles	0243	21.1035	$1,145.69	$431.39	$229.14
67314	T		Revise eye muscle	0243	21.1035	$1,145.69	$431.39	$229.14
67316	T		Revise two eye muscles	0243	21.1035	$1,145.69	$431.39	$229.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67318	T		Revise eye muscle(s)	0243	21.1035	$1,145.69	$431.39	$229.14
67320	T		Revise eye muscle(s) add-on	0243	21.1035	$1,145.69	$431.39	$229.14
67331	T		Eye surgery follow-up add-on	0243	21.1035	$1,145.69	$431.39	$229.14
67332	T		Rerevise eye muscles add-on	0243	21.1035	$1,145.69	$431.39	$229.14
67334	T		Revise eye muscle w/suture	0243	21.1035	$1,145.69	$431.39	$229.14
67335	T		Eye suture during surgery	0243	21.1035	$1,145.69	$431.39	$229.14
67340	T		Revise eye muscle add-on	0243	21.1035	$1,145.69	$431.39	$229.14
67343	T		Release eye tissue	0243	21.1035	$1,145.69	$431.39	$229.14
67345	T		Destroy nerve of eye muscle	0238	3.2016	$173.81	$58.96	$34.76
67350	T		Biopsy eye muscle	0699	2.2211	$120.58	$54.26	$24.12
67399	T		Eye muscle surgery procedure	0243	21.1035	$1,145.69	$431.39	$229.14
67400	T		Explore/biopsy eye socket	0241	21.9830	$1,193.44	$384.47	$238.69
67405	T		Explore/drain eye socket	0241	21.9830	$1,193.44	$384.47	$238.69
67412	T		Explore/treat eye socket	0241	21.9830	$1,193.44	$384.47	$238.69
67413	T		Explore/treat eye socket	0241	21.9830	$1,193.44	$384.47	$238.69
67414	T		Explr/decompress eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67415	T		Aspiration, orbital contents	0239	6.2432	$338.94	$110.62	$67.79
67420	T		Explore/treat eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67430	T		Explore/treat eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67440	T		Explore/drain eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67445	T		Explr/decompress eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67450	T		Explore/biopsy eye socket	0242	29.2193	$1,586.29	$597.36	$317.26
67500	S		Inject/treat eye socket	0231	2.0880	$113.36	$50.94	$22.67
67505	T		Inject/treat eye socket	0238	3.2016	$173.81	$58.96	$34.76
67515	T		Inject/treat eye socket	0239	6.2432	$338.94	$110.62	$67.79
67550	T		Insert eye socket implant	0242	29.2193	$1,586.29	$597.36	$317.26
67560	T		Revise eye socket implant	0241	21.9830	$1,193.44	$384.47	$238.69
67570	T		Decompress optic nerve	0242	29.2193	$1,586.29	$597.36	$317.26
67599	T		Orbit surgery procedure	0239	6.2432	$338.94	$110.62	$67.79
67700	T		Drainage of eyelid abscess	0238	3.2016	$173.81	$58.96	$34.76
67710	T		Incision of eyelid	0239	6.2432	$338.94	$110.62	$67.79
67715	T		Incision of eyelid fold	0240	17.3397	$941.35	$315.31	$188.27
67800	T		Remove eyelid lesion	0238	3.2016	$173.81	$58.96	$34.76
67801	T		Remove eyelid lesions	0239	6.2432	$338.94	$110.62	$67.79
67805	T		Remove eyelid lesions	0238	3.2016	$173.81	$58.96	$34.76
67808	T		Remove eyelid lesion(s)	0240	17.3397	$941.35	$315.31	$188.27
67810	T		Biopsy of eyelid	0238	3.2016	$173.81	$58.96	$34.76
67820	S		Revise eyelashes	0698	0.9355	$50.79	$18.72	$10.16
67825	T		Revise eyelashes	0238	3.2016	$173.81	$58.96	$34.76
67830	T		Revise eyelashes	0239	6.2432	$338.94	$110.62	$67.79
67835	T		Revise eyelashes	0240	17.3397	$941.35	$315.31	$188.27
67840	T		Remove eyelid lesion	0239	6.2432	$338.94	$110.62	$67.79
67850	T		Treat eyelid lesion	0239	6.2432	$338.94	$110.62	$67.79
67875	T		Closure of eyelid by suture	0239	6.2432	$338.94	$110.62	$67.79
67880	T		Revision of eyelid	0233	14.5435	$789.55	$266.33	$157.91
67882	T		Revision of eyelid	0240	17.3397	$941.35	$315.31	$188.27
67900	T		Repair brow defect	0240	17.3397	$941.35	$315.31	$188.27
67901	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67902	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67903	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67904	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67906	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67908	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67909	T		Revise eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67911	T		Revise eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67914	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67915	T		Repair eyelid defect	0239	6.2432	$338.94	$110.62	$67.79
67916	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67917	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67921	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67922	T		Repair eyelid defect	0239	6.2432	$338.94	$110.62	$67.79
67923	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67924	T		Repair eyelid defect	0240	17.3397	$941.35	$315.31	$188.27
67930	T		Repair eyelid wound	0240	17.3397	$941.35	$315.31	$188.27
67935	T		Repair eyelid wound	0240	17.3397	$941.35	$315.31	$188.27
67938	S		Remove eyelid foreign body	0698	0.9355	$50.79	$18.72	$10.16

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67950	T		Revision of eyelid	0240	17.3397	$941.35	$315.31	$188.27
67961	T		Revision of eyelid	0240	17.3397	$941.35	$315.31	$188.27
67966	T		Revision of eyelid	0240	17.3397	$941.35	$315.31	$188.27
67971	T		Reconstruction of eyelid	0241	21.9830	$1,193.44	$384.47	$238.69
67973	T		Reconstruction of eyelid	0241	21.9830	$1,193.44	$384.47	$238.69
67974	T		Reconstruction of eyelid	0241	21.9830	$1,193.44	$384.47	$238.69
67975	T		Reconstruction of eyelid	0240	17.3397	$941.35	$315.31	$188.27
67999	T		Revision of eyelid	0240	17.3397	$941.35	$315.31	$188.27
68020	T		Incise/drain eyelid lining	0240	17.3397	$941.35	$315.31	$188.27
68040	S		Treatment of eyelid lesions	0698	0.9355	$50.79	$18.72	$10.16
68100	T		Biopsy of eyelid lining	0232	4.9739	$270.03	$103.17	$54.01
68110	T		Remove eyelid lining lesion	0699	2.2211	$120.58	$54.26	$24.12
68115	T		Remove eyelid lining lesion	0239	6.2432	$338.94	$110.62	$67.79
68130	T		Remove eyelid lining lesion	0233	14.5435	$789.55	$266.33	$157.91
68135	T		Remove eyelid lining lesion	0239	6.2432	$338.94	$110.62	$67.79
68200	S		Treat eyelid by injection	0698	0.9355	$50.79	$18.72	$10.16
68320	T		Revise/graft eyelid lining	0240	17.3397	$941.35	$315.31	$188.27
68325	T		Revise/graft eyelid lining	0242	29.2193	$1,586.29	$597.36	$317.26
68326	T		Revise/graft eyelid lining	0241	21.9830	$1,193.44	$384.47	$238.69
68328	T		Revise/graft eyelid lining	0241	21.9830	$1,193.44	$384.47	$238.69
68330	T		Revise eyelid lining	0233	14.5435	$789.55	$266.33	$157.91
68335	T		Revise/graft eyelid lining	0241	21.9830	$1,193.44	$384.47	$238.69
68340	T		Separate eyelid adhesions	0240	17.3397	$941.35	$315.31	$188.27
68360	T		Revise eyelid lining	0234	21.5482	$1,169.83	$511.31	$233.97
68362	T		Revise eyelid lining	0234	21.5482	$1,169.83	$511.31	$233.97
68399	T		Eyelid lining surgery	0239	6.2432	$338.94	$110.62	$67.79
68400	T		Incise/drain tear gland	0238	3.2016	$173.81	$58.96	$34.76
68420	T		Incise/drain tear sac	0240	17.3397	$941.35	$315.31	$188.27
68440	T		Incise tear duct opening	0238	3.2016	$173.81	$58.96	$34.76
68500	T		Removal of tear gland	0241	21.9830	$1,193.44	$384.47	$238.69
68505	T		Partial removal, tear gland	0241	21.9830	$1,193.44	$384.47	$238.69
68510	T		Biopsy of tear gland	0240	17.3397	$941.35	$315.31	$188.27
68520	T		Removal of tear sac	0241	21.9830	$1,193.44	$384.47	$238.69
68525	T		Biopsy of tear sac	0240	17.3397	$941.35	$315.31	$188.27
68530	T		Clearance of tear duct	0240	17.3397	$941.35	$315.31	$188.27
68540	T		Remove tear gland lesion	0241	21.9830	$1,193.44	$384.47	$238.69
68550	T		Remove tear gland lesion	0242	29.2193	$1,586.29	$597.36	$317.26
68700	T		Repair tear ducts	0241	21.9830	$1,193.44	$384.47	$238.69
68705	T		Revise tear duct opening	0238	3.2016	$173.81	$58.96	$34.76
68720	T		Create tear sac drain	0242	29.2193	$1,586.29	$597.36	$317.26
68745	T		Create tear duct drain	0241	21.9830	$1,193.44	$384.47	$238.69
68750	T		Create tear duct drain	0242	29.2193	$1,586.29	$597.36	$317.26
68760	S		Close tear duct opening	0698	0.9355	$50.79	$18.72	$10.16
68761	S		Close tear duct opening	0231	2.0880	$113.36	$50.94	$22.67
68770	T		Close tear system fistula	0240	17.3397	$941.35	$315.31	$188.27
68801	S		Dilate tear duct opening	0231	2.0880	$113.36	$50.94	$22.67
68810	T		Probe nasolacrimal duct	0699	2.2211	$120.58	$54.26	$24.12
68811	T		Probe nasolacrimal duct	0240	17.3397	$941.35	$315.31	$188.27
68815	T		Probe nasolacrimal duct	0240	17.3397	$941.35	$315.31	$188.27
68840	T		Explore/irrigate tear ducts	0699	2.2211	$120.58	$54.26	$24.12
68850	N		Injection for tear sac x-ray					
68899	T		Tear duct system surgery	0699	2.2211	$120.58	$54.26	$24.12
69000	T		Drain external ear lesion	0006	1.7487	$94.94	$24.12	$18.99
69005	T		Drain external ear lesion	0007	11.4943	$624.01		$124.80
69020	T		Drain outer ear canal lesion	0006	1.7487	$94.94	$24.12	$18.99
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	3.9807	$216.11	$71.87	$43.22
69105	T		Biopsy of external ear canal	0253	15.1698	$823.55	$282.29	$164.71
69110	T		Remove external ear, partial	0021	14.5749	$791.26	$219.48	$158.25
69120	T		Removal of external ear	0254	21.4368	$1,163.78	$321.35	$232.76
69140	T		Remove ear canal lesion(s)	0254	21.4368	$1,163.78	$321.35	$232.76
69145	T		Remove ear canal lesion(s)	0021	14.5749	$791.26	$219.48	$158.25
69150	T		Extensive ear canal surgery	0252	6.5416	$355.14	$113.41	$71.03
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6232	$33.83		$6.77
69205	T		Clear outer ear canal	0022	18.6725	$1,013.71	$354.45	$202.74

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69210	X		Remove impacted ear wax	0340	0.6232	$33.83		$6.77
69220	T		Clean out mastoid cavity	0012	0.8203	$44.53	$11.18	$8.91
69222	T		Clean out mastoid cavity	0253	15.1698	$823.55	$282.29	$164.71
69300	T		Revise external ear	0254	21.4368	$1,163.78	$321.35	$232.76
69310	T		Rebuild outer ear canal	0256	35.0866	$1,904.82		$380.96
69320	T		Rebuild outer ear canal	0256	35.0866	$1,904.82		$380.96
69399	T		Outer ear surgery procedure	0251	1.8643	$101.21		$20.24
69400	T		Inflate middle ear canal	0251	1.8643	$101.21		$20.24
69401	T		Inflate middle ear canal	0251	1.8643	$101.21		$20.24
69405	T		Catheterize middle ear canal	0252	6.5416	$355.14	$113.41	$71.03
69410	T		Inset middle ear (baffle)	0252	6.5416	$355.14	$113.41	$71.03
69420	T		Incision of eardrum	0252	6.5416	$355.14	$113.41	$71.03
69421	T		Incision of eardrum	0253	15.1698	$823.55	$282.29	$164.71
69424	T		Remove ventilating tube	0252	6.5416	$355.14	$113.41	$71.03
69433	T		Create eardrum opening	0252	6.5416	$355.14	$113.41	$71.03
69436	T		Create eardrum opening	0253	15.1698	$823.55	$282.29	$164.71
69440	T		Exploration of middle ear	0254	21.4368	$1,163.78	$321.35	$232.76
69450	T		Eardrum revision	0256	35.0866	$1,904.82		$380.96
69501	T		Mastoidectomy	0256	35.0866	$1,904.82		$380.96
69502	T		Mastoidectomy	0254	21.4368	$1,163.78	$321.35	$232.76
69505	T		Remove mastoid structures	0256	35.0866	$1,904.82		$380.96
69511	T		Extensive mastoid surgery	0256	35.0866	$1,904.82		$380.96
69530	T		Extensive mastoid surgery	0256	35.0866	$1,904.82		$380.96
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	15.1698	$823.55	$282.29	$164.71
69550	T		Remove ear lesion	0256	35.0866	$1,904.82		$380.96
69552	T		Remove ear lesion	0256	35.0866	$1,904.82		$380.96
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	35.0866	$1,904.82		$380.96
69602	T		Mastoid surgery revision	0256	35.0866	$1,904.82		$380.96
69603	T		Mastoid surgery revision	0256	35.0866	$1,904.82		$380.96
69604	T		Mastoid surgery revision	0256	35.0866	$1,904.82		$380.96
69605	T		Mastoid surgery revision	0256	35.0866	$1,904.82		$380.96
69610	T		Repair of eardrum	0254	21.4368	$1,163.78	$321.35	$232.76
69620	T		Repair of eardrum	0254	21.4368	$1,163.78	$321.35	$232.76
69631	T		Repair eardrum structures	0256	35.0866	$1,904.82		$380.96
69632	T		Rebuild eardrum structures	0256	35.0866	$1,904.82		$380.96
69633	T		Rebuild eardrum structures	0256	35.0866	$1,904.82		$380.96
69635	T		Repair eardrum structures	0256	35.0866	$1,904.82		$380.96
69636	T		Rebuild eardrum structures	0256	35.0866	$1,904.82		$380.96
69637	T		Rebuild eardrum structures	0256	35.0866	$1,904.82		$380.96
69641	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69642	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69643	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69644	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69645	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69646	T		Revise middle ear & mastoid	0256	35.0866	$1,904.82		$380.96
69650	T		Release middle ear bone	0254	21.4368	$1,163.78	$321.35	$232.76
69660	T		Revise middle ear bone	0256	35.0866	$1,904.82		$380.96
69661	T		Revise middle ear bone	0256	35.0866	$1,904.82		$380.96
69662	T		Revise middle ear bone	0256	35.0866	$1,904.82		$380.96
69666	T		Repair middle ear structures	0256	35.0866	$1,904.82		$380.96
69667	T		Repair middle ear structures	0256	35.0866	$1,904.82		$380.96
69670	T		Remove mastoid air cells	0256	35.0866	$1,904.82		$380.96
69676	T		Remove middle ear nerve	0256	35.0866	$1,904.82		$380.96
69700	T		Close mastoid fistula	0256	35.0866	$1,904.82		$380.96
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	35.0866	$1,904.82		$380.96
69714	T		Implant temple bone w/stimul	0256	35.0866	$1,904.82		$380.96
69715	T		Temple bne implnt w/stimulat	0256	35.0866	$1,904.82		$380.96
69717	T		Temple bone implant revision	0256	35.0866	$1,904.82		$380.96
69718	T		Revise temple bone implant	0256	35.0866	$1,904.82		$380.96
69720	T		Release facial nerve	0256	35.0866	$1,904.82		$380.96
69725	T		Release facial nerve	0256	35.0866	$1,904.82		$380.96
69740	T		Repair facial nerve	0256	35.0866	$1,904.82		$380.96
69745	T		Repair facial nerve	0256	35.0866	$1,904.82		$380.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69799	T		Middle ear surgery procedure	0253	15.1698	$823.55	$282.29	$164.71
69801	T		Incise inner ear	0256	35.0866	$1,904.82		$380.96
69802	T		Incise inner ear	0256	35.0866	$1,904.82		$380.96
69805	T		Explore inner ear	0256	35.0866	$1,904.82		$380.96
69806	T		Explore inner ear	0256	35.0866	$1,904.82		$380.96
69820	T		Establish inner ear window	0256	35.0866	$1,904.82		$380.96
69840	T		Revise inner ear window	0256	35.0866	$1,904.82		$380.96
69905	T		Remove inner ear	0256	35.0866	$1,904.82		$380.96
69910	T		Remove inner ear & mastoid	0256	35.0866	$1,904.82		$380.96
69915	T		Incise inner ear nerve	0256	35.0866	$1,904.82		$380.96
69930	T		Implant cochlear device	0259	389.1764	$21,128.00	$9,394.83	$4,225.60
69949	T		Inner ear surgery procedure	0253	15.1698	$823.55	$282.29	$164.71
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	35.0866	$1,904.82		$380.96
69960	T		Release inner ear canal	0256	35.0866	$1,904.82		$380.96
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.8643	$101.21		$20.24
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.5837	$194.56	$92.92	$38.91
70015	S		Contrast x-ray of brain	0274	3.5837	$194.56	$92.92	$38.91
70030	X		X-ray eye for foreign body	0260	0.7845	$42.59	$21.29	$8.52
70100	X		X-ray exam of jaw	0260	0.7845	$42.59	$21.29	$8.52
70110	X		X-ray exam of jaw	0260	0.7845	$42.59	$21.29	$8.52
70120	X		X-ray exam of mastoids	0260	0.7845	$42.59	$21.29	$8.52
70130	X		X-ray exam of mastoids	0260	0.7845	$42.59	$21.29	$8.52
70134	X		X-ray exam of middle ear	0261	1.3238	$71.87		$14.37
70140	X		X-ray exam of facial bones	0260	0.7845	$42.59	$21.29	$8.52
70150	X		X-ray exam of facial bones	0260	0.7845	$42.59	$21.29	$8.52
70160	X		X-ray exam of nasal bones	0260	0.7845	$42.59	$21.29	$8.52
70170	X		X-ray exam of tear duct	0263	2.1875	$118.76	$43.58	$23.75
70190	X		X-ray exam of eye sockets	0260	0.7845	$42.59	$21.29	$8.52
70200	X		X-ray exam of eye sockets	0260	0.7845	$42.59	$21.29	$8.52
70210	X		X-ray exam of sinuses	0260	0.7845	$42.59	$21.29	$8.52
70220	X		X-ray exam of sinuses	0260	0.7845	$42.59	$21.29	$8.52
70240	X		X-ray exam, pituitary saddle	0260	0.7845	$42.59	$21.29	$8.52
70250	X		X-ray exam of skull	0260	0.7845	$42.59	$21.29	$8.52
70260	X		X-ray exam of skull	0261	1.3238	$71.87		$14.37
70300	X		X-ray exam of teeth	0262	0.7851	$42.62	$9.82	$8.52
70310	X		X-ray exam of teeth	0262	0.7851	$42.62	$9.82	$8.52
70320	X		Full mouth x-ray of teeth	0262	0.7851	$42.62	$9.82	$8.52
70328	X		X-ray exam of jaw joint	0260	0.7845	$42.59	$21.29	$8.52
70330	X		X-ray exam of jaw joints	0260	0.7845	$42.59	$21.29	$8.52
70332	S		X-ray exam of jaw joint	0275	3.2967	$178.97	$69.09	$35.79
70336	S		Magnetic image, jaw joint	0335	6.4453	$349.91	$151.46	$69.98
70350	X		X-ray head for orthodontia	0260	0.7845	$42.59	$21.29	$8.52
70355	X		Panoramic x-ray of jaws	0260	0.7845	$42.59	$21.29	$8.52
70360	X		X-ray exam of neck	0260	0.7845	$42.59	$21.29	$8.52
70370	X		Throat x-ray & fluoroscopy	0272	1.4086	$76.47	$38.23	$15.29
70371	X		Speech evaluation, complex	0272	1.4086	$76.47	$38.23	$15.29
70373	X		Contrast x-ray of larynx	0263	2.1875	$118.76	$43.58	$23.75
70380	X		X-ray exam of salivary gland	0260	0.7845	$42.59	$21.29	$8.52
70390	X		X-ray exam of salivary duct	0264	3.0022	$162.99	$79.41	$32.60
70450	S		Ct head/brain w/o dye	0332	3.3916	$184.13	$91.27	$36.83
70460	S		Ct head/brain w/dye	0283	4.6121	$250.39	$125.19	$50.08
70470	S		Ct head/brain w/o&w dye	0333	5.4299	$294.78	$146.98	$58.96
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.3916	$184.13	$91.27	$36.83
70481	S		Ct orbit/ear/fossa w/dye	0283	4.6121	$250.39	$125.19	$50.08
70482	S		Ct orbit/ear/fossa w/o&w dye	0333	5.4299	$294.78	$146.98	$58.96
70486	S		Ct maxillofacial w/o dye	0332	3.3916	$184.13	$91.27	$36.83
70487	S		Ct maxillofacial w/dye	0283	4.6121	$250.39	$125.19	$50.08
70488	S		Ct maxillofacial w/o&w dye	0333	5.4299	$294.78	$146.98	$58.96
70490	S		Ct soft tissue neck w/o dye	0332	3.3916	$184.13	$91.27	$36.83
70491	S		Ct soft tissue neck w/dye	0283	4.6121	$250.39	$125.19	$50.08
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.4299	$294.78	$146.98	$58.96
70496	S		Ct angiography, head	0662	5.8751	$318.95	$156.47	$63.79
70498	S		Ct angiography, neck	0662	5.8751	$318.95	$156.47	$63.79

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70540	S		Mri orbit/face/neck w/o dye	0336	6.4817	$351.89	$175.94	$70.38
70542	S		Mri orbit/face/neck w/dye	0284	7.0207	$381.15	$190.57	$76.23
70543	S		Mri orbt/fac/nck w/o&w dye	0337	9.3215	$506.05	$240.77	$101.21
70544	S		Mr angiography head w/o dye	0336	6.4817	$351.89	$175.94	$70.38
70545	S		Mr angiography head w/dye	0284	7.0207	$381.15	$190.57	$76.23
70546	S		Mr angiograph head w/o&w dye	0337	9.3215	$506.05	$240.77	$101.21
70547	S		Mr angiography neck w/o dye	0336	6.4817	$351.89	$175.94	$70.38
70548	S		Mr angiography neck w/dye	0284	7.0207	$381.15	$190.57	$76.23
70549	S		Mr angiograph neck w/o&w dye	0337	9.3215	$506.05	$240.77	$101.21
70551	S		Mri brain w/o dye	0336	6.4817	$351.89	$175.94	$70.38
70552	S		Mri brain w/dye	0284	7.0207	$381.15	$190.57	$76.23
70553	S		Mri brain w/o&w dye	0337	9.3215	$506.05	$240.77	$101.21
71010	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71015	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71020	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71021	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71022	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71023	X		Chest x-ray and fluoroscopy	0272	1.4086	$76.47	$38.23	$15.29
71030	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71034	X		Chest x-ray and fluoroscopy	0272	1.4086	$76.47	$38.23	$15.29
71035	X		Chest x-ray	0260	0.7845	$42.59	$21.29	$8.52
71040	X		Contrast x-ray of bronchi	0263	2.1875	$118.76	$43.58	$23.75
71060	X		Contrast x-ray of bronchi	0264	3.0022	$162.99	$79.41	$32.60
71090	X		X-ray & pacemaker insertion	0272	1.4086	$76.47	$38.23	$15.29
71100	X		X-ray exam of ribs	0260	0.7845	$42.59	$21.29	$8.52
71101	X		X-ray exam of ribs/chest	0260	0.7845	$42.59	$21.29	$8.52
71110	X		X-ray exam of ribs	0260	0.7845	$42.59	$21.29	$8.52
71111	X		X-ray exam of ribs/ chest	0261	1.3238	$71.87		$14.37
71120	X		X-ray exam of breastbone	0260	0.7845	$42.59	$21.29	$8.52
71130	X		X-ray exam of breastbone	0260	0.7845	$42.59	$21.29	$8.52
71250	S		Ct thorax w/o dye	0332	3.3916	$184.13	$91.27	$36.83
71260	S		Ct thorax w/dye	0283	4.6121	$250.39	$125.19	$50.08
71270	S		Ct thorax w/o&w dye	0333	5.4299	$294.78	$146.98	$58.96
71275	S		Ct angiography, chest	0662	5.8751	$318.95	$156.47	$63.79
71550	S		Mri chest w/o dye	0336	6.4817	$351.89	$175.94	$70.38
71551	S		Mri chest w/dye	0284	7.0207	$381.15	$190.57	$76.23
71552	S		Mri chest w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
71555	E		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.3238	$71.87		$14.37
72020	X		X-ray exam of spine	0260	0.7845	$42.59	$21.29	$8.52
72040	X		X-ray exam of neck spine	0260	0.7845	$42.59	$21.29	$8.52
72050	X		X-ray exam of neck spine	0261	1.3238	$71.87		$14.37
72052	X		X-ray exam of neck spine	0261	1.3238	$71.87		$14.37
72069	X		X-ray exam of trunk spine	0260	0.7845	$42.59	$21.29	$8.52
72070	X		X-ray exam of thoracic spine	0260	0.7845	$42.59	$21.29	$8.52
72072	X		X-ray exam of thoracic spine	0260	0.7845	$42.59	$21.29	$8.52
72074	X		X-ray exam of thoracic spine	0260	0.7845	$42.59	$21.29	$8.52
72080	X		X-ray exam of trunk spine	0260	0.7845	$42.59	$21.29	$8.52
72090	X		X-ray exam of trunk spine	0261	1.3238	$71.87		$14.37
72100	X		X-ray exam of lower spine	0260	0.7845	$42.59	$21.29	$8.52
72110	X		X-ray exam of lower spine	0261	1.3238	$71.87		$14.37
72114	X		X-ray exam of lower spine	0261	1.3238	$71.87		$14.37
72120	X		X-ray exam of lower spine	0260	0.7845	$42.59	$21.29	$8.52
72125	S		Ct neck spine w/o dye	0332	3.3916	$184.13	$91.27	$36.83
72126	S		Ct neck spine w/dye	0283	4.6121	$250.39	$125.19	$50.08
72127	S		Ct neck spine w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
72128	S		Ct chest spine w/o dye	0332	3.3916	$184.13	$91.27	$36.83
72129	S		Ct chest spine w/dye	0283	4.6121	$250.39	$125.19	$50.08
72130	S		Ct chest spine w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
72131	S		Ct lumbar spine w/o dye	0332	3.3916	$184.13	$91.27	$36.83
72132	S		Ct lumbar spine w/dye	0283	4.6121	$250.39	$125.19	$50.08
72133	S		Ct lumbar spine w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
72141	S		Mri neck spine w/o dye	0336	6.4817	$351.89	$175.94	$70.38
72142	S		Mri neck spine w/dye	0284	7.0207	$381.15	$190.57	$76.23
72146	S		Mri chest spine w/o dye	0336	6.4817	$351.89	$175.94	$70.38
72147	S		Mri chest spine w/dye	0284	7.0207	$381.15	$190.57	$76.23

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72148	S		Mri lumbar spine w/o dye	0336	6.4817	$351.89	$175.94	$70.38
72149	S		Mri lumbar spine w/dye	0284	7.0207	$381.15	$190.57	$76.23
72156	S		Mri neck spine w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
72157	S		Mri chest spine w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
72158	S		Mri lumbar spine w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7845	$42.59	$21.29	$8.52
72190	X		X-ray exam of pelvis	0260	0.7845	$42.59	$21.29	$8.52
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.8751	$318.95	$156.47	$63.79
72192	S		Ct pelvis w/o dye	0332	3.3916	$184.13	$91.27	$36.83
72193	S		Ct pelvis w/dye	0283	4.6121	$250.39	$125.19	$50.08
72194	S		Ct pelvis w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
72195	S		Mri pelvis w/o dye	0336	6.4817	$351.89	$175.94	$70.38
72196	S		Mri pelvis w/dye	0284	7.0207	$381.15	$190.57	$76.23
72197	S		Mri pelvis w/o & w/dye	0337	9.3215	$506.05	$240.77	$101.21
72198	E		Mr angio pelvis w/o&w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7845	$42.59	$21.29	$8.52
72202	X		X-ray exam sacroiliac joints	0260	0.7845	$42.59	$21.29	$8.52
72220	X		X-ray exam of tailbone	0260	0.7845	$42.59	$21.29	$8.52
72240	S		Contrast x-ray of neck spine	0274	3.5837	$194.56	$92.92	$38.91
72255	S		Contrast x-ray, thorax spine	0274	3.5837	$194.56	$92.92	$38.91
72265	S		Contrast x-ray, lower spine	0274	3.5837	$194.56	$92.92	$38.91
72270	S		Contrast x-ray of spine	0274	3.5837	$194.56	$92.92	$38.91
72275	S		Epidurography	0274	3.5837	$194.56	$92.92	$38.91
72285	S		X-ray c/t spine disk	0388	11.7450	$637.62	$304.54	$127.52
72295	S		X-ray of lower spine disk	0388	11.7450	$637.62	$304.54	$127.52
73000	X		X-ray exam of collar bone	0260	0.7845	$42.59	$21.29	$8.52
73010	X		X-ray exam of shoulder blade	0260	0.7845	$42.59	$21.29	$8.52
73020	X		X-ray exam of shoulder	0260	0.7845	$42.59	$21.29	$8.52
73030	X		X-ray exam of shoulder	0260	0.7845	$42.59	$21.29	$8.52
73040	S		Contrast x-ray of shoulder	0275	3.2967	$178.97	$69.09	$35.79
73050	X		X-ray exam of shoulders	0260	0.7845	$42.59	$21.29	$8.52
73060	X		X-ray exam of humerus	0260	0.7845	$42.59	$21.29	$8.52
73070	X		X-ray exam of elbow	0260	0.7845	$42.59	$21.29	$8.52
73080	X		X-ray exam of elbow	0260	0.7845	$42.59	$21.29	$8.52
73085	S		Contrast x-ray of elbow	0275	3.2967	$178.97	$69.09	$35.79
73090	X		X-ray exam of forearm	0260	0.7845	$42.59	$21.29	$8.52
73092	X		X-ray exam of arm, infant	0260	0.7845	$42.59	$21.29	$8.52
73100	X		X-ray exam of wrist	0260	0.7845	$42.59	$21.29	$8.52
73110	X		X-ray exam of wrist	0260	0.7845	$42.59	$21.29	$8.52
73115	S		Contrast x-ray of wrist	0275	3.2967	$178.97	$69.09	$35.79
73120	X		X-ray exam of hand	0260	0.7845	$42.59	$21.29	$8.52
73130	X		X-ray exam of hand	0260	0.7845	$42.59	$21.29	$8.52
73140	X		X-ray exam of finger(s)	0260	0.7845	$42.59	$21.29	$8.52
73200	S		Ct upper extremity w/o dye	0332	3.3916	$184.13	$91.27	$36.83
73201	S		Ct upper extremity w/dye	0283	4.6121	$250.39	$125.19	$50.08
73202	S		Ct uppr extremity w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.8751	$318.95	$156.47	$63.79
73218	S		Mri upper extremity w/o dye	0336	6.4817	$351.89	$175.94	$70.38
73219	S		Mri upper extremity w/dye	0284	7.0207	$381.15	$190.57	$76.23
73220	S		Mri uppr extremity w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
73221	S		Mri joint upr extrem w/o dye	0336	6.4817	$351.89	$175.94	$70.38
73222	S		Mri joint upr extrem w/dye	0284	7.0207	$381.15	$190.57	$76.23
73223	S		Mri joint upr extr w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7845	$42.59	$21.29	$8.52
73510	X		X-ray exam of hip	0260	0.7845	$42.59	$21.29	$8.52
73520	X		X-ray exam of hips	0260	0.7845	$42.59	$21.29	$8.52
73525	S		Contrast x-ray of hip	0275	3.2967	$178.97	$69.09	$35.79
73530	X		X-ray exam of hip	0261	1.3238	$71.87		$14.37
73540	X		X-ray exam of pelvis & hips	0260	0.7845	$42.59	$21.29	$8.52
73542	S		X-ray exam, sacroiliac joint	0275	3.2967	$178.97	$69.09	$35.79
73550	X		X-ray exam of thigh	0260	0.7845	$42.59	$21.29	$8.52
73560	X		X-ray exam of knee, 1 or 2	0260	0.7845	$42.59	$21.29	$8.52
73562	X		X-ray exam of knee, 3	0260	0.7845	$42.59	$21.29	$8.52
73564	X		X-ray exam, knee, 4 or more	0260	0.7845	$42.59	$21.29	$8.52

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73565	X		X-ray exam of knees	0260	0.7845	$42.59	$21.29	$8.52
73580	S		Contrast x-ray of knee joint	0275	3.2967	$178.97	$69.09	$35.79
73590	X		X-ray exam of lower leg	0260	0.7845	$42.59	$21.29	$8.52
73592	X		X-ray exam of leg, infant	0260	0.7845	$42.59	$21.29	$8.52
73600	X		X-ray exam of ankle	0260	0.7845	$42.59	$21.29	$8.52
73610	X		X-ray exam of ankle	0260	0.7845	$42.59	$21.29	$8.52
73615	S		Contrast x-ray of ankle	0275	3.2967	$178.97	$69.09	$35.79
73620	X		X-ray exam of foot	0260	0.7845	$42.59	$21.29	$8.52
73630	X		X-ray exam of foot	0260	0.7845	$42.59	$21.29	$8.52
73650	X		X-ray exam of heel	0260	0.7845	$42.59	$21.29	$8.52
73660	X		X-ray exam of toe(s)	0260	0.7845	$42.59	$21.29	$8.52
73700	S		Ct lower extremity w/o dye	0332	3.3916	$184.13	$91.27	$36.83
73701	S		Ct lower extremity w/dye	0283	4.6121	$250.39	$125.19	$50.08
73702	S		Ct lwr extremity w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.8751	$318.95	$156.47	$63.79
73718	S		Mri lower extremity w/o dye	0336	6.4817	$351.89	$175.94	$70.38
73719	S		Mri lower extremity w/dye	0284	7.0207	$381.15	$190.57	$76.23
73720	S		Mri lwr extremity w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
73721	S		Mri jnt of lwr extre w/o dye	0336	6.4817	$351.89	$175.94	$70.38
73722	S		Mri joint of lwr extr w/dye	0284	7.0207	$381.15	$190.57	$76.23
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
73725	E		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7845	$42.59	$21.29	$8.52
74010	X		X-ray exam of abdomen	0260	0.7845	$42.59	$21.29	$8.52
74020	X		X-ray exam of abdomen	0260	0.7845	$42.59	$21.29	$8.52
74022	X		X-ray exam series, abdomen	0261	1.3238	$71.87		$14.37
74150	S		Ct abdomen w/o dye	0332	3.3916	$184.13	$91.27	$36.83
74160	S		Ct abdomen w/dye	0283	4.6121	$250.39	$125.19	$50.08
74170	S		Ct abdomen w/o&w/dye	0333	5.4299	$294.78	$146.98	$58.96
74175	S		Ct angio abdom w/o&w/dye	0662	5.8751	$318.95	$156.47	$63.79
74181	S		Mri abdomen w/o dye	0336	6.4817	$351.89	$175.94	$70.38
74182	S		Mri abdomen w/dye	0284	7.0207	$381.15	$190.57	$76.23
74183	S		Mri abdomen w/o&w/dye	0337	9.3215	$506.05	$240.77	$101.21
74185	E		Mri angio, abdom w or w/o dy					
74190	X		X-ray exam of peritoneum	0263	2.1875	$118.76	$43.58	$23.75
74210	S		Contrst x-ray exam of throat	0276	1.6025	$87.00	$41.72	$17.40
74220	S		Contrast x-ray, esophagus	0276	1.6025	$87.00	$41.72	$17.40
74230	S		Cine/vid x-ray, throat/esoph	0276	1.6025	$87.00	$41.72	$17.40
74235	S		Remove esophagus obstruction	0296	3.1381	$170.36	$69.20	$34.07
74240	S		X-ray exam, upper gi tract	0276	1.6025	$87.00	$41.72	$17.40
74241	S		X-ray exam, upper gi tract	0276	1.6025	$87.00	$41.72	$17.40
74245	S		X-ray exam, upper gi tract	0277	2.4462	$132.80	$60.47	$26.56
74246	S		Contrst x-ray uppr gi tract	0276	1.6025	$87.00	$41.72	$17.40
74247	S		Contrst x-ray uppr gi tract	0276	1.6025	$87.00	$41.72	$17.40
74249	S		Contrst x-ray uppr gi tract	0277	2.4462	$132.80	$60.47	$26.56
74250	S		X-ray exam of small bowel	0276	1.6025	$87.00	$41.72	$17.40
74251	S		X-ray exam of small bowel	0277	2.4462	$132.80	$60.47	$26.56
74260	S		X-ray exam of small bowel	0277	2.4462	$132.80	$60.47	$26.56
74270	S		Contrast x-ray exam of colon	0276	1.6025	$87.00	$41.72	$17.40
74280	S		Contrast x-ray exam of colon	0277	2.4462	$132.80	$60.47	$26.56
74283	S		Contrast x-ray exam of colon	0276	1.6025	$87.00	$41.72	$17.40
74290	S		Contrast x-ray, gallbladder	0276	1.6025	$87.00	$41.72	$17.40
74291	S		Contrast x-rays, gallbladder	0276	1.6025	$87.00	$41.72	$17.40
74300	X		X-ray bile ducts/pancreas	0263	2.1875	$118.76	$43.58	$23.75
74301	X		X-rays at surgery add-on	0263	2.1875	$118.76	$43.58	$23.75
74305	X		X-ray bile ducts/pancreas	0263	2.1875	$118.76	$43.58	$23.75
74320	X		Contrast x-ray of bile ducts	0264	3.0022	$162.99	$79.41	$32.60
74327	S		X-ray bile stone removal	0296	3.1381	$170.36	$69.20	$34.07
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	1.4086	$76.47	$38.23	$15.29
74350	X		X-ray guide, stomach tube	0263	2.1875	$118.76	$43.58	$23.75
74355	X		X-ray guide, intestinal tube	0263	2.1875	$118.76	$43.58	$23.75
74360	S		X-ray guide, GI dilation	0296	3.1381	$170.36	$69.20	$34.07
74363	S		X-ray, bile duct dilation	0297	8.1532	$442.63	$172.51	$88.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74400	S		Contrst x-ray, urinary tract	0278	2.7365	$148.56	$66.07	$29.71
74410	S		Contrst x-ray, urinary tract	0278	2.7365	$148.56	$66.07	$29.71
74415	S		Contrst x-ray, urinary tract	0278	2.7365	$148.56	$66.07	$29.71
74420	S		Contrst x-ray, urinary tract	0278	2.7365	$148.56	$66.07	$29.71
74425	S		Contrst x-ray, urinary tract	0278	2.7365	$148.56	$66.07	$29.71
74430	S		Contrast x-ray, bladder	0278	2.7365	$148.56	$66.07	$29.71
74440	S		X-ray, male genital tract	0278	2.7365	$148.56	$66.07	$29.71
74445	S		X-ray exam of penis	0278	2.7365	$148.56	$66.07	$29.71
74450	S		X-ray, urethra/bladder	0278	2.7365	$148.56	$66.07	$29.71
74455	S		X-ray, urethra/bladder	0278	2.7365	$148.56	$66.07	$29.71
74470	X		X-ray exam of kidney lesion	0264	3.0022	$162.99	$79.41	$32.60
74475	S		X-ray control, cath insert	0297	8.1532	$442.63	$172.51	$88.53
74480	S		X-ray control, cath insert	0296	3.1381	$170.36	$69.20	$34.07
74485	S		X-ray guide, GU dilation	0296	3.1381	$170.36	$69.20	$34.07
74710	X		X-ray measurement of pelvis	0260	0.7845	$42.59	$21.29	$8.52
74740	X		X-ray, female genital tract	0264	3.0022	$162.99	$79.41	$32.60
74742	X		X-ray, fallopian tube	0263	2.1875	$118.76	$43.58	$23.75
74775	S		X-ray exam of perineum	0278	2.7365	$148.56	$66.07	$29.71
75552	S		Heart mri for morph w/o dye	0336	6.4817	$351.89	$175.94	$70.38
75553	S		Heart mri for morph w/dye	0284	7.0207	$381.15	$190.57	$76.23
75554	S		Cardiac MRI/function	0335	6.4453	$349.91	$151.46	$69.98
75555	S		Cardiac MRI/limited study	0335	6.4453	$349.91	$151.46	$69.98
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	19.0237	$1,032.78	$353.85	$206.56
75605	S		Contrast x-ray exam of aorta	0280	19.0237	$1,032.78	$353.85	$206.56
75625	S		Contrast x-ray exam of aorta	0280	19.0237	$1,032.78	$353.85	$206.56
75630	S		X-ray aorta, leg arteries	0280	19.0237	$1,032.78	$353.85	$206.56
75635	S		Ct angio abdominal arteries	0662	5.8751	$318.95	$156.47	$63.79
75650	S		Artery x-rays, head & neck	0280	19.0237	$1,032.78	$353.85	$206.56
75658	S		Artery x-rays, arm	0280	19.0237	$1,032.78	$353.85	$206.56
75660	S		Artery x-rays, head & neck	0279	11.0678	$600.86	$174.57	$120.17
75662	S		Artery x-rays, head & neck	0279	11.0678	$600.86	$174.57	$120.17
75665	S		Artery x-rays, head & neck	0280	19.0237	$1,032.78	$353.85	$206.56
75671	S		Artery x-rays, head & neck	0280	19.0237	$1,032.78	$353.85	$206.56
75676	S		Artery x-rays, neck	0280	19.0237	$1,032.78	$353.85	$206.56
75680	S		Artery x-rays, neck	0280	19.0237	$1,032.78	$353.85	$206.56
75685	S		Artery x-rays, spine	0279	11.0678	$600.86	$174.57	$120.17
75705	S		Artery x-rays, spine	0279	11.0678	$600.86	$174.57	$120.17
75710	S		Artery x-rays, arm/leg	0280	19.0237	$1,032.78	$353.85	$206.56
75716	S		Artery x-rays, arms/legs	0280	19.0237	$1,032.78	$353.85	$206.56
75722	S		Artery x-rays, kidney	0280	19.0237	$1,032.78	$353.85	$206.56
75724	S		Artery x-rays, kidneys	0280	19.0237	$1,032.78	$353.85	$206.56
75726	S		Artery x-rays, abdomen	0280	19.0237	$1,032.78	$353.85	$206.56
75731	S		Artery x-rays, adrenal gland	0280	19.0237	$1,032.78	$353.85	$206.56
75733	S		Artery x-rays, adrenals	0280	19.0237	$1,032.78	$353.85	$206.56
75736	S		Artery x-rays, pelvis	0280	19.0237	$1,032.78	$353.85	$206.56
75741	S		Artery x-rays, lung	0279	11.0678	$600.86	$174.57	$120.17
75743	S		Artery x-rays, lungs	0280	19.0237	$1,032.78	$353.85	$206.56
75746	S		Artery x-rays, lung	0279	11.0678	$600.86	$174.57	$120.17
75756	S		Artery x-rays, chest	0279	11.0678	$600.86	$174.57	$120.17
75774	S		Artery x-ray, each vessel	0668	10.4896	$569.47	$237.76	$113.89
75790	S		Visualize A-V shunt	0281	6.6888	$363.13	$115.16	$72.63
75801	X		Lymph vessel x-ray, arm/leg	0264	3.0022	$162.99	$79.41	$32.60
75803	X		Lymph vessel x-ray,arms/legs	0264	3.0022	$162.99	$79.41	$32.60
75805	X		Lymph vessel x-ray, trunk	0264	3.0022	$162.99	$79.41	$32.60
75807	X		Lymph vessel x-ray, trunk	0264	3.0022	$162.99	$79.41	$32.60
75809	X		Nonvascular shunt, x-ray	0263	2.1875	$118.76	$43.58	$23.75
75810	S		Vein x-ray, spleen/liver	0279	11.0678	$600.86	$174.57	$120.17
75820	S		Vein x-ray, arm/leg	0281	6.6888	$363.13	$115.16	$72.63
75822	S		Vein x-ray, arms/legs	0281	6.6888	$363.13	$115.16	$72.63
75825	S		Vein x-ray, trunk	0279	11.0678	$600.86	$174.57	$120.17
75827	S		Vein x-ray, chest	0279	11.0678	$600.86	$174.57	$120.17
75831	S		Vein x-ray, kidney	0287	6.2829	$341.09	$107.20	$68.22
75833	S		Vein x-ray, kidneys	0279	11.0678	$600.86	$174.57	$120.17
75840	S		Vein x-ray, adrenal gland	0287	6.2829	$341.09	$107.20	$68.22
75842	S		Vein x-ray, adrenal glands	0287	6.2829	$341.09	$107.20	$68.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75860	S		Vein x-ray, neck	0287	6.2829	$341.09	$107.20	$68.22
75870	S		Vein x-ray, skull	0287	6.2829	$341.09	$107.20	$68.22
75872	S		Vein x-ray, skull	0287	6.2829	$341.09	$107.20	$68.22
75880	S		Vein x-ray, eye socket	0287	6.2829	$341.09	$107.20	$68.22
75885	S		Vein x-ray, liver	0279	11.0678	$600.86	$174.57	$120.17
75887	S		Vein x-ray, liver	0280	19.0237	$1,032.78	$353.85	$206.56
75889	S		Vein x-ray, liver	0279	11.0678	$600.86	$174.57	$120.17
75891	S		Vein x-ray, liver	0279	11.0678	$600.86	$174.57	$120.17
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	8.1532	$442.63	$172.51	$88.53
75896	S		X-rays, transcath therapy	0297	8.1532	$442.63	$172.51	$88.53
75898	X		Follow-up angiography	0264	3.0022	$162.99	$79.41	$32.60
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0264	3.0022	$162.99	$79.41	$32.60
75902	X		Remove cva lumen obstruct	0263	2.1875	$118.76	$43.58	$23.75
75940	X		X-ray placement, vein filter	0187	4.4274	$240.36	$90.71	$48.07
75945	S		Intravascular us	0267	2.4805	$134.66	$65.52	$26.93
75946	S		Intravascular us add-on	0267	2.4805	$134.66	$65.52	$26.93
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0280	19.0237	$1,032.78	$353.85	$206.56
75961	S		Retrieval, broken catheter	0280	19.0237	$1,032.78	$353.85	$206.56
75962	S		Repair arterial blockage	0280	19.0237	$1,032.78	$353.85	$206.56
75964	S		Repair artery blockage, each	0280	19.0237	$1,032.78	$353.85	$206.56
75966	S		Repair arterial blockage	0280	19.0237	$1,032.78	$353.85	$206.56
75968	S		Repair artery blockage, each	0280	19.0237	$1,032.78	$353.85	$206.56
75970	S		Vascular biopsy	0280	19.0237	$1,032.78	$353.85	$206.56
75978	S		Repair venous blockage	0668	10.4896	$569.47	$237.76	$113.89
75980	S		Contrast xray exam bile duct	0296	3.1381	$170.36	$69.20	$34.07
75982	S		Contrast xray exam bile duct	0297	8.1532	$442.63	$172.51	$88.53
75984	X		Xray control catheter change	0264	3.0022	$162.99	$79.41	$32.60
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0280	19.0237	$1,032.78	$353.85	$206.56
75993	S		Atherectomy, x-ray exam	0280	19.0237	$1,032.78	$353.85	$206.56
75994	S		Atherectomy, x-ray exam	0280	19.0237	$1,032.78	$353.85	$206.56
75995	S		Atherectomy, x-ray exam	0280	19.0237	$1,032.78	$353.85	$206.56
75996	S		Atherectomy, x-ray exam	0280	19.0237	$1,032.78	$353.85	$206.56
76000	X		Fluoroscope examination	0272	1.4086	$76.47	$38.23	$15.29
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	0.7845	$42.59	$21.29	$8.52
76010	X		X-ray, nose to rectum	0260	0.7845	$42.59	$21.29	$8.52
76012	S		Percut vertebroplasty fluor	0274	3.5837	$194.56	$92.92	$38.91
76013	S		Percut vertebroplasty, ct	0274	3.5837	$194.56	$92.92	$38.91
76020	X		X-rays for bone age	0260	0.7845	$42.59	$21.29	$8.52
76040	X		X-rays, bone evaluation	0260	0.7845	$42.59	$21.29	$8.52
76061	X		X-rays, bone survey	0261	1.3238	$71.87		$14.37
76062	X		X-rays, bone survey	0261	1.3238	$71.87		$14.37
76065	X		X-rays, bone evaluation	0261	1.3238	$71.87		$14.37
76066	X		Joint survey, single view	0260	0.7845	$42.59	$21.29	$8.52
76070	S		CT scan, bone density study	0288	1.2854	$69.78		$13.96
76071	S		Ct bone density, peripheral	0282	1.6813	$91.28	$44.51	$18.26
76075	S		Dexa, axial skeleton study	0288	1.2854	$69.78		$13.96
76076	S		Dexa, peripheral study	0665	0.7225	$39.22		$7.84
76078	X		Radiographic absorptiometry	0261	1.3238	$71.87		$14.37
76080	X		X-ray exam of fistula	0263	2.1875	$118.76	$43.58	$23.75
76085	A		Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	2.1875	$118.76	$43.58	$23.75
76088	X		X-ray of mammary ducts	0263	2.1875	$118.76	$43.58	$23.75
76090	S		Mammogram, one breast	0271	0.6548	$35.55	$16.80	$7.11
76091	S		Mammogram, both breasts	0271	0.6548	$35.55	$16.80	$7.11
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76095	X		Stereotactic breast biopsy	0187	4.4274	$240.36	$90.71	$48.07
76096	X		X-ray of needle wire, breast	0289	3.6386	$197.54	$44.80	$39.51
76098	X		X-ray exam, breast specimen	0260	0.7845	$42.59	$21.29	$8.52
76100	X		X-ray exam of body section	0261	1.3238	$71.87		$14.37
76101	X		Complex body section x-ray	0264	3.0022	$162.99	$79.41	$32.60
76102	X		Complex body section x-rays	0264	3.0022	$162.99	$79.41	$32.60
76120	X		Cine/video x-rays	0272	1.4086	$76.47	$38.23	$15.29
76125	X		Cine/video x-rays add-on	0260	0.7845	$42.59	$21.29	$8.52
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7845	$42.59	$21.29	$8.52
76350	N		Special x-ray contrast study					
76355	S		CAT scan for localization	0283	4.6121	$250.39	$125.19	$50.08
76360	S		CAT scan for needle biopsy	0283	4.6121	$250.39	$125.19	$50.08
76362	S		Cat scan for tissue ablation	0332	3.3916	$184.13	$91.27	$36.83
76370	S		CAT scan for therapy guide	0282	1.6813	$91.28	$44.51	$18.26
76375	S		3d/holograph reconstr add-on	0282	1.6813	$91.28	$44.51	$18.26
76380	S		CAT scan follow-up study	0282	1.6813	$91.28	$44.51	$18.26
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	6.4453	$349.91	$151.46	$69.98
76394	S		Mri for tissue ablation	0335	6.4453	$349.91	$151.46	$69.98
76400	S		Magnetic image, bone marrow	0335	6.4453	$349.91	$151.46	$69.98
76490	S		Us for tissue ablation	0268	1.2640	$68.62		$13.72
76496	X		Fluoroscopic procedure	0272	1.4086	$76.47	$38.23	$15.29
76497	S		Ct procedure	0282	1.6813	$91.28	$44.51	$18.26
76498	S		Mri procedure	0335	6.4453	$349.91	$151.46	$69.98
76499	X		Radiographic procedure	0260	0.7845	$42.59	$21.29	$8.52
76506	S		Echo exam of head	0266	1.6234	$88.13	$44.06	$17.63
76511	S		Echo exam of eye	0266	1.6234	$88.13	$44.06	$17.63
76512	S		Echo exam of eye	0266	1.6234	$88.13	$44.06	$17.63
76513	S		Echo exam of eye, water bath	0265	1.0245	$55.62	$27.81	$11.12
76516	S		Echo exam of eye	0266	1.6234	$88.13	$44.06	$17.63
76519	S		Echo exam of eye	0266	1.6234	$88.13	$44.06	$17.63
76529	S		Echo exam of eye	0265	1.0245	$55.62	$27.81	$11.12
76536	S		Us exam of head and neck	0266	1.6234	$88.13	$44.06	$17.63
76604	S		Us exam, chest, b-scan	0266	1.6234	$88.13	$44.06	$17.63
76645	S		Us exam, breast(s)	0265	1.0245	$55.62	$27.81	$11.12
76700	S		Us exam, abdom, complete	0266	1.6234	$88.13	$44.06	$17.63
76705	S		Echo exam of abdomen	0266	1.6234	$88.13	$44.06	$17.63
76770	S		Us exam abdo back wall, comp	0266	1.6234	$88.13	$44.06	$17.63
76775	S		Us eam abdo back wall, lim	0266	1.6234	$88.13	$44.06	$17.63
76778	S		Us exam kidney transplant	0266	1.6234	$88.13	$44.06	$17.63
76800	S		Us exam, spinal canal	0266	1.6234	$88.13	$44.06	$17.63
76801	S		Ob us < 14 wks, single fetus	0265	1.0245	$55.62	$27.81	$11.12
76802	S		Ob us < 14 wks, addl fetus	0265	1.0245	$55.62	$27.81	$11.12
76805	S		Us exam, pg uterus, compl	0266	1.6234	$88.13	$44.06	$17.63
76810	S		Us exam, pg uterus, mult	0265	1.0245	$55.62	$27.81	$11.12
76811	S		Ob us, detailed, sngl fetus	0267	2.4805	$134.66	$65.52	$26.93
76812	S		Ob us, detailed, addl fetus	0266	1.6234	$88.13	$44.06	$17.63
76815	S		Us exam, pg uterus limit	0265	1.0245	$55.62	$27.81	$11.12
76816	S		Us exam pg uterus repeat	0265	1.0245	$55.62	$27.81	$11.12
76817	S		Transvaginal us, obstetric	0265	1.0245	$55.62	$27.81	$11.12
76818	S		Fetal biophys profile w/nst	0266	1.6234	$88.13	$44.06	$17.63
76819	S		Fetal biophys profil w/o nst	0266	1.6234	$88.13	$44.06	$17.63
76825	S		Echo exam of fetal heart	0671	1.6392	$88.99	$44.49	$17.80
76826	S		Echo exam of fetal heart	0697	1.4621	$79.38	$39.69	$15.88
76827	S		Echo exam of fetal heart	0671	1.6392	$88.99	$44.49	$17.80
76828	S		Echo exam of fetal heart	0697	1.4621	$79.38	$39.69	$15.88
76830	S		Transvaginal us, non-ob	0266	1.6234	$88.13	$44.06	$17.63
76831	S		Echo exam, uterus	0266	1.6234	$88.13	$44.06	$17.63
76856	S		Us exam, pelvic, complete	0266	1.6234	$88.13	$44.06	$17.63
76857	S		Us exam, pelvic, limited	0265	1.0245	$55.62	$27.81	$11.12
76870	S		Us exam, scrotum	0266	1.6234	$88.13	$44.06	$17.63
76872	S		Echo exam, transrectal	0266	1.6234	$88.13	$44.06	$17.63
76873	S		Echograp trans r, pros study	0266	1.6234	$88.13	$44.06	$17.63
76880	S		Us exam, extremity	0266	1.6234	$88.13	$44.06	$17.63
76885	S		Us exam infant hips, dynamic	0266	1.6234	$88.13	$44.06	$17.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76886	S		Us exam infant hips, static	0266	1.6234	$88.13	$44.06	$17.63
76930	S		Echo guide, cardiocentesis	0268	1.2640	$68.62		$13.72
76932	S		Echo guide for heart biopsy	0268	1.2640	$68.62		$13.72
76936	S		Echo guide for artery repair	0268	1.2640	$68.62		$13.72
76941	S		Echo guide for transfusion	0268	1.2640	$68.62		$13.72
76942	S		Echo guide for biopsy	0268	1.2640	$68.62		$13.72
76945	S		Echo guide, villus sampling	0268	1.2640	$68.62		$13.72
76946	S		Echo guide for amniocentesis	0268	1.2640	$68.62		$13.72
76948	S		Echo guide, ova aspiration	0268	1.2640	$68.62		$13.72
76950	S		Echo guidance radiotherapy	0268	1.2640	$68.62		$13.72
76965	S		Echo guidance radiotherapy	0268	1.2640	$68.62		$13.72
76970	S		Ultrasound exam follow-up	0265	1.0245	$55.62	$27.81	$11.12
76975	S		GI endoscopic ultrasound	0266	1.6234	$88.13	$44.06	$17.63
76977	X		Us bone density measure	0340	0.6232	$33.83		$6.77
76986	S		Ultrasound guide intraoper	0266	1.6234	$88.13	$44.06	$17.63
76999	S		Echo examination procedure	0265	1.0245	$55.62	$27.81	$11.12
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.6599	$90.11	$41.52	$18.02
77285	X		Set radiation therapy field	0305	3.6649	$198.96	$91.38	$39.79
77290	X		Set radiation therapy field	0305	3.6649	$198.96	$91.38	$39.79
77295	X		Set radiation therapy field	0310	13.7085	$744.22	$325.27	$148.84
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.6599	$90.11	$41.52	$18.02
77301	S		Radiotherapy dose plan, imrt	0413	6.0369	$327.74		$65.55
77305	X		Teletx isodose plan simple	0304	1.6599	$90.11	$41.52	$18.02
77310	X		Teletx isodose plan intermed	0304	1.6599	$90.11	$41.52	$18.02
77315	X		Teletx isodose plan complex	0305	3.6649	$198.96	$91.38	$39.79
77321	X		Special teletx port plan	0305	3.6649	$198.96	$91.38	$39.79
77326	X		Radiation therapy dose plan	0305	3.6649	$198.96	$91.38	$39.79
77327	X		Brachytx isodose calc interm	0305	3.6649	$198.96	$91.38	$39.79
77328	X		Brachytx isodose plan compl	0305	3.6649	$198.96	$91.38	$39.79
77331	X		Special radiation dosimetry	0304	1.6599	$90.11	$41.52	$18.02
77332	X		Radiation treatment aid(s)	0303	2.8636	$155.46	$66.95	$31.09
77333	X		Radiation treatment aid(s)	0303	2.8636	$155.46	$66.95	$31.09
77334	X		Radiation treatment aid(s)	0303	2.8636	$155.46	$66.95	$31.09
77336	X		Radiation physics consult	0304	1.6599	$90.11	$41.52	$18.02
77370	X		Radiation physics consult	0305	3.6649	$198.96	$91.38	$39.79
77399	X		External radiation dosimetry	0304	1.6599	$90.11	$41.52	$18.02
77401	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77402	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77403	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77404	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77406	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77407	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77408	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77409	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77411	S		Radiation treatment delivery	0300	1.5112	$82.04		$16.41
77412	S		Radiation treatment delivery	0301	2.1337	$115.84	$23.17	$23.17
77413	S		Radiation treatment delivery	0301	2.1337	$115.84	$23.17	$23.17
77414	S		Radiation treatment delivery	0301	2.1337	$115.84	$23.17	$23.17
77416	S		Radiation treatment delivery	0301	2.1337	$115.84	$23.17	$23.17
77417	X		Radiology port film(s)	0260	0.7845	$42.59	$21.29	$8.52
77418	S		Radiation tx delivery, imrt	0412	5.2832	$286.82		$57.36
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.7427	$311.77	$62.36	$62.35
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	9.6828	$525.67		$105.13
77522	S		Proton trmt, simple w/comp	0664	9.6828	$525.67		$105.13
77523	S		Proton trmt, intermediate	1511		$950.00		$190.00
77525	S		Proton treatment, complex	1511		$950.00		$190.00
77600	S		Hyperthermia treatment	0314	5.0930	$276.49	$101.77	$55.30
77605	S		Hyperthermia treatment	0314	5.0930	$276.49	$101.77	$55.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77610	S		Hyperthermia treatment	0314	5.0930	$276.49	$101.77	$55.30
77615	S		Hyperthermia treatment	0314	5.0930	$276.49	$101.77	$55.30
77620	S		Hyperthermia treatment	0314	5.0930	$276.49	$101.77	$55.30
77750	S		Infuse radioactive materials	0300	1.5112	$82.04		$16.41
77761	S		Apply intrcav radiat simple	0312	3.6892	$200.28	$40.06	$40.06
77762	S		Apply intrcav radiat interm	0312	3.6892	$200.28	$40.06	$40.06
77763	S		Apply intrcav radiat compl	0312	3.6892	$200.28	$40.06	$40.06
77776	S		Apply interstit radiat simpl	0312	3.6892	$200.28	$40.06	$40.06
77777	S		Apply interstit radiat inter	0312	3.6892	$200.28	$40.06	$40.06
77778	S		Apply interstit radiat compl	0651	10.0459	$545.38	$109.08	$109.08
77781	S		High intensity brachytherapy	0313	13.1258	$712.59		$142.52
77782	S		High intensity brachytherapy	0313	13.1258	$712.59		$142.52
77783	S		High intensity brachytherapy	0313	13.1258	$712.59		$142.52
77784	S		High intensity brachytherapy	0313	13.1258	$712.59		$142.52
77789	S		Apply surface radiation	0300	1.5112	$82.04		$16.41
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	13.1258	$712.59		$142.52
78000	S		Thyroid, single uptake	0389	1.6475	$89.44	$44.72	$17.89
78001	S		Thyroid, multiple uptakes	0389	1.6475	$89.44	$44.72	$17.89
78003	S		Thyroid suppress/stimul	0389	1.6475	$89.44	$44.72	$17.89
78006	S		Thyroid imaging with uptake	0390	2.8434	$154.37	$77.18	$30.87
78007	S		Thyroid image, mult uptakes	0391	3.7174	$201.81	$100.90	$40.36
78010	S		Thyroid imaging	0390	2.8434	$154.37	$77.18	$30.87
78011	S		Thyroid imaging with flow	0391	3.7174	$201.81	$100.90	$40.36
78015	S		Thyroid met imaging	0390	2.8434	$154.37	$77.18	$30.87
78016	S		Thyroid met imaging/studies	0390	2.8434	$154.37	$77.18	$30.87
78018	S		Thyroid met imaging, body	0391	3.7174	$201.81	$100.90	$40.36
78020	S		Thyroid met uptake	0389	1.6475	$89.44	$44.72	$17.89
78070	S		Parathyroid nuclear imaging	0391	3.7174	$201.81	$100.90	$40.36
78075	S		Adrenal nuclear imaging	0392	6.7081	$364.18	$182.08	$72.84
78099	S		Endocrine nuclear procedure	0389	1.6475	$89.44	$44.72	$17.89
78102	S		Bone marrow imaging, ltd	0400	3.8691	$210.05	$105.02	$42.01
78103	S		Bone marrow imaging, mult	0400	3.8691	$210.05	$105.02	$42.01
78104	S		Bone marrow imaging, body	0400	3.8691	$210.05	$105.02	$42.01
78110	S		Plasma volume, single	0393	4.0720	$221.06	$110.53	$44.21
78111	S		Plasma volume, multiple	0393	4.0720	$221.06	$110.53	$44.21
78120	S		Red cell mass, single	0393	4.0720	$221.06	$110.53	$44.21
78121	S		Red cell mass, multiple	0393	4.0720	$221.06	$110.53	$44.21
78122	S		Blood volume	0393	4.0720	$221.06	$110.53	$44.21
78130	S		Red cell survival study	0393	4.0720	$221.06	$110.53	$44.21
78135	S		Red cell survival kinetics	0393	4.0720	$221.06	$110.53	$44.21
78140	S		Red cell sequestration	0393	4.0720	$221.06	$110.53	$44.21
78160	S		Plasma iron turnover	0393	4.0720	$221.06	$110.53	$44.21
78162	S		Radioiron absorption exam	0393	4.0720	$221.06	$110.53	$44.21
78170	S		Red cell iron utilization	0393	4.0720	$221.06	$110.53	$44.21
78172	S		Total body iron estimation	0393	4.0720	$221.06	$110.53	$44.21
78185	S		Spleen imaging	0400	3.8691	$210.05	$105.02	$42.01
78190	S		Platelet survival, kinetics	0389	1.6475	$89.44	$44.72	$17.89
78191	S		Platelet survival	0389	1.6475	$89.44	$44.72	$17.89
78195	S		Lymph system imaging	0400	3.8691	$210.05	$105.02	$42.01
78199	S		Blood/lymph nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78201	S		Liver imaging	0394	4.4370	$240.88	$120.44	$48.18
78202	S		Liver imaging with flow	0394	4.4370	$240.88	$120.44	$48.18
78205	S		Liver imaging (3D)	0394	4.4370	$240.88	$120.44	$48.18
78206	S		Liver image (3d) with flow	0394	4.4370	$240.88	$120.44	$48.18
78215	S		Liver and spleen imaging	0394	4.4370	$240.88	$120.44	$48.18
78216	S		Liver & spleen image/flow	0394	4.4370	$240.88	$120.44	$48.18
78220	S		Liver function study	0394	4.4370	$240.88	$120.44	$48.18
78223	S		Hepatobiliary imaging	0394	4.4370	$240.88	$120.44	$48.18
78230	S		Salivary gland imaging	0395	3.9372	$213.75	$106.87	$42.75
78231	S		Serial salivary imaging	0395	3.9372	$213.75	$106.87	$42.75
78232	S		Salivary gland function exam	0395	3.9372	$213.75	$106.87	$42.75
78258	S		Esophageal motility study	0395	3.9372	$213.75	$106.87	$42.75
78261	S		Gastric mucosa imaging	0395	3.9372	$213.75	$106.87	$42.75
78262	S		Gastroesophageal reflux exam	0395	3.9372	$213.75	$106.87	$42.75
78264	S		Gastric emptying study	0395	3.9372	$213.75	$106.87	$42.75

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

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	0395	3.9372	$213.75	$106.87	$42.75
78271	S		Vit b-12 absrp exam, int fac	0395	3.9372	$213.75	$106.87	$42.75
78272	S		Vit B-12 absorp, combined	0395	3.9372	$213.75	$106.87	$42.75
78278	S		Acute GI blood loss imaging	0395	3.9372	$213.75	$106.87	$42.75
78282	S		GI protein loss exam	0395	3.9372	$213.75	$106.87	$42.75
78290	S		Meckel's divert exam	0395	3.9372	$213.75	$106.87	$42.75
78291	S		Leveen/shunt patency exam	0395	3.9372	$213.75	$106.87	$42.75
78299	S		GI nuclear procedure	0389	1.6475	$89.44	$44.72	$17.89
78300	S		Bone imaging, limited area	0396	4.2445	$230.43	$115.21	$46.09
78305	S		Bone imaging, multiple areas	0396	4.2445	$230.43	$115.21	$46.09
78306	S		Bone imaging, whole body	0396	4.2445	$230.43	$115.21	$46.09
78315	S		Bone imaging, 3 phase	0396	4.2445	$230.43	$115.21	$46.09
78320	S		Bone imaging (3D)	0396	4.2445	$230.43	$115.21	$46.09
78350	X		Bone mineral, single photon	0261	1.3238	$71.87		$14.37
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78414	S		Non-imaging heart function	0397	2.4737	$134.29	$67.14	$26.86
78428	S		Cardiac shunt imaging	0398	6.6521	$361.14	$180.57	$72.23
78445	S		Vascular flow imaging	0397	2.4737	$134.29	$67.14	$26.86
78455	S		Venous thrombosis study	0397	2.4737	$134.29	$67.14	$26.86
78456	S		Acute venous thrombus image	0397	2.4737	$134.29	$67.14	$26.86
78457	S		Venous thrombosis imaging	0397	2.4737	$134.29	$67.14	$26.86
78458	S		Ven thrombosis images, bilat	0397	2.4737	$134.29	$67.14	$26.86
78459	S		Heart muscle imaging (PET)	0285	19.5044	$1,058.87	$409.56	$211.77
78460	S		Heart muscle blood, single	0398	6.6521	$361.14	$180.57	$72.23
78461	S		Heart muscle blood, multiple	0398	6.6521	$361.14	$180.57	$72.23
78464	S		Heart image (3d), single	0398	6.6521	$361.14	$180.57	$72.23
78465	S		Heart image (3d), multiple	0398	6.6521	$361.14	$180.57	$72.23
78466	S		Heart infarct image	0398	6.6521	$361.14	$180.57	$72.23
78468	S		Heart infarct image (ef)	0398	6.6521	$361.14	$180.57	$72.23
78469	S		Heart infarct image (3D)	0398	6.6521	$361.14	$180.57	$72.23
78472	S		Gated heart, planar, single	0398	6.6521	$361.14	$180.57	$72.23
78473	S		Gated heart, multiple	0398	6.6521	$361.14	$180.57	$72.23
78478	S		Heart wall motion add-on	0399	1.6033	$87.04	$43.52	$17.41
78480	S		Heart function add-on	0399	1.6033	$87.04	$43.52	$17.41
78481	S		Heart first pass, single	0398	6.6521	$361.14	$180.57	$72.23
78483	S		Heart first pass, multiple	0398	6.6521	$361.14	$180.57	$72.23
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0398	6.6521	$361.14	$180.57	$72.23
78496	S		Heart first pass add-on	0399	1.6033	$87.04	$43.52	$17.41
78499	S		Cardiovascular nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78580	S		Lung perfusion imaging	0401	4.9130	$266.72	$133.35	$53.34
78584	S		Lung V/Q image single breath	0401	4.9130	$266.72	$133.35	$53.34
78585	S		Lung V/Q imaging	0401	4.9130	$266.72	$133.35	$53.34
78586	S		Aerosol lung image, single	0401	4.9130	$266.72	$133.35	$53.34
78587	S		Aerosol lung image, multiple	0401	4.9130	$266.72	$133.35	$53.34
78588	S		Perfusion lung image	0401	4.9130	$266.72	$133.35	$53.34
78591	S		Vent image, 1 breath, 1 proj	0401	4.9130	$266.72	$133.35	$53.34
78593	S		Vent image, 1 proj, gas	0401	4.9130	$266.72	$133.35	$53.34
78594	S		Vent image, mult proj, gas	0401	4.9130	$266.72	$133.35	$53.34
78596	S		Lung differential function	0401	4.9130	$266.72	$133.35	$53.34
78599	S		Respiratory nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78600	S		Brain imaging, ltd static	0402	5.4818	$297.60	$148.79	$59.52
78601	S		Brain imaging, ltd w/ flow	0402	5.4818	$297.60	$148.79	$59.52
78605	S		Brain imaging, complete	0402	5.4818	$297.60	$148.79	$59.52
78606	S		Brain imaging, compl w/flow	0402	5.4818	$297.60	$148.79	$59.52
78607	S		Brain imaging (3D)	0402	5.4818	$297.60	$148.79	$59.52
78608	E		Brain imaging (PET)					
78609	E		Brain imaging (PET)					
78610	S		Brain flow imaging only	0402	5.4818	$297.60	$148.79	$59.52
78615	S		Cerebral vascular flow image	0402	5.4818	$297.60	$148.79	$59.52
78630	S		Cerebrospinal fluid scan	0403	3.9265	$213.17	$106.58	$42.63
78635	S		CSF ventriculography	0403	3.9265	$213.17	$106.58	$42.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78645	S		CSF shunt evaluation	0403	3.9265	$213.17	$106.58	$42.63
78647	S		Cerebrospinal fluid scan	0403	3.9265	$213.17	$106.58	$42.63
78650	S		CSF leakage imaging	0403	3.9265	$213.17	$106.58	$42.63
78660	S		Nuclear exam of tear flow	0403	3.9265	$213.17	$106.58	$42.63
78699	S		Nervous system nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78700	S		Kidney imaging, static	0404	5.1538	$279.79	$139.89	$55.96
78701	S		Kidney imaging with flow	0404	5.1538	$279.79	$139.89	$55.96
78704	S		Imaging renogram	0404	5.1538	$279.79	$139.89	$55.96
78707	S		Kidney flow/function image	0404	5.1538	$279.79	$139.89	$55.96
78708	S		Kidney flow/function image	0404	5.1538	$279.79	$139.89	$55.96
78709	S		Kidney flow/function image	0404	5.1538	$279.79	$139.89	$55.96
78710	S		Kidney imaging (3D)	0404	5.1538	$279.79	$139.89	$55.96
78715	S		Renal vascular flow exam	0404	5.1538	$279.79	$139.89	$55.96
78725	S		Kidney function study	0389	1.6475	$89.44	$44.72	$17.89
78730	S		Urinary bladder retention	0405	0.7739	$42.01	$21.00	$8.40
78740	S		Ureteral reflux study	0405	0.7739	$42.01	$21.00	$8.40
78760	S		Testicular imaging	0405	0.7739	$42.01	$21.00	$8.40
78761	S		Testicular imaging/flow	0405	0.7739	$42.01	$21.00	$8.40
78799	S		Genitourinary nuclear exam	0389	1.6475	$89.44	$44.72	$17.89
78800	S		Tumor imaging, limited area	0406	4.7542	$258.10		$51.62
78801	S		Tumor imaging, mult areas	0406	4.7542	$258.10		$51.62
78802	S		Tumor imaging, whole body	0406	4.7542	$258.10		$51.62
78803	S		Tumor imaging (3D)	0406	4.7542	$258.10		$51.62
78805	S		Abscess imaging, ltd area	0406	4.7542	$258.10		$51.62
78806	S		Abscess imaging, whole body	0406	4.7542	$258.10		$51.62
78807	S		Nuclear localization/abscess	0406	4.7542	$258.10		$51.62
78810	E		Tumor imaging (PET)					
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78990	E		Provide diag radionuclide(s)					
78999	S		Nuclear diagnostic exam	0389	1.6475	$89.44	$44.72	$17.89
79000	S		Init hyperthyroid therapy	0407	4.2797	$232.34	$116.17	$46.47
79001	S		Repeat hyperthyroid therapy	0407	4.2797	$232.34	$116.17	$46.47
79020	S		Thyroid ablation	0407	4.2797	$232.34	$116.17	$46.47
79030	S		Thyroid ablation, carcinoma	0407	4.2797	$232.34	$116.17	$46.47
79035	S		Thyroid metastatic therapy	0407	4.2797	$232.34	$116.17	$46.47
79100	S		Hematopoetic nuclear therapy	0408	4.0000	$217.16		$43.43
79200	S		Intracavitary nuclear trmt	0408	4.0000	$217.16		$43.43
79300	S		Interstitial nuclear therapy	0408	4.0000	$217.16		$43.43
79400	S		Nonhemato nuclear therapy	0408	4.0000	$217.16		$43.43
79420	S		Intravascular nuclear ther	0408	4.0000	$217.16		$43.43
79440	S		Nuclear joint therapy	0408	4.0000	$217.16		$43.43
79900	N		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0389	1.6475	$89.44	$44.72	$17.89
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					
80100	A		Drug screen, qualitate/multi					
80101	A		Drug screen, single					
80102	A		Drug confirmation					
80103	N		Drug analysis, tissue prep					
80150	A		Assay of amikacin					
80152	A		Assay of amitriptyline					
80154	A		Assay of benzodiazepines					
80156	A		Assay, carbamazepine, total					
80157	A		Assay, carbamazepine, free					
80158	A		Assay of cyclosporine					
80160	A		Assay of desipramine					
80162	A		Assay of digoxin					
80164	A		Assay, dipropylacetic acid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.4662	$25.31	$12.55	$5.06
80502	X		Lab pathology consultation	0342	0.2169	$11.78	$5.88	$2.36
81000	A		Urinalysis, nonauto w/scope					
81001	A		Urinalysis, auto w/scope					
81002	A		Urinalysis nonauto w/o scope					
81003	A		Urinalysis, auto, w/o scope					
81005	A		Urinalysis					
81007	A		Urine screen for bacteria					
81015	A		Microscopic exam of urine					
81020	A		Urinalysis, glass test					
81025	A		Urine pregnancy test					
81050	A		Urinalysis, volume measure					
81099	A		Urinalysis test procedure					
82000	A		Assay of blood acetaldehyde					
82003	A		Assay of acetaminophen					
82009	A		Test for acetone/ketones					
82010	A		Acetone assay					
82013	A		Acetylcholinesterase assay					
82016	A		Acylcarnitines, qual					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A		Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					
83937	A		Assay of osteocalcin					
83945	A		Assay of oxalate					
83950	A		Oncoprotein, her-2/neu					
83970	A		Assay of parathormone					
83986	A		Assay of body fluid acidity					
83992	A		Assay for phencyclidine					
84022	A		Assay of phenothiazine					
84030	A		Assay of blood pku					
84035	A		Assay of phenylketones					
84060	A		Assay acid phosphatase					
84061	A		Phosphatase, forensic exam					
84066	A		Assay prostate phosphatase					
84075	A		Assay alkaline phosphatase					
84078	A		Assay alkaline phosphatase					
84080	A		Assay alkaline phosphatases					
84081	A		Amniotic fluid enzyme test					
84085	A		Assay of rbc pg6d enzyme					
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					
84106	A		Test for porphobilinogen					
84110	A		Assay of porphobilinogen					
84119	A		Test urine for porphyrins					
84120	A		Assay of urine porphyrins					
84126	A		Assay of feces porphyrins					
84127	A		Assay of feces porphyrins					
84132	A		Assay of serum potassium					
84133	A		Assay of urine potassium					
84134	A		Assay of prealbumin					
84135	A		Assay of pregnanediol					
84138	A		Assay of pregnanetriol					
84140	A		Assay of pregnenolone					
84143	A		Assay of 17-hydroxypregneno					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars single quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					
84460	A		Alanine amino (ALT) (SGPT)					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A		Automated diff wbc count					
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85032	A		Manual cell count, each					
85041	A		Red blood cell (RBC) count					
85044	A		Reticulocyte count					
85045	A		Reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		White blood cell (WBC) count					
85049	A		Automated platelet count					
85060	X		Blood smear interpretation	0342	0.2169	$11.78	$5.88	$2.36
85097	X		Bone marrow interpretation	0343	0.4662	$25.31	$12.55	$5.06
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					
85220	A		Blood clot factor V test					
85230	A		Blood clot factor VII test					
85240	A		Blood clot factor VIII test					
85244	A		Blood clot factor VIII test					
85245	A		Blood clot factor VIII test					
85246	A		Blood clot factor VIII test					
85247	A		Blood clot factor VIII test					
85250	A		Blood clot factor IX test					
85260	A		Blood clot factor X test					
85270	A		Blood clot factor XI test					
85280	A		Blood clot factor XII test					
85290	A		Blood clot factor XIII test					
85291	A		Blood clot factor XIII test					
85292	A		Blood clot factor assay					
85293	A		Blood clot factor assay					
85300	A		Antithrombin III test					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degradation					
85379	A		Fibrin degradation, quant					
85380	A		Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85400	A		Fibrinolytic plasmin					
85410	A		Fibrinolytic antiplasmin					
85415	A		Fibrinolytic plasminogen					
85420	A		Fibrinolytic plasminogen					
85421	A		Fibrinolytic plasminogen					
85441	A		Heinz bodies, direct					
85445	A		Heinz bodies, induced					
85460	A		Hemoglobin, fetal					
85461	A		Hemoglobin, fetal					
85475	A		Hemolysin					
85520	A		Heparin assay					
85525	A		Heparin neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85597	A		Platelet neutralization					
85610	A		Prothrombin time					
85611	A		Prothrombin test					
85612	A		Viper venom prothrombin time					
85613	A		Russell viper venom, diluted					
85635	A		Reptilase test					
85651	A		Rbc sed rate, nonautomated					
85652	A		Rbc sed rate, automated					
85660	A		RBC sickle cell test					
85670	A		Thrombin time, plasma					
85675	A		Thrombin time, titer					
85705	A		Thromboplastin inhibition					
85730	A		Thromboplastin time, partial					
85732	A		Thromboplastin time, partial					
85810	A		Blood viscosity examination					
85999	A		Hematology procedure					
86000	A		Agglutinins, febrile					
86001	A		Allergen specific igg					
86003	A		Allergen specific IgE					
86005	A		Allergen specific IgE					
86021	A		WBC antibody identification					
86022	A		Platelet antibodies					
86023	A		Immunoglobulin assay					
86038	A		Antinuclear antibodies					
86039	A		Antinuclear antibodies (ANA)					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86060	A		Antistreptolysin o, titer					
86063	A		Antistreptolysin o, screen					
86077	A		Physician blood bank service					
86078	A		Physician blood bank service					
86079	A		Physician blood bank service					
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
86294	A		Immunoassay, tumor qual					
86300	A		Immunoassay, tumor ca 15-3					
86301	A		Immunoassay, tumor ca 19-9					
86304	A		Immunoassay, tumor, ca 125					
86308	A		Heterophile antibodies					
86309	A		Heterophile antibodies					
86310	A		Heterophile antibodies					
86316	A		Immunoassay, tumor other					
86317	A		Immunoassay,infectious agent					
86318	A		Immunoassay,infectious agent					
86320	A		Serum immunoelectrophoresis					
86325	A		Other immunoelectrophoresis					
86327	A		Immunoelectrophoresis assay					
86329	A		Immunodiffusion					
86331	A		Immunodiffusion ouchterlony					
86332	A		Immune complex assay					
86334	A		Immunofixation procedure					
86336	A		Inhibin A					
86337	A		Insulin antibodies					
86340	A		Intrinsic factor antibody					
86341	A		Islet cell antibody					
86343	A		Leukocyte histamine release					
86344	A		Leukocyte phagocytosis					
86353	A		Lymphocyte transformation					
86359	A		T cells, total count					
86360	A		T cell, absolute count/ratio					
86361	A		T cell, absolute count					
86376	A		Microsomal antibody					
86378	A		Migration inhibitory factor					
86382	A		Neutralization test, viral					
86384	A		Nitroblue tetrazolium dye					
86403	A		Particle agglutination test					
86406	A		Particle agglutination test					
86430	A		Rheumatoid factor test					
86431	A		Rheumatoid factor, quant					
86485	X		Skin test, candida	0341	0.1468	$7.97	$3.08	$1.59
86490	X		Coccidioidomycosis skin test	0341	0.1468	$7.97	$3.08	$1.59
86510	X		Histoplasmosis skin test	0341	0.1468	$7.97	$3.08	$1.59
86580	X		TB intradermal test	0341	0.1468	$7.97	$3.08	$1.59

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86585	X		TB tine test	0341	0.1468	$7.97	$3.08	$1.59
86586	X		Skin test, unlisted	0341	0.1468	$7.97	$3.08	$1.59
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.2589	$14.06	$3.10	$2.81
86860	X		RBC antibody elution	0346	0.3877	$21.05	$5.31	$4.21
86870	X		RBC antibody identification	0346	0.3877	$21.05	$5.31	$4.21
86880	X		Coombs test, direct	0409	0.1385	$7.52	$2.31	$1.50
86885	X		Coombs test, indirect, qual	0409	0.1385	$7.52	$2.31	$1.50
86886	X		Coombs test, indirect, titer	0409	0.1385	$7.52	$2.31	$1.50
86890	X		Autologous blood process	0347	0.9646	$52.37	$13.19	$10.47
86891	X		Autologous blood, op salvage	0345	0.2589	$14.06	$3.10	$2.81
86900	X		Blood typing, ABO	0409	0.1385	$7.52	$2.31	$1.50
86901	X		Blood typing, Rh (D)	0409	0.1385	$7.52	$2.31	$1.50
86903	X		Blood typing, antigen screen	0345	0.2589	$14.06	$3.10	$2.81
86904	X		Blood typing, patient serum	0345	0.2589	$14.06	$3.10	$2.81
86905	X		Blood typing, RBC antigens	0345	0.2589	$14.06	$3.10	$2.81
86906	X		Blood typing, Rh phenotype	0345	0.2589	$14.06	$3.10	$2.81
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86920	X		Compatibility test	0346	0.3877	$21.05	$5.31	$4.21
86921	X		Compatibility test	0345	0.2589	$14.06	$3.10	$2.81
86922	X		Compatibility test	0346	0.3877	$21.05	$5.31	$4.21
86927	X		Plasma, fresh frozen	0346	0.3877	$21.05	$5.31	$4.21
86930	X		Frozen blood prep	0347	0.9646	$52.37	$13.19	$10.47
86931	X		Frozen blood thaw	0347	0.9646	$52.37	$13.19	$10.47
86932	X		Frozen blood freeze/thaw	0347	0.9646	$52.37	$13.19	$10.47
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.3877	$21.05	$5.31	$4.21
86950	X		Leukacyte transfusion	0347	0.9646	$52.37	$13.19	$10.47
86965	X		Pooling blood platelets	0346	0.3877	$21.05	$5.31	$4.21
86970	X		RBC pretreatment	0345	0.2589	$14.06	$3.10	$2.81
86971	X		RBC pretreatment	0345	0.2589	$14.06	$3.10	$2.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86972	X		RBC pretreatment	0345	0.2589	$14.06	$3.10	$2.81
86975	X		RBC pretreatment, serum	0345	0.2589	$14.06	$3.10	$2.81
86976	X		RBC pretreatment, serum	0345	0.2589	$14.06	$3.10	$2.81
86977	X		RBC pretreatment, serum	0345	0.2589	$14.06	$3.10	$2.81
86978	X		RBC pretreatment, serum	0345	0.2589	$14.06	$3.10	$2.81
86985	X		Split blood or products	0347	0.9646	$52.37	$13.19	$10.47
86999	X		Transfusion procedure	0345	0.2589	$14.06	$3.10	$2.81
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					
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					
87205	A		Smear, gram stain					
87206	A		Smear, fluorescent/acid stai					
87207	A		Smear, special stain					
87210	A		Smear, wet mount, saline/ink					
87220	A		Tissue exam for fungi					
87230	A		Assay, toxin or antitoxin					
87250	A		Virus inoculate, eggs/animal					
87252	A		Virus inoculation, tissue					
87253	A		Virus inoculate tissue, addl					
87254	A		Virus inoculation, shell via					
87255	A		Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87267	A		Enterovirus antibody, dfa					
87270	A		Chlamydia trachomatis ag, if					
87271	A		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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87516	A		Hepatitis b, dna, amp probe					
87517	A		Hepatitis b, dna, quant					
87520	A		Hepatitis c, rna, dir probe					
87521	A		Hepatitis c, rna, amp probe					
87522	A		Hepatitis c, rna, quant					
87525	A		Hepatitis g, dna, dir probe					
87526	A		Hepatitis g, dna, amp probe					
87527	A		Hepatitis g, dna, quant					
87528	A		Hsv, dna, dir probe					
87529	A		Hsv, dna, amp probe					
87530	A		Hsv, dna, quant					
87531	A		Hhv-6, dna, dir probe					
87532	A		Hhv-6, dna, amp probe					
87533	A		Hhv-6, dna, quant					
87534	A		Hiv-1, dna, dir probe					
87535	A		Hiv-1, dna, amp probe					
87536	A		Hiv-1, dna, quant					
87537	A		Hiv-2, dna, dir probe					
87538	A		Hiv-2, dna, amp probe					
87539	A		Hiv-2, dna, quant					
87540	A		Legion pneumo, dna, dir prob					
87541	A		Legion pneumo, dna, amp prob					
87542	A		Legion pneumo, dna, quant					
87550	A		Mycobacteria, dna, dir probe					
87551	A		Mycobacteria, dna, amp probe					
87552	A		Mycobacteria, dna, quant					
87555	A		M.tuberculo, dna, dir probe					
87556	A		M.tuberculo, dna, amp probe					
87557	A		M.tuberculo, dna, quant					
87560	A		M.avium-intra, dna, dir prob					
87561	A		M.avium-intra, dna, amp prob					
87562	A		M.avium-intra, dna, quant					
87580	A		M.pneumon, dna, dir probe					
87581	A		M.pneumon, dna, amp probe					
87582	A		M.pneumon, dna, quant					
87590	A		N.gonorrhoeae, dna, dir prob					
87591	A		N.gonorrhoeae, dna, amp prob					
87592	A		N.gonorrhoeae, dna, quant					
87620	A		Hpv, dna, dir probe					
87621	A		Hpv, dna, amp probe					
87622	A		Hpv, dna, quant					
87650	A		Strep a, dna, dir probe					
87651	A		Strep a, dna, amp probe					
87652	A		Strep a, dna, quant					
87797	A		Detect agent nos, dna, dir					
87798	A		Detect agent nos, dna, amp					
87799	A		Detect agent nos, dna, quant					
87800	A		Detect agnt mult, dna, direc					
87801	A		Detect agnt mult, dna, ampli					
87802	A		Strep b assay w/optic					
87803	A		Clostridium toxin a w/optic					
87804	A		Influenza assay w/optic					
87810	A		Chylmd trach assay w/optic					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.4662	$25.31	$12.55	$5.06
88106	X		Cytopathology, fluids	0343	0.4662	$25.31	$12.55	$5.06
88107	X		Cytopathology, fluids	0343	0.4662	$25.31	$12.55	$5.06
88108	X		Cytopath, concentrate tech	0343	0.4662	$25.31	$12.55	$5.06
88125	X		Forensic cytopathology	0342	0.2169	$11.78	$5.88	$2.36
88130	A		Sex chromatin identification					
88140	A		Sex chromatin identification					
88141	N		Cytopath, c/v, interpret					
88142	A		Cytopath, c/v, thin layer					
88143	A		Cytopath c/v thin layer redo					
88147	A		Cytopath, c/v, automated					
88148	A		Cytopath, c/v, auto rescreen					
88150	A		Cytopath, c/v, manual					
88152	A		Cytopath, c/v, auto redo					
88153	A		Cytopath, c/v, redo					
88154	A		Cytopath, c/v, select					
88155	A		Cytopath, c/v, index add-on					
88160	X		Cytopath smear, other source	0342	0.2169	$11.78	$5.88	$2.36
88161	X		Cytopath smear, other source	0343	0.4662	$25.31	$12.55	$5.06
88162	X		Cytopath smear, other source	0343	0.4662	$25.31	$12.55	$5.06
88164	A		Cytopath tbs, c/v, manual					
88165	A		Cytopath tbs, c/v, redo					
88166	A		Cytopath tbs, c/v, auto redo					
88167	A		Cytopath tbs, c/v, select					
88172	X		Cytopathology eval of fna	0343	0.4662	$25.31	$12.55	$5.06
88173	X		Cytopath eval, fna, report	0343	0.4662	$25.31	$12.55	$5.06
88174	A		Cytopath, c/v auto, in fluid					
88175	A		Cytopath c/v auto fluid redo					
88180	X		Cell marker study	0343	0.4662	$25.31	$12.55	$5.06
88182	X		Cell marker study	0344	0.6278	$34.08	$17.04	$6.82
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88289	A		Chromosome study, additional					
88291	A		Cyto/molecular report					
88299	X		Cytogenetic study	0342	0.2169	$11.78	$5.88	$2.36
88300	X		Surgical path, gross	0342	0.2169	$11.78	$5.88	$2.36
88302	X		Tissue exam by pathologist	0342	0.2169	$11.78	$5.88	$2.36
88304	X		Tissue exam by pathologist	0343	0.4662	$25.31	$12.55	$5.06
88305	X		Tissue exam by pathologist	0343	0.4662	$25.31	$12.55	$5.06
88307	X		Tissue exam by pathologist	0344	0.6278	$34.08	$17.04	$6.82
88309	X		Tissue exam by pathologist	0344	0.6278	$34.08	$17.04	$6.82
88311	X		Decalcify tissue	0342	0.2169	$11.78	$5.88	$2.36
88312	X		Special stains	0342	0.2169	$11.78	$5.88	$2.36
88313	X		Special stains	0342	0.2169	$11.78	$5.88	$2.36
88314	X		Histochemical stain	0342	0.2169	$11.78	$5.88	$2.36
88318	X		Chemical histochemistry	0342	0.2169	$11.78	$5.88	$2.36
88319	X		Enzyme histochemistry	0342	0.2169	$11.78	$5.88	$2.36
88321	X		Microslide consultation	0342	0.2169	$11.78	$5.88	$2.36
88323	X		Microslide consultation	0343	0.4662	$25.31	$12.55	$5.06
88325	X		Comprehensive review of data	0344	0.6278	$34.08	$17.04	$6.82
88329	X		Path consult introp	0342	0.2169	$11.78	$5.88	$2.36
88331	X		Path consult intraop, 1 bloc	0343	0.4662	$25.31	$12.55	$5.06
88332	X		Path consult intraop, addl	0342	0.2169	$11.78	$5.88	$2.36
88342	X		Immunocytochemistry	0344	0.6278	$34.08	$17.04	$6.82
88346	X		Immunofluorescent study	0343	0.4662	$25.31	$12.55	$5.06
88347	X		Immunofluorescent study	0344	0.6278	$34.08	$17.04	$6.82
88348	X		Electron microscopy	0661	3.3215	$180.32	$90.16	$36.06
88349	X		Scanning electron microscopy	0661	3.3215	$180.32	$90.16	$36.06
88355	X		Analysis, skeletal muscle	0344	0.6278	$34.08	$17.04	$6.82
88356	X		Analysis, nerve	0344	0.6278	$34.08	$17.04	$6.82
88358	X		Analysis, tumor	0344	0.6278	$34.08	$17.04	$6.82
88362	X		Nerve teasing preparations	0343	0.4662	$25.31	$12.55	$5.06
88365	X		Tissue hybridization	0344	0.6278	$34.08	$17.04	$6.82
88371	A		Protein, western blot tissue					
88372	A		Protein analysis w/probe					
88380	A		Microdissection					
88399	A		Surgical pathology procedure					
88400	A		Bilirubin total transcut					
89050	A		Body fluid cell count					
89051	A		Body fluid cell count					
89055	A		Leukocyte count, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.7088	$92.77	$42.45	$18.55
89105	X		Sample intestinal contents	0360	1.7088	$92.77	$42.45	$18.55
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89132	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89135	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89136	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89140	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89141	X		Sample stomach contents	0360	1.7088	$92.77	$42.45	$18.55
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89250	X		Fertilization of oocyte	0348	1.2207	$66.27		$13.25
89251	X		Culture oocyte w/embryos	0348	1.2207	$66.27		$13.25
89252	X		Assist oocyte fertilization	0348	1.2207	$66.27		$13.25
89253	X		Embryo hatching	0348	1.2207	$66.27		$13.25
89254	X		Oocyte identification	0348	1.2207	$66.27		$13.25
89255	X		Prepare embryo for transfer	0348	1.2207	$66.27		$13.25
89256	X		Prepare cryopreserved embryo	0348	1.2207	$66.27		$13.25
89257	X		Sperm identification	0348	1.2207	$66.27		$13.25
89258	X		Cryopreservation, embryo	0348	1.2207	$66.27		$13.25
89259	X		Cryopreservation, sperm	0348	1.2207	$66.27		$13.25
89260	X		Sperm isolation, simple	0348	1.2207	$66.27		$13.25
89261	X		Sperm isolation, complex	0348	1.2207	$66.27		$13.25
89264	X		Identify sperm tissue	0348	1.2207	$66.27		$13.25
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.6278	$34.08	$17.04	$6.82
89355	A		Exam feces for starch					
89360	X		Collect sweat for test	0344	0.6278	$34.08	$17.04	$6.82
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	0.4353	$23.63		$4.73
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	0356	0.4353	$23.63		$4.73
90376	K		Rabies ig, heat treated	0356	0.4353	$23.63		$4.73
90378	E		Rsv ig, im, 50mg					
90379	K		Rsv ig, iv	0356	0.4353	$23.63		$4.73
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					
90476	N		Adenovirus vaccine, type 4					
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	0356	0.4353	$23.63		$4.73
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	0.2667	$14.48		$2.90
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	0.4353	$23.63		$4.73
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90708	N		Measles-rubella vaccine, sc					
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	0.4353	$23.63		$4.73
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	K		Hepb vacc, ill pat 3 dose im	0356	0.4353	$23.63		$4.73
90743	K		Hep b vacc, adol, 2 dose, im	0356	0.4353	$23.63		$4.73
90744	K		Hepb vacc ped/adol 3 dose im	0356	0.4353	$23.63		$4.73
90746	K		Hep b vaccine, adult, im	0356	0.4353	$23.63		$4.73
90747	K		Hepb vacc, ill pat 4 dose im	0356	0.4353	$23.63		$4.73
90748	K		Hep b/hib vaccine, im	0356	0.4353	$23.63		$4.73
90749	N		Vaccine toxoid					
90780	E		IV infusion therapy, 1 hour					
90781	E		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.4106	$22.29		$4.46
90783	X		Injection, ia	0359	0.8794	$47.74		$9.55
90784	X		Injection, iv	0359	0.8794	$47.74		$9.55
90788	X		Injection of antibiotic	0359	0.8794	$47.74		$9.55
90799	X		Ther/prophylactic/dx inject	0352	0.1076	$5.84		$1.17
90801	S		Psy dx interview	0323	1.7955	$97.48	$21.26	$19.50
90802	S		Intac psy dx interview	0323	1.7955	$97.48	$21.26	$19.50
90804	S		Psytx, office, 20-30 min	0322	1.3091	$71.07		$14.21
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.3091	$71.07		$14.21
90806	S		Psytx, off, 45-50 min	0323	1.7955	$97.48	$21.26	$19.50
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90808	S		Psytx, office, 75-80 min	0323	1.7955	$97.48	$21.26	$19.50
90809	S		Psytx, off, 75-80, w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90810	S		Intac psytx, off, 20-30 min	0322	1.3091	$71.07		$14.21
90811	S		Intac psytx, 20-30, w/e&m	0322	1.3091	$71.07		$14.21
90812	S		Intac psytx, off, 45-50 min	0323	1.7955	$97.48	$21.26	$19.50
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90814	S		Intac psytx, off, 75-80 min	0323	1.7955	$97.48	$21.26	$19.50
90815	S		Intac psytx, 75-80 w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90816	S		Psytx, hosp, 20-30 min	0322	1.3091	$71.07		$14.21
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.3091	$71.07		$14.21
90818	S		Psytx, hosp, 45-50 min	0323	1.7955	$97.48	$21.26	$19.50
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90821	S		Psytx, hosp, 75-80 min	0323	1.7955	$97.48	$21.26	$19.50
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90823	S		Intac psytx, hosp, 20-30 min	0322	1.3091	$71.07		$14.21
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.3091	$71.07		$14.21
90826	S		Intac psytx, hosp, 45-50 min	0323	1.7955	$97.48	$21.26	$19.50
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90828	S		Intac psytx, hosp, 75-80 min	0323	1.7955	$97.48	$21.26	$19.50
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.7955	$97.48	$21.26	$19.50
90845	S		Psychoanalysis	0323	1.7955	$97.48	$21.26	$19.50
90846	S		Family psytx w/o patient	0324	2.8219	$153.20		$30.64
90847	S		Family psytx w/patient	0324	2.8219	$153.20		$30.64
90849	S		Multiple family group psytx	0325	1.5820	$85.89	$18.27	$17.18
90853	S		Group psychotherapy	0325	1.5820	$85.89	$18.27	$17.18
90857	S		Intac group psytx	0325	1.5820	$85.89	$18.27	$17.18
90862	X		Medication management	0374	1.1062	$60.05		$12.01
90865	S		Narcosynthesis	0323	1.7955	$97.48	$21.26	$19.50
90870	S		Electroconvulsive therapy	0320	5.4480	$295.77	$80.06	$59.15
90871	E		Electroconvulsive therapy					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.7955	$97.48	$21.26	$19.50
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	1.3091	$71.07		$14.21
90901	S		Biofeedback train, any meth	0321	1.2462	$67.65	$21.78	$13.53
90911	S		Biofeedback peri/uro/rectal	0321	1.2462	$67.65	$21.78	$13.53
90918	A		ESRD related services, month					
90919	A		ESRD related services, month					
90920	A		ESRD related services, month					
90921	A		ESRD related services, month					
90922	A		ESRD related services, day					
90923	A		Esrd related services, day					
90924	A		Esrd related services, day					
90925	A		Esrd related services, day					
90935	S		Hemodialysis, one evaluation	0170	5.9427	$322.62		$64.52
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	5.9427	$322.62		$64.52
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	3.5574	$193.13	$83.23	$38.63
91010	X		Esophagus motility study	0361	3.5574	$193.13	$83.23	$38.63
91011	X		Esophagus motility study	0361	3.5574	$193.13	$83.23	$38.63
91012	X		Esophagus motility study	0361	3.5574	$193.13	$83.23	$38.63
91020	X		Gastric motility	0361	3.5574	$193.13	$83.23	$38.63
91030	X		Acid perfusion of esophagus	0361	3.5574	$193.13	$83.23	$38.63
91032	X		Esophagus, acid reflux test	0361	3.5574	$193.13	$83.23	$38.63
91033	X		Prolonged acid reflux test	0361	3.5574	$193.13	$83.23	$38.63
91052	X		Gastric analysis test	0361	3.5574	$193.13	$83.23	$38.63
91055	X		Gastric intubation for smear	0360	1.7088	$92.77	$42.45	$18.55
91060	X		Gastric saline load test	0360	1.7088	$92.77	$42.45	$18.55
91065	X		Breath hydrogen test	0360	1.7088	$92.77	$42.45	$18.55
91100	X		Pass intestine bleeding tube	0360	1.7088	$92.77	$42.45	$18.55
91105	X		Gastric intubation treatment	0360	1.7088	$92.77	$42.45	$18.55
91122	T		Anal pressure record	0156	3.1438	$170.67	$46.55	$34.13
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.7088	$92.77	$42.45	$18.55
91133	X		Electrogastrography w/test	0360	1.7088	$92.77	$42.45	$18.55
91299	X		Gastroenterology procedure	0360	1.7088	$92.77	$42.45	$18.55
92002	V		Eye exam, new patient	0601	1.0031	$54.46		$10.89
92004	V		Eye exam, new patient	0602	1.5603	$84.71		$16.94
92012	V		Eye exam established pat	0600	0.9376	$50.90		$10.18
92014	V		Eye exam & treatment	0602	1.5603	$84.71		$16.94
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	2.2211	$120.58	$54.26	$24.12
92019	S		Eye exam & treatment	0698	0.9355	$50.79	$18.72	$10.16
92020	S		Special eye evaluation	0230	0.7379	$40.06	$14.97	$8.01
92060	S		Special eye evaluation	0230	0.7379	$40.06	$14.97	$8.01
92065	S		Orthoptic/pleoptic training	0230	0.7379	$40.06	$14.97	$8.01
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7379	$40.06	$14.97	$8.01
92082	S		Visual field examination(s)	0698	0.9355	$50.79	$18.72	$10.16
92083	S		Visual field examination(s)	0698	0.9355	$50.79	$18.72	$10.16
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7379	$40.06	$14.97	$8.01
92130	S		Water provocation tonography	0698	0.9355	$50.79	$18.72	$10.16
92135	S		Opthalmic dx imaging	0230	0.7379	$40.06	$14.97	$8.01
92136	S		Ophthalmic biometry	0230	0.7379	$40.06	$14.97	$8.01

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92140	S		Glaucoma provocative tests	0698	0.9355	$50.79	$18.72	$10.16
92225	S		Special eye exam, initial	0698	0.9355	$50.79	$18.72	$10.16
92226	S		Special eye exam, subsequent	0698	0.9355	$50.79	$18.72	$10.16
92230	T		Eye exam with photos	0699	2.2211	$120.58	$54.26	$24.12
92235	T		Eye exam with photos	0699	2.2211	$120.58	$54.26	$24.12
92240	S		Icg angiography	0231	2.0880	$113.36	$50.94	$22.67
92250	S		Eye exam with photos	0230	0.7379	$40.06	$14.97	$8.01
92260	S		Ophthalmoscopy/dynamometry	0230	0.7379	$40.06	$14.97	$8.01
92265	S		Eye muscle evaluation	0231	2.0880	$113.36	$50.94	$22.67
92270	S		Electro-oculography	0698	0.9355	$50.79	$18.72	$10.16
92275	S		Electroretinography	0231	2.0880	$113.36	$50.94	$22.67
92283	S		Color vision examination	0230	0.7379	$40.06	$14.97	$8.01
92284	S		Dark adaptation eye exam	0698	0.9355	$50.79	$18.72	$10.16
92285	S		Eye photography	0230	0.7379	$40.06	$14.97	$8.01
92286	S		Internal eye photography	0698	0.9355	$50.79	$18.72	$10.16
92287	S		Internal eye photography	0231	2.0880	$113.36	$50.94	$22.67
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.5384	$137.81		$27.56
92312	X		Contact lens fitting	0362	2.5384	$137.81		$27.56
92313	X		Contact lens fitting	0362	2.5384	$137.81		$27.56
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.5384	$137.81		$27.56
92316	X		Prescription of contact lens	0362	2.5384	$137.81		$27.56
92317	X		Prescription of contact lens	0362	2.5384	$137.81		$27.56
92325	X		Modification of contact lens	0362	2.5384	$137.81		$27.56
92326	X		Replacement of contact lens	0362	2.5384	$137.81		$27.56
92330	S		Fitting of artificial eye	0230	0.7379	$40.06	$14.97	$8.01
92335	N		Fitting of artificial eye					
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.5384	$137.81		$27.56
92353	X		Special spectacles fitting	0362	2.5384	$137.81		$27.56
92354	X		Special spectacles fitting	0362	2.5384	$137.81		$27.56
92355	X		Special spectacles fitting	0362	2.5384	$137.81		$27.56
92358	X		Eye prosthesis service	0362	2.5384	$137.81		$27.56
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.5384	$137.81		$27.56
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	0.7379	$40.06	$14.97	$8.01
92502	T		Ear and throat examination	0251	1.8643	$101.21		$20.24
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	0.9012	$48.93	$12.89	$9.79
92512	X		Nasal function studies	0363	0.8536	$46.34	$17.15	$9.27
92516	X		Facial nerve function test	0660	1.7330	$94.08	$30.66	$18.82
92520	X		Laryngeal function studies	0660	1.7330	$94.08	$30.66	$18.82
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	0.8536	$46.34	$17.15	$9.27
92542	X		Positional nystagmus test	0363	0.8536	$46.34	$17.15	$9.27
92543	X		Caloric vestibular test	0363	0.8536	$46.34	$17.15	$9.27
92544	X		Optokinetic nystagmus test	0363	0.8536	$46.34	$17.15	$9.27
92545	X		Oscillating tracking test	0363	0.8536	$46.34	$17.15	$9.27
92546	X		Sinusoidal rotational test	0660	1.7330	$94.08	$30.66	$18.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92547	X		Supplemental electrical test	0363	0.8536	$46.34	$17.15	$9.27
92548	X		Posturography	0660	1.7330	$94.08	$30.66	$18.82
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4415	$23.97	$9.06	$4.79
92553	X		Audiometry, air & bone	0365	1.1915	$64.69	$18.95	$12.94
92555	X		Speech threshold audiometry	0364	0.4415	$23.97	$9.06	$4.79
92556	X		Speech audiometry, complete	0364	0.4415	$23.97	$9.06	$4.79
92557	X		Comprehensive hearing test	0365	1.1915	$64.69	$18.95	$12.94
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					
92561	X		Bekesy audiometry, diagnosis	0365	1.1915	$64.69	$18.95	$12.94
92562	X		Loudness balance test	0364	0.4415	$23.97	$9.06	$4.79
92563	X		Tone decay hearing test	0364	0.4415	$23.97	$9.06	$4.79
92564	X		Sisi hearing test	0364	0.4415	$23.97	$9.06	$4.79
92565	X		Stenger test, pure tone	0364	0.4415	$23.97	$9.06	$4.79
92567	X		Tympanometry	0364	0.4415	$23.97	$9.06	$4.79
92568	X		Acoustic reflex testing	0364	0.4415	$23.97	$9.06	$4.79
92569	X		Acoustic reflex decay test	0364	0.4415	$23.97	$9.06	$4.79
92571	X		Filtered speech hearing test	0364	0.4415	$23.97	$9.06	$4.79
92572	X		Staggered spondaic word test	0364	0.4415	$23.97	$9.06	$4.79
92573	X		Lombard test	0364	0.4415	$23.97	$9.06	$4.79
92575	X		Sensorineural acuity test	0365	1.1915	$64.69	$18.95	$12.94
92576	X		Synthetic sentence test	0364	0.4415	$23.97	$9.06	$4.79
92577	X		Stenger test, speech	0365	1.1915	$64.69	$18.95	$12.94
92579	X		Visual audiometry (vra)	0365	1.1915	$64.69	$18.95	$12.94
92582	X		Conditioning play audiometry	0365	1.1915	$64.69	$18.95	$12.94
92583	X		Select picture audiometry	0364	0.4415	$23.97	$9.06	$4.79
92584	X		Electrocochleography	0660	1.7330	$94.08	$30.66	$18.82
92585	S		Auditor evoke potent, compre	0216	2.8332	$153.81	$67.98	$30.76
92586	S		Auditor evoke potent, limit	0218	1.1296	$61.32		$12.26
92587	X		Evoked auditory test	0363	0.8536	$46.34	$17.15	$9.27
92588	X		Evoked auditory test	0363	0.8536	$46.34	$17.15	$9.27
92589	X		Auditory function test(s)	0364	0.4415	$23.97	$9.06	$4.79
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	1.1915	$64.69	$18.95	$12.94
92597	E		Voice Prosthetic Evaluation					
92601	A		Cochlear implt f/up exam < 7					
92602	A		Reprogram cochlear implt < 7					
92603	A		Cochlear implt f/up exam 7 >					
92604	A		Reprogram cochlear implt 7 >					
92605	A		Eval for nonspeech device rx					
92606	A		Non-speech device service					
92607	A		Ex for speech device rx, 1hr					
92608	A		Ex for speech device rx addl					
92609	A		Use of speech device service					
92610	A		Evaluate swallowing function					
92611	A		Motion fluoroscopy/swallow					
92612	A		Endoscopy swallow tst (fees)					
92613	E		Endoscopy swallow tst (fees)					
92614	A		Laryngoscopic sensory test					
92615	E		Eval laryngoscopy sense tst					
92616	A		Fees w/laryngeal sense test					
92617	E		Interprt fees/laryngeal test					
92700	X		Ent procedure/service	0364	0.4415	$23.97	$9.06	$4.79
92950	S		Heart/lung resuscitation cpr	0094	2.6412	$143.39	$48.46	$28.68
92953	S		Temporary external pacing	0094	2.6412	$143.39	$48.46	$28.68
92960	S		Cardioversion electric, ext	0679	5.4862	$297.84	$95.30	$59.57
92961	S		Cardioversion, electric, int	0679	5.4862	$297.84	$95.30	$59.57
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	1541		$250.00		$50.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92974	T		Cath place, cardio brachytx	1559		$2,250.00		$450.00
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0676	3.7505	$203.61	$55.06	$40.72
92978	S		Intravasc us, heart add-on	0670	26.5472	$1,441.22	$521.95	$288.24
92979	S		Intravasc us, heart add-on	0670	26.5472	$1,441.22	$521.95	$288.24
92980	T		Insert intracoronary stent	0104	80.8877	$4,391.31		$878.26
92981	T		Insert intracoronary stent	0104	80.8877	$4,391.31		$878.26
92982	T		Coronary artery dilation	0083	59.3417	$3,221.60		$644.32
92984	T		Coronary artery dilation	0083	59.3417	$3,221.60		$644.32
92986	T		Revision of aortic valve	0083	59.3417	$3,221.60		$644.32
92987	T		Revision of mitral valve	0083	59.3417	$3,221.60		$644.32
92990	T		Revision of pulmonary valve	0083	59.3417	$3,221.60		$644.32
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	100.3996	$5,450.59	$1,293.59	$1,090.12
92996	T		Coronary atherectomy add-on	0082	100.3996	$5,450.59	$1,293.59	$1,090.12
92997	T		Pul art balloon repr, percut	0081	34.8355	$1,891.18		$378.24
92998	T		Pul art balloon repr, percut	0081	34.8355	$1,891.18		$378.24
93000	E		Electrocardiogram, complete					
93005	S		Electrocardiogram, tracing	0099	0.3708	$20.13		$4.03
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	E		Report on transmitted ecg					
93015	E		Cardiovascular stress test					
93016	E		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	1.6726	$90.80	$41.44	$18.16
93018	E		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	1.6726	$90.80	$41.44	$18.16
93025	X		Microvolt t-wave assess	0100	1.6726	$90.80	$41.44	$18.16
93040	E		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3708	$20.13		$4.03
93042	E		Rhythm ECG, report					
93224	E		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0565	$57.36	$23.80	$11.47
93226	X		ECG monitor/report, 24 hrs	0097	1.0565	$57.36	$23.80	$11.47
93227	E		ECG monitor/review, 24 hrs					
93230	E		ECG monitor/report, 24 hrs					
93231	X		Ecg monitor/record, 24 hrs	0097	1.0565	$57.36	$23.80	$11.47
93232	X		ECG monitor/report, 24 hrs	0097	1.0565	$57.36	$23.80	$11.47
93233	E		ECG monitor/review, 24 hrs					
93235	E		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0565	$57.36	$23.80	$11.47
93237	E		ECG monitor/review, 24 hrs					
93268	E		ECG record/review					
93270	X		ECG recording	0097	1.0565	$57.36	$23.80	$11.47
93271	X		Ecg/monitoring and analysis	0097	1.0565	$57.36	$23.80	$11.47
93272	E		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3708	$20.13		$4.03
93303	S		Echo transthoracic	0269	3.2517	$176.53	$87.24	$35.31
93304	S		Echo transthoracic	0697	1.4621	$79.38	$39.69	$15.88
93307	S		Echo exam of heart	0269	3.2517	$176.53	$87.24	$35.31
93308	S		Echo exam of heart	0697	1.4621	$79.38	$39.69	$15.88
93312	S		Echo transesophageal	0270	5.9057	$320.61	$146.79	$64.12
93313	S		Echo transesophageal	0270	5.9057	$320.61	$146.79	$64.12
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	5.9057	$320.61	$146.79	$64.12
93316	S		Echo transesophageal	0270	5.9057	$320.61	$146.79	$64.12
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	5.9057	$320.61	$146.79	$64.12
93320	S		Doppler echo exam, heart	0671	1.6392	$88.99	$44.49	$17.80
93321	S		Doppler echo exam, heart	0697	1.4621	$79.38	$39.69	$15.88
93325	S		Doppler color flow add-on	0697	1.4621	$79.38	$39.69	$15.88
93350	S		Echo transthoracic	0269	3.2517	$176.53	$87.24	$35.31
93501	T		Right heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93503	T		Insert/place heart catheter	0103	12.1256	$658.29	$223.63	$131.66
93505	T		Biopsy of heart lining	0103	12.1256	$658.29	$223.63	$131.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93508	T		Cath placement, angiography	0080	36.0982	$1,959.74	$838.92	$391.95
93510	T		Left heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93511	T		Left heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93514	T		Left heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93524	T		Left heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93526	T		Rt & Lt heart catheters	0080	36.0982	$1,959.74	$838.92	$391.95
93527	T		Rt & Lt heart catheters	0080	36.0982	$1,959.74	$838.92	$391.95
93528	T		Rt & Lt heart catheters	0080	36.0982	$1,959.74	$838.92	$391.95
93529	T		Rt, lt heart catheterization	0080	36.0982	$1,959.74	$838.92	$391.95
93530	T		Rt heart cath, congenital	0080	36.0982	$1,959.74	$838.92	$391.95
93531	T		R & l heart cath, congenital	0080	36.0982	$1,959.74	$838.92	$391.95
93532	T		R & l heart cath, congenital	0080	36.0982	$1,959.74	$838.92	$391.95
93533	T		R & l heart cath, congenital	0080	36.0982	$1,959.74	$838.92	$391.95
93539	N		Injection, cardiac cath					
93540	N		Injection, cardiac cath					
93541	N		Injection for lung angiogram					
93542	N		Injection for heart x-rays					
93543	N		Injection for heart x-rays					
93544	N		Injection for aortography					
93545	N		Inject for coronary x-rays					
93555	N		Imaging, cardiac cath					
93556	N		Imaging, cardiac cath					
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	N		Heart flow reserve measure					
93572	N		Heart flow reserve measure					
93580	T		Transcath closure of asd	1559		$2,250.00		$450.00
93581	T		Transcath closure of vsd	1559		$2,250.00		$450.00
93600	T		Bundle of His recording	0087	40.4579	$2,196.42		$439.28
93602	T		Intra-atrial recording	0087	40.4579	$2,196.42		$439.28
93603	T		Right ventricular recording	0087	40.4579	$2,196.42		$439.28
93609	T		Map tachycardia, add-on	0087	40.4579	$2,196.42		$439.28
93610	T		Intra-atrial pacing	0087	40.4579	$2,196.42		$439.28
93612	T		Intraventricular pacing	0087	40.4579	$2,196.42		$439.28
93613	T		Electrophys map 3d, add-on	0087	40.4579	$2,196.42		$439.28
93615	T		Esophageal recording	0087	40.4579	$2,196.42		$439.28
93616	T		Esophageal recording	0087	40.4579	$2,196.42		$439.28
93618	T		Heart rhythm pacing	0087	40.4579	$2,196.42		$439.28
93619	T		Electrophysiology evaluation	0085	36.3284	$1,972.23	$435.09	$394.45
93620	T		Electrophysiology evaluation	0085	36.3284	$1,972.23	$435.09	$394.45
93621	T		Electrophysiology evaluation	0085	36.3284	$1,972.23	$435.09	$394.45
93622	T		Electrophysiology evaluation	0085	36.3284	$1,972.23	$435.09	$394.45
93623	T		Stimulation, pacing heart	0087	40.4579	$2,196.42		$439.28
93624	S		Electrophysiologic study	0084	10.3392	$561.30		$112.26
93631	T		Heart pacing, mapping	0087	40.4579	$2,196.42		$439.28
93640	S		Evaluation heart device	0084	10.3392	$561.30		$112.26
93641	S		Electrophysiology evaluation	0084	10.3392	$561.30		$112.26
93642	S		Electrophysiology evaluation	0084	10.3392	$561.30		$112.26
93650	T		Ablate heart dysrhythm focus	0086	44.5652	$2,419.40	$822.28	$483.88
93651	T		Ablate heart dysrhythm focus	0086	44.5652	$2,419.40	$822.28	$483.88
93652	T		Ablate heart dysrhythm focus	0086	44.5652	$2,419.40	$822.28	$483.88
93660	S		Tilt table evaluation	0101	4.3675	$237.11	$105.27	$47.42
93662	S		Intracardiac ecg (ice)	0670	26.5472	$1,441.22	$521.95	$288.24
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3708	$20.13		$4.03
93720	E		Total body plethysmography					
93721	X		Plethysmography tracing	0368	0.9321	$50.60	$25.30	$10.12
93722	E		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.3986	$21.64	$10.35	$4.33
93727	S		Analyze ilr system	0690	0.3986	$21.64	$10.35	$4.33
93731	S		Analyze pacemaker system	0690	0.3986	$21.64	$10.35	$4.33
93732	S		Analyze pacemaker system	0690	0.3986	$21.64	$10.35	$4.33
93733	S		Telephone analy, pacemaker	0690	0.3986	$21.64	$10.35	$4.33
93734	S		Analyze pacemaker system	0690	0.3986	$21.64	$10.35	$4.33
93735	S		Analyze pacemaker system	0690	0.3986	$21.64	$10.35	$4.33
93736	S		Telephone analy, pacemaker	0690	0.3986	$21.64	$10.35	$4.33

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93740	X		Temperature gradient studies	0367	0.5828	$31.64	$15.16	$6.33
93741	S		Analyze ht pace device sngl	0689	0.5427	$29.46		$5.89
93742	S		Analyze ht pace device sngl	0689	0.5427	$29.46		$5.89
93743	S		Analyze ht pace device dual	0689	0.5427	$29.46		$5.89
93744	S		Analyze ht pace device dual	0689	0.5427	$29.46		$5.89
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0565	$57.36	$23.80	$11.47
93788	E		Ambulatory BP analysis					
93790	E		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.5984	$32.49	$16.24	$6.50
93798	S		Cardiac rehab/monitor	0095	0.5984	$32.49	$16.24	$6.50
93799	S		Cardiovascular procedure	0096	1.7332	$94.09	$47.04	$18.82
93875	S		Extracranial study	0096	1.7332	$94.09	$47.04	$18.82
93880	S		Extracranial study	0267	2.4805	$134.66	$65.52	$26.93
93882	S		Extracranial study	0267	2.4805	$134.66	$65.52	$26.93
93886	S		Intracranial study	0267	2.4805	$134.66	$65.52	$26.93
93888	S		Intracranial study	0266	1.6234	$88.13	$44.06	$17.63
93922	S		Extremity study	0096	1.7332	$94.09	$47.04	$18.82
93923	S		Extremity study	0096	1.7332	$94.09	$47.04	$18.82
93924	S		Extremity study	0096	1.7332	$94.09	$47.04	$18.82
93925	S		Lower extremity study	0267	2.4805	$134.66	$65.52	$26.93
93926	S		Lower extremity study	0267	2.4805	$134.66	$65.52	$26.93
93930	S		Upper extremity study	0267	2.4805	$134.66	$65.52	$26.93
93931	S		Upper extremity study	0266	1.6234	$88.13	$44.06	$17.63
93965	S		Extremity study	0096	1.7332	$94.09	$47.04	$18.82
93970	S		Extremity study	0267	2.4805	$134.66	$65.52	$26.93
93971	S		Extremity study	0267	2.4805	$134.66	$65.52	$26.93
93975	S		Vascular study	0267	2.4805	$134.66	$65.52	$26.93
93976	S		Vascular study	0267	2.4805	$134.66	$65.52	$26.93
93978	S		Vascular study	0267	2.4805	$134.66	$65.52	$26.93
93979	S		Vascular study	0267	2.4805	$134.66	$65.52	$26.93
93980	S		Penile vascular study	0267	2.4805	$134.66	$65.52	$26.93
93981	S		Penile vascular study	0267	2.4805	$134.66	$65.52	$26.93
93990	S		Doppler flow testing	0267	2.4805	$134.66	$65.52	$26.93
94010	X		Breathing capacity test	0368	0.9321	$50.60	$25.30	$10.12
94014	X		Patient recorded spirometry	0367	0.5828	$31.64	$15.16	$6.33
94015	X		Patient recorded spirometry	0367	0.5828	$31.64	$15.16	$6.33
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9321	$50.60	$25.30	$10.12
94070	X		Evaluation of wheezing	0369	2.5282	$137.25	$44.18	$27.45
94150	X		Vital capacity test	0367	0.5828	$31.64	$15.16	$6.33
94200	X		Lung function test (MBC/MVV)	0367	0.5828	$31.64	$15.16	$6.33
94240	X		Residual lung capacity	0368	0.9321	$50.60	$25.30	$10.12
94250	X		Expired gas collection	0367	0.5828	$31.64	$15.16	$6.33
94260	X		Thoracic gas volume	0368	0.9321	$50.60	$25.30	$10.12
94350	X		Lung nitrogen washout curve	0368	0.9321	$50.60	$25.30	$10.12
94360	X		Measure airflow resistance	0367	0.5828	$31.64	$15.16	$6.33
94370	X		Breath airway closing volume	0367	0.5828	$31.64	$15.16	$6.33
94375	X		Respiratory flow volume loop	0367	0.5828	$31.64	$15.16	$6.33
94400	X		CO2 breathing response curve	0367	0.5828	$31.64	$15.16	$6.33
94450	X		Hypoxia response curve	0367	0.5828	$31.64	$15.16	$6.33
94620	X		Pulmonary stress test/simple	0368	0.9321	$50.60	$25.30	$10.12
94621	X		Pulm stress test/complex	0369	2.5282	$137.25	$44.18	$27.45
94640	S		Airway inhalation treatment	0077	0.2772	$15.05	$7.52	$3.01
94642	S		Aerosol inhalation treatment	0078	0.7731	$41.97	$14.55	$8.39
94656	S		Initial ventilator mgmt	0079	2.2837	$123.98		$24.80
94657	S		Continued ventilator mgmt	0079	2.2837	$123.98		$24.80
94660	S		Pos airway pressure, CPAP	0068	1.1234	$60.99	$30.49	$12.20
94662	S		Neg press ventilation, cnp	0079	2.2837	$123.98		$24.80
94664	S		Aerosol or vapor inhalations	0077	0.2772	$15.05	$7.52	$3.01
94667	S		Chest wall manipulation	0077	0.2772	$15.05	$7.52	$3.01
94668	S		Chest wall manipulation	0077	0.2772	$15.05	$7.52	$3.01
94680	X		Exhaled air analysis, o2	0367	0.5828	$31.64	$15.16	$6.33

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94681	X		Exhaled air analysis, o2/co2	0368	0.9321	$50.60	$25.30	$10.12
94690	X		Exhaled air analysis	0367	0.5828	$31.64	$15.16	$6.33
94720	X		Monoxide diffusing capacity	0368	0.9321	$50.60	$25.30	$10.12
94725	X		Membrane diffusion capacity	0368	0.9321	$50.60	$25.30	$10.12
94750	X		Pulmonary compliance study	0367	0.5828	$31.64	$15.16	$6.33
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	0.5828	$31.64	$15.16	$6.33
94772	X		Breath recording, infant	0369	2.5282	$137.25	$44.18	$27.45
94799	X		Pulmonary service/procedure	0367	0.5828	$31.64	$15.16	$6.33
95004	X		Percut allergy skin tests	0370	0.8858	$48.09	$11.58	$9.62
95010	X		Percut allergy titrate test	0370	0.8858	$48.09	$11.58	$9.62
95015	X		Id allergy titrate-drug/bug	0370	0.8858	$48.09	$11.58	$9.62
95024	X		Id allergy test, drug/bug	0370	0.8858	$48.09	$11.58	$9.62
95027	X		Skin end point titration	0370	0.8858	$48.09	$11.58	$9.62
95028	X		Id allergy test-delayed type	0370	0.8858	$48.09	$11.58	$9.62
95044	X		Allergy patch tests	0370	0.8858	$48.09	$11.58	$9.62
95052	X		Photo patch test	0370	0.8858	$48.09	$11.58	$9.62
95056	X		Photosensitivity tests	0370	0.8858	$48.09	$11.58	$9.62
95060	X		Eye allergy tests	0370	0.8858	$48.09	$11.58	$9.62
95065	X		Nose allergy test	0370	0.8858	$48.09	$11.58	$9.62
95070	X		Bronchial allergy tests	0369	2.5282	$137.25	$44.18	$27.45
95071	X		Bronchial allergy tests	0369	2.5282	$137.25	$44.18	$27.45
95075	X		Ingestion challenge test	0361	3.5574	$193.13	$83.23	$38.63
95078	X		Provocative testing	0370	0.8858	$48.09	$11.58	$9.62
95115	X		Immunotherapy, one injection	0352	0.1076	$5.84		$1.17
95117	X		Immunotherapy injections	0353	0.4106	$22.29		$4.46
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	0.4084	$22.17	$4.44	$4.43
95145	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95146	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95147	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95148	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95149	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95165	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95170	X		Antigen therapy services	0371	0.4084	$22.17	$4.44	$4.43
95180	X		Rapid desensitization	0370	0.8858	$48.09	$11.58	$9.62
95199	X		Allergy immunology services	0370	0.8858	$48.09	$11.58	$9.62
95250	T		Glucose monitoring, cont	1540		$150.00		$30.00
95805	S		Multiple sleep latency test	0209	11.5352	$626.23	$280.58	$125.25
95806	S		Sleep study, unattended	0213	3.2422	$176.02	$70.41	$35.20
95807	S		Sleep study, attended	0209	11.5352	$626.23	$280.58	$125.25
95808	S		Polysomnography, 1-3	0209	11.5352	$626.23	$280.58	$125.25
95810	S		Polysomnography, 4 or more	0209	11.5352	$626.23	$280.58	$125.25
95811	S		Polysomnography w/cpap	0209	11.5352	$626.23	$280.58	$125.25
95812	S		Electroencephalogram (EEG)	0213	3.2422	$176.02	$70.41	$35.20
95813	S		Eeg, over 1 hour	0213	3.2422	$176.02	$70.41	$35.20
95816	S		Electroencephalogram (EEG)	0214	2.2459	$121.93	$58.12	$24.39
95819	S		Electroencephalogram (EEG)	0214	2.2459	$121.93	$58.12	$24.39
95822	S		Sleep electroencephalogram	0214	2.2459	$121.93	$58.12	$24.39
95824	S		Eeg, cerebral death only	0214	2.2459	$121.93	$58.12	$24.39
95827	S		Night electroencephalogram	0209	11.5352	$626.23	$280.58	$125.25
95829	S		Surgery electrocorticogram	0214	2.2459	$121.93	$58.12	$24.39
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95852	N		Range of motion measurements					
95857	S		Tensilon test	0218	1.1296	$61.32		$12.26
95858	S		Tensilon test & myogram	0215	0.6390	$34.69	$15.76	$6.94
95860	S		Muscle test, one limb	0218	1.1296	$61.32		$12.26
95861	S		Muscle test, 2 limbs	0218	1.1296	$61.32		$12.26
95863	S		Muscle test, 3 limbs	0218	1.1296	$61.32		$12.26
95864	S		Muscle test, 4 limbs	0218	1.1296	$61.32		$12.26
95867	S		Muscle test, head or neck	0218	1.1296	$61.32		$12.26
95868	S		Muscle test cran nerve bilat	0218	1.1296	$61.32		$12.26
95869	S		Muscle test, thor paraspinal	0215	0.6390	$34.69	$15.76	$6.94
95870	S		Muscle test, nonparaspinal	0215	0.6390	$34.69	$15.76	$6.94
95872	S		Muscle test, one fiber	0218	1.1296	$61.32		$12.26
95875	S		Limb exercise test	0215	0.6390	$34.69	$15.76	$6.94
95900	S		Motor nerve conduction test	0215	0.6390	$34.69	$15.76	$6.94
95903	S		Motor nerve conduction test	0215	0.6390	$34.69	$15.76	$6.94
95904	S		Sense nerve conduction test	0215	0.6390	$34.69	$15.76	$6.94
95920	S		Intraop nerve test add-on	0216	2.8332	$153.81	$67.98	$30.76
95921	S		Autonomic nerv function test	0218	1.1296	$61.32		$12.26
95922	S		Autonomic nerv function test	0218	1.1296	$61.32		$12.26
95923	S		Autonomic nerv function test	0215	0.6390	$34.69	$15.76	$6.94
95925	S		Somatosensory testing	0216	2.8332	$153.81	$67.98	$30.76
95926	S		Somatosensory testing	0216	2.8332	$153.81	$67.98	$30.76
95927	S		Somatosensory testing	0216	2.8332	$153.81	$67.98	$30.76
95930	S		Visual evoked potential test	0218	1.1296	$61.32		$12.26
95933	S		Blink reflex test	0215	0.6390	$34.69	$15.76	$6.94
95934	S		H-reflex test	0215	0.6390	$34.69	$15.76	$6.94
95936	S		H-reflex test	0215	0.6390	$34.69	$15.76	$6.94
95937	S		Neuromuscular junction test	0218	1.1296	$61.32		$12.26
95950	S		Ambulatory eeg monitoring	0213	3.2422	$176.02	$70.41	$35.20
95951	S		EEG monitoring/videorecord	0209	11.5352	$626.23	$280.58	$125.25
95953	S		EEG monitoring/computer	0209	11.5352	$626.23	$280.58	$125.25
95954	S		EEG monitoring/giving drugs	0214	2.2459	$121.93	$58.12	$24.39
95955	S		EEG during surgery	0213	3.2422	$176.02	$70.41	$35.20
95956	S		Eeg monitoring, cable/radio	0214	2.2459	$121.93	$58.12	$24.39
95957	S		EEG digital analysis	0214	2.2459	$121.93	$58.12	$24.39
95958	S		EEG monitoring/function test	0213	3.2422	$176.02	$70.41	$35.20
95961	S		Electrode stimulation, brain	0216	2.8332	$153.81	$67.98	$30.76
95962	S		Electrode stim, brain add-on	0216	2.8332	$153.81	$67.98	$30.76
95965	S		Meg, spontaneous	1528		$5,250.00		$1,050.00
95966	S		Meg, evoked, single	1516		$1,450.00		$290.00
95967	S		Meg, evoked, each addl	1511		$950.00		$190.00
95970	S		Analyze neurostim, no prog	0692	0.9625	$52.25	$26.12	$10.45
95971	S		Analyze neurostim, simple	0692	0.9625	$52.25	$26.12	$10.45
95972	S		Analyze neurostim, complex	0692	0.9625	$52.25	$26.12	$10.45
95973	S		Analyze neurostim, complex	0692	0.9625	$52.25	$26.12	$10.45
95974	S		Cranial neurostim, complex	0692	0.9625	$52.25	$26.12	$10.45
95975	S		Cranial neurostim, complex	0692	0.9625	$52.25	$26.12	$10.45
95990	T		Spin/brain pump refil & main	0125	2.5105	$136.29		$27.26
95999	S		Neurological procedure	0215	0.6390	$34.69	$15.76	$6.94
96000	S		Motion analysis, video/3d	1503		$150.00		$30.00
96001	S		Motion test w/ft press meas	1503		$150.00		$30.00
96002	S		Dynamic surface emg	1503		$150.00		$30.00
96003	S		Dynamic fine wire emg	1503		$150.00		$30.00
96004	E		Phys review of motion tests					
96100	X		Psychological testing	0373	2.1165	$114.90	$22.98	$22.98
96105	X		Assessment of aphasia	0373	2.1165	$114.90	$22.98	$22.98
96110	X		Developmental test, lim	0373	2.1165	$114.90	$22.98	$22.98
96111	X		Developmental test, extend	0373	2.1165	$114.90	$22.98	$22.98
96115	X		Neurobehavior status exam	0373	2.1165	$114.90	$22.98	$22.98
96117	X		Neuropsych test battery	0373	2.1165	$114.90	$22.98	$22.98
96150	S		Assess lth/behave, init	0322	1.3091	$71.07		$14.21
96151	S		Assess hlth/behave, subseq	0322	1.3091	$71.07		$14.21
96152	S		Intervene hlth/behave, indiv	0322	1.3091	$71.07		$14.21
96153	S		Intervene hlth/behave, group	0322	1.3091	$71.07		$14.21
96154	S		Interv hlth/behav, fam w/pt	0322	1.3091	$71.07		$14.21
96155	S		Interv hlth/behav fam no pt	0322	1.3091	$71.07		$14.21

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96400	E		Chemotherapy, sc/im					
96405	E		Intralesional chemo admin					
96406	E		Intralesional chemo admin					
96408	E		Chemotherapy, push technique					
96410	E		Chemotherapy, infusion method					
96412	E		Chemo, infuse method add-on					
96414	E		Chemo, infuse method add-on					
96420	E		Chemotherapy, push technique					
96422	E		Chemotherapy,infusion method					
96423	E		Chemo, infuse method add-on					
96425	E		Chemotherapy, infusion method					
96440	E		Chemotherapy, intracavitary					
96445	E		Chemotherapy, intracavitary					
96450	E		Chemotherapy, into CNS					
96520	T		Port pump refill & main	0125	2.5105	$136.29		$27.26
96530	T		Pump refilling, maintenance	0125	2.5105	$136.29		$27.26
96542	E		Chemotherapy injection					
96545	E		Provide chemotherapy agent					
96549	E		Chemotherapy, unspecified					
96567	T		Photodynamic tx, skin	1540		$150.00		$30.00
96570	T		Photodynamic tx, 30 min	1541		$250.00		$50.00
96571	T		Photodynamic tx, addl 15 min	1541		$250.00		$50.00
96900	S		Ultraviolet light therapy	0001	0.3940	$21.39	$7.09	$4.28
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.3940	$21.39	$7.09	$4.28
96912	S		Photochemotherapy with UV-A	0001	0.3940	$21.39	$7.09	$4.28
96913	S		Photochemotherapy, UV-A or B	0683	1.7915	$97.26	$35.01	$19.45
96920	T		Laser tx, skin < 250 sq cm	0012	0.8203	$44.53	$11.18	$8.91
96921	T		Laser tx, skin 250-500 sq cm	0012	0.8203	$44.53	$11.18	$8.91
96922	T		Laser tx, skin > 500 sq cm	0013	1.1420	$62.00	$14.20	$12.40
96999	T		Dermatological procedure	0010	0.6806	$36.95	$10.08	$7.39
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
97003	A		Ot evaluation					
97004	A		Ot re-evaluation					
97005	E		Athletic train eval					
97006	E		Athletic train reeval					
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	E		Electric stimulation therapy					
97016	A		Vasopneumatic device therapy					
97018	A		Paraffin bath therapy					
97020	A		Microwave therapy					
97022	A		Whirlpool therapy					
97024	A		Diathermy treatment					
97026	A		Infrared therapy					
97028	A		Ultraviolet therapy					
97032	A		Electrical stimulation					
97033	A		Electric current therapy					
97034	A		Contrast bath therapy					
97035	A		Ultrasound therapy					
97036	A		Hydrotherapy					
97039	A		Physical therapy treatment					
97110	A		Therapeutic exercises					
97112	A		Neuromuscular reeducation					
97113	A		Aquatic therapy/exercises					
97116	A		Gait training therapy					
97124	A		Massage therapy					
97139	A		Physical medicine procedure					
97140	A		Manual therapy					
97150	A		Group therapeutic procedures					
97504	A		Orthotic training					
97520	A		Prosthetic training					
97530	A		Therapeutic activities					
97532	A		Cognitive skills development					
97533	A		Sensory integration					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
98925	S		Osteopathic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98926	S		Osteopathic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98927	S		Osteopathic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98928	S		Osteopathic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98929	S		Osteopathic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98940	S		Chiropractic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98941	S		Chiropractic manipulation	0060	0.3151	$17.11	$3.43	$3.42
98942	S		Chiropractic manipulation	0060	0.3151	$17.11	$3.43	$3.42
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		In-hospital on call service					
99027	E		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	0.1679	$9.12	$2.65	$1.82
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	0.5529	$30.02	$10.09	$6.00
99199	E		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.9376	$50.90		$10.18
99202	V		Office/outpatient visit, new	0600	0.9376	$50.90		$10.18
99203	V		Office/outpatient visit, new	0601	1.0031	$54.46		$10.89
99204	V		Office/outpatient visit, new	0602	1.5603	$84.71		$16.94

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99205	V		Office/outpatient visit, new	0602	1.5603	$84.71		$16.94
99211	V		Office/outpatient visit, est	0600	0.9376	$50.90		$10.18
99212	V		Office/outpatient visit, est	0600	0.9376	$50.90		$10.18
99213	V		Office/outpatient visit, est	0601	1.0031	$54.46		$10.89
99214	V		Office/outpatient visit, est	0602	1.5603	$84.71		$16.94
99215	V		Office/outpatient visit, est	0602	1.5603	$84.71		$16.94
99217	N		Observation care discharge					
99218	N		Observation care					
99219	N		Observation care					
99220	N		Observation care					
99221	E		Initial hospital care					
99222	E		Initial hospital care					
99223	E		Initial hospital care					
99231	E		Subsequent hospital care					
99232	E		Subsequent hospital care					
99233	E		Subsequent hospital care					
99234	N		Observ/hosp same date					
99235	N		Observ/hosp same date					
99236	N		Observ/hosp same date					
99238	E		Hospital discharge day					
99239	E		Hospital discharge day					
99241	V		Office consultation	0600	0.9376	$50.90		$10.18
99242	V		Office consultation	0600	0.9376	$50.90		$10.18
99243	V		Office consultation	0601	1.0031	$54.46		$10.89
99244	V		Office consultation	0602	1.5603	$84.71		$16.94
99245	V		Office consultation	0602	1.5603	$84.71		$16.94
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	0.9376	$50.90		$10.18
99272	V		Confirmatory consultation	0600	0.9376	$50.90		$10.18
99273	V		Confirmatory consultation	0601	1.0031	$54.46		$10.89
99274	V		Confirmatory consultation	0602	1.5603	$84.71		$16.94
99275	V		Confirmatory consultation	0602	1.5603	$84.71		$16.94
99281	V		Emergency dept visit	0610	1.4146	$76.80	$19.57	$15.36
99282	V		Emergency dept visit	0610	1.4146	$76.80	$19.57	$15.36
99283	V		Emergency dept visit	0611	2.4881	$135.08	$36.47	$27.02
99284	V		Emergency dept visit	0612	4.3235	$234.72	$54.14	$46.94
99285	V		Emergency dept visit	0612	4.3235	$234.72	$54.14	$46.94
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	9.2657	$503.03	$145.78	$100.61
99292	N		Critical care, addl 30 min					
99293	C		Ped critical care, initial					
99294	C		Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99298	C		Neonatal critical care					
99299	C		Ic, lbw infant 1500-2500 gm					
99301	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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99331	E		Rest home visit, est pat					
99332	E		Rest home visit, est pat					
99333	E		Rest home visit, est pat					
99341	E		Home visit, new patient					
99342	E		Home visit, new patient					
99343	E		Home visit, new patient					
99344	E		Home visit, new patient					
99345	E		Home visit, new patient					
99347	E		Home visit, est patient					
99348	E		Home visit, est patient					
99349	E		Home visit, est patient					
99350	E		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					
99356	C		Prolonged service, inpatient					
99357	C		Prolonged service, inpatient					
99358	N		Prolonged serv, w/o contact					
99359	N		Prolonged serv, w/o contact					
99360	E		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	E		Physician phone consultation					
99372	E		Physician phone consultation					
99373	E		Physician phone consultation					
99374	E		Home health care supervision					
99377	E		Hospice care supervision					
99379	E		Nursing fac care supervision					
99380	E		Nursing fac care supervision					
99381	E		Prev visit, new, infant					
99382	E		Prev visit, new, age 1-4					
99383	E		Prev visit, new, age 5-11					
99384	E		Prev visit, new, age 12-17					
99385	E		Prev visit, new, age 18-39					
99386	E		Prev visit, new, age 40-64					
99387	E		Prev visit, new, 65 & over					
99391	E		Prev visit, est, infant					
99392	E		Prev visit, est, age 1-4					
99393	E		Prev visit, est, age 5-11					
99394	E		Prev visit, est, age 12-17					
99395	E		Prev visit, est, age 18-39					
99396	E		Prev visit, est, age 40-64					
99397	E		Prev visit, est, 65 & over					
99401	E		Preventive counseling, indiv					
99402	E		Preventive counseling, indiv					
99403	E		Preventive counseling, indiv					
99404	E		Preventive counseling, indiv					
99411	E		Preventive counseling, group					
99412	E		Preventive counseling, group					
99420	E		Health risk assessment test					
99429	E		Unlisted preventive service					
99431	V		Initial care, normal newborn	0600	0.9376	$50.90		$10.18
99432	N		Newborn care, not in hosp					
99433	C		Normal newborn care/hospital					
99435	E		Newborn discharge day hosp					
99436	N		Attendance, birth					
99440	S		Newborn resuscitation	0094	2.6412	$143.39	$48.46	$28.68
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
99509	E		Home visit day life activity					
99510	E		Home visit, sing/m/fam couns					
99511	E		Home visit, fecal/enema mgmt					
99512	E		Home visit, hemodialysis					
99551	E		Home infus, pain mgmt, iv/sc					
99552	E		Hm infus pain mgmt, epid/ith					
99553	E		Home infuse, tocolytic tx					
99554	E		Home infus, hormone/platelet					
99555	E		Home infuse, chemotheraphy					
99556	E		Home infus, antibio/fung/vir					
99557	E		Home infuse, anticoagulant					
99558	E		Home infuse, immunotherapy					
99559	E		Home infus, periton dialysis					
99560	E		Home infus, entero nutrition					
99561	E		Home infuse, hydration tx					
99562	E		Home infus, parent nutrition					
99563	E		Home admin, pentamidine					
99564	E		Hme infus, antihemophil agnt					
99565	E		Home infus, proteinase inhib					
99566	E		Home infuse, iv therapy					
99567	E		Home infuse, sympath agent					
99568	E		Home infus, misc drug, daily					
99569	E		Home infuse, each addl tx					
99600	E		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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	E		Syringe w/needle insulin 3cc					
A4244	E		Alcohol or peroxide per pint					
A4245	E		Alcohol wipes per box					
A4246	E		Betadine/phisohex solution					
A4247	E		Betadine/iodine swabs/wipes					
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		Diaphragm					
A4267	E		Male condom					
A4268	E		Female condom					
A4269	E		Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E		Replacement breastpump tube					
A4282	E		Replacement breastpump adpt					
A4283	E		Replacement breastpump cap					
A4284	E		Replcmnt breast pump shield					
A4285	E		Replcmnt breast pump bottle					
A4286	E		Replcmnt breastpump lok ring					
A4290	E		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		Implantable access syst perc					
A4305	A		Drug delivery system >=50 ML					
A4306	A		Drug delivery system <=5 ML					
A4310	A		Insert tray w/o bag/cath					
A4311	A		Catheter w/o bag 2-way latex					
A4312	A		Cath w/o bag 2-way silicone					
A4313	A		Catheter w/bag 3-way					
A4314	A		Cath w/drainage 2-way latex					
A4315	A		Cath w/drainage 2-way silcne					
A4316	A		Cath w/drainage 3-way					
A4319	A		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4328	A		Fem urinary collect pouch					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lubricant for cath insertion					
A4333	A		Urinary cath anchor device					
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4347	A		Male external catheter					
A4348	A		Male ext cath extended wear					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					
A4377	A		Drainable plstic pch w/o fp					
A4378	A		Drainable rubber pch w/o fp					
A4379	A		Urinary plastic pouch w fcpl					
A4380	A		Urinary rubber pouch w fcplt					
A4381	A		Urinary plastic pouch w/o fp					
A4382	A		Urinary hvy plstc pch w/o fp					
A4383	A		Urinary rubber pouch w/o fp					
A4384	A		Ostomy faceplt/silicone ring					
A4385	A		Ost skn barrier sld ext wear					
A4387	A		Ost clsd pouch w att st barr					
A4388	A		Drainable pch w ex wear barr					
A4389	A		Drainable pch w st wear barr					
A4390	A		Drainable pch ex wear convex					
A4391	A		Urinary pouch w ex wear barr					
A4392	A		Urinary pouch w st wear barr					
A4393	A		Urine pch w ex wear bar conv					
A4394	A		Ostomy pouch liq deodorant					
A4395	A		Ostomy pouch solid deodorant					
A4396	A		Peristomal hernia supprt blt					
A4397	A		Irrigation supply sleeve					
A4398	A		Ostomy irrigation bag					
A4399	A		Ostomy irrig cone/cath w brs					
A4400	A		Ostomy irrigation set					
A4402	A		Lubricant per ounce					
A4404	A		Ostomy ring each					
A4405	A		Nonpectin based ostomy paste					
A4406	A		Pectin based ostomy paste					
A4407	A		Ext wear ost skn barr <=4sq″					
A4408	A		Ext wear ost skn barr >4sq″					
A4409	A		Ost skn barr w flng <=4 ″					
A4410	A		Ost skn barr w flng >4sq″					
A4413	A		2 pc drainable ost pouch					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4414	A		Ostomy sknbarr w flng <=4sq″					
A4415	A		Ostomy skn barr w flng >4sq″					
A4421	A		Ostomy supply misc					
A4422	A		Ost pouch absorbent material					
A4450	A		Non-waterproof tape					
A4452	A		Waterproof tape					
A4455	A		Adhesive remover per ounce					
A4458	E		Reusable enema bag					
A4462	A		Abdmnl drssng holder/binder					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
A4483	A		Moisture exchanger					
A4490	E		Above knee surgical stocking					
A4495	E		Thigh length surg stocking					
A4500	E		Below knee surgical stocking					
A4510	E		Full length surg stocking					
A4521	E		Adult size diaper sm each					
A4522	E		Adult size diaper med each					
A4523	E		Adult size diaper lg each					
A4524	E		Adult size diaper xl each					
A4525	E		Adult size brief sm each					
A4526	E		Adult size brief med each					
A4527	E		Adult size brief lg each					
A4528	E		Adult size brief xl each					
A4529	E		Child size diaper sm/med ea					
A4530	E		Child size diaper lg each					
A4531	E		Child size brief sm/med each					
A4532	E		Child size brief lg each					
A4533	E		Youth size diaper each					
A4534	E		Youth size brief each					
A4535	E		Disp incont liner/shield ea					
A4536	E		Prot underwr wshbl any sz ea					
A4537	E		Under pad reusable any sz ea					
A4538	E		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					
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		Oxygen probe used w oximeter					
A4608	A		Transtracheal oxygen cath					
A4609	A		Trach suction cath clsed sys					
A4610	A		Trach sctn cath 72h clsedsys					
A4611	A		Heavy duty battery					
A4612	A		Battery cables					
A4613	A		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	A		Cannula nasal					
A4616	A		Tubing (oxygen) per foot					
A4617	A		Mouth piece					
A4618	A		Breathing circuits					
A4619	A		Face tent					
A4620	A		Variable concentration mask					
A4621	A		Tracheotomy mask or collar					
A4622	A		Tracheostomy or larngectomy					
A4623	A		Tracheostomy inner cannula					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	E		Infus pump rplcemnt battery					
A4633	A		Uvl replacement bulb					
A4634	A		Replacement bulb th lightbox					
A4635	A		Underarm crutch pad					
A4636	A		Handgrip for cane etc					
A4637	A		Repl tip cane/crutch/walker					
A4639	A		Infrared ht sys replcmnt pad					
A4640	A		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	K		Satumomab pendetide per dose	0704	2.9212	$158.59		$31.72
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		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 > 999cc					
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					
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A		Sterile, gloves per pair					
A4931	A		Reusable oral thermometer					
A4932	E		Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		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					
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		Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6410	A		Sterile eye pad					
A6411	A		Non-sterile eye pad					
A6412	E		Occlusive eye patch					
A6421	A		Pad bandage >=3 <5in w /roll					
A6422	A		Conf bandage ns >=3<5“w/roll					
A6424	A		Conf bandage ns >=5“w /roll					
A6426	A		Conf bandage s >=3<5“w/roll					
A6428	A		Conf bandage s >=5“w /roll					
A6430	A		Lt compres bdg >=3<5“w /roll					
A6432	A		Lt compres bdg >=5“w /roll					
A6434	A		Mo compres bdg >=3<5“w /roll					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6436	A		Hi compres bdg >=3<5“w /roll					
A6438	A		Self-adher bdg >=3<5“w /roll					
A6440	A		Zinc paste bdg >=3<5“w /roll					
A6501	A		Compres burngarment bodysuit					
A6502	A		Compres burngarment chinstrp					
A6503	A		Compres burngarment facehood					
A6504	A		Cmprsburngarment glove-wrist					
A6505	A		Cmprsburngarment glove-elbow					
A6506	A		Cmprsburngrmnt glove-axilla					
A6507	A		Cmprs burngarment foot-knee					
A6508	A		Cmprs burngarment foot-thigh					
A6509	A		Compres burn garment jacket					
A6510	A		Compres burn garment leotard					
A6511	A		Compres burn garment panty					
A6512	A		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		Replace chest compress vest					
A7026	A		Replace chst cmprss sys hose					
A7030	A		CPAP full face mask					
A7031	A		Replacement facemask interfa					
A7032	A		Replacement nasal cushion					
A7033	A		Replacement nasal pillows					
A7034	A		Nasal application device					
A7035	A		Pos airway press headgear					
A7036	A		Pos airway press chinstrap					
A7037	A		Pos airway pressure tubing					
A7038	A		Pos airway pressure filter					
A7039	A		Filter, non disposable w pap					
A7042	A		Implanted pleural catheter					
A7043	A		Vacuum drainagebottle/tubing					
A7044	A		PAP oral interface					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9504	N		Technetium tc 99m apcitide					
A9505	N		Thallous chloride TL 201/mci					
A9507	K		Indium/111 capromab pendetid	1604	12.4029	$673.34		$134.67
A9508	K		Iobenguane sulfate I-131, per 0.5 mCi.	1045	2.9293	$159.03		$31.81
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	3.7042	$201.10		$40.22
A9512	N		Technetiumtc99mpertechnetate					
A9513	N		Technetium tc-99m mebrofenin					
A9514	N		Technetiumtc99mpyrophosphate					
A9515	N		Technetium tc-99m pentetate					
A9516	N		I-123 sodium iodide capsule					
A9517	K		I-131 sodium iodide capsule	1064	0.1007	$5.47		$1.09
A9518	K		I-131 sodium iodide solution	1065	0.0002	$.01		
A9519	N		Technetiumtc-99mmacroag albu					
A9520	N		Technetiumtc-99m sulfur clld					
A9521	K		Technetiumtc-99m exametazine	1096	3.8103	$206.86		$41.37
A9522	K		Indium111ibritumomabtiuxetan	9118	38.3972	$2,084.55		$416.91
A9523	K		Yttrium90ibritumomabtiuxetan	9117	332.7763	$18,066.09		$3,613.22
A9524	K		Iodinated I-131 serumalbumin, per 5uci.	9100	0.0071	$.39		$.08
A9600	K		Strontium-89 chloride	0701	7.4586	$404.92		$80.98
A9605	K		Samarium sm153 lexidronamm	0702	16.1415	$876.31		$175.26
A9699	N		Noc therapeutic radiopharm					
A9700	E		Echocardiography Contrast					
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		Food thickener oral					
B4150	A		Enteral formulae category i					
B4151	A		Enteral formulae cat1natural					
B4152	A		Enteral formulae category ii					
B4153	A		Enteral formulae categoryIII					
B4154	A		Enteral formulae category IV					
B4155	A		Enteral formulae category v					
B4156	A		Enteral formulae category vi					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					
B4189	A		Parenteral sol amino acid &					
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B9999	A		Parenteral supp not othrws c					
C1010	K		Blood, L/R, CMV-NEG	1010	2.1361	$115.97		$23.19
C1011	K		Platelets, HLA-m, L/R, unit	1011	8.2851	$449.79		$89.96
C1015	K		Plt, pher,L/R,CMV, irrad	1020	9.6266	$522.62		$104.52
C1016	K		BLOOD,L/R,FROZ/DEGLY/Washed	1016	5.0012	$271.51		$54.30
C1017	K		Plt, APH/PHER,L/R,CMV-NEG	1017	6.5175	$353.83		$70.77
C1018	K		Blood, L/R, IRRADIATED	1018	2.1950	$119.16		$23.83
C1020	K		RBC, frz/deg/wsh, L/R, irrad	1021	6.5287	$354.44		$70.89
C1021	K		RBC, L/R, CMV neg, irrad	1022	3.9139	$212.48		$42.50
C1022	K		Plasma, frz within 24 hour	0955	1.5750	$85.51		$17.10
C1079	N		CO 57/58 per 0.5 uCi					
C1088	T		LASER OPTIC TR Sys	1557		$1,850.00		$370.00
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	4.0535	$220.06		$44.01
C1092	K		IN 111 pentetate per 0.5 mCi	1092	4.0824	$221.63		$44.33
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	9.6556	$524.19		$104.84
C1166	N		CYTARABINE LIPOSOMAL, 10 mg					
C1167	K		EPIRUBICIN HCL, 2 mg	1167	0.3597	$19.53		$3.91
C1178	K		BUSULFAN IV, 6 Mg	1178	6.0245	$327.06		$65.41
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	N		TC 99M SUCCIMER, PER Vial					
C1300	S		HYPERBARIC Oxygen	0659	3.2220	$174.92		$34.98
C1305	K		Apligraf	1305	11.2075	$608.44		$121.69
C1716	K		Brachytx source, Gold 198	1716	1.3399	$72.74		$14.55
C1718	K		Brachytx source, Iodine 125	1718	0.6695	$36.35		$7.27
C1719	K		Brachytx sour,Non-HDR Ir-192	1719	0.3053	$16.57		$3.31
C1720	K		Brachytx sour, Palladium 103	1720	0.8104	$44.00		$8.80
C1765	N		Adhesion barrier					
C1774	K		Darbepoetin alfa, 1 mcg	0734	0.0463	$2.51		$.50
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	5.8606	$318.17		$63.63
C1783	H		Ocular imp, aqueous drain dev	1783				
C1814	H		Retinal tamp, silicone oil	1814				
C1818	H		Integrated keratoprosthesis	1818				
C1900	H		Lead coronary venous	1900				
C2614	H		Probe, perc lumb disc	2614				
C2616	K		Brachytx source, Yttrium-90	2616	163.4011	$8,870.88		$1,774.18
C2618	N		Probe, cryoablation					
C2632	H		Brachytx sol, I-125, per mCi	2632				
C8900	S		MRA w/cont, abd	0284	7.0207	$381.15	$190.57	$76.23
C8901	S		MRA w/o cont, abd	0336	6.4817	$351.89	$175.94	$70.38
C8902	S		MRA w/o fol w/cont, abd	0337	9.3215	$506.05	$240.77	$101.21
C8903	S		MRI w/cont, breast, uni	0284	7.0207	$381.15	$190.57	$76.23
C8904	S		MRI w/o cont, breast, uni	0336	6.4817	$351.89	$175.94	$70.38
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.3215	$506.05	$240.77	$101.21
C8906	S		MRI w/cont, breast, bi	0284	7.0207	$381.15	$190.57	$76.23
C8907	S		MRI w/o cont, breast, bi	0336	6.4817	$351.89	$175.94	$70.38
C8908	S		MRI w/o fol w/cont, breast,	0337	9.3215	$506.05	$240.77	$101.21
C8909	S		MRA w/cont, chest	0284	7.0207	$381.15	$190.57	$76.23
C8910	S		MRA w/o cont, chest	0336	6.4817	$351.89	$175.94	$70.38
C8911	S		MRA w/o fol w/cont, chest	0337	9.3215	$506.05	$240.77	$101.21
C8912	S		MRA w/cont, lwr ext	0284	7.0207	$381.15	$190.57	$76.23
C8913	S		MRA w/o cont, lwr ext	0336	6.4817	$351.89	$175.94	$70.38
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.3215	$506.05	$240.77	$101.21
C8918	S		MRA w/cont, pelvis	0284	7.0207	$381.15	$190.57	$76.23
C8919	S		MRA w/o cont, pelvis	0336	6.4817	$351.89	$175.94	$70.38
C8920	S		MRA w/o fol w/cont, pelvis	0337	9.3215	$506.05	$240.77	$101.21
C9000	K		Na chromateCr51, per 0.25mCi	9000	1.2631	$68.57		$13.71
C9003	K		Palivizumab, per 50 mg	9003	6.3850	$346.64		$69.33
C9007	N		Baclofen Intrathecal kit-1am					
C9008	N		Baclofen Refill Kit-500mcg					
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7478	$40.60		$8.12
C9010	K		Baclofen Refill Kit--4000mcg	9010	0.7340	$39.85		$7.97
C9013	N		Co 57 cobaltous chloride					
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105	1.5621	$84.80		$16.96
C9109	K		Tirofiban hcl, 6.25 mg	9109	2.2328	$121.22		$24.24

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9111	G		Inj, bivalirudin, 250mg vial	9111		$397.81		$59.46
C9112	G		Perflutren lipid micro, 2ml	9112		$148.20		$22.15
C9113	G		Inj pantoprazole sodium, via	9113		$22.80		$3.41
C9116	G		Ertapenem sodium, per 1 gm	9116		$45.31		$6.77
C9120	G		Injection, fulvestrant	9120		$175.16		$26.18
C9121	G		Injection, argatroban	9121		$14.25		$2.13
C9200	G		Orcel, per 36 cm2	9200		$1,135.25		$169.69
C9201	K		Dermagraft, per 37.5 sq cm	9201	7.9288	$430.45		$86.09
C9202	K		Octafluoropropane	9202	2.1253	$115.38		$23.08
C9203	G		Perflexane lipid micro	9203		$142.50		$21.30
C9204	G		Ziprasidone mesylate	9204		$41.56		$6.21
C9205	G		Oxaliplatin	9205		$94.46		$14.12
C9503	K		Fresh frozen plasma, ea unit	9503	1.1560	$62.76		$12.55
C9701	T		Stretta System	1557		$1,850.00		$370.00
C9703	T		Bard Endoscopic Suturing Sys	1555		$1,650.00		$330.00
C9711	T		H.E.L.P. Apheresis System	1552		$1,350.00		$270.00
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	0.5609	$30.45	$6.09	$6.09
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E		Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	0.5609	$30.45	$6.09	$6.09
D0250	S		Extraoral first film	0330	0.5609	$30.45	$6.09	$6.09
D0260	S		Extraoral ea additional film	0330	0.5609	$30.45	$6.09	$6.09
D0270	S		Dental bitewing single film	0330	0.5609	$30.45	$6.09	$6.09
D0272	S		Dental bitewings two films	0330	0.5609	$30.45	$6.09	$6.09
D0274	S		Dental bitewings four films	0330	0.5609	$30.45	$6.09	$6.09
D0277	S		Vert bitewings-sev to eight	0330	0.5609	$30.45	$6.09	$6.09
D0290	E		Dental film skull/facial bon					
D0310	E		Dental saliography					
D0320	E		Dental tmj arthrogram incl i					
D0321	E		Dental other tmj films					
D0322	E		Dental tomographic survey					
D0330	E		Dental panoramic film					
D0340	E		Dental cephalometric film					
D0350	E		Oral/facial images					
D0415	E		Bacteriologic study					
D0425	E		Caries susceptibility test					
D0460	S		Pulp vitality test	0330	0.5609	$30.45	$6.09	$6.09
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	0.5609	$30.45	$6.09	$6.09
D0473	S		Micro exam, prep & report	0330	0.5609	$30.45	$6.09	$6.09
D0474	S		Micro w exam of surg margins	0330	0.5609	$30.45	$6.09	$6.09
D0480	S		Cytopath smear prep & report	0330	0.5609	$30.45	$6.09	$6.09
D0502	S		Other oral pathology procedu	0330	0.5609	$30.45	$6.09	$6.09
D0999	S		Unspecified diagnostic proce	0330	0.5609	$30.45	$6.09	$6.09
D1110	E		Dental prophylaxis adult					
D1120	E		Dental prophylaxis child					
D1201	E		Topical fluor w prophy child					
D1203	E		Topical fluor w/o prophy chi					
D1204	E		Topical fluor w/o prophy adu					
D1205	E		Topical fluoride w/ prophy a					
D1310	E		Nutri counsel-control caries					
D1320	E		Tobacco counseling					
D1330	E		Oral hygiene instruction					
D1351	E		Dental sealant per tooth					
D1510	S		Space maintainer fxd unilat	0330	0.5609	$30.45	$6.09	$6.09
D1515	S		Fixed bilat space maintainer	0330	0.5609	$30.45	$6.09	$6.09
D1520	S		Remove unilat space maintain	0330	0.5609	$30.45	$6.09	$6.09
D1525	S		Remove bilat space maintain	0330	0.5609	$30.45	$6.09	$6.09
D1550	S		Recement space maintainer	0330	0.5609	$30.45	$6.09	$6.09
D2140	E		Amalgam one surface permanen					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2150	E		Amalgam two surfaces permane					
D2160	E		Amalgam three surfaces perma					
D2161	E		Amalgam 4 or > surfaces perm					
D2330	E		Resin one surface-anterior					
D2331	E		Resin two surfaces-anterior					
D2332	E		Resin three surfaces-anterio					
D2335	E		Resin 4/> surf or w incis an					
D2390	E		Ant resin-based cmpst crown					
D2391	E		Post 1 srfc resinbased cmpst					
D2392	E		Post 2 srfc resinbased cmpst					
D2393	E		Post 3 srfc resinbased cmpst					
D2394	E		Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					
D2642	E		Dental onlay porcelin 2 surf					
D2643	E		Dental onlay porcelin 3 surf					
D2644	E		Dental onlay porc 4/more sur					
D2650	E		Inlay composite/resin one su					
D2651	E		Inlay composite/resin two su					
D2652	E		Dental inlay resin 3/mre sur					
D2662	E		Dental onlay resin 2 surface					
D2663	E		Dental onlay resin 3 surface					
D2664	E		Dental onlay resin 4/mre sur					
D2710	E		Crown resin laboratory					
D2720	E		Crown resin w/ high noble me					
D2721	E		Crown resin w/ base metal					
D2722	E		Crown resin w/ noble metal					
D2740	E		Crown porcelain/ceramic subs					
D2750	E		Crown porcelain w/ h noble m					
D2751	E		Crown porcelain fused base m					
D2752	E		Crown porcelain w/ noble met					
D2780	E		Crown 3/4 cast hi noble met					
D2781	E		Crown 3/4 cast base metal					
D2782	E		Crown 3/4 cast noble metal					
D2783	E		Crown 3/4 porcelain/ceramic					
D2790	E		Crown full cast high noble m					
D2791	E		Crown full cast base metal					
D2792	E		Crown full cast noble metal					
D2799	E		Provisional crown					
D2910	E		Dental recement inlay					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					
D2931	E		Prefab stnlss steel crown pe					
D2932	E		Prefabricated resin crown					
D2933	E		Prefab stainless steel crown					
D2940	E		Dental sedative filling					
D2950	E		Core build-up incl any pins					
D2951	E		Tooth pin retention					
D2952	E		Post and core cast + crown					
D2953	E		Each addtnl cast post					
D2954	E		Prefab post/core + crown					
D2955	E		Post removal					
D2957	E		Each addtnl prefab post					
D2960	E		Laminate labial veneer					
D2961	E		Lab labial veneer resin					
D2962	E		Lab labial veneer porcelain					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2970	S		Temporary- fractured tooth	0330	0.5609	$30.45	$6.09	$6.09
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	0.5609	$30.45	$6.09	$6.09
D3110	E		Pulp cap direct					
D3120	E		Pulp cap indirect					
D3220	E		Therapeutic pulpotomy					
D3221	E		Gross pulpal debridement					
D3230	E		Pulpal therapy anterior prim					
D3240	E		Pulpal therapy posterior pri					
D3310	E		Anterior					
D3320	E		Root canal therapy 2 canals					
D3330	E		Root canal therapy 3 canals					
D3331	E		Non-surg tx root canal obs					
D3332	E		Incomplete endodontic tx					
D3333	E		Internal root repair					
D3346	E		Retreat root canal anterior					
D3347	E		Retreat root canal bicuspid					
D3348	E		Retreat root canal molar					
D3351	E		Apexification/recalc initial					
D3352	E		Apexification/recalc interim					
D3353	E		Apexification/recalc final					
D3410	E		Apicoect/perirad surg anter					
D3421	E		Root surgery bicuspid					
D3425	E		Root surgery molar					
D3426	E		Root surgery ea add root					
D3430	E		Retrograde filling					
D3450	E		Root amputation					
D3460	S		Endodontic endosseous implan	0330	0.5609	$30.45	$6.09	$6.09
D3470	E		Intentional replantation					
D3910	E		Isolation- tooth w rubb dam					
D3920	E		Tooth splitting					
D3950	E		Canal prep/fitting of dowel					
D3999	S		Endodontic procedure	0330	0.5609	$30.45	$6.09	$6.09
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4240	E		Gingival flap proc w/ planin					
D4241	E		Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	0.5609	$30.45	$6.09	$6.09
D4261	E		Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	0.5609	$30.45	$6.09	$6.09
D4264	S		Bone replce graft each add	0330	0.5609	$30.45	$6.09	$6.09
D4265	E		Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	0.5609	$30.45	$6.09	$6.09
D4270	S		Pedicle soft tissue graft pr	0330	0.5609	$30.45	$6.09	$6.09
D4271	S		Free soft tissue graft proc	0330	0.5609	$30.45	$6.09	$6.09
D4273	S		Subepithelial tissue graft	0330	0.5609	$30.45	$6.09	$6.09
D4274	E		Distal/proximal wedge proc					
D4275	E		Soft tissue allograft					
D4276	E		Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E		Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	0.5609	$30.45	$6.09	$6.09
D4381	S		Localized chemo delivery	0330	0.5609	$30.45	$6.09	$6.09
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E		Replc tth&acrlc on mtl frmwk					
D5671	E		Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	0.5609	$30.45	$6.09	$6.09
D5912	S		Facial moulage complete	0330	0.5609	$30.45	$6.09	$6.09
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	0.5609	$30.45	$6.09	$6.09
D5984	S		Radiation shield	0330	0.5609	$30.45	$6.09	$6.09
D5985	S		Radiation cone locator	0330	0.5609	$30.45	$6.09	$6.09
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	0.5609	$30.45	$6.09	$6.09
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6020	E		Odontics abutment placement					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E		Implnt/abtmnt spprt remv dnt					
D6054	E		Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					
D6080	E		Implant maintenance					
D6090	E		Repair implant					
D6095	E		Odontics repr abutment					
D6100	E		Removal of implant					
D6199	E		Implant procedure					
D6210	E		Prosthodont high noble metal					
D6211	E		Bridge base metal cast					
D6212	E		Bridge noble metal cast					
D6240	E		Bridge porcelain high noble					
D6241	E		Bridge porcelain base metal					
D6242	E		Bridge porcelain nobel metal					
D6245	E		Bridge porcelain/ceramic					
D6250	E		Bridge resin w/high noble					
D6251	E		Bridge resin base metal					
D6252	E		Bridge resin w/noble metal					
D6253	E		Provisional pontic					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E		Porcelain/ceramic inlay 2srf					
D6601	E		Porc/ceram inlay >= 3 surfac					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6602	E		Cst hgh nble mtl inlay 2 srf					
D6603	E		Cst hgh nble mtl inlay >=3sr					
D6604	E		Cst bse mtl inlay 2 surfaces					
D6605	E		Cst bse mtl inlay >= 3 surfa					
D6606	E		Cast noble metal inlay 2 sur					
D6607	E		Cst noble mtl inlay >=3 surf					
D6608	E		Onlay porc/crmc 2 surfaces					
D6609	E		Onlay porc/crmc >=3 surfaces					
D6610	E		Onlay cst hgh nbl mtl 2 srfc					
D6611	E		Onlay cst hgh nbl mtl >=3srf					
D6612	E		Onlay cst base mtl 2 surface					
D6613	E		Onlay cst base mtl >=3 surfa					
D6614	E		Onlay cst nbl mtl 2 surfaces					
D6615	E		Onlay cst nbl mtl >=3 surfac					
D6720	E		Retain crown resin w hi nble					
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E		Provisional retainer crown					
D6920	S		Dental connector bar	0330	0.5609	$30.45	$6.09	$6.09
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E		Pediatric partial denture fx					
D6999	E		Fixed prosthodontic proc					
D7111	S		Coronal remnants deciduous t	0330	0.5609	$30.45	$6.09	$6.09
D7140	S		Extraction erupted tooth/exr	0330	0.5609	$30.45	$6.09	$6.09
D7210	S		Rem imp tooth w mucoper flp	0330	0.5609	$30.45	$6.09	$6.09
D7220	S		Impact tooth remov soft tiss	0330	0.5609	$30.45	$6.09	$6.09
D7230	S		Impact tooth remov part bony	0330	0.5609	$30.45	$6.09	$6.09
D7240	S		Impact tooth remov comp bony	0330	0.5609	$30.45	$6.09	$6.09
D7241	S		Impact tooth rem bony w/comp	0330	0.5609	$30.45	$6.09	$6.09
D7250	S		Tooth root removal	0330	0.5609	$30.45	$6.09	$6.09
D7260	S		Oral antral fistula closure	0330	0.5609	$30.45	$6.09	$6.09
D7261	S		Primary closure sinus perf	0330	0.5609	$30.45	$6.09	$6.09
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	E		Exposure tooth aid eruption					
D7282	E		Mobilize erupted/malpos toot					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E		Cytology sample collection					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	0.5609	$30.45	$6.09	$6.09
D7310	E		Alveoplasty w/ extraction					
D7320	E		Alveoplasty w/o extraction					
D7340	E		Vestibuloplasty ridge extens					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E		Excision benign lesion>1.25c					
D7412	E		Excision benign lesion compl					
D7413	E		Excision malig lesion<=1.25c					
D7414	E		Excision malig lesion>1.25cm					
D7415	E		Excision malig les complicat					
D7440	E		Malig tumor exc to 1.25 cm					
D7441	E		Malig tumor > 1.25 cm					
D7450	E		Rem odontogen cyst to 1.25cm					
D7451	E		Rem odontogen cyst > 1.25 cm					
D7460	E		Rem nonodonto cyst to 1.25cm					
D7461	E		Rem nonodonto cyst > 1.25 cm					
D7465	E		Lesion destruction					
D7471	E		Rem exostosis any site					
D7472	E		Removal of torus palatinus					
D7473	E		Remove torus mandibularis					
D7485	E		Surg reduct osseoustuberosit					
D7490	E		Mandible resection					
D7510	E		I&d absc intraoral soft tiss					
D7520	E		I&d abscess extraoral					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E		Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					
D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E		Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	0.5609	$30.45	$6.09	$6.09
D7941	E		Bone cutting ramus closed					
D7943	E		Cutting ramus open w/graft					
D7944	E		Bone cutting segmented					
D7945	E		Bone cutting body mandible					
D7946	E		Reconstruction maxilla total					
D7947	E		Reconstruct maxilla segment					
D7948	E		Reconstruct midface no graft					
D7949	E		Reconstruct midface w/graft					
D7950	E		Mandible graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E		Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E		Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	0.5609	$30.45	$6.09	$6.09
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	0.5609	$30.45	$6.09	$6.09
D9940	S		Dental occlusal guard	0330	0.5609	$30.45	$6.09	$6.09
D9941	E		Fabrication athletic guard					
D9950	S		Occlusion analysis	0330	0.5609	$30.45	$6.09	$6.09
D9951	S		Limited occlusal adjustment	0330	0.5609	$30.45	$6.09	$6.09
D9952	S		Complete occlusal adjustment	0330	0.5609	$30.45	$6.09	$6.09
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		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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0193	A		Powered air flotation bed					
E0194	A		Air fluidized bed					
E0196	A		Gel pressure mattress					
E0197	A		Air pressure pad for mattres					
E0198	A		Water pressure pad for mattr					
E0199	A		Dry pressure pad for mattres					
E0200	A		Heat lamp without stand					
E0202	A		Phototherapy light w/ photom					
E0203	A		Therapeutic lightbox tabletp					
E0205	A		Heat lamp with stand					
E0210	A		Electric heat pad standard					
E0215	A		Electric heat pad moist					
E0217	A		Water circ heat pad w pump					
E0218	E		Water circ cold pad w pump					
E0220	A		Hot water bottle					
E0221	A		Infrared heating pad system					
E0225	A		Hydrocollator unit					
E0230	A		Ice cap or collar					
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0372	A		Powered air mattress overlay					
E0373	A		Nonpowered pressure mattress					
E0424	A		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	A		Portable gaseous 02					
E0434	A		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	A		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	A		Oxygen contents, gaseous					
E0442	A		Oxygen contents, liquid					
E0443	A		Portable 02 contents, gas					
E0444	A		Portable 02 contents, liquid					
E0445	A		Oximeter non-invasive					
E0450	A		Volume vent stationary/porta					
E0454	A		Pressure ventilator					
E0455	A		Oxygen tent excl croup/ped t					
E0457	A		Chest shell					
E0459	A		Chest wrap					
E0460	A		Neg press vent portabl/statn					
E0461	A		Vol vent noninvasive interfa					
E0462	A		Rocking bed w/ or w/o side r					
E0480	A		Percussor elect/pneum home m					
E0481	E		Intrpulmnry percuss vent sys					
E0482	A		Cough stimulating device					
E0483	A		Chest compression gen system					
E0484	A		Non-elec oscillatory pep dvc					
E0500	A		Ippb all types					
E0550	A		Humidif extens supple w ippb					
E0555	A		Humidifier for use w/ regula					
E0560	A		Humidifier supplemental w/ i					
E0565	A		Compressor air power source					
E0570	A		Nebulizer with compression					
E0571	A		Aerosol compressor for svneb					
E0572	A		Aerosol compressor adjust pr					
E0574	A		Ultrasonic generator w svneb					
E0575	A		Nebulizer ultrasonic					
E0580	A		Nebulizer for use w/ regulat					
E0585	A		Nebulizer w/ compressor & he					
E0590	A		Dispensing fee dme neb drug					
E0600	A		Suction pump portab hom modl					
E0601	A		Cont airway pressure device					
E0602	E		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	A		Vaporizer room type					
E0606	A		Drainage board postural					
E0607	A		Blood glucose monitor home					
E0610	A		Pacemaker monitr audible/vis					
E0615	A		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	A		Automatic ext defibrillator					
E0618	A		Apnea monitor					
E0619	A		Apnea monitor w recorder					
E0620	A		Cap bld skin piercing laser					
E0621	A		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	A		Seat lift incorp lift-chair					
E0628	A		Seat lift for pt furn-electr					
E0629	A		Seat lift for pt furn-non-el					
E0630	A		Patient lift hydraulic					
E0635	A		Patient lift electric					
E0636	A		PT support & positioning sys					
E0650	A		Pneuma compresor non-segment					
E0651	A		Pneum compressor segmental					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E0691	A		Uvl pnl 2 sq ft or less					
E0692	A		Uvl sys panel 4 ft					
E0693	A		Uvl sys panel 6 ft					
E0694	A		Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	A		Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	A		Tens two lead					
E0730	A		Tens four lead					
E0731	A		Conductive garment for tens/					
E0740	E		Incontinence treatment systm					
E0744	A		Neuromuscular stim for scoli					
E0745	A		Neuromuscular stim for shock					
E0746	E		Electromyograph biofeedback					
E0747	A		Elec osteogen stim not spine					
E0748	A		Elec osteogen stim spinal					
E0749	N		Elec osteogen stim implanted					
E0752	N		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	N		Implantable pulse generator					
E0757	N		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	E		Osteogen ultrasound stimltor					
E0761	E		Nontherm electromgntc device					
E0765	E		Nerve stimulator for tx n&v					
E0776	A		Iv pole					
E0779	A		Amb infusion pump mechanical					
E0780	A		Mech amb infusion pump <8hrs					
E0781	A		External ambulatory infus pu					
E0782	N		Non-programble infusion pump					
E0783	N		Programmable infusion pump					
E0784	A		Ext amb infusn pump insulin					
E0785	N		Replacement impl pump cathet					
E0786	N		Implantable pump replacement					
E0791	A		Parenteral infusion pump sta					
E0830	N		Ambulatory traction device					
E0840	A		Tract frame attach headboard					
E0850	A		Traction stand free standing					
E0855	A		Cervical traction equipment					
E0860	A		Tract equip cervical tract					
E0870	A		Tract frame attach footboard					
E0880	A		Trac stand free stand extrem					
E0890	A		Traction frame attach pelvic					
E0900	A		Trac stand free stand pelvic					
E0910	A		Trapeze bar attached to bed					
E0920	A		Fracture frame attached to b					
E0930	A		Fracture frame free standing					
E0935	A		Exercise device passive moti					
E0940	A		Trapeze bar free standing					
E0941	A		Gravity assisted traction de					
E0942	A		Cervical head harness/halter					
E0943	A		Cervical pillow					
E0944	A		Pelvic belt/harness/boot					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0945	A		Belt/harness extremity					
E0946	A		Fracture frame dual w cross					
E0947	A		Fracture frame attachmnts pe					
E0948	A		Fracture frame attachmnts ce					
E0950	E		Tray					
E0951	E		Loop heel					
E0952	E		Loop tie					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	E		Amputee adapter					
E0961	E		Wheelchair brake extension					
E0962	A		Wheelchair 1 inch cushion					
E0963	A		Wheelchair 2 inch cushion					
E0964	A		Wheelchair 3 inch cushion					
E0965	A		Wheelchair 4 inch cushion					
E0966	E		Wheelchair head rest extensi					
E0967	E		Wheelchair hand rims					
E0968	A		Wheelchair commode seat					
E0969	E		Wheelchair narrowing device					
E0970	E		Wheelchair no. 2 footplates					
E0971	E		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	E		Wheelchair adjustabl height					
E0974	E		Wheelchair grade-aid					
E0975	E		Wheelchair reinforced seat u					
E0976	E		Wheelchair reinforced back u					
E0977	E		Wheelchair wedge cushion					
E0978	E		Wheelchair belt w/airplane b					
E0979	E		Wheelchair belt with velcro					
E0980	E		Wheelchair safety vest					
E0990	E		Whellchair elevating leg res					
E0991	E		Wheelchair upholstry seat					
E0992	E		Wheelchair solid seat insert					
E0993	E		Wheelchair back upholstery					
E0994	E		Wheelchair arm rest					
E0995	E		Wheelchair calf rest					
E0996	E		Wheelchair tire solid					
E0997	E		Wheelchair caster w/ a fork					
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		Ped wc modify width adjustm					
E1012	A		Int seat sys planar ped w/c					
E1013	A		Int seat sys contour ped w/c					
E1014	A		Reclining back add ped w/c					
E1015	A		Shock absorber for man w/c					
E1016	A		Shock absorber for power w/c					
E1017	A		HD shck absrbr for hd man wc					
E1018	A		HD shck absrber for hd powwc					
E1020	A		Residual limb support system					
E1025	A		Pedwc lat/thor sup nocontour					
E1026	A		Pedwc contoured lat/thor sup					
E1027	A		Ped wc lat/ant support					
E1031	A		Rollabout chair with casters					
E1035	E		Patient transfer system					
E1037	A		Transport chair, ped size					
E1038	A		Transport chair, adult size					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					
E1065	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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	A		Whlchr moto ful arm leg rest					
E1211	A		Wheelchair motorized w/ det					
E1212	A		Wheelchair motorized w full					
E1213	A		Wheelchair motorized w/ det					
E1220	A		Whlchr special size/constrc					
E1221	A		Wheelchair spec size w foot					
E1222	A		Wheelchair spec size w/ leg					
E1223	A		Wheelchair spec size w foot					
E1224	A		Wheelchair spec size w/ leg					
E1225	A		Wheelchair spec sz semi-recl					
E1226	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		Rigid ped w/c tilt-in-space					
E1232	A		Folding ped wc tilt-in-space					
E1233	A		Rig ped wc tltnspc w/o seat					
E1234	A		Fld ped wc tltnspc w/o seat					
E1235	A		Rigid ped wc adjustable					
E1236	A		Folding ped wc adjustable					
E1237	A		Rgd ped wc adjstabl w/o seat					
E1238	A		Fld ped wc adjstabl w/o seat					
E1240	A		Whchr litwt det arm leg rest					
E1250	A		Wheelchair lightwt fixed arm					
E1260	A		Wheelchair lightwt foot rest					
E1270	A		Wheelchair lightweight leg r					
E1280	A		Whchr h-duty det arm leg res					
E1285	A		Wheelchair heavy duty fixed					
E1290	A		Wheelchair hvy duty detach a					
E1295	A		Wheelchair heavy duty fixed					
E1296	A		Wheelchair special seat heig					
E1297	A		Wheelchair special seat dept					
E1298	A		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	A		Whirlpool non-portable					
E1340	A		Repair for DME, per 15 min					
E1353	A		Oxygen supplies regulator					
E1355	A		Oxygen supplies stand/rack					
E1372	A		Oxy suppl heater for nebuliz					
E1390	A		Oxygen concentrator					
E1399	A		Durable medical equipment mi					
E1405	A		O2/water vapor enrich w/heat					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	A		Jaw motion rehab system					
E1701	A		Repl cushions for jaw motion					
E1702	A		Repl measr scales jaw motion					
E1800	A		Adjust elbow ext/flex device					
E1801	A		SPS elbow device					
E1802	A		Adjst forearm pro/sup device					
E1805	A		Adjust wrist ext/flex device					
E1806	A		SPS wrist device					
E1810	A		Adjust knee ext/flex device					
E1811	A		SPS knee device					
E1815	A		Adjust ankle ext/flex device					
E1816	A		SPS ankle device					
E1818	A		SPS forearm device					
E1820	A		Soft interface material					
E1821	A		Replacement interface SPSD					
E1825	A		Adjust finger ext/flex devc					
E1830	A		Adjust toe ext/flex device					
E1840	A		Adj shoulder ext/flex device					
E1902	A		AAC non-electronic board					
E2000	A		Gastric suction pump hme mdl					
E2100	A		Bld glucose monitor w voice					
E2101	A		Bld glucose monitor w lance					
G0001	A		Drawing blood for specimen					
G0008	L		Admin influenza virus vac					
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.2667	$14.48		$2.90
G0025	N		Collagen skin test kit					
G0030	S		PET imaging prev PET single	0285	19.5044	$1,058.87	$409.56	$211.77
G0031	S		PET imaging prev PET multple	0285	19.5044	$1,058.87	$409.56	$211.77
G0032	S		PET follow SPECT 78464 singl	0285	19.5044	$1,058.87	$409.56	$211.77
G0033	S		PET follow SPECT 78464 mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0034	S		PET follow SPECT 76865 singl	0285	19.5044	$1,058.87	$409.56	$211.77
G0035	S		PET follow SPECT 78465 mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0036	S		PET follow cornry angio sing	0285	19.5044	$1,058.87	$409.56	$211.77
G0037	S		PET follow cornry angio mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0038	S		PET follow myocard perf sing	0285	19.5044	$1,058.87	$409.56	$211.77
G0039	S		PET follow myocard perf mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0040	S		PET follow stress echo singl	0285	19.5044	$1,058.87	$409.56	$211.77
G0041	S		PET follow stress echo mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0042	S		PET follow ventriculogm sing	0285	19.5044	$1,058.87	$409.56	$211.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0043	S		PET follow ventriculogm mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0044	S		PET following rest ECG singl	0285	19.5044	$1,058.87	$409.56	$211.77
G0045	S		PET following rest ECG mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0046	S		PET follow stress ECG singl	0285	19.5044	$1,058.87	$409.56	$211.77
G0047	S		PET follow stress ECG mult	0285	19.5044	$1,058.87	$409.56	$211.77
G0101	V		CA screen;pelvic/breast exam	0600	0.9376	$50.90		$10.18
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.7168	$147.49	$36.87	$29.50
G0105	T		Colorectal scrn; hi risk ind	0158	7.4187	$402.75	$100.69	$80.55
G0106	S		Colon CA screen;barium enema	0157	2.4771	$134.48		$26.90
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					
G0109	A		Diab manage trn ind/group					
G0110	A		Nett pulm-rehab educ; ind					
G0111	A		Nett pulm-rehab educ; group					
G0112	A		Nett;nutrition guid, initial					
G0113	A		Nett;nutrition guid,subseqnt					
G0114	A		Nett; psychosocial consult					
G0115	A		Nett; psychological testing					
G0116	A		Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.7379	$40.06	$14.97	$8.01
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7379	$40.06	$14.97	$8.01
G0120	S		Colon ca scrn; barium enema	0157	2.4771	$134.48		$26.90
G0121	T		Colon ca scrn not hi rsk ind	0158	7.4187	$402.75	$100.69	$80.55
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	1516		$1,450.00		$290.00
G0127	T		Trim nail(s)	0009	0.6597	$35.81	$8.34	$7.16
G0128	E		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	3.8397	$208.45	$41.83	$41.69
G0130	X		Single energy x-ray study	0260	0.7845	$42.59	$21.29	$8.52
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	2.0622	$111.95		$22.39
G0167	E		Hyperbaric oz tx;no md reqrd					
G0168	X		Wound closure by adhesive	0340	0.6232	$33.83		$6.77
G0173	S		Stereo radoisurgery,complete	1528		$5,250.00		$1,050.00
G0175	V		OPPS Service,sched team conf	0602	1.5603	$84.71		$16.94
G0176	P		OPPS/PHP;activity therapy	0033	3.8397	$208.45	$41.83	$41.69
G0177	P		OPPS/PHP; train & educ serv	0033	3.8397	$208.45	$41.83	$41.69
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0186	T		Dstry eye lesn,fdr vssl tech	0235	4.9900	$270.90	$72.04	$54.18
G0202	A		Screeningmammographydigital					
G0204	S		Diagnosticmammographydigital	0669	0.9111	$49.46		$9.89
G0206	S		Diagnosticmammographydigital	0669	0.9111	$49.46		$9.89
G0210	S		PET img whbd ring dxlung ca	1516		$1,450.00		$290.00
G0211	S		PET img whbd ring init lung	1516		$1,450.00		$290.00
G0212	S		PET img whbd ring restag lun	1516		$1,450.00		$290.00
G0213	S		PET img whbd ring dx colorec	1516		$1,450.00		$290.00
G0214	S		PET img whbd ring init colre	1516		$1,450.00		$290.00
G0215	S		PET img whbd restag col	1516		$1,450.00		$290.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0216	S		PET img whbd ring dx melanom	1516		$1,450.00		$290.00
G0217	S		PET img whbd ring init melan	1516		$1,450.00		$290.00
G0218	S		PET img whbd ring restag mel	1516		$1,450.00		$290.00
G0219	E		PET img whbd ring noncov ind					
G0220	S		PET img whbd ring dx lymphom	1516		$1,450.00		$290.00
G0221	S		PET img whbd ring init lymph	1516		$1,450.00		$290.00
G0222	S		PET img whbd ring resta lymp	1516		$1,450.00		$290.00
G0223	S		PET img whbd reg ring dx hea	1516		$1,450.00		$290.00
G0224	S		PETimg whbd reg ring ini hea	1516		$1,450.00		$290.00
G0225	S		PET img whbd ring restag hea	1516		$1,450.00		$290.00
G0226	S		PET img whbd dx esophag	1516		$1,450.00		$290.00
G0227	S		PET img whbd ring ini esopha	1516		$1,450.00		$290.00
G0228	S		PET img whbd ring restg esop	1516		$1,450.00		$290.00
G0229	S		PET img metabolic brain ring	1516		$1,450.00		$290.00
G0230	S		PET myocard viability ring	1516		$1,450.00		$290.00
G0231	S		PET WhBD colorec; gamma cam	1516		$1,450.00		$290.00
G0232	S		PET whbd lymphoma; gamma cam	1516		$1,450.00		$290.00
G0233	S		PET whbd melanoma; gamma cam	1516		$1,450.00		$290.00
G0234	S		PET WhBD pulm nod; gamma cam	1516		$1,450.00		$290.00
G0236	S		Digital film convert diag ma	0410	0.1473	$8.00		$1.60
G0237	S		Therapeutic procd strg endur	0411	0.4207	$22.84		$4.57
G0238	S		Oth resp proc, indiv	0411	0.4207	$22.84		$4.57
G0239	S		Oth resp proc, group	0411	0.4207	$22.84		$4.57
G0242	S		Multisource photon ster plan	1516		$1,450.00		$290.00
G0243	S		Multisour photon stero treat	1528		$5,250.00		$1,050.00
G0244	S		Observ care by facility topt	0339	7.2016	$390.97		$78.19
G0245	V		Initial Foot Exam PTLOPS	0600	0.9376	$50.90		$10.18
G0246	V		Follow-up Eval of Foot PTLOPS	0600	0.9376	$50.90		$10.18
G0247	T		Routine footcare w LOPS	0009	0.6597	$35.81	$8.34	$7.16
G0248	S		Demonstrate use home INR mon	1503		$150.00		$30.00
G0249	S		Provide test material,equipm	1503		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S		Linear acc based stero radio	1513		$1,150.00		$230.00
G0252	E		PET imaging initial dx					
G0253	S		PET image brst dection recur	1516		$1,450.00		$290.00
G0254	S		PET image brst eval to tx	1516		$1,450.00		$290.00
G0255	E		Current percep threshold tst					
G0256	T		Prostate brachy w palladium	0649	119.0281	$6,461.92		$1,292.38
G0257	S		Unsched dialysis ESRD pt hos	0170	5.9427	$322.62		$64.52
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0204	2.2209	$120.57	$40.13	$24.11
G0261	T		Prostate brachy w iodine see	0684	104.7194	$5,685.11		$1,137.02
G0262	S		Sm intestinal image capsule	1508		$650.00		$130.00
G0263	N		Adm with CHF, CP, asthma					
G0264	V		Assmt otr CHF, CP, asthma	0600	0.9376	$50.90		$10.18
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.7128	$201.56		$40.31
G0268	X		Removal of impacted wax md	0340	0.6232	$33.83		$6.77
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
G0272	X		Naso/oro gastric tube pl MD	0272	1.4086	$76.47	$38.23	$15.29
G0273	S		Pretx planning, non-Hodgkins	0406	4.7542	$258.10		$51.62
G0274	S		Radiopharm tx, non-Hodgkins	0408	4.0000	$217.16		$43.43
G0275	N		Renal angio, cardiac cath					
G0278	N		Iliac art angio,cardiac cath					
G0279	A		Excorp shock tx, elbow epi					
G0280	A		Excorp shock tx other than					
G0281	A		Elec stim unattend for press					
G0282	A		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for surg plan	0414	4.8012	$260.65		$52.13
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	101.3662	$5,503.07		$1,100.61
G0291	T		Drug-eluting stents,each add	0656	101.3662	$5,503.07		$1,100.61

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0292	S		Adm exp drugs,clinical trial	1503		$150.00		$30.00
G0293	S		Non-cov surg proc,clin trial	1505		$350.00		$70.00
G0294	S		Non-cov proc, clinical trial	1502		$75.00		$15.00
G0295	E		Electromagnetic therapy onc					
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					
GXXX1	S		Infusion, pkgd noncancer	0382	4.6839	$254.28		$50.86
GXXX3	S		Pkgd cancer chemo, other	0376	2.1479	$116.61		$23.32
GXXX4	S		Infusion of pkgd cancer	0378	4.3955	$238.63		$47.73
GXXX5	S		Pkgd cancer chemo, both	0380	5.1857	$281.53		$56.31
GYYY1	S		Infusion, separate noncancer	0383	1.8419	$99.99		$20.00
GYYY3	S		Sep cancer chemo, other	0377	0.6673	$36.23		$7.25
GYYY4	S		Infusion, separate cancer	0379	2.4298	$131.91		$26.38
GYYY5	S		Sep cancer chemo, both	0381	2.1596	$117.24		$23.45
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		MH health assess by non-md					
H0032	E		MH svc plan dev by non-md					
H0033	E		Oral med adm direct observe					
H0034	E		Med trng & support per 15min					
H0035	E		MH partial hosp tx under 24h					
H0036	E		Comm psy face-face per 15min					
H0037	E		Comm psy sup tx pgm per diem					
H0038	E		Self-help/peer svc per 15min					
H0039	E		Asser com tx face-face/15min					
H0040	E		Assert comm tx pgm per diem					
H0041	E		Fos c chld non-ther per diem					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
H0042	E		Fos c chld non-ther per mon					
H0043	E		Supported housing, per diem					
H0044	E		Supported housing, per month					
H0045	E		Respite not-in-home per diem					
H0046	E		Mental health service, nos					
H0047	E		Alcohol/drug abuse svc nos					
H0048	E		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		Nonmed family planning ed					
H1011	E		Family assessment					
H2000	E		Comp multidisipln evaluation					
H2001	E		Rehabilitation program 1/2 d					
J0120	N		Tetracyclin injection					
J0130	K		Abciximab injection	1605	5.2806	$286.68		$57.34
J0150	N		Injection adenosine 6 MG					
J0151	K		Adenosine injection	0917	2.3474	$127.44		$25.49
J0170	N		Adrenalin epinephrin inject					
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	K		Alglucerase injection	0900	0.5473	$29.71		$5.94
J0207	K		Amifostine	7000	3.9932	$216.79		$43.36
J0210	N		Methyldopate hcl injection					
J0256	K		Alpha 1 proteinase inhibitor	0901	0.0214	$1.16		$.23
J0270	E		Alprostadil for injection					
J0275	E		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	N		Amiodarone HCl					
J0285	N		Amphotericin B					
J0287	K		Amphotericin b lipid complex	9024	0.4174	$22.66		$4.53
J0288	N		Ampho b cholesteryl sulfate					
J0289	N		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	K		Injection anistreplase 30 u	1606	25.3116	$1,374.14		$274.83
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	0.0460	$2.50		$.50
J0587	K		Botulinum toxin type B	9018	0.1272	$6.91		$1.38
J0592	N		Buprenorphine hydrochloride					
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					
J0630	N		Calcitonin salmon injection					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0636	N		Inj calcitriol per 0.1 mcg					
J0637	K		Caspofungin acetate	9019	0.5334	$28.96		$5.79
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
J0710	N		Cephapirin sodium injection					
J0713	N		Inj ceftazidime per 500 mg					
J0715	N		Ceftizoxime sodium / 500 MG					
J0720	N		Chloramphenicol sodium injec					
J0725	N		Chorionic gonadotropin/1000u					
J0735	N		Clonidine hydrochloride					
J0740	N		Cidofovir injection					
J0743	N		Cilastatin sodium injection					
J0744	N		Ciprofloxacin iv					
J0745	N		Inj codeine phosphate /30 MG					
J0760	N		Colchicine injection					
J0770	N		Colistimethate sodium inj					
J0780	N		Prochlorperazine injection					
J0800	N		Corticotropin injection					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903	5.0754	$275.54		$55.11
J0880	E		Darbepoetin alfa injection					
J0895	N		Deferoxamine mesylate inj					
J0900	N		Testosterone enanthate inj					
J0945	N		Brompheniramine maleate inj					
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1051	N		Medroxyprogesterone inj					
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N		Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	N		Inj dihydroergotamine mesylt					
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	N		Dyphylline injection					
J1190	K		Dexrazoxane HCl injection	0726	1.9860	$107.82		$21.56
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					
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	K		Eptifibatide injection	1607	0.1426	$7.74		$1.55
J1330	N		Ergonovine maleate injection					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	2.2544	$122.39		$24.48
J1441	K		Filgrastim 480 mcg injection	7049	3.1998	$173.71		$34.74
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					
J1563	K		Immune globulin, 1 g	0905	0.8103	$43.99		$8.80
J1564	K		Immune globulin 10 mg	9021	0.0080	$.43		$.09
J1565	K		RSV-ivig	0906	6.0142	$326.50		$65.30
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		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	0.6841	$37.14		$7.43
J1750	N		Iron dextran					
J1756	N		Iron sucrose injection					
J1785	K		Injection imiglucerase /unit	0916	0.0531	$2.88		$.58
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N		Insulin injection					
J1817	N		Insulin for insulin pump use					
J1825	K		Interferon beta-1a	0909	2.8010	$152.06		$30.41
J1830	K		Interferon beta-1b / .25 MG	0910	1.9843	$107.73		$21.55
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	3.3020	$179.26		$35.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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, per 5 mg					
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		Nesiritide, per 0.5 mg vial	9114		$144.40		$21.58
J2352	K		Octreotide acetate injection	7031	1.0339	$56.13		$11.23
J2355	K		Oprelvekin injection	7011	2.7246	$147.92		$29.58
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	2.0537	$111.49		$22.30
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2501	N		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					
J2765	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2788	K		Rho d immune globulin 50 mcg	9023	0.0523	$2.84		$.57
J2790	K		Rho d immune globulin inj	0884	0.2312	$12.55		$2.51
J2792	K		Rho(D) immune globulin h, sd	1609	0.1863	$10.11		$2.02
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	N		Sargramostim injection					
J2910	N		Aurothioglucose injeciton					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2912	N		Sodium chloride injection					
J2916	N		Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034	0.9206	$49.98		$10.00
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005	10.1332	$550.12		$110.02
J2995	K		Inj streptokinase /250000 IU	0911	1.6055	$87.16		$17.43
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	23.2303	$1,261.15		$252.23
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	6.6059	$358.63		$71.73
J3245	K		Tirofiban hydrochloride	7041	4.2976	$233.31		$46.66
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	1.2099	$65.68		$13.14
J3310	N		Perphenazine injeciton					
J3315	G		Triptorelin pamoate	9122		$415.24		$62.07
J3320	N		Spectinomycn di-hcl inj					
J3350	N		Urea injection					
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	K		Urokinase 250,000 IU inj	7036	5.1032	$277.05		$55.41
J3370	N		Vancomycin hcl injection					
J3395	K		Verteporfin injection	1203	16.1946	$879.19		$175.84
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		Zoledronic acid	9115		$203.40		$30.40
J3490	N		Drugs unclassified injection					
J3520	E		Edetate disodium per 150 mg					
J3530	N		Nasal vaccine inhalation					
J3535	E		Metered dose inhaler drug					
J3570	E		Laetrile amygdalin vit B17					
J3590	N		Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					
J7100	N		Dextran 40 infusion					
J7110	N		Dextran 75 infusion					
J7120	N		Ringers lactate infusion					
J7130	N		Hypertonic saline solution					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7190	K		Factor viii	0925	0.0085	$.46		$.09
J7191	K		Factor VIII (porcine)	0926	0.0253	$1.37		$.27
J7192	K		Factor viii recombinant	0927	0.0168	$.91		$.18
J7193	K		Factor IX non-recombinant	0931	0.0104	$.56		$.11
J7194	K		Factor ix complex	0928	0.0085	$.46		$.09
J7195	K		Factor IX recombinant	0932	0.0168	$.91		$.18
J7197	K		Antithrombin iii injection	0930	0.0117	$.64		$.13
J7198	K		Anti-inhibitor	0929	0.0168	$.91		$.18
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					
J7317	N		Sodium hyaluronate injection					
J7320	K		Hylan G-F 20 injection	1611	2.1566	$117.08		$23.42
J7330	E		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	N		Metabolically active tissue					
J7350	N		Injectable human tissue					
J7500	N		Azathioprine oral 50mg					
J7501	N		Azathioprine parenteral					
J7502	K		Cyclosporine oral 100 mg	0888	0.0482	$2.62		$.52
J7504	K		Lymphocyte immune globulin	0890	2.1958	$119.21		$23.84
J7505	K		Monoclonal antibodies	7038	5.8452	$317.33		$63.47
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891	0.0236	$1.28		$.26
J7508	E		Tacrolimus oral per 5 MG					
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104	2.9801	$161.79		$32.36
J7513	K		Daclizumab, parenteral	1612	3.7304	$202.52		$40.50
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015	0.0373	$2.02		$.40
J7520	K		Sirolimus, oral	9020	0.0520	$2.82		$.56
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		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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	K		Oral busulfan	7015	0.0263	$1.43		$.29
J8520	K		Capecitabine, oral, 150 mg	7042	0.0290	$1.57		$.31
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802	0.4830	$26.22		$5.24
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolmide	1086	0.0643	$3.49		$.70
J8999	E		Oral prescription drug chemo					
J9000	N		Doxorubic hcl 10 MG vl chemo					
J9001	K		Doxorubicin hcl liposome inj	7046	4.6362	$251.69		$50.34
J9010	K		Alemtuzumab injection	9110	7.6422	$414.89		$82.98
J9015	K		Aldesleukin/single use vial	0807	7.0936	$385.10		$77.02
J9017	K		Arsenic trioxide	9012	0.4837	$26.26		$5.25
J9020	N		Asparaginase injection					
J9031	N		Bcg live intravesical vac					
J9040	K		Bleomycin sulfate injection	0857	2.2352	$121.35		$24.27
J9045	K		Carboplatin injection	0811	1.5475	$84.01		$16.80
J9050	K		Carmus bischl nitro inj	0812	0.9972	$54.14		$10.83
J9060	K		Cisplatin 10 MG injection	0813	0.3594	$19.51		$3.90
J9062	E		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858	0.7031	$38.17		$7.63
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	.6052	$32.86		$6.57
J9151	K		Daunorubicin citrate liposom	0821	2.9697	$161.22		$32.24
J9160	K		Denileukin diftitox, 300 mcg	1084	15.0913	$819.29		$163.86
J9165	K		Diethylstilbestrol injection	0822	1.3274	$72.06		$14.41
J9170	K		Docetaxel	0823	4.0041	$217.38		$43.48
J9180	E		Epirubicin HCl injection					
J9181	N		Etoposide 10 MG inj					
J9182	E		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842	3.6854	$200.08		$40.02
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827	2.1836	$118.55		$23.71
J9201	K		Gemcitabine HCl	0828	1.4523	$78.84		$15.77
J9202	K		Goserelin acetate implant	0810	4.9549	$269.00		$53.80
J9206	K		Irinotecan injection	0830	1.8626	$101.12		$20.22
J9208	K		Ifosfomide injection	0831	1.1616	$63.06		$12.61
J9209	K		Mesna injection	0732	0.4908	$26.65		$5.33
J9211	K		Idarubicin hcl injection	0832	3.2438	$176.10		$35.22
J9212	N		Interferon alfacon-1					
J9213	N		Interferon alfa-2a inj					
J9214	K		Interferon alfa-2b inj	0836	0.2000	$10.86		$2.17
J9215	K		Interferon alfa-n3 inj	0865	1.5823	$85.90		$17.18
J9216	K		Interferon gamma 1-b inj	0838	2.4742	$134.32		$26.86
J9217	K		Leuprolide acetate suspnsion	9217	5.5128	$299.28		$59.86
J9218	K		Leuprolide acetate injeciton	0861	0.8223	$44.64		$8.93
J9219	K		Leuprolide acetate implant	7051	68.9392	$3,742.64		$748.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840	4.4072	$239.26		$47.85
J9250	N		Methotrexate sodium inj					
J9260	E		Methotrexate sodium inj					
J9265	K		Paclitaxel injection	0863	1.2674	$68.81		$13.76
J9266	K		Pegaspargase/singl dose vial	0843	5.7621	$312.82		$62.56
J9268	K		Pentostatin injection	0844	17.4201	$945.72		$189.14
J9270	N		Plicamycin (mithramycin) inj					
J9280	K		Mitomycin 5 MG inj	0862	0.9557	$51.88		$10.38
J9290	E		Mitomycin 20 MG inj					
J9291	E		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	3.1513	$171.08		$34.22
J9300	K		Gemtuzumab ozogamicin	9004	17.5020	$950.17		$190.03
J9310	K		Rituximab cancer treatment	0849	5.5636	$302.04		$60.41
J9320	K		Streptozocin injection	0850	1.3942	$75.69		$15.14
J9340	N		Thiotepa injection					
J9350	K		Topotecan	0852	7.9075	$429.29		$85.86
J9355	K		Trastuzumab	1613	0.7384	$40.09		$8.02
J9357	K		Valrubicin, 200 mg	1614	9.6183	$522.17		$104.43
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	1.1683	$63.43		$12.69
J9600	K		Porfimer sodium	0856	25.3788	$1,377.79		$275.56
J9999	N		Chemotherapy drug					
K0001	A		Standard wheelchair					
K0002	A		Stnd hemi (low seat) whlchr					
K0003	A		Lightweight wheelchair					
K0004	A		High strength ltwt whlchr					
K0005	A		Ultralightweight wheelchair					
K0006	A		Heavy duty wheelchair					
K0007	A		Extra heavy duty wheelchair					
K0009	A		Other manual wheelchair/base					
K0010	A		Stnd wt frame power whlchr					
K0011	A		Stnd wt pwr whlchr w control					
K0012	A		Ltwt portbl power whlchr					
K0014	A		Other power whlchr base					
K0015	A		Detach non-adjus hght armrst					
K0016	A		Detach adjust armrst cmplete					
K0017	A		Detach adjust armrest base					
K0018	A		Detach adjust armrst upper					
K0019	A		Arm pad each					
K0020	A		Fixed adjust armrest pair					
K0022	A		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					
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0045	A		Footrest complete assembly					
K0046	A		Elevat legrst low extension					
K0047	A		Elevat legrst up hangr brack					
K0048	A		Elevate legrest complete					
K0049	A		Calf pad each					
K0050	A		Ratchet assembly					
K0051	A		Cam relese assem ftrst/lgrst					
K0052	A		Swingaway detach footrest					
K0053	A		Elevate footrest articulate					
K0054	A		Seat wdth 10-12/15/17/20 wc					
K0055	A		Seat dpth 15/17/18 ltwt wc					
K0056	A		Seat ht >17 or <=21 ltwt wc					
K0057	A		Seat wdth 19/20 hvy dty wc					
K0058	A		Seat dpth 17/18 power wc					
K0059	A		Plastic coated handrim each					
K0060	A		Steel handrim each					
K0061	A		Aluminum handrim each					
K0062	A		Handrim 8-10 vert/obliq proj					
K0063	A		Hndrm 12-16 vert/obliq proj					
K0064	A		Zero pressure tube flat free					
K0065	A		Spoke protectors					
K0066	A		Solid tire any size each					
K0067	A		Pneumatic tire any size each					
K0068	A		Pneumatic tire tube each					
K0069	A		Rear whl complete solid tire					
K0070	A		Rear whl compl pneum tire					
K0071	A		Front castr compl pneum tire					
K0072	A		Frnt cstr cmpl sem-pneum tir					
K0073	A		Caster pin lock each					
K0074	A		Pneumatic caster tire each					
K0075	A		Semi-pneumatic caster tire					
K0076	A		Solid caster tire each					
K0077	A		Front caster assem complete					
K0078	A		Pneumatic caster tire tube					
K0079	A		Wheel lock extension pair					
K0080	A		Anti-rollback device pair					
K0081	A		Wheel lock assembly complete					
K0082	A		22 nf deep cycl acid battery					
K0083	A		22 nf gel cell battery each					
K0084	A		Grp 24 deep cycl acid battry					
K0085	A		Group 24 gel cell battery					
K0086	A		U-1 lead acid battery each					
K0087	A		U-1 gel cell battery each					
K0088	A		Battry chrgr acid/gel cell					
K0089	A		Battery charger dual mode					
K0090	A		Rear tire power wheelchair					
K0091	A		Rear tire tube power whlchr					
K0092	A		Rear assem cmplt powr whlchr					
K0093	A		Rear zero pressure tire tube					
K0094	A		Wheel tire for power base					
K0095	A		Wheel tire tube each base					
K0096	A		Wheel assem powr base complt					
K0097	A		Wheel zero presure tire tube					
K0098	A		Drive belt power wheelchair					
K0099	A		Pwr wheelchair front caster					
K0100	A		Amputee adapter pair					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0115	A		Back module orthotic system					
K0116	A		Back & seat modul orthot sys					
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					
K0556	A		Socket insert w lock mech					
K0557	A		Socket insert w/o lock mech					
K0558	A		Intl custm cong/atyp insert					
K0559	A		Initial custom socket insert					
K0560	N		Mcp joint 2-piece for implant					
K0581	A		Ost pch clsd w barrier/filtr					
K0582	A		Ost pch w bar/bltinconv/fltr					
K0583	A		Ost pch clsd w/o bar w filtr					
K0584	A		Ost pch for bar w flange/flt					
K0585	A		Ost pch clsd for bar w lk fl					
K0586	A		Ost pch for bar w lk fl/fltr					
K0587	A		Ost pch drain w bar & filter					
K0588	A		Ost pch drain for barrier fl					
K0589	A		Ost pch drain 2 piece system					
K0590	A		Ost pch drain/barr lk flng/f					
K0591	A		Urine ost pouch w faucet/tap					
K0592	A		Urine ost pouch w bltinconv					
K0593	A		Ost urine pch w b/bltin conv					
K0594	A		Ost pch urine w barrier/tapv					
K0595	A		Os pch urine w bar/fange/tap					
K0596	A		Urine ost pch bar w lock fln					
K0597	A		Ost pch urine w lock flng/ft					
K0600	A		Functional neuromuscular stim					
K0601	A		Repl batt silver oxide 1.5 v					
K0602	A		Repl batt silver oxide 3 v					
K0603	A		Repl batt alkaline 1.5 v					
K0604	A		Repl batt lithium 3.6 v					
K0605	A		Repl batt lithium 4.5 v					
K0606	A		AED garment w/elec analysis					
K0607	A		Repl batt for AED device					
K0608	A		Repl garment for AED					
K0609	A		Repl electrode for AED					
K0610	A		Peritoneal dialysis clamp					
K0611	A		Disposable cycler set					
K0612	A		Drainage ext line, dialysis					
K0613	A		Ext line w/easy lock connect					
K0614	A		Chem/antiseptic solution, 8oz					
K0615	A		SGD prerec mes >8min <20min					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0616	A		SGD prerec mes >20min <40min					
K0617	A		SGD prerec mes >40min					
K0618	A		TLSO 2 piece rigid shell					
K0619	A		TLSO 3 piece rigid shell					
K0620	A		Tubular elastic dressing					
K0621	A		Gauze, non-impreg pack strip					
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					
L0450	A		TLSO flex prefab thoracic					
L0452	A		tlso flex custom fab thoraci					
L0454	A		TLSO flex prefab sacrococ-T9					
L0456	A		TLSO flex prefab					
L0458	A		TLSO 2Mod symphis-xipho pre					
L0460	A		TLSO2Mod symphysis-stern pre					
L0462	A		TLSO 3Mod sacro-scap pre					
L0464	A		TLSO 4Mod sacro-scap pre					
L0466	A		TLSO rigid frame pre soft ap					
L0468	A		TLSO rigid frame prefab pelv					
L0470	A		TLSO rigid frame pre subclav					
L0472	A		TLSO rigid frame hyperex pre					
L0474	A		TLSO rigid frame pre pelvic					
L0476	A		TLSO flexion compres jac pre					
L0478	A		TLSO flexion compres jac cus					
L0480	A		TLSO rigid plastic custom fa					
L0482	A		TLSO rigid lined custom fab					
L0484	A		TLSO rigid plastic cust fab					
L0486	A		TLSO rigidlined cust fab two					
L0488	A		TLSO rigid lined pre one pie					
L0490	A		TLSO rigid plastic pre one					
L0500	A		Lso flex surgical support					
L0510	A		Lso flexible custom fabricat					
L0515	A		Lso flex elas w/ rig post pa					
L0520	A		Lso a-p-l control with apron					
L0530	A		Lso ant-pos control w apron					
L0540	A		Lso lumbar flexion a-p-l					
L0550	A		Lso a-p-l control molded					
L0560	A		Lso a-p-l w interface					
L0561	A		Prefab lso					
L0565	A		Lso a-p-l control custom					
L0600	A		Sacroiliac flex surg support					
L0610	A		Sacroiliac flexible custm fa					
L0620	A		Sacroiliac semi-rig w apron					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
L1005	A		Tension based scoliosis orth					
L1010	A		Ctlso axilla sling					
L1020	A		Kyphosis pad					
L1025	A		Kyphosis pad floating					
L1030	A		Lumbar bolster pad					
L1040	A		Lumbar or lumbar rib pad					
L1050	A		Sternal pad					
L1060	A		Thoracic pad					
L1070	A		Trapezius sling					
L1080	A		Outrigger					
L1085	A		Outrigger bil w/ vert extens					
L1090	A		Lumbar sling					
L1100	A		Ring flange plastic/leather					
L1110	A		Ring flange plas/leather mol					
L1120	A		Covers for upright each					
L1200	A		Furnsh initial orthosis only					
L1210	A		Lateral thoracic extension					
L1220	A		Anterior thoracic extension					
L1230	A		Milwaukee type superstructur					
L1240	A		Lumbar derotation pad					
L1250	A		Anterior asis pad					
L1260	A		Anterior thoracic derotation					
L1270	A		Abdominal pad					
L1280	A		Rib gusset (elastic) each					
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A		HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					
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		Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		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/					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2240	A		Round caliper and plate atta					
L2250	A		Foot plate molded stirrup at					
L2260	A		Reinforced solid stirrup					
L2265	A		Long tongue stirrup					
L2270	A		Varus/valgus strap padded/li					
L2275	A		Plastic mod low ext pad/line					
L2280	A		Molded inner boot					
L2300	A		Abduction bar jointed adjust					
L2310	A		Abduction bar-straight					
L2320	A		Non-molded lacer					
L2330	A		Lacer molded to patient mode					
L2335	A		Anterior swing band					
L2340	A		Pre-tibial shell molded to p					
L2350	A		Prosthetic type socket molde					
L2360	A		Extended steel shank					
L2370	A		Patten bottom					
L2375	A		Torsion ank & half solid sti					
L2380	A		Torsion straight knee joint					
L2385	A		Straight knee joint heavy du					
L2390	A		Offset knee joint each					
L2395	A		Offset knee joint heavy duty					
L2397	A		Suspension sleeve lower ext					
L2405	A		Knee joint drop lock ea jnt					
L2415	A		Knee joint cam lock each joi					
L2425	A		Knee disc/dial lock/adj flex					
L2430	A		Knee jnt ratchet lock ea jnt					
L2435	A		Knee joint polycentric joint					
L2492	A		Knee lift loop drop lock rin					
L2500	A		Thi/glut/ischia wgt bearing					
L2510	A		Th/wght bear quad-lat brim m					
L2520	A		Th/wght bear quad-lat brim c					
L2525	A		Th/wght bear nar m-l brim mo					
L2526	A		Th/wght bear nar m-l brim cu					
L2530	A		Thigh/wght bear lacer non-mo					
L2540	A		Thigh/wght bear lacer molded					
L2550	A		Thigh/wght bear high roll cu					
L2570	A		Hip clevis type 2 posit jnt					
L2580	A		Pelvic control pelvic sling					
L2600	A		Hip clevis/thrust bearing fr					
L2610	A		Hip clevis/thrust bearing lo					
L2620	A		Pelvic control hip heavy dut					
L2622	A		Hip joint adjustable flexion					
L2624	A		Hip adj flex ext abduct cont					
L2627	A		Plastic mold recipro hip & c					
L2628	A		Metal frame recipro hip & ca					
L2630	A		Pelvic control band & belt u					
L2640	A		Pelvic control band & belt b					
L2650	A		Pelv & thor control gluteal					
L2660	A		Thoracic control thoracic ba					
L2670	A		Thorac cont paraspinal uprig					
L2680	A		Thorac cont lat support upri					
L2750	A		Plating chrome/nickel pr bar					
L2755	A		Carbon graphite lamination					
L2760	A		Extension per extension per					
L2768	A		Ortho sidebar disconnect					
L2770	A		Low ext orthosis per bar/jnt					
L2780	A		Non-corrosive finish					
L2785	A		Drop lock retainer each					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2999	A		Lower extremity orthosis NOS					
L3000	E		Ft insert ucb berkeley shell					
L3001	E		Foot insert remov molded spe					
L3002	E		Foot insert plastazote or eq					
L3003	E		Foot insert silicone gel eac					
L3010	E		Foot longitudinal arch suppo					
L3020	E		Foot longitud/metatarsal sup					
L3030	E		Foot arch support remov prem					
L3040	E		Ft arch suprt premold longit					
L3050	E		Foot arch supp premold metat					
L3060	E		Foot arch supp longitud/meta					
L3070	E		Arch suprt att to sho longit					
L3080	E		Arch supp att to shoe metata					
L3090	E		Arch supp att to shoe long/m					
L3100	E		Hallus-valgus nght dynamic s					
L3140	E		Abduction rotation bar shoe					
L3150	E		Abduct rotation bar w/o shoe					
L3160	E		Shoe styled positioning dev					
L3170	E		Foot plastic heel stabilizer					
L3201	E		Oxford w supinat/pronat inf					
L3202	E		Oxford w/ supinat/pronator c					
L3203	E		Oxford w/ supinator/pronator					
L3204	E		Hightop w/ supp/pronator inf					
L3206	E		Hightop w/ supp/pronator chi					
L3207	E		Hightop w/ supp/pronator jun					
L3208	E		Surgical boot each infant					
L3209	E		Surgical boot each child					
L3211	E		Surgical boot each junior					
L3212	E		Benesch boot pair infant					
L3213	E		Benesch boot pair child					
L3214	E		Benesch boot pair junior					
L3215	E		Orthopedic ftwear ladies oxf					
L3216	E		Orthoped ladies shoes dpth i					
L3217	E		Ladies shoes hightop depth i					
L3219	E		Orthopedic mens shoes oxford					
L3221	E		Orthopedic mens shoes dpth i					
L3222	E		Mens shoes hightop depth inl					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230	E		Custom shoes depth inlay					
L3250	E		Custom mold shoe remov prost					
L3251	E		Shoe molded to pt silicone s					
L3252	E		Shoe molded plastazote cust					
L3253	E		Shoe molded plastazote cust					
L3254	E		Orth foot non-stndard size/w					
L3255	E		Orth foot non-standard size/					
L3257	E		Orth foot add charge split s					
L3260	E		Ambulatory surgical boot eac					
L3265	E		Plastazote sandal each					
L3300	E		Sho lift taper to metatarsal					
L3310	E		Shoe lift elev heel/sole neo					
L3320	E		Shoe lift elev heel/sole cor					
L3330	E		Lifts elevation metal extens					
L3332	E		Shoe lifts tapered to one-ha					
L3334	E		Shoe lifts elevation heel /i					
L3340	E		Shoe wedge sach					
L3350	E		Shoe heel wedge					
L3360	E		Shoe sole wedge outside sole					
L3370	E		Shoe sole wedge between sole					
L3380	E		Shoe clubfoot wedge					
L3390	E		Shoe outflare wedge					
L3400	E		Shoe metatarsal bar wedge ro					
L3410	E		Shoe metatarsal bar between					
L3420	E		Full sole/heel wedge btween					
L3430	E		Sho heel count plast reinfor					
L3440	E		Heel leather reinforced					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3450	E		Shoe heel sach cushion type					
L3455	E		Shoe heel new leather standa					
L3460	E		Shoe heel new rubber standar					
L3465	E		Shoe heel thomas with wedge					
L3470	E		Shoe heel thomas extend to b					
L3480	E		Shoe heel pad & depress for					
L3485	E		Shoe heel pad removable for					
L3500	E		Ortho shoe add leather insol					
L3510	E		Orthopedic shoe add rub insl					
L3520	E		O shoe add felt w leath insl					
L3530	E		Ortho shoe add half sole					
L3540	E		Ortho shoe add full sole					
L3550	E		O shoe add standard toe tap					
L3560	E		O shoe add horseshoe toe tap					
L3570	E		O shoe add instep extension					
L3580	E		O shoe add instep velcro clo					
L3590	E		O shoe convert to sof counte					
L3595	E		Ortho shoe add march bar					
L3600	E		Trans shoe calip plate exist					
L3610	E		Trans shoe caliper plate new					
L3620	E		Trans shoe solid stirrup exi					
L3630	E		Trans shoe solid stirrup new					
L3640	E		Shoe dennis browne splint bo					
L3649	E		Orthopedic shoe modifica NOS					
L3650	A		Shlder fig 8 abduct restrain					
L3651	A		Prefab shoulder orthosis					
L3652	A		Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	E		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A		Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A		Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	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		Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A		Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5645	A		Bk flex inner socket ext fra					
L5646	A		Below knee air cushion socke					
L5647	A		Below knee suction socket					
L5648	A		Above knee air cushion socke					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5661	A		Multi-durometer symes					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
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		Lower limb pros vacuum pump					
L5782	A		HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5846	A		Knee-shin sys microprocessor					
L5847	A		Microprocessor cntrl feature					
L5848	A		Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					
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		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		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6388	A		Postop applicat rigid dsg on					
L6400	A		Below elbow prosth tiss shap					
L6450	A		Elb disart prosth tiss shap					
L6500	A		Above elbow prosth tiss shap					
L6550	A		Shldr disar prosth tiss shap					
L6570	A		Scap thorac prosth tiss shap					
L6580	A		Wrist/elbow bowden cable mol					
L6582	A		Wrist/elbow bowden cbl dir f					
L6584	A		Elbow fair lead cable molded					
L6586	A		Elbow fair lead cable dir fo					
L6588	A		Shdr fair lead cable molded					
L6590	A		Shdr fair lead cable direct					
L6600	A		Polycentric hinge pair					
L6605	A		Single pivot hinge pair					
L6610	A		Flexible metal hinge pair					
L6615	A		Disconnect locking wrist uni					
L6616	A		Disconnect insert locking wr					
L6620	A		Flexion-friction wrist unit					
L6623	A		Spring-ass rot wrst w/ latch					
L6625	A		Rotation wrst w/ cable lock					
L6628	A		Quick disconn hook adapter o					
L6629	A		Lamination collar w/ couplin					
L6630	A		Stainless steel any wrist					
L6632	A		Latex suspension sleeve each					
L6635	A		Lift assist for elbow					
L6637	A		Nudge control elbow lock					
L6638	A		Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A		Multipo locking shoulder jnt					
L6647	A		Shoulder lock actuator					
L6648	A		Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model#555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					
L6835	A		Hand sierra vo					
L6840	A		Hand becker imperial					
L6845	A		Hand becker lock grip					
L6850	A		Term dvc-hand becker plylite					
L6855	A		Hand robin-aids vo					
L6860	A		Hand robin-aids vo soft					
L6865	A		Hand passive hand					
L6867	A		Hand detroit infant hand					
L6868	A		Passive inf hand steeper/hos					
L6870	A		Hand child mitt					
L6872	A		Hand nyu child hand					
L6873	A		Hand mech inf steeper or equ					
L6875	A		Hand bock vc					
L6880	A		Hand bock vo					
L6881	A		Autograsp feature ul term dv					
L6882	A		Microprocessor control uplmb					
L6890	A		Production glove					
L6895	A		Custom glove					
L6900	A		Hand restorat thumb/1 finger					
L6905	A		Hand restoration multiple fi					
L6910	A		Hand restoration no fingers					
L6915	A		Hand restoration replacmnt g					
L6920	A		Wrist disarticul switch ctrl					
L6925	A		Wrist disart myoelectronic c					
L6930	A		Below elbow switch control					
L6935	A		Below elbow myoelectronic ct					
L6940	A		Elbow disarticulation switch					
L6945	A		Elbow disart myoelectronic c					
L6950	A		Above elbow switch control					
L6955	A		Above elbow myoelectronic ct					
L6960	A		Shldr disartic switch contro					
L6965	A		Shldr disartic myoelectronic					
L6970	A		Interscapular-thor switch ct					
L6975	A		Interscap-thor myoelectronic					
L7010	A		Hand otto back steeper/eq sw					
L7015	A		Hand sys teknik village swit					
L7020	A		Electronic greifer switch ct					
L7025	A		Electron hand myoelectronic					
L7030	A		Hand sys teknik vill myoelec					
L7035	A		Electron greifer myoelectro					
L7040	A		Prehensile actuator hosmer s					
L7045	A		Electron hook child michigan					
L7170	A		Electronic elbow hosmer swit					
L7180	A		Electronic elbow utah myoele					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A		Replacemnt lithium ionbatter					
L7368	A		Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Vacuum erection system					
L8000	A		Mastectomy bra					
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	N		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					
L8614	E		Cochlear device/system					
L8619	A		Replace cochlear processor					
L8630	N		Metacarpophalangeal implant					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint implnt					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.1062	$60.05		$12.01
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	1.4575	$79.13		$15.83
P9011	K		Blood split unit	0957	0.6870	$37.30		$7.46
P9012	K		Cryoprecipitate each unit	0952	0.4860	$26.38		$5.28
P9016	K		RBC leukocytes reduced	0954	1.9770	$107.33		$21.47
P9017	K		One donor fresh frozn plasma	0955	1.5750	$85.51		$17.10
P9019	K		Platelets, each unit	0957	0.6870	$37.30		$7.46
P9020	K		Plaelet rich plasma unit	0958	1.1296	$61.32		$12.26
P9021	K		Red blood cells unit	0959	1.4326	$77.77		$15.55
P9022	K		Washed red blood cells unit	0960	2.6638	$144.62		$28.92
P9023	K		Frozen plasma, pooled, sd	0949	2.0608	$111.88		$22.38
P9031	K		Platelets leukocytes reduced	1013	0.9101	$49.41		$9.88
P9032	K		Platelets, irradiated	9500	1.2398	$67.31		$13.46
P9033	K		Platelets leukoreduced irrad	0954	1.9770	$107.33		$21.47
P9034	K		Platelets, pheresis	9501	6.7772	$367.93		$73.59
P9035	K		Platelet pheres leukoreduced	9501	6.7772	$367.93		$73.59
P9036	K		Platelet pheresis irradiated	9502	7.3552	$399.31		$79.86
P9037	K		Plate pheres leukoredu irrad	1019	6.7353	$365.65		$73.13
P9038	K		RBC irradiated	9505	1.8011	$97.78		$19.56
P9039	K		RBC deglycerolized	9504	3.9764	$215.87		$43.17
P9040	K		RBC leukoreduced irradiated	9504	3.9764	$215.87		$43.17
P9041	K		Albumin (human),5%, 50ml	0961	0.7319	$39.73		$7.95
P9043	K		Plasma protein fract,5%,50ml	0956	1.5414	$83.68		$16.74
P9044	K		Cryoprecipitatereducedplasma	1009	0.9447	$51.29		$10.26
P9045	K		Albumin (human), 5%, 250 ml	0963	3.4713	$188.45		$37.69
P9046	K		Albumin (human), 25%, 20 ml	0964	0.7911	$42.95		$8.59
P9047	K		Albumin (human), 25%, 50ml	0965	1.9432	$105.49		$21.10
P9048	K		Plasmaprotein fract,5%,250ml	0966	7.7071	$418.41		$83.68
P9050	K		Granulocytes, pheresis unit	9506	20.7004	$1,123.80		$224.76
P9603	A		One-way allow prorated miles					
P9604	A		One-way allow prorated trip					
P9612	N		Catheterize for urine spec					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9615	N		Urine specimen collect mult					
Q0035	X		Cardiokymography	0100	1.6726	$90.80	$41.44	$18.16
Q0081	E		Infusion ther other than che					
Q0083	E		Chemo by other than infusion					
Q0084	E		Chemotherapy by infusion					
Q0085	E		Chemo by both infusion and o					
Q0086	A		Physical therapy evaluation/					
Q0091	T		Obtaining screen pap smear	0191	0.1679	$9.12	$2.65	$1.82
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733	0.1782	$9.67		$1.93
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					
Q0187	K		Factor viia recombinant	1409	17.9693	$975.54		$195.11
Q1001	N		Ntiol category 1					
Q1002	N		Ntiol category 2					
Q1003	N		Ntiol category 3					
Q1004	N		Ntiol category 4					
Q1005	N		Ntiol category 5					
Q2001	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	3.4880	$189.36		$37.87
Q2006	K		Digoxin immune fab (ovine)	7025	4.4789	$243.16		$48.63
Q2007	N		Ethanolamine oleate 100 mg					
Q2008	K		Fomepizole, 15 mg	7027	0.2215	$12.03		$2.41
Q2009	N		Fosphenytoin, 50 mg					
Q2010	N		Glatiramer acetate, per dose					
Q2011	K		Hemin, per 1 mg	7030	0.0119	$.65		$.13
Q2012	N		Pegademase bovine, 25 iu					
Q2013	N		Pentastarch 10% solution					
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035	1.5530	$84.31		$16.86
Q2018	K		Urofollitropin, 75 iu	7037	1.1321	$61.46		$12.29
Q2019	K		Basiliximab	1615	11.2007	$608.07		$121.61
Q2020	E		Histrelin acetate					
Q2021	N		Lepirudin					
Q2022	K		VonWillebrandFactrCmplxperIU	1618	0.0168	$.91		$.18
Q3000	K		Rubidium-Rb-82	9025	2.5939	$140.82		$28.16
Q3001	N		Brachytherapy Radioelements					
Q3002	N		Gallium ga 67					
Q3003	K		Technetium tc99m bicisate	1620	3.3106	$179.73		$35.95

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	6.8170	$370.09		$74.02
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	2.0103	$109.14		$21.83
Q3012	N		Cyanocobalamin cobalt co57					
Q3014	A		Telehealth facility fee					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3021	E		Ped hepatitis b vaccine inj					
Q3022	E		Hepatitis b vaccine adult ds					
Q3023	E		Injection hepatitis Bvaccine					
Q3025	K		IM inj interferon beta 1-a	9022	0.9417	$51.12		$10.22
Q3026	N		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q4050	A		Cast supplies unlisted					
Q4051	A		Splint supplies misc					
Q4052	K		Octreotide injection, depot	1207	1.1849	$64.33		$12.87
Q4053	G		Pegfilgrastim, per 1 mg	9119		$467.09		$69.82
Q9920	A		Epoetin with hct <= 20					
Q9921	A		Epoetin with hct = 21					
Q9922	A		Epoetin with hct = 22					
Q9923	A		Epoetin with hct = 23					
Q9924	A		Epoetin with hct = 24					
Q9925	A		Epoetin with hct = 25					
Q9926	A		Epoetin with hct = 26					
Q9927	A		Epoetin with hct = 27					
Q9928	A		Epoetin with hct = 28					
Q9929	A		Epoetin with hct = 29					
Q9930	A		Epoetin with hct = 30					
Q9931	A		Epoetin with hct = 31					
Q9932	A		Epoetin with hct = 32					
Q9933	A		Epoetin with hct = 33					
Q9934	A		Epoetin with hct = 34					
Q9935	A		Epoetin with hct = 35					
Q9936	A		Epoetin with hct = 36					
Q9937	A		Epoetin with hct = 37					
Q9938	A		Epoetin with hct = 38					
Q9939	A		Epoetin with hct = 39					
Q9940	A		Epoetin with hct >= 40					
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
T1015	E		Clinic service					
T1016	E		Case management					
T1017	E		Targeted case management					
T1018	E		School-based IEP ser bundled					
T1019	E		Personal care ser per 15 min					
T1020	E		Personal care ser per diem					
T1021	E		HH Aide or cn aide per visit					
T1022	E		Contracted services per day					
T1023	E		Program intake assessment					
T1024	E		Team evaluation & management					
T1025	E		Ped compr care pkg, per diem					
T1026	E		Ped compr care pkg, per hour					
T1027	E		Family training & counseling					
T1028	E		Home environment assessment					
T1029	E		Dwelling lead investigation					
T1030	E		RN home care per diem					
T1031	E		LPN home care per diem					
T1500	E		Reusable diaper/pant					
T1502	E		Medication admin visit					
T1999	E		NOC retail items andsupplies					
T2001	E		N-et; patient attend/escort					
T2002	E		N-et; per diem					
T2003	E		N-et; encounter/trip					
T2004	E		N-et; commerc carrier pass					
T2005	E		N-et; stretcher van					
T2006	E		Amb response & trt, no trans					
T2007	E		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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2109	A		Spherocylinder 4.25d/4.25-6d					
V2110	A		Spherocylinder 4.25d/over 6d					
V2111	A		Spherocylindr 7.25d/.25-2.25					
V2112	A		Spherocylindr 7.25d/2.25-4d					
V2113	A		Spherocylindr 7.25d/4.25-6d					
V2114	A		Spherocylinder over 12.00d					
V2115	A		Lens lenticular bifocal					
V2116	A		Nonaspheric lens bifocal					
V2117	A		Aspheric lens bifocal					
V2118	A		Lens aniseikonic single					
V2199	A		Lens single vision not oth c					
V2200	A		Lens spher bifoc plano 4.00d					
V2201	A		Lens sphere bifocal 4.12-7.0					
V2202	A		Lens sphere bifocal 7.12-20.					
V2203	A		Lens sphcyl bifocal 4.00d/.1					
V2204	A		Lens sphcy bifocal 4.00d/2.1					
V2205	A		Lens sphcy bifocal 4.00d/4.2					
V2206	A		Lens sphcy bifocal 4.00d/ove					
V2207	A		Lens sphcy bifocal 4.25-7d/.					
V2208	A		Lens sphcy bifocal 4.25-7/2.					
V2209	A		Lens sphcy bifocal 4.25-7/4.					
V2210	A		Lens sphcy bifocal 4.25-7/ov					
V2211	A		Lens sphcy bifo 7.25-12/.25-					
V2212	A		Lens sphcyl bifo 7.25-12/2.2					
V2213	A		Lens sphcyl bifo 7.25-12/4.2					
V2214	A		Lens sphcyl bifocal over 12.					
V2215	A		Lens lenticular bifocal					
V2216	A		Lens lenticular nonaspheric					
V2217	A		Lens lenticular aspheric bif					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2299	A		Lens bifocal speciality					
V2300	A		Lens sphere trifocal 4.00d					
V2301	A		Lens sphere trifocal 4.12-7.					
V2302	A		Lens sphere trifocal 7.12-20					
V2303	A		Lens sphcy trifocal 4.0/.12-					
V2304	A		Lens sphcy trifocal 4.0/2.25					
V2305	A		Lens sphcy trifocal 4.0/4.25					
V2306	A		Lens sphcyl trifocal 4.00/>6					
V2307	A		Lens sphcy trifocal 4.25-7/.					
V2308	A		Lens sphc trifocal 4.25-7/2.					
V2309	A		Lens sphc trifocal 4.25-7/4.					
V2310	A		Lens sphc trifocal 4.25-7/>6					
V2311	A		Lens sphc trifo 7.25-12/.25-					
V2312	A		Lens sphc trifo 7.25-12/2.25					
V2313	A		Lens sphc trifo 7.25-12/4.25					
V2314	A		Lens sphcyl trifocal over 12					
V2315	A		Lens lenticular trifocal					
V2316	A		Lens lenticular nonaspheric					
V2317	A		Lens lenticular aspheric tri					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2740	A		Rose tint plastic					
V2741	A		Non-rose tint plastic					
V2742	A		Rose tint glass					
V2743	A		Non-rose tint glass					
V2744	A		Tint photochromatic lens/es					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2760	A		Scratch resistant coating					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	E		Progressive lens per lens					
V2785	F		Corneal tissue processing					
V2790	N		Amniotic membrane					
V2799	A		Miscellaneous vision service					
V5008	E		Hearing screening					
V5010	E		Assessment for hearing aid					
V5011	E		Hearing aid fitting/checking					
V5014	E		Hearing aid repair/modifying					
V5020	E		Conformity evaluation					
V5030	E		Body-worn hearing aid air					
V5040	E		Body-worn hearing aid bone					
V5050	E		Hearing aid monaural in ear					
V5060	E		Behind ear hearing aid					
V5070	E		Glasses air conduction					
V5080	E		Glasses bone conduction					
V5090	E		Hearing aid dispensing fee					
V5095	E		Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2004—Continued

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E		Hearing aid noc					
V5299	E		Hearing service					
V5336	E		Repair communication device					
V5362	A		Speech screening					
V5363	A		Language screening					
V5364	A		Dysphagia screening					

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Services Paid under a Fee Schedule Other than OPPS, *e.g.,* Clinical Diagnostic Laboratory Services; Physical, Occupational and Speech Therapy; and Screening Mammography.	Paid under a Payment System other than OPPS.
C	Inpatient Procedures	Not Paid under OPPS; Admit Patient; Bill as Inpatient.
D	Deleted Code	Not Paid under Medicare.
E	Non-Covered Items and Services; Codes not Payable in Hospital Outpatient Setting; Codes Not Recognized by OPPS but for Which an Alternate Code may be Applicable..	Not Covered under Medicare, or not an Allowed Code when Performed in a Hospital Outpatient Setting.
F	Corneal Tissue Acquisition	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 Agent, Certain Brachytherapy Sources.	Paid under OPPS; Separate APC.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Paid at Reasonable Cost; Not Subject to Deductible or Coinsurance.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Indicator	Service	Status
N	Items and Services Packaged into APC Rate	Paid under OPPS; Payment is Packaged into Payment for Other Services.
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	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC.
X	Ancillary Service	Paid under OPPS; Separate APC.

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
0001T	C	Endovas repr abdo ao aneurys
0002T	C	Endovas repr abdo ao aneurys
0005T	C	Perc cath stent/brain cv art
0006T	C	Perc cath stent/brain cv art
0007T	C	Perc cath stent/brain cv art
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
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
00562	C	Anesth, open heart surgery
00580	C	Anesth, heart/lung transplnt
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Incise burn scab, addl incis
19200	C	Removal of breast
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply, rem fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant forearm, complete
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
33979	C	Insert intracorporeal device
33980	C	Remove intracorporeal device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34804	C	Endovasc abdo repr w/device
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Femoral endovas graft add-on
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, addl
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Partial removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty congenital
43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/o taper, cong
44127	C	Enterectomy w/taper, cong
44128	C	Enterectomy cong, add-on

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservior
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49201	C	Remove abdom lesion, complex
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Renal abscess, open drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder/revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder/revise tract
51595	C	Remove bladder/revise tract
51596	C	Remove bladder/create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54411	C	Remov/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58146	C	Myomectomy abdom complex
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vag hyst including t/o
58263	C	Vag hyst w/t/o & vag repair
58267	C	Vag hyst w/urinary repair
58270	C	Vag hyst w/enterocele repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61320	C	Open skull for drainage
61321	C	Open skull for drainage
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr, simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61862	C	Implant neurostimul, subcort
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
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

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	Status indicator	Description
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
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.7678
Taylor, TX	
0060 Aguadilla, PR	0.4335
Aguada, PR	
Aguadilla, PR	
Moca, PR	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
0080 Akron, OH	0.9445
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0838
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8693
Albany, NY	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9431
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
0220 Alexandria, LA	0.8087
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9576
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8886
Blair, PA	
0320 Amarillo, TX	0.8968
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2433
Anchorage, AK	
0440 Ann Arbor, MI	1.1069
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8140
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI [2]	0.9130
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4130
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9697
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9664
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA [1]	1.0027
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	1.0862
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8540
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9725
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX [1]	0.9551
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA [2]	0.9907
Kern, CA	
0720 Baltimore, MD [1]	0.9951
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9750
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.2893
Barnstable, MA	
0760 Baton Rouge, LA	0.8271
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8503
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1834
Whatcom, WA	
0870 Benton Harbor, MI	0.8949
Berrien, MI	
0875 Bergen-Passaic, NJ [1]	1.1655
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8889
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.9089
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY [2]	0.8530
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9251
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.8101
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8968
Monroe, IN	
1040 Bloomington-Normal, IL	0.8954
McLean, IL	
1080 Boise City, ID	0.9295
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH [1]	1.1269
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0119
Boulder, CO	
1145 Brazoria, TX	0.8324
Brazoria, TX	
1150 Bremerton, WA	1.0601
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	21.0231
Cameron, TX	
1260 Bryan-College Station, TX.	
Brazos, TX	
0.9044.	
1280 Buffalo-Niagara Falls, NY [1]	0.9600
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9768
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4229
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9128
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9239
Natrona, WY	
1360 Cedar Rapids, IA	0.8933
Linn, IA	
1400 Champaign-Urbana, IL	0.9907
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9307
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8753
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC [1]	0.9766
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0092
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.8985
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY [2]	0.9137
Laramie, WY	
1600 Chicago, IL [1]	1.1012
Cook, IL	
DeKalb, IL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0147
Butte, CA	
1640 Cincinnati, OH-KY-IN [1]	0.9452
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	0.8410
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH [1]	0.9686
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO [2]	0.8897
El Paso, CO	
1740 Columbia, MO	0.8745
Boone, MO	
1760 Columbia, SC	0.8958
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8700
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH [1]	0.9649
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8565
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1593
Benton, OR	
1900 Cumberland, MD-WV [2] (MD Hospitals)	0.9175
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospitals)	0.8224
Allegany, MD	
Mineral, WV	
1920 Dallas, TX [1]	0.9733
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.9095
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8727
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9432
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9208
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8882
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL [2]	0.8282
Macon, IL	
2080 Denver, CO [1]	1.0776
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9053
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI [1]	1.0097
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7931
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9870
Kent, DE	
2200 Dubuque, IA	0.8946
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0133
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0966
Dutchess, NY	
2290 Eau Claire, WI	0.9141
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9267
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9848
Elkhart, IN	
2335 Elmira, NY [2]	0.8530
Chemung, NY	
2340 Enid, OK	0.8616
Garfield, OK	
2360 Erie, PA	0.8636
Erie, PA	
2400 Eugene-Springfield, OR	1.1212
Lane, OR	
2440 Evansville-Henderson, IN-KY [2] (IN Hospitals)	0.8770
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8442
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9650
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8957
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8038
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1283
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0929
Genesee, MI	
2650 Florence, AL	0.7824
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8763
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0201
Larimer, CO	
2680 Ft. Lauderdale, FL [1]	1.0534
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9877
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0227
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK [2] (AR Hospitals)	0.7746
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2720 Fort Smith, AR-OK (OK Hospitals)	0.7740
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8929
Okaloosa, FL	
2760 Fort Wayne, IN	0.9674
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX [1]	0.9268
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0157
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8295

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Etowah, AL	
2900 Gainesville, FL [2]	0.8782
Alachua, FL	
2920 Galveston-Texas City, TX	0.9360
Galveston, TX	
2960 Gary, IN	0.9462
Lake, IN	
Porter, IN	
2975 Glens Falls, NY [2]	0.8530
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8679
Wayne, NC	
2985 Grand Forks, ND-MN (ND Hospitals)	0.9031
Polk, MN	
Grand Forks, ND	
2985 Grand Forks, ND-MN [2] (MN Hospitals)	0.9243
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9940
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI [1]	0.9406
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8977
Cascade, MT	
3060 Greeley, CO	0.9516
Weld, CO	
3080 Green Bay, WI	0.9524
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC [1]	0.8533
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9621
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9289
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9233
Washington, MD	
3200 Hamilton-Middletown, OH	0.9236
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9178
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT [1, 2]	1.2199
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS [2]	0.7810
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9090
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1176
Honolulu, HI	
3350 Houma, LA	0.7763
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX [1]	0.9591
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9620
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9238
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN [1]	0.9934
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9605
Johnson, IA	
3520 Jackson, MI	0.9043
Jackson, MI	
3560 Jackson, MS	0.8459
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8602
Madison, TN	
Chester, TN	
3600 Jacksonville, FL [1]	0.9426
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8589
Onslow, NC	
3610 Jamestown, NY [2]	0.8530
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9344
Rock, WI	
3640 Jersey City, NJ	1.1203
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8371
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 Johnson City-Kingsport-Bristol, TN-VA [2] (VA Hospitals)	0.8542
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA [2]	0.8429
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR [2]	0.7755
Craighead, AR	
3710 Joplin, MO	0.8739
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0554
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.1074
Kankakee, IL	
3760 Kansas City, KS-MO [1]	0.9551
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	0.9826
Kenosha, WI	
3810 Killeen-Temple, TX	0.9221
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8987
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8963
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9259
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8271
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9052
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.8460
Calcasieu, LA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
3980 Lakeland-Winter Haven, FL [2]	0.8782
Polk, FL	
4000 Lancaster, PA	0.9325
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9270
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8145
Webb, TX	
4100 Las Cruces, NM	0.8532
Dona Ana, NM	
4120 Las Vegas, NV-AZ [1]	1.1457
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS [2]	0.7860
Douglas, KS	
4200 Lawton, OK	0.8322
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9389
Androscoggin, ME	
4280 Lexington, KY	0.8622
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9457
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0101
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8905
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9141
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA [1]	1.1656
Los Angeles, CA	
4520 Louisville, KY-IN [1]	0.9174
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8330
Lubbock, TX	
4640 Lynchburg, VA	0.9202
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9011
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0235
Dane, WI	
4800 Mansfield, OH	0.9059
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4780
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.9084
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0844
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9837
Brevard, Fl	
4920 Memphis, TN-AR-MS [1]	0.9325
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA [2]	0.9907
Merced, CA	
5000 Miami, FL [1]	0.9888
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ [1]	1.1437
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI [1]	0.9888
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI [1]	1.1064
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.8943
Missoula, MT	
5160 Mobile, AL	0.7948
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1344
Stanislaus, CA	
5190 Monmouth-Ocean, NJ [1]	1.1094
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7978
Ouachita, LA	
5240 Montgomery, AL	0.7856
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN [2]	0.8770
Delaware, IN	
5330 Myrtle Beach, SC	0.8950
Horry, SC	
5345 Naples, FL	0.9866
Collier, FL	
5360 Nashville, TN [1]	0.9836
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY [1]	1.3011
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT [1]	1.2525
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT [2]	1.2199
New London, CT	
5560 New Orleans, LA [1]	0.9167
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]	1.3867
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ [1]	1.1417
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1377
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC [1]	0.8659
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	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
York, VA	
5775 Oakland, CA [1]	1.5204
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9788
Marion, FL	
5800 Odessa-Midland, TX	0.9447
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK [1]	0.9027
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1030
Thurston, WA	
5920 Omaha, NE-IA	0.9744
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA [1]	1.1235
Orange, CA	
5960 Orlando, FL [1]	0.9612
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8429
Daviess, KY	
6015 Panama City, FL [2]	0.8782
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8093
Washington, OH	
Wood, WV	
6020 Parkersburg-Marietta, WV-OH [2] (OH Hospitals)	0.8756
Washington, OH	
Wood, WV	
6080 Pensacola, FL [2]	0.8782
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8811
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ [1]	1.0947
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ [1]	1.0213
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7753
Jefferson, AR	
6280 Pittsburgh, PA [1]	0.8788
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA [2]	1.1234
Berkshire, MA	
6340 Pocatello, ID	0.9103
Bannock, ID	
6360 Ponce, PR	0.4762
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9985
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA [1]	1.1193
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI [1]	1.1025
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0043
Utah, UT	
6560 Pueblo, CO [2]	0.8897
Pueblo, CO	
6580 Punta Gorda, FL	0.9518
Charlotte, FL	
6600 Racine, WI [2]	0.9130
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC [1]	1.0084
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8865
Pennington, SD	
6680 Reading, PA	0.9042
Berks, PA	
6690 Redding, CA	1.1357
Shasta, CA	
6720 Reno, NV	1.0758
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0639
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9402
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]	1.1318
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8759
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1802
Olmsted, MN	
6840 Rochester, NY [1]	0.9556
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9730
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9058
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA [1]	1.1911
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9620
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9723
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO [2]	0.7793
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL [1]	0.9049
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	1.0594
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4435
Monterey, CA	
7160 Salt Lake City-Ogden, UT [1]	0.9899
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8288
Tom Green, TX	
7240 San Antonio, TX [1]	0.8876
Bexar, TX	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA [1]	1.1206
San Diego, CA	
7360 San Francisco, CA [1]	1.4349
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA [1]	1.4642
Santa Clara, CA	
7440 San Juan-Bayamon, PR [1]	0.4904
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	1.1484
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0511
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3012
Santa Cruz, CA	
7490 Santa Fe, NM	1.0639
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2836
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9834
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9556
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA [2]	0.8429
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA [1]	1.1557
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA [2]	0.8429
Mercer, PA	
7620 Sheboygan, WI [2]	0.9130
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9508
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9127
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9052
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9371
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9887
St. Joseph, IN	
7840 Spokane, WA	1.0954
Spokane, WA	
7880 Springfield, IL	0.9004
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8470
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA [2]	1.1234
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8798
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8454
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.1168
San Joaquin, CA	
8140 Sumter, SC [2]	0.8489
Sumter, SC	
8160 Syracuse, NY	0.9482
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA [2]	1.0242
Pierce, WA	
8240 Tallahassee, FL [2]	0.8782
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL [1]	0.9111
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN [2]	0.8770
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8198
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9551
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9021
Shawnee, KS	
8480 Trenton, NJ	1.0556
Mercer, NJ	
8520 Tucson, AZ	0.8958
Pima, AZ	
8560 Tulsa, OK	0.9093
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8239
Tuscaloosa, AL	
8640 Tyler, TX	0.8789
Smith, TX	
8680 Utica-Rome, NY [2]	0.8530
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3500
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0472
Ventura, CA	
8750 Victoria, TX	0.8105
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0475
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA [2]	0.9907
Tulare, CA	
8800 Waco, TX	0.8449
McLennan, TX	
8840 Washington, DC-MD-VA-WV [1]	1.0707
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, 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	0.8422
Black Hawk, IA	
8940 Wausau, WI	0.9806
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL [1]	0.9784
Palm Beach, FL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
9000 Wheeling, WV-OH[2] (WV Hospitals)	0.8008
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 Wheeling, WV-OH[2] (OH Hospitals)	0.8756
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9300
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8407
Archer, TX	
Wichita, TX	
9140 Williamsport, PA[2]	0.8429
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0955
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9604
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0320
Yakima, WA	
9270Yolo, CA[2]	0.9907
Yolo, CA	
9280 York, PA	0.9154
York, PA	
9320 Youngstown-Warren, OH	0.9273
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0264
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8954
Yuma, AZ	

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alaska	1.1958
Arizona	0.8906
Arkansas	0.7746
California	0.9907
Colorado	0.8897
Connecticut	1.2199
Delaware	0.9669
Florida	0.8782
Georgia	0.8365
Hawaii	0.9896
Idaho	0.8907
Illinois	0.8282
Indiana	0.8770
Iowa	0.8278
Kansas	0.7860
Kentucky	0.7924
Louisiana	0.7565
Maine	0.8995

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Maryland	0.9175
Massachusetts	1.1234
Michigan	0.8807
Minnesota	0.9243
Mississippi	0.7810
Missouri	0.7793
Montana	0.8530
Nebraska	0.8326
Nevada	0.9758
New Hampshire	0.9944
New Jersey[1]	.....
New Mexico	0.8314
New York	0.8530
North Carolina	0.8355
North Dakota	0.7536
Ohio	0.8756
Oklahoma	0.7577
Oregon	0.9939
Pennsylvania	0.8429
Puerto Rico	0.4037
Rhode Island[1]	.....
South Carolina	0.8489
South Dakota	0.8093
Tennessee	0.7945
Texas	0.7673
Utah	0.9034
Vermont	0.9401
Virginia	0.8542
Washington	1.0242
West Virginia	0.8008
Wisconsin	0.9130
Wyoming	0.9137

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Akron, OH	0.9445
Albany, GA	1.0643
Albuquerque, NM	0.9431
Alexandria, LA	0.8087
Altoona, PA	0.8886
Amarillo, TX	0.8814
Anchorage, AK	1.2433
Ann Arbor, MI	1.0859
Anniston, AL	0.8025
Asheville, NC	0.9503
Athens, GA	0.9437
Atlanta, GA	0.9912
Atlantic-Cape May, NJ	1.0597
Augusta-Aiken, GA-SC	0.9491
Austin-San Marcos, TX	0.9551
Bangor, ME	0.9750
Barnstable-Yarmouth, MA	1.2703
Baton Rouge, LA	0.8271
Bellingham, WA	1.1834
Benton Harbor, MI	0.8949
Bergen-Passaic, NJ	1.1655
Billings, MT	0.8889
Biloxi-Gulfport-Pascagoula, MS	0.8449
Binghamton, NY	0.8433
Birmingham, AL	0.9251
Bismarck, ND	0.8101
Bloomington-Normal, IL	0.8954
Boise City, ID	0.9295

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1269
Burlington, VT	0.9442
Caguas, PR	0.4229
Casper, WY	0.9239
Champaign-Urbana, IL	0.9385
Charleston-North Charleston, SC	0.9307
Charleston, WV (WV Hospitals)	0.8510
Charleston, WV (OH Hospitals)	0.8756
Charlotte-Gastonia-Rock Hill, NC-SC	0.9636
Charlottesville, VA	0.9946
Chattanooga, TN-GA	0.8985
Chicago, IL	1.0863
Cincinnati, OH-KY-IN	0.9452
Clarksville-Hopkinsville, TN-KY	0.8410
Cleveland-Lorain-Elyria, OH	0.9686
Columbia, MO	0.8607
Columbia, SC	0.8958
Columbus, GA-AL	0.8505
Columbus, OH	0.9649
Corpus Christi, TX	0.8565
Corvallis, OR	1.1316
Dallas, TX	0.9733
Davenport-Moline-Rock Island, IA-IL	0.8727
Dayton-Springfield, OH	0.9432
Decatur, AL	0.8633
Denver, CO	1.0581
Des Moines, IA	0.9053
Detroit, MI	1.0097
Dothan, AL	0.7931
Dover, DE	0.9669
Duluth-Superior, MN-WI	1.0133
Dutchess County, NY	1.0769
Eau Claire, WI	0.9141
Elkhart-Goshen, IN	0.9613
Erie, PA	0.8530
Eugene-Springfield, OR	1.0889
Fargo-Moorhead, ND-MN	0.9444
Fayetteville, NC	0.8957
Flagstaff, AZ-UT	1.1086
Flint, MI	1.0929
Florence, AL	0.7824
Florence, SC	0.8763
Fort Collins-Loveland, CO	1.0201
Ft. Lauderdale, FL	1.0534
Fort Pierce-Port St. Lucie, FL	1.0227
Fort Smith, AR-OK	0.7577
Fort Walton Beach, FL	0.8700
Forth Worth-Arlington, TX	0.9268
Gadsden, AL	0.8295
Grand Forks, ND-MN (ND Hospitals)	0.9031
Grand Forks, ND-MN (MN Hospitals)	0.9243
Grand Junction, CO	0.9940
Grand Rapids-Muskegon-Holland, MI	0.9406
Great Falls, MT	0.8977
Greeley, CO	0.9516
Green Bay, WI	0.9201
Greensboro-Winston-Salem-High Point, NC (NC Hospitals)	0.8533
Greensboro-Winston-Salem-High Point, NC (VA Hospitals)	0.8542
Greenville, NC	0.9621
Hamilton-Middletown, OH	0.9236
Harrisburg-Lebanon-Carlisle, PA	0.9178

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Hartford, CT (MA Hospitals)	1.1234
Hartford, CT (NY Hospitals)	1.1211
Hattiesburg, MS	0.7810
Hickory-Morganton-Lenoir, NC	0.8987
Honolulu, HI	1.1176
Houston, TX	0.9591
Huntington-Ashland, WV-KY-OH	0.9080
Huntsville, AL	0.8954
Indianapolis, IN	0.9934
Iowa City, IA	0.9460
Jackson, MS	0.8459
Jackson, TN	0.8602
Jacksonville, FL	0.9426
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8542
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8371
Jonesboro, AR (AR Hospitals)	0.7755
Jonesboro, AR (MO Hospitals)	0.7793
Joplin, MO	0.8621
Kalamazoo-Battlecreek, MI	1.0554
Kansas City, KS-MO	0.9551
Knoxville, TN	0.8987
Kokomo, IN	0.8963
Lafayette, LA	0.8271
Lakeland-Winter Haven, FL	0.8782
Las Vegas, NV-AZ	1.1341
Lawton, OK	0.8194
Lexington, KY	0.8424
Lima, OH	0.9457
Lincoln, NE	0.9613
Little Rock-North Little Rock, AR	0.8905
Longview-Marshall, TX	0.8969
Los Angeles-Long Beach, CA	1.1656
Louisville, KY-IN	0.9056
Lubbock, TX	0.8330
Lynchburg, VA	0.9004
Macon, GA	0.9011
Madison, WI	1.0108
Medford-Ashland, OR	1.0494
Melbourne-Titusville-Palm Bay, FL	0.9837
Memphis, TN-AR-MS	0.9010
Miami, FL	0.9888
Milwaukee-Waukesha, WI	0.9760
Minneapolis-St. Paul, MN-WI	1.1064
Missoula, MT	0.8943
Mobile, AL	0.7948
Modesto, CA	1.1183
Monmouth-Ocean, NJ	1.1094
Monroe, LA	0.7978
Montgomery, AL	0.7856
Nashville, TN	0.9582
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2525
New Orleans, LA	0.9167
New York, NY	1.3867
Newark, NJ	1.1417
Newburgh, NY-PA	1.1377
Norfolk-Virginia Beach-Newport News, VA-NC	0.8659
Oakland, CA	1.5204
Ocala, FL	0.9646
Odessa-Midland, TX	0.9156
Oklahoma City, OK	0.9027
Olympia, WA	1.1030
Omaha, NE-IA	0.9744
Orange County, CA	1.1235
Orlando, FL	0.9612
Peoria-Pekin, IL	0.8811
Philadelphia, PA-NJ	1.0947
Phoenix-Mesa, AZ	1.0213
Pine Bluff, AR	0.7810
Pittsburgh, PA	0.8788
Pittsfield, MA	0.9861
Pocatello, ID (ID Hospitals)	0.9103
Pocatello, ID (WY Hospitals)	0.9137
Portland, ME	0.9784
Portland-Vancouver, OR-WA	1.1193
Provo-Orem, UT	0.9912
Raleigh-Durham-Chapel Hill, NC	0.9756
Rapid City, SD	0.8865
Reading, PA	0.8910
Redding, CA	1.1357
Reno, NV	1.0758
Richland-Kennewick-Pasco, WA	1.0639
Richmond-Petersburg, VA	0.9402
Roanoke, VA	0.8759
Rochester, MN	1.1802
Rockford, IL	0.9500
Sacramento, CA	1.1911
Saginaw-Bay City-Midland, MI	0.9470
St. Cloud, MN	0.9723
St. Joseph, MO	0.9694
St. Louis, MO-IL	0.9049
Salinas, CA	1.4435
Salt Lake City-Ogden, UT	0.9899
San Antonio, TX	0.8876
Santa Fe, NM	0.9543
Santa Rosa, CA	1.2836
Sarasota-Bradenton, FL	0.9834
Savannah, GA	0.9556
Seattle-Bellevue-Everett, WA	1.1557
Sherman-Denison, TX	0.9084
Shreveport-Bossier City, LA	0.9127
Sioux City, IA-NE	0.8806
Sioux Falls, SD	0.9246
South Bend, IN	0.9780
Spokane, WA	1.0770
Springfield, IL	0.9004
Springfield, MO	0.8269
Stockton-Lodi, CA	1.1168
Syracuse, NY	0.9381
Tampa-St. Petersburg-Clearwater, FL	0.9111
Texarkana, AR-Texarkana, TX	0.8018
Toledo, OH	0.9551
Topeka, KS	0.8791
Tucson, AZ	0.8958
Tulsa, OK	0.8876
Tuscaloosa, AL	0.8134
Tyler, TX	0.8789
Vallejo-Fairfield-Napa, CA	1.3500
Victoria, TX	0.8105
Waco, TX	0.8449
Washington, DC-MD-VA-WV	1.0707
Waterloo-Cedar Falls, IA	0.8422
Wausau, WI	0.9806
West Palm Beach-Boca Raton, FL	0.9784
Wichita, KS	0.9053
Wichita Falls, TX	0.8407
Wilmington-Newark, DE-MD	1.0782
Wilmington, NC	0.9402
York, PA	0.9154
Youngstown-Warren, OH	0.9273
Rural Alabama	0.7517
Rural Florida	0.8782
Rural Illinois	0.8282
Rural Kentucky	0.7924
Rural Louisiana	0.7565
Rural Michigan	0.8807
Rural Minnesota	0.9243
Rural Mississippi	0.7810
Rural Missouri	0.7793
Rural Nebraska	0.8326
Rural New Hampshire	0.9944
Rural Texas	0.7673
Rural Washington	1.0242
Rural Wyoming	0.9020

ADDENDUM L.—PACKAGED NON-CHEMOTHERAPY INFUSION DRUGS CALENDAR YEAR 2004

HCPCS	Descriptor
J0706	Caffeine citrate injection
J1260	Dolasetron mesylate
J1325	Epoprostenol injection
J1436	Etidronate disodium inj
J1570	Ganciclovir sodium injection
J1626	Granisetron HCl injection
J2020	Linezolid injection
J2260	Inj milrinone lactate, per 5
J2275	Morphine sulfate injection
J2405	Ondansetron hcl injection
J2765	Metoclopramide hcl injection
J2770	Quinupristin/dalfopristin
J2820	Sargramostim injection
J2997	Alteplase recombinant
J3010	Fentanyl citrate injeciton
J7501	Azathioprine parenteral
J7516	Cyclosporin parenteral 250mg
J7525	Tacrolimus injection
Q2003	Aprotinin, 10,000 kiu
Q2007	Ethanolamine oleate 100 mg
Q2009	Fosphenytoin, 50 mg
Q2013	Pentastarch 10% solution
Q2021	Lepirudin

ADDENDUM M.—SEPARATELY PAID NONCHEMOTOLOGY INFUSION DRUGS CALENDAR YEAR 2004

HCPCS	Descriptor
C1178	BUSULFAN IV, 6 Mg
C9019	Caspofungin acetate, 5 mg
C9109	Tirofiban hcl, 6.25 mg
J0130	Abciximab injection
J0151	Adenosine injection
J0286	Amphotericin B lipid complex
J0350	Injection anistreplase 30 u
J0850	Cytomegalovirus imm IV /vial
J1327	Eptifibatide injection
J1440	Filgrastim 300 mcg injection
J1441	Filgrastim 480 mcg injection
J1561	Immune globulin 500 mg
J1563	Immune globulin, 1 g
J1564	Immune globulin 10 mg
J1565	RSV-ivig
J1745	Infliximab injection
J2792	Rho(D) immune globulin h, sd
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU

ADDENDUM M.—SEPARATELY PAID NONCHEMOTOLOGY INFUSION DRUGS CALENDAR YEAR 2004—Continued

HCPCS	Descriptor
J3245	Tirofiban hydrochloride
J3305	Inj trimetrexate glucoronate
J3365	Urokinase 250,000 IU inj
J3395	Verteporfin injection
J7197	Antithrombin iii injection
J7504	Lymphocyte immune globulin
J7511	Antithymocyte globuln rabbit
J9200	Floxuridine injection
J9600	Porfimer sodium
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250 ml
P9046	Albumin (human), 25%, 20 ml
P9047	Albumin (human), 25%, 50ml
Q2006	Digoxin immune fab (ovine)
Q2008	Fomepizole, 15 mg
Q2011	Hemin, per 1 mg

ADDENDUM N.—PACKAGED CHEMOTHERAPY DRUG OTHER THAN INFUSION CALENDAR YEAR 2004

HCPCS	Short descriptor
J9000 ..	Doxorubic hcl 10 MG vl chemo
J9190 ..	Fluorouracil injection
J9212 ..	Interferon alfacon-1
J9213 ..	Interferon alfa-2a inj
J9230 ..	Mechlorethamine hcl inj
J9250 ..	Methotrexate sodium inj
J9360 ..	Vinblastine sulfate inj
J9370 ..	Vincristine sulfate 1 MG inj

ADDENDUM O.—SEPARATELY PAID CHEMOTHERAPY DRUGS OTHER THAN INFUSION CALENDAR YEAR 2004

HCPCS	Short descriptor
J2352 ..	Octreotide acetate injection
J9202 ..	Goserelin acetate implant
J9214 ..	Interferon alfa-2b inj
J9217 ..	Leuprolide acetate suspnsion
J9218 ..	Leuprolide acetate inj
J9219 ..	Leuprolide acetate implant

ADDENDUM P.—PACKAGED CHEMOTHERAPY DRUGS INFUSION ONLY CALENDAR YEAR 2004

HCPCS	Short descriptor
C1166	CYTARABINE LIPOSOMAL, 10 mg
J1620	Gonadorelin hydroch/100 mcg
J9020	Asparaginase injection
J9031	Bcg live intravesical vac
J9070	Cyclophosphamide 100 MG inj
J9093	Cyclophosphamide lyophilized
J9100	Cytarabine hcl 100 MG inj
J9120	Dactinomycin actinomycin d
J9130	Dacarbazine 10 MG inj
J9181	Etoposide 10 MG inj
J9270	Plicamycin (mithramycin) inj
J9340	Thiotepa injection

ADDENDUM Q.—SEPARATELY PAID CHEMOTHERAPY DRUGS INFUSION ONLY CALENDAR YEAR 2004

HCPCS	Short descriptor
C1167	EPIRUBICIN HCL, 2 mg
C1207	OCTREOTIDE ACETATE DEPOT 1mg
C9110	Alemtuzumab, per 10mg/ml
J0207	Amifostine

ADDENDUM Q.—SEPARATELY PAID CHEMOTHERAPY DRUGS INFUSION ONLY CALENDAR YEAR 2004—Continued

HCPCS	Short descriptor
J1190	Dexrazoxane HCl injection
J1950	Leuprolide acetate /3.75 MG
J2355	Oprelvekin injection
J2430	Pamidronate disodium /30 MG
J9001	Doxorubicin hcl liposome inj
J9015	Aldesleukin/single use vial
J9017	Arsenic trioxide
J9040	Bleomycin sulfate injection
J9045	Carboplatin injection
J9050	Carmus bischl nitro inj
J9060	Cisplatin 10 MG injection
J9065	Inj cladribine per 1 MG
J9150	Daunorubicin
J9151	Daunorubicin citrate liposom
J9160	Denileukin diftitox, 300 mcg
J9165	Diethylstilbestrol injection
J9170	Docetaxel
J9185	Fludarabine phosphate inj
J9201	Gemcitabine HCl
J9206	Irinotecan injection
J9208	Ifosfomide injection
J9209	Mesna injection
J9211	Idarubicin hcl injection
J9245	Inj melphalan hydrochl 50 MG
J9265	Paclitaxel injection
J9266	Pegaspargase/singl dose vial
J9268	Pentostatin injection
J9280	Mitomycin 5 MG inj
J9293	Mitoxantrone hydrochl/5 MG
J9300	Gemtuzumab ozogamicin
J9310	Rituximab cancer treatment
J9320	Streptozocin injection
J9350	Topotecan
J9355	Trastuzumab
J9357	Valrubicin, 200 mg
J9390	Vinorelbine tartrate/10 mg
Q2017	Teniposide, 50 mg

[FR Doc. 03–20280 Filed 8–6–03; 8:45 am]

BILLING CODE 4120–01–P

Reader Aids

Federal Register

Vol. 68, No. 155

Tuesday, August 12, 2003

CUSTOMER SERVICE AND INFORMATION

Federal Register/Code of Federal Regulations	
General Information, indexes and other finding aids	**202–741–6000**
Laws	**741–6000**
Presidential Documents	
Executive orders and proclamations	**741–6000**
The United States Government Manual	**741–6000**
Other Services	
Electronic and on-line services (voice)	**741–6020**
Privacy Act Compilation	**741–6064**
Public Laws Update Service (numbers, dates, etc.)	**741–6043**
TTY for the deaf-and-hard-of-hearing	**741–6086**

ELECTRONIC RESEARCH

World Wide Web

Full text of the daily Federal Register, CFR and other publications is located at: **http://www.access.gpo.gov/nara**

Federal Register information and research tools, including Public Inspection List, indexes, and links to GPO Access are located at: **http://www.archives.gov/federal_register/**

E-mail

FEDREGTOC-L (Federal Register Table of Contents LISTSERV) is an open e-mail service that provides subscribers with a digital form of the Federal Register Table of Contents. The digital form of the Federal Register Table of Contents includes HTML and PDF links to the full text of each document.

To join or leave, go to **http://listserv.access.gpo.gov** and select *Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings);* then follow the instructions.

PENS (Public Law Electronic Notification Service) is an e-mail service that notifies subscribers of recently enacted laws.

To subscribe, go to **http://listserv.gsa.gov/archives/publaws-l.html** and select *Join or leave the list* (or change settings); then follow the instructions.

FEDREGTOC-L and **PENS** are mailing lists only. We cannot respond to specific inquiries.

Reference questions. Send questions and comments about the Federal Register system to: **info@fedreg.nara.gov**

The Federal Register staff cannot interpret specific documents or regulations.

FEDERAL REGISTER PAGES AND DATE, AUGUST

45157–45740 1
45741–46072 4
46073–46432 5
46433–46918 6
46919–47200 7
47201–47440 8
47441–47834 11
47835–48248 12

CFR PARTS AFFECTED DURING AUGUST

At the end of each month, the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

3 CFR

Executive Orders:
12722 (See: Notice of July 31, 2003) 45739
12724 (See: Notice of July 31, 2003) 45739
13290 (See: Notice of July 31, 2003) 45739
13313 46073
13222 (See: Notice of August 7, 2003) 47833

Administrative Orders:
Notices:
Notice of July 31, 2003) 45739
Notice of August 7, 2003 47833
Presidential Determinations:
No. 2003–28 47441
No. 2003–29 47443

5 CFR

Proposed Rules:
532 47877

7 CFR

51 46433
250 46434
340 46434
993 46436
996 46919
1778 46077
1794 45157

Proposed Rules:
52 46504
331 45787
783 47499
983 45990
1124 46505
1131 46505
1778 46119
4279 46509

8 CFR

204 46925
212 46926
214 46926
231 46926
233 46926

9 CFR

77 47201
82 45741
94 47835
206 47802

10 CFR

140 46929

Proposed Rules:
30 45172
170 46439
171 46439

11 CFR

104 47386
107 47386
110 47386
9001 47386
9003 47386
9004 47386
9008 47386
9031 47386
9032 47386
9033 47386
9034 47386
9035 47386
9036 47386
9038 47386

12 CFR

701 46439

Proposed Rules:
3 45900
7 46119
34 46119
208 45900
225 45900
325 45900
567 45900
614 47502
615 47502

14 CFR

25 ..... 46428, 47202, 47445
39 ..... 46441, 46443, 46444, 47202, 47204, 47207, 47208, 47211, 47213, 47216, 47218, 47447, 47842
71 ..... 47447, 47448, 47449, 47637, 47844, 47846
119 47798

Proposed Rules:
21 46283
39 ..... 45176, 45177, 46514, 47267, 47513
61 46283
65 46283
71 ..... 47515, 47516, 47518
77 46283
91 47269
107 46283
109 46283
121 ..... 46283, 47269
135 ..... 46283, 47269
145 46283
154 46283

15 CFR

911 45160

Proposed Rules:
303 45177

16 CFR

305 47449

17 CFR

4.....47221
30.....46446
240.....46446
Proposed Rules:
1.....46516

18 CFR

1304.....46930
Proposed Rules:
2.....46452
284.....48133
388.....46456

19 CFR

103.....47453
111.....47455

20 CFR

218.....45315
225.....45315
Proposed Rules:
404.....45180, 47877
416.....45180

21 CFR

172.....46364, 46403
558.....47237
Proposed Rules:
310.....48133
334.....48133
510.....47272
558.....47272

22 CFR

41.....46948, 47460

24 CFR

905.....45730
Proposed Rules:
960.....45734
3282.....47881

25 CFR

Proposed Rules:
Ch. 1.....45787

26 CFR

1.....45745, 45772, 46081
301.....46081
602.....46081
Proposed Rules:
1.....46516, 46983

28 CFR

549.....47847

Proposed Rules
16.....47519
522.....46138

29 CFR

697.....46949
Proposed Rules
Ch. X.....46983

30 CFR

926.....46460
Proposed Rules
72.....47886

31 CFR

591.....45777
592.....45777

32 CFR

21.....47150
22.....47150
32.....47150
34.....47150
37.....47150
Proposed Rules
199.....46526

33 CFR

100.....46087, 47237
117.....45784, 47462, 47850, 47851
165.....45164, 45165, 47237, 47239, 47241, 47243, 47245, 47464, 47465, 47852, 47854
Proposed Rules:
110.....45190
117.....46139, 47520, 47522
165.....46984, 47277

36 CFR

4.....46477
Proposed Rules:
7.....47524

39 CFR

224.....47527
261.....47527
262.....47527
263.....47527
264.....47527
265.....47527
266.....47527
267.....47527
268.....47527
Proposed Rules:
111.....45192

40 CFR

52.....45897, 46089, 46099, 46101, 46479, 46484, 46487, 47466, 47468, 47473, 47477, 47482
60.....46489
63.....46102
70.....46489
71.....45167
81.....47964
180.....46491, 47246
261.....46951
Proposed Rules:
Ch. 1.....46435
19.....45788
27.....45788
51.....46436
52.....46141, 46437, 47279, 47530, 45731, 47532, 47533
63.....46142
70.....46438
141.....47640
142.....47640
194.....47887
271.....45192

41 CFR

Proposed Rules:
51-3.....45195
51-4.....45195

42 CFR

409.....46036
411.....46036
412.....45346, 45674, 47637
413.....45346, 46036
440.....46036
483.....46036
488.....46036
489.....46036
Proposed Rules:
410.....47966
419.....47966

46 CFR

188.....45785
189.....45785

47 CFR

2.....46957
13.....46957
25.....47856
54.....47253
69.....46500
80.....46957
73.....45786, 46286, 46502, 47255, 47256
Proposed Rules:
73.....46359, 47282, 47283, 47284, 47285

48 CFR

1806.....45168
1807.....45168
1811.....45168
1814.....45168
1815.....45168
1817.....45168
1819.....45168
1825.....45168
1827.....45168
1844.....45168
1852.....45168
1872.....45168

49 CFR

191.....46109
192.....46109
195.....46109
390.....47860
398.....47860
571.....47485
Proposed Rules:
71.....47533
380.....47890
391.....47890
571.....46539, 46546
585.....46546
586.....46546
589.....46546
590.....46546
596.....46546

50 CFR

17.....46684, 46870
300.....47256
622.....47498
635.....45169
660.....46112
648.....47264
679.....45170, 45766, 46116, 46117, 46502, 47265, 47266, 47875
Proposed Rules:
15.....46559
17.....46143, 46989
20.....47424
600.....45196
635.....45196, 47404

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.

RULES GOING INTO EFFECT AUGUST 12, 2003

ENVIRONMENTAL PROTECTION AGENCY

Air programs; approval and promulgation; State plans for designated facilities and pollutants:
- Various States; published 6-13-03

Toxic substances:
- Significant new uses—
  - Burkholderia cepacia complex; published 6-13-03

TRANSPORTATION DEPARTMENT

Federal Aviation Administration

Airworthiness directives:
- Bell; published 7-8-03
- Schweizer Aircraft Corp.; published 7-8-03

VETERANS AFFAIRS DEPARTMENT

Privacy Act; implementation; published 6-13-03

COMMENTS DUE NEXT WEEK

AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Potatoes (Irish) grown in—
- Colorado; comments due by 8-20-03; published 7-21-03 [FR 03-18447]

Soybean promotion and research order:
- United Soybean Board; membership adjustment; comments due by 8-18-03; published 6-17-03 [FR 03-15270]

COMMERCE DEPARTMENT

National Oceanic and Atmospheric Administration

Fishery conservation and management:
- Alaska; fisheries of Exclusive Economic Zone—
  - Salmon; comments due by 8-22-03; published 7-23-03 [FR 03-18734]
- Atlantic coastal fisheries cooperative management—
  - Atlantic striped bass; comments due by 8-20-03; published 7-21-03 [FR 03-18491]
- Northeastern United States fisheries—
  - Atlantic mackerel, squid, and butterfish; comments due by 8-18-03; published 7-18-03 [FR 03-18343]

DEFENSE DEPARTMENT

Courts-Martial Manual; review; comments due by 8-19-03; published 6-20-03 [FR 03-15574]

ENERGY DEPARTMENT

Federal Energy Regulatory Commission

Natural Gas Policy Act:
- Blanket sales certificates; comments due by 8-18-03; published 8-5-03 [FR 03-19879]

ENVIRONMENTAL PROTECTION AGENCY

Air pollution control; new motor vehicles and engines:
- Nonroad diesel engines and fuel; emissions standards; comments due by 8-20-03; published 5-23-03 [FR 03-09737]

Air quality implementation plans; approval and promulgation; various States; air quality planning purposes; designation of areas:
- Colorado; comments due by 8-21-03; published 7-22-03 [FR 03-18302]
- Pennsylvania; comments due by 8-18-03; published 7-18-03 [FR 03-18294]

Air quality implementation plans; approval and promulgation; various States:
- California; comments due by 8-22-03; published 7-23-03 [FR 03-18739]
- Florida; comments due by 8-21-03; published 7-22-03 [FR 03-18500]
- Georgia; comments due by 8-18-03; published 7-18-03 [FR 03-18153]
- Indiana; comments due by 8-20-03; published 7-21-03 [FR 03-18298]
- New York; comments due by 8-20-03; published 7-21-03 [FR 03-18300]
- Texas; comments due by 8-20-03; published 7-1-03 [FR 03-16582]

Hazardous waste program authorizations:
- Georgia; comments due by 8-18-03; published 7-18-03 [FR 03-18296]

Human testing; standards and criteria; comments due by 8-20-03; published 8-6-03 [FR 03-20154]

Pesticides; tolerances in food, animal feeds, and raw agricultural commodities:
- Azoxystrobin; comments due by 8-18-03; published 6-18-03 [FR 03-15261]
- Bacillus pumilus (strain QST2808); comments due by 8-18-03; published 6-18-03 [FR 03-15129]
- Glyphosate; comments due by 8-18-03; published 6-18-03 [FR 03-15128]

FEDERAL COMMUNICATIONS COMMISSION

Common carrier services:
- Federal-State Joint Board on Universal Service—
  - Lifeline and Link-Up programs; comments due by 8-18-03; published 7-17-03 [FR 03-18056]
- Telecommunications Act of 1996; implementation—
  - Numbering resource optimization; telephone number portability; comments due by 8-20-03; published 7-21-03 [FR 03-18364]

Radio stations; table of assignments:
- California and Texas; comments due by 8-22-03; published 7-18-03 [FR 03-18228]
- Michigan; comments due by 8-22-03; published 7-18-03 [FR 03-18249]
- Various States; comments due by 8-22-03; published 7-18-03 [FR 03-18227]

HOMELAND SECURITY DEPARTMENT

Customs and Border Protection Bureau

Electronic cargo information; advance presentation requirement; comments due by 8-22-03; published 7-23-03 [FR 03-18558]

INTERIOR DEPARTMENT

Fish and Wildlife Service

Endangered and threatened species:
- Findings on petitions, etc.—
  - Johnston's frankenia; delisting; comments due by 8-20-03; published 5-22-03 [FR 03-12748]
- Slickspot peppergrass; comments due by 8-18-03; published 7-18-03 [FR 03-18402]

Migratory bird hunting:
- Federal Indian reservations, off-reservation trust lands, and ceded lands; comments due by 8-18-03; published 8-8-03 [FR 03-20290]

INTERIOR DEPARTMENT

Surface Mining Reclamation and Enforcement Office

Permanent program and abandoned mine land reclamation plan submissions:
- Ohio; comments due by 8-20-03; published 7-21-03 [FR 03-18468]

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

Organization, functions, and authority delegations:
- Temporary duty travel; issuance of motor vehicle for home-to-work transportation; comments due by 8-22-03; published 6-23-03 [FR 03-15693]

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

NARA facilities:
- Exhibition Hall; hours of operation; comments due by 8-18-03; published 6-17-03 [FR 03-15190]

NUCLEAR REGULATORY COMMISSION

Spent nuclear fuel and high-level radioactive waste; independent storage; licensing requirements:
- Approved spent fuel storage casks; list; comments due by 8-18-03; published 7-18-03 [FR 03-18260]

TRANSPORTATION DEPARTMENT

Federal Aviation Administration

Airworthiness directives:
- Boeing; comments due by 8-18-03; published 7-2-03 [FR 03-16694]
- GROB-WERKE; comments due by 8-18-03; published 7-15-03 [FR 03-17818]
- McDonnell Douglas; comments due by 8-18-03; published 7-24-03 [FR 03-18791]
- Pratt & Whitney; comments due by 8-18-03; published 6-17-03 [FR 03-15224]
- Rolls-Royce plc; comments due by 8-21-03; published 8-6-03 [FR 03-19475]
- Saab; comments due by 8-20-03; published 7-21-03 [FR 03-18419]

Airworthiness standards:
- Special conditions—

LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. It may be used in conjunction with ''P L U S'' (Public Laws Update Service) on 202–741–6043. This list is also available online at *http://www.nara.gov/fedreg/plawcurr.html*.

The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.access.gpo.gov/nara/nara005.html*. Some laws may not yet be available.

H.R. 74/P.L. 108–67

To direct the Secretary of Agriculture to convey certain land in the Lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California. (Aug. 1, 2003; 117 Stat. 880)

S. 1280/P.L. 108–68

To amend the PROTECT Act to clarify certain volunteer liability. (Aug. 1, 2003; 117 Stat. 883)

Last List August 1, 2003

Public Laws Electronic Notification Service (PENS)

PENS is a free electronic mail notification service of newly enacted public laws. To subscribe, go to *http://listserv.gsa.gov/archives/publaws-l.html*

Note: This service is strictly for E-mail notification of new laws. The text of laws is not available through this service. **PENS** cannot respond to specific inquiries sent to this address.