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42 CFR Parts 419 and 485

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 419 and 485

[CMS–1501–FC]

RIN 0938–AN46

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the final rule with comment period describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This final rule with comment period also changes the requirement for physician oversight of mid-level practitioners in critical access hospitals (CAHs).

In this final rule with comment period, we also are responding to public comments received on the November 15, 2004, final rule with comment period pertaining to the ambulatory payment classification (APC) group assignment of Healthcare Common Procedure Coding System (HCPCS) codes identified in Addendum B of that rule with the new interim (NI) comment indicator. These changes are applicable to services furnished on or after January 1, 2006.

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2006.

Comment Date: We will consider comments on the payment classification assigned to HCPCS codes identified in Addendum B with the NI comment code and other areas specified through the preamble if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 9, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1501–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this final rule with comment period to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. *By regular mail.* You may 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–1501–FC, P.O. Box 8016, Baltimore, MD 21244–8018.

3. *By express or overnight mail.* You may send 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–1501–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain 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 received after the comment period.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy 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, MD 21244–1850, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Requirements for Issuance of Regulations: Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of Pub. L. 108–173 also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule with comment period finalizes provisions set forth in the CY 2006 OPPA proposed rule (70 FR 42674, July 25, 2005). In addition, this final rule has been published within the 3-year time limit imposed by section 902 of Pub. L. 108–173. This final rule also finalizes the November 15, 2004 final rule with comment period (69 FR 65681) to address public comments pertaining to the APC group assignment of HCPCS codes identified in Addendum B of that rule with the NI comment indicator. Again, we finalized the rule within the 3-year timeframe imposed under section 902 of Pub. L. 108–173. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

FOR FURTHER INFORMATION, CONTACT: Rebecca Kane, (410) 786–0378, Outpatient prospective payment issues and Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health centers issues.

SUPPLEMENTARY INFORMATION:

Electronic Access

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Alphabetical List of Acronyms Appearing in the Final Rule With Comment Period

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASP Average sales price
ASC Ambulatory surgical center
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
CAH Critical access hospital
CBSA Core-Based Statistical Areas
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)
CNS Clinical nurse specialist
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2005, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRGY Diagnosis-related group
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FDA Food and Drug Administration
FI Fiscal intermediary
FSS Federal Supply Schedule
FY Federal fiscal year
GAO Government Accountability Office
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, Pub. L. 104–191
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
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NP Nurse practitioner
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPD (Hospital) Outpatient department
OPPS (Hospital) Outpatient prospective payment system
PA Physician assistant
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
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 of 1982, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

To assist readers in referencing sections contained in this document, we are providing the following outline of contents:

Outline of Contents

I. Background
A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System
B. Excluded OPPS Services and Hospitals
C. Prior Rulemaking
D. APC Advisory Panel
1. Authority for the APC Panel
2. Establishment of the APC Panel
3. APC Panel Meetings and Organizational Structure
E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 That Will Be Implemented in CY 2006
1. Hold Harmless Provisions
2. Study and Authorization of Adjustment for Rural Hospitals
3. Payment for ''Specified Covered Outpatient Drugs''
4. Adjustment in Payment Rates for ''Specified Covered Outpatient Drugs'' for Overhead Costs
5. Budget Neutrality Adjustment
F. CMS' Commitment to New Technologies
G. Summary of the Provisions of the CY 2006 OPPS Proposed Rule
H. Public Comments Received on the CY 2006 OPPS Proposed Rule
I. Public Comments Received on the November 15, 2004 OPPS Final Rule With Comment Period
II. Updates Affecting Payments for CY 2006
A. Recalibration of APC Relative Weights for CY 2006
1. Database Construction
a. Database Source and Methodology
b. Use of Single and Multiple Procedure Claims
2. Calculation of Median Costs for CY 2006
3. Calculation of Scaled OPPS Payment Weights
4. Changes to Packaged Services
a. Background
b. Responses to the APC Panel Recommendations
B. Payment for Partial Hospitalization
1. Background
2. PHP APC Update for CY 2006
3. Separate Threshold for Outlier Payments to CMHCs
C. Conversion Factor Update for CY 2006
D. Wage Index Changes for CY 2006
E. Statewide Average Default Cost-to-Charge Ratios (CCRs)
F. Expiring Hold Harmless Provision for Transitional Corridor Payments for Certain Rural Hospitals
G. Adjustment for Rural Hospitals
1. Factors Contributing to Unit Cost Differences Between Rural Hospitals and Urban Hospitals and Associated Explanatory Variables
2. Results
H. Hospital Outpatient Outlier Payments
I. Calculation of the National Unadjusted Medicare Payment
J. Beneficiary Copayments for CY 2006
1. Background
2. Copayment for CY 2006
3. Calculation of the Unadjusted Copayment Amount for CY 2006
III. Ambulatory Payment Classification (APC) Group Policies
A. Introduction
1. Treatment of New HCPCS Codes Discussed in the CY 2006 OPPS Proposed Rule
2. Treatment of New CY 2006 HCPCS Codes
3. Treatment of New Mid-Year Category III CPT Codes
B. Variations within APCs
1. Background
2. Application of the 2 Times Rule
a. APC 0146: Level I Sigmoidoscopy
b. APC 0342: Level I Pathology
c. Other Comments on the Proposed List of APC Assignments to Address 2 Times Violations
3. Exceptions to the 2 Times Rule
C. New Technology APCs
1. Introduction
2. Refinement of New Technology Cost Bands
3. Requirements for Assigning Services to New Technology APCs
4. New Technology Services
a. Ablation of Bone Tumors
b. Breast Brachytherapy
c. Enteryx Procedure
d. Extracorporeal Shock Wave Treatment
e. GreenLight Laser
f. Magnetoencephalography (MEG)
g. Positron Emission Tomography (PET) Scans
h. Proton Beam Treatment
i. Smoking Cessation Counseling
j. Stereoscopic Kv X-ray
k. Stereotactic Radiosurgery (SRS)
D. APC-Specific Policies
1. Cardiac and Vascular Procedures
a. Acoustic Heart Sound Recording and Analysis

b. Cardiac Electrophysiologic Services (APC 0087)
c. Cardioverter-Defibrillator Implantation (APCs 0107 and 0108)
d. Endovenous Ablation (APC 0092)
e. External Counterpulsation Therapy (APC 0678)
f. Intracardiac Echocardiography (APC 0670)
g. Percutaneous Thrombectomy and Thrombolysis (APC 0676)
h. Coronary Flow Reserve (APCs 0416 and 0670)
i. Vascular Access Procedures (APCs 0621, 0622, and 0623)
2. Radiology, Radiation Oncology, and Nuclear Medicine
a. Angiography and Venography (APCs 0279, 0280, and 0668)
b. Brachytherapy (APCs 0312, 0313, and0651)
c. Computed Tomography (APCs 0283 and 0333)
d. Computed Tomographic Angiography (APC 0333)
e. Computed Tomographic Guidance (APC 0332)
f. Computerized Reconstruction (APC 0417)
g. Diagnostic Computed Tomographic Colonography (APC 0333)
h. Intensity Modulated Radiation Therapy (IMRT) (APCs 0310 and 0412)
i. Kidney Imaging (APC 0267)
j. Magnetic Resonance Guided Focused Ultrasound Ablation (APC 0193)
k. Non-Imaging Nuclear Medicine Studies (APC 0389)
l. Therapeutic Radiation Treatment (APC 0304)
m. Urinary Bladder Study (APC 0340)
3. Gastrointestinal and Genitourinary Procedures
a. Cystourethroscopy with Lithotripsy (APC 0163)
b. GI Stenting (APC 0384)
c. Insertion of Uterine Tandems and/or Vaginal Ovoids for Clinical Brachytherapy (APC 0192)
d. Laparoscopic Ablation Procedures (APC 0131)
e. Plicator Procedure (APC 0422)
f. Prostate Cryosurgery (APC 0674)
g. Stretta Procedure (APC 0422)
h. Urological Stenting Procedures (APCs 0163 and 0164)
4. Other Surgical Services
a. Excision-Malignant Lesions (APCs 0019 and 0020)
b. External Fixation (APCs 0046 and 0050)
c. Intradiscal Annuloplasty (APC 0203)
d. Kyphoplasty (APC 0051)
e. Neurostimulator Electrode Implantation (APCs 0040 and 0225)
f. Neurostimulator Generator Implantation (APC 0222)
g. Thoracentesis/Lavage (APC 0070)
5. Other Services
a. Allergy Testing (APC 0370)
b. Apheresis (APC 0112)
c. Audiology (APCs 0364, 0365, and 0366)
d. Bone Marrow Harvesting (APC 0111)
e. Computer Assisted Navigational Procedures
f. Hyperbaric Oxygen Therapy (APC 0659)
g. Ophthalmology Examinations (APC 0601)
h. Pathology Services
i. Photodynamic Therapy of the Skin (APC 0013)
j. Wound Care
IV. Payment Changes for Devices
A. Device-Dependent APCs
1. Public Comments and Our Responses on the November 15, 2004 Final Rule With Comment Period
2. CY 2006 Proposal, APC Panel Recommendations, and Responses to Public Comments Received
a. APC Panel Recommendations
b. Public Comments Received and Our Responses
(1) Adjustment of Median Costs
(2) Effects of Inconsistent Markup of Charges
(3) Effects of Multiple Procedure Reduction
(4) Impact of Proposed Rates on Access to Care
(5) Addition of Other APCs as Device-Dependent APCs
(6) Instructions on Reporting Device Charges
(7) Application of Wage Index to Package Containing Device
(8) Recalls of High Cost Devices
(9) Separate Payment for High Cost Devices
B. Pass-Through Payments for Devices
1. Expiration of Transitional Pass-Through Payments for Certain Devices
2. Proposed and Final Policy for CY 2006
C. Other Policy Issues Relating to Pass-Through Device Categories
1. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups
a. Background
b. Policy for CY 2006
2. Criteria for Establishing New Pass-Through Device Categories
a. Surgical Insertion and Implantation Criterion
(1) Public Comments Received on November 15, 2004 OPPS Final Rule with Comment Period and Our Responses
(2) Public Comments Received on the CY 2006 OPPS Proposed Rule and Our Responses
b. Existing Device Category Criterion
V. Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents
A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals
1. Background
2. Expiration in CY 2005 of Pass-Through Status for Drugs and Biologicals
3. Drugs and Biologicals With Pass-Through Status in CY 2006
B. Payment for Drugs, Biologicals, and Radiopharmaceutical Agents Without Pass-Through Status
1. Background
2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceutical Agents
3. Payment for Drugs, Biologicals, and Radiopharmaceutical Agents Without Pass-Through Status That Are Not Packaged
a. Payment for Specified Covered Outpatient Drugs
(1) Background
(2) Changes for CY 2006 Related to Pub. L. 108–173
(3) Data Sources Available for Setting CY 2006 Payment Rates
(4) CY 2006 Payment Policy for Radiopharmaceutical Agents
(5) MedPAC Report on APC Payment Rate Adjustment of Specified Covered Outpatient Drugs
b. CY 2006 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceutical Agents With HCPCS Codes But Without OPPS Hospital Claims Data
C. Coding and Billing Changes for Specified Covered Outpatient Drugs
1. Background
2. CY 2006 Payment Policy
D. Payment for New Drugs, Biologicals, and Radiopharmaceutical Agents Before HCPCS Codes Are Assigned
1. Background
2. CY 2006 Payment Policy
E. Payment for Vaccines
F. Changes in Payments for Single Indication Orphan Drugs
VI. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices
A. Total Allowed Pass-Through Spending
B. Estimate of Pass-Through Spending for CY 2006
VII. Brachytherapy Payment Changes
A. Background
B. Changes Related to Pub. L. 108–173
C. CY 2006 Payment Policy
VIII. Coding and Payment for Drug Administration
A. Background
B. Policy Changes for Drug Administration for CY 2006
C. Policy Changes for Vaccine Administration for CY 2006
IX. Hospital Coding for Evaluation and Management (E/M) Services
X. Payment for Blood and Blood Products
A. Background
B. Policy Changes for CY 2006
XI. Payment for Observation Services
A. Background
B. CY 2006 Coding Changes for Observation Services and Direct Admission to Observation
C. Criteria for Separate Payment for Direct Admission to Observation
D. Criteria for Separately Payable Observation Services (APC 0339)
1. Diagnosis Requirements
2. Observation Time
3. Additional Hospital Services
4. Physician Evaluation
XII. Procedures That Will Be Paid Only as Inpatient Procedures
A. Background
B. Policy Changes to the Inpatient List
C. Ancillary Outpatient Services When Patient Expires
XIII. Indicator Assignments
A. Status Indicator Assignments
B. Comment Indicators for the CY 2006 OPPS Final Rule
XIV. Nonrecurring Policy Changes
A. Payment for Multiple Diagnostic Imaging Procedures
B. Interrupted Procedure Payment Policies (Modifiers –52, –73, and –74)

XV. OPPS Policy and Payment Recommendations
A. MedPAC Recommendations
1. Report to the Congress: Medicare Payment Policy (March 2005)
2. Report to the Congress: Issues in a Modernized Medicare Program—Payment for Pharmacy Handling Costs in Hospitals
B. APC Panel Recommendations
C. GAO Recommendations
XVI. Physician Oversight of Nonphysician Practitioners in Critical Access Hospitals
A. Background
B. Proposed Policy Change in Proposed Rule
C. Public Comments Received on Proposed Rule and Our Responses
D. Final Policy
XVII. Files Available to the Public via the Internet
XVIII. Collection of Information Requirements
XIX. Regulatory Impact Analysis
A. OPPS: General
1. Executive Order 12866
2. Regulatory Flexibility Act (RFA)
3. Small Rural Hospitals
4. Unfunded Mandates
5. Federalism
B. Impact of Changes in this Final Rule with Comment Period
C. Alternatives Considered
1. Option Considered for Payment Policy for Separately Payable Drugs and Biologicals
2. Payment Adjustment for Rural SCHs
3. Change in the Percentage of Total OPPS Payments Dedicated to Outlier Payments
D. Limitations of Our Analysis
E. Estimated Impacts of this Final Rule with Comment Period on Hospitals
F. Estimated Impact of the Change in Outlier Policy
G. Accounting Statement
H. Estimated Impacts of this Final Rule with Comment Period on Beneficiaries
XX. Waiver of Proposed Rulemaking

Regulation Text

Addenda

Addendum A—List of Ambulatory Payment Classification (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts—CY 2006
Addendum B—Payment Status by HCPCS Code and Related Information—CY 2006
Addendum D1—Payment Status Indicators for the Hospital Outpatient Prospective Payment System
Addendum D2—Comment Indicators
Addendum E—CPT Codes That Are Paid Only as Inpatient Procedures
Addendum L-Out-Migration Wage Adjustment for CY 2006

I. Background

A. Legislative and Regulatory Authority for the Hospital 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 reasonable 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 Medicare, Medicaid, and SCHIP 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. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, enacted on December 8, 2003. (Discussion of provisions related specifically to the CY 2006 OPPS is included in sections II.C., II.F., II.G., and V.B.3.a.(2) of this final rule with comment period.) The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR Part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this final rule with comment period. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 provided for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS. In addition, the OPPS includes payment for partial hospitalization services furnished by community mental health centers (CMHCs).

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the inpatient hospital wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items 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 APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

Special payments under the OPPS may be made for new technology items and services in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of medical devices for at least 2 but not more than 3 years. For new technology services that are not eligible for pass-through payments and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as ''APC cost bands.'' These cost bands allow us to price these new procedures more appropriately and consistently. Similar to pass-through payments, these special payments for new technology services are also temporary; that is, we retain a service within a new technology APC group until we acquire adequate data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excluded payment for ambulance, physical and occupational therapy, and speech-

language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the broad authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule; services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS); and certain services furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B. We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20 of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain 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. Since implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. For a full discussion of the changes to the OPPS, we refer readers to these **Federal Register** final rules.[1]

On November 15, 2004, we published in the **Federal Register** a final rule with comment period (69 FR 65681) that revised the OPPS to update the payment weights and conversion factor for services payable under the calendar year (CY) 2005 OPPS on the basis of claims data from January 1, 2003 through December 31, 2003, and to implement certain provisions of Pub. L. 108–173. In addition, we responded to public comments received on the January 6, 2004 interim final rule with comment period relating to Pub. L. 108–173 provisions that were effective January 1, 2004, and finalized those policies. Further, we responded to public comments received on the November 7, 2003 final rule with comment period pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the NI comment indicator; and public comments received on the August 16, 2004 OPPS proposed rule (69 FR 50448).

Subsequent to publishing the November 15, 2004 final rule with comment period, we published a correction of final rule with comment period on December 30, 2004 (69 FR 78315). This document corrected technical errors that appeared in the November 15, 2004 final rule with comment period. It also provided additional information about the CY 2005 wage indices for the OPPS that was not published in the November 15, 2004 final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and weights under the OPPS. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills this requirement. The Act further specifies that the APC Panel will act in an advisory capacity. This expert panel, which may be composed of up to 15 representatives of hospitals and other Medicare providers subject to the OPPS (currently employed full-time and in their respective areas of expertise), reviews and advises CMS about the clinical integrity of the APC groups and their weights. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary originally signed the charter establishing the APC Panel. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA), as amended (Pub. L. 92–463). Since its initial chartering, the Secretary has twice renewed the APC Panel's charter: on November 1, 2002, and on November 1, 2004. The renewed charter indicates that the APC Panel continues to be technical in nature; is governed by the provisions of FACA with a Designated Federal Official (DFO) to oversee the day-to-day administration of the FACA requirements and to provide to the Committee Management Officer all committee reports for forwarding to the Library of Congress; may convene up to three meetings per year; and is chaired by a Federal official who also serves as a CMS medical officer.

Originally, in establishing the APC 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 who nominated either colleagues or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the APC Panel. Because four APC Panel members' terms of office expired on March 31, 2004, we published a **Federal Register** notice on January 23, 2004 (69 FR 3370) that solicited nominations for APC Panel membership. From the 24 nominations that we received, we chose four new members. Six members' terms expired on March 31, 2005; therefore, a **Federal Register** notice was published on February 25, 2005, requesting nominations to the APC Panel. We received only 13 nominations before the nomination period closed on March 15, 2005. Consequently, we extended the deadline for nominations to May 9, 2005, and announced the extension in the **Federal Register** on April 8, 2005 (70 FR 18028). From a total of 26 nominees from the two notices, we

[1] Interim final rule with comment period, August 3, 2000 (65 FR 47670); interim final rule with comment period, November 13, 2000 (65 FR 67798); final rule and interim final rule with comment period, November 2, 2001 (66 FR 55850 and 55857); final rule, November 30, 2001 (66 FR 59856); final rule, December 31, 2001 (66 FR 67494); final rule, March 1, 2002 (67 FR 9556); final rule, November 1, 2002 (67 FR 66718); final rule with comment period, November 7, 2003 (68 FR 63398); correction of the November 7, 2003 final rule with comment period, December 31, 2003 (68 FR 75442); interim final rule with comment period, January 6, 2004 (69 FR 820); and final rule with comment period, November 15, 2004 (69 FR 65681).

chose 6 new members who were announced in the **Federal Register** on August 26, 2005 (70 FR 50358). The entire APC Panel membership and information pertaining to it, including **Federal Register** notices, meeting dates, agenda topics, and meeting reports are identified on the CMS Web site: *http://www.cms.hhs.gov/faca/apc/apcmem.asp.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held seven subsequent meetings. The most recent meeting took place on August 17 and 18, 2005, which was announced in the meeting notice published on July 8, 2005 (70 FR 39514). Prior to each of these biennial meetings, we published a notice in the **Federal Register** to announce each meeting and, when necessary, to solicit and announce nominations for APC Panel membership. For a more detailed discussion about these announcements, refer to the following **Federal Register** notices: December 5, 2000 (65 FR 75943), December 14, 2001 (66 FR 64838), December 27, 2002 (67 FR 79107), July 25, 2003 (68 FR 44089), December 24, 2003 (68 FR 74621), August 5, 2004 (69 FR 47446), December 30, 2004 (69 FR 78464), and July 8, 2005 (70 FR 39514).

During these meetings, the APC Panel established its operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. Currently, the three subcommittees are the Data Subcommittee, the Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending viable options for resolving them. This subcommittee was initially established on April 23, 2001, as the Research Subcommittee and reestablished as the Data Subcommittee on April 13, 2004, February 11, 2005, and August 15, 2005. The Observation Subcommittee, which was established on June 24, 2003, and reestablished with new members on March 8, 2004, February 11, 2005, and August 15, 2005, reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPPS, such as coding and operational issues. The Packaging Subcommittee, which was established on March 8, 2004, and reestablished with new members on February 11, 2005, and August 15, 2005, studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

For a detailed discussion of the APC Panel meetings, refer to the hospital OPPS final rules cited in section I.C. of this preamble. Full discussion of the recommendations resulting from the APC Panel's February 2005 and August 2005 meetings are included in the sections of this preamble that are specific to each recommendation.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 That Will Be Implemented in CY 2006

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, was enacted. Pub. L. 108–173 made changes to the Act relating to the Medicare OPPS. In the January 6, 2004 interim final rule with comment period and the November 15, 2004 final rule with comment period, we implemented provisions of Pub. L. 108–173 relating to the OPPS that were effective for CY 2004 and CY 2005, respectively. Provisions of Pub. L. 108–173 that were implemented in CY 2004 or CY 2005, and that are continuing in CY 2006, are discussed throughout this final rule with comment period. Moreover, in this final rule with comment period, we finalize our proposal to implement the following provisions of Pub. L. 108–173 that affect the OPPS beginning in CY 2006:

1. Hold Harmless Provisions

Section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act and extended the hold harmless provision for small rural hospitals having 100 or fewer beds through December 31, 2005. Section 411 of Pub. L. 108–173 further amended section 1833(t)(7) of the Act to provide that hold harmless transitional corridor payments shall apply through December 31, 2005 to sole community hospitals (SCHs) (as defined in section 1886(d)(5)(D)(iii) of the Act) located in a rural area. In accordance with these provisions, effective January 1, 2006, we proposed to discontinue transitional corridor payments for small rural hospitals having 100 or fewer beds and for SCHs located in a rural area.

2. Study and Authorization of Adjustment for Rural Hospitals

Section 411(b) of Pub. L. 108–173 added a new paragraph (13) to section 1833(t) of the Act to authorize an ''Adjustment for Rural Hospitals.'' This provision requires us to conduct a study to determine if costs incurred by hospitals located in rural areas by APCs exceed those costs incurred by hospitals located in urban areas. This provision further requires us to provide for an appropriate adjustment by January 1, 2006, if we find that the costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas. In accordance with these provisions, effective January 1, 2006, as we proposed, we are implementing an adjustment for rural sole community hospitals (SCHs), as discussed below.

3. Payment for ''Specified Covered Outpatient Drugs''

Section 621(a)(1) of Pub. L. 108–173 added section 1833(t)(14) to the Act that specifies payments for certain ''specified covered outpatient drugs'' beginning in 2006. Specifically, section 1833(t)(14)(A)(iii)(I) of the Act states that such payment shall be equal to what we determine to be the average acquisition cost for the drug, taking into account hospital acquisition cost survey data furnished by the Government Accountability Office (GAO). Section 1833(t)(14)(A)(iii)(II) of the Act further notes that if hospital acquisition cost data are not available, payment for specified covered outpatient drugs shall equal the average price for the drug established under section 1842(o), section 1847(A), or section 1847(B) of the Act as calculated and adjusted by the Secretary as necessary. Both payment approaches are subject to adjustments under section 1833(t)(14)(E) of the Act as discussed below.

4. Adjustment in Payment Rates for ''Specified Covered Outpatient Drugs'' for Overhead Costs

Section 621(a)(1) of Pub. L. 108–173 added section 1833(t)(14)(E) to the Act. Section 1833(t)(14)(E)(ii) of the Act authorizes us to make an adjustment to payments for ''specified covered outpatient drugs'' to take into account overhead and related expenses such as pharmacy services and handling costs, based on recommendations contained in a report prepared by the Medicare Payment Advisory Commission (MedPAC).

5. Budget Neutrality Adjustment

Section 621(a)(1) of Pub. L. 108–173 amended the Act by adding section

1833(t)(14)(H), which requires that additional expenditures resulting from adjustments in APC payment rates for specified covered outpatient drugs be taken into account beginning in CY 2006 and continuing in subsequent years, in establishing the OPPS conversion, weighting, and other adjustment factors.

F. CMS' Commitment to New Technologies

As we indicated in the CY 2006 proposed rule, CMS is committed to ensuring that Medicare beneficiaries will have timely access to new medical treatments and technologies that are well-evaluated and demonstrated to be effective. We launched the Council on Technology and Innovation (CTI) to provide the Agency with improved methods for developing practical information about the clinical benefits of new medical technologies to result in faster and more efficient coverage and payment of these medical technologies. The CTI supports CMS efforts to develop better evidence on the safety, effectiveness, and cost of new and approved technologies to help promote their more effective use.

We want to provide doctors and patients with better information about the benefits of new medical treatments or technologies, or both, especially compared to other treatment options. We also want beneficiaries to have access to valuable new medical innovations as quickly and efficiently as possible. We note there are a number of payment mechanisms in the OPPS and the IPPS designed to achieve appropriate payment of promising new technologies. In the OPPS, qualifying new medical devices may be paid on a cost basis by means of transitional pass-through payments, in addition to the APC payments for the procedures which utilize the devices. In addition, qualifying new services may be assigned for payment to New Technology APCs or, if appropriate, to regular clinical APCs. In the IPPS, qualifying new technologies may receive add-on payments to the standard diagnosis-related group (DRG) payments. We also note that collaborative efforts are underway to facilitate coordination between the Food and Drug Administration (FDA) and CMS with regard to streamlining the CMS coverage process by which new technologies come to the marketplace.

To promote timely access to new medical treatments and technologies, in the CY 2006 OPPS proposed rule, we proposed enhancements to both the OPPS pass-through payment criteria for devices as discussed in section IV.D.2. of that rule and the qualifying process for assignment of new services to New Technology APCs or regular clinical APCs discussed in section III.C.3. of that rule. In the CY 2006 OPPS proposed rule, we proposed to make device pass-through eligibility available to a broader range of qualifying devices. We also proposed to change the application and review process for assignment of new services to New Technology APCs to promote thoughtful review of the coding, clinical use and efficacy of new services by the wider medical community, encouraging appropriate dissemination of new technologies.

We received a large number of public comments generally supporting our commitment to new technologies. Many of these comments in support of this commitment were stated in the context of our proposals to enhance the OPPS pass-through payment criteria for devices or the application requirements for assignment of a service to a New Technology APC. Specific comments are addressed in those respective sections.

G. Summary of the Provisions of the CY 2006 OPPS Proposed Rule

On July 25, 2005, we published a proposed rule in the **Federal Register** (70 FR 42674) that set forth proposed changes to the Medicare hospital OPPS for CY 2006 to implement statutory requirements and changes arising from our continuing experience with the system, to implement provisions of Pub. L. 108–173 specified in sections II.C., II.F., II.G., and V.B.3.a.(2) of this preamble, and to change the requirement for physician oversight of nonphysician practitioners in CAHs that will be effective for services furnished on or after January 1, 2006. Subsequent to publishing the proposed rule, we published a correction of the proposed rule on August 26, 2005 (70 FR 50679) that corrected technical errors that appeared in the proposed rule. The following is a summary of the major changes included in the CY 2006 OPPS proposed rule that we proposed to make:

1. Updates to Payments for CY 2006

In the proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights and the proposed recalibration of the relative payment weights for CY 2006.
- The proposed payment for partial hospitalization, including the proposed separate threshold for outlier payments for CMHCs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS for CY 2006.
- The proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount for CY 2006.
- The proposed update of statewide average default cost-to-charge ratios.
- Proposed changes relating to the expiring hold harmless payment provision.
- Proposed changes to payment for rural SCHs for CY 2006.
- Proposed changes in the way we calculate hospital outpatient outlier payments for CY 2006.
- Calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayment for OPPS services for CY 2006.

2. Ambulatory Payment Classification (APC) Group Policies

In the proposed rule, we discussed establishing a number of new APCs and making changes to the assignment of HCPCS codes under a number of existing APCs based on our analyses of Medicare claims data and recommendations of the APC Panel. We also discussed the application of the 2 times rule and proposed exceptions to it; proposed changes for specific APCs; the proposed refinement of the New Technology cost bands; the proposed movement of procedures from the New Technology APCs; and the proposed additions of new procedure codes to the APC groups.

3. Payment Changes for Devices

In the proposed rule, we discussed proposed changes to the device-dependent APCs, to related regulations under §§ 419.66(b)(3) and 419.66(c)(1), and to the pass-through payment for three categories of devices.

4. Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents

In the proposed rule, we discussed proposed payment changes for drugs, biologicals, radiopharmaceutical agents, and vaccines.

5. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

In the proposed rule, we discussed the proposed methodology for estimating total pass-through spending and whether there should be a pro rata reduction for transitional pass-through drugs, biologicals, radiopharmacials, and categories of devices for CY 2006.

6. Brachytherapy Payment Changes

In the proposed rule, we included a discussion of our proposal concerning coding and payment for the sources of brachytherapy.

7. Coding and Payment for Drug Administration

In the proposed rule, we discussed our proposed coding and payment changes for drug administration services.

8. Hospital Coding for Evaluation and Management (E/M) Services

In the proposed rule, we discussed our proposal for developing coding guidelines for evaluation and management services.

9. Payment for Blood and Blood Products

In the proposed rule, we discussed our proposed payment changes for blood and blood products.

10. Payment for Observation Services

In the proposed rule, we discussed our proposed criteria and coding changes for observation services.

11. Procedures That Will Be Paid Only as Inpatient Services

In the proposed rule, we discussed the procedures that we proposed to remove from the inpatient list and assign to APCs.

12. Indicator Assignments

In the proposed rule, we discussed proposed changes to the list of status indicators assigned to APCs and presented our comment indicators that we proposed to use in this final rule with comment period.

13. Nonrecurring Policy Changes

In the proposed rule, we discussed proposed changes in payments for multiple diagnostic imaging procedures and proposed changes in payment policy for interrupted procedures.

14. OPPS Policy and Payment Recommendations

In the proposed rule, we addressed recommendations made by MedPAC, the APC Panel, and the GAO regarding the OPPS for CY 2006.

15. Physician Oversight in Critical Access Hospitals

In the proposed rule, we discussed physician oversight for services provided by nonphysician practitioners such as physician assistants, nurse practitioners, and clinical nurse specialists in CAHs.

H. Public Comments Received on the CY 2006 OPPS Proposed Rule

We received over 1,000 timely pieces of correspondence containing multiple comments on the CY 2006 OPPS proposed rule. Summaries of the public comments and our responses to those comments are set forth in the various sections under the appropriate headings.

Comment: One commenter objected to the short time between the end of the comment period and the effective date of the final rule. The commenter stated that the brief time period gives inadequate time for systems and software changes. The commenter asked that the proposed rule be published July 1 and that the final rule be published no later than October 1 of each year. The commenter indicated that hospitals need the extra month to implement the OPPS because it is much more complex for hospitals to implement than the IPPS.

Response: We understand the commenter's concern about the difficulty of implementing the annual OPPS update in 60 days. We do our best to issue the proposed rule and the final rule as promptly as possible and to make all of the supporting documentation available on the CMS Web site as soon as we can. However, factors such as the use of the most recent claims data and cost report data on which we base the proposed and final rates delay the issuance of the proposed rule and the final rule. Hospital delays in submission of hospital bills are an important factor in timing of the OPPS updates as well, because we want to use as many claims as possible in setting the OPPS rates. Moreover, we cannot issue the final rule until the HCPCS code files for the forthcoming year are final because we assign a stataus indicator to each HCPCS code in the OPPS OCE. The HCPCS files are not final until they are published in October.

Comment: Commenters asked that CMS include an indirect medical education adjustment in the OPPS because it is the only major Medicare payment system that does not include a teaching adjustment. One commenter asked that CMS conduct a study to determine the special roles and costs related to medical education and the appropriateness of including a teaching hospital adjustment.

Response: We have not developed an indirect medical education add-on payment made under the OPPS because the statute does not provide for this adjustment, and we are not convinced that it would be appropriate in a budget-neutral payment system where such changes would result in reduced payments to all other hospitals. Moreover, in the final rule, we have developed payment weights that we believe resolve many of the public concerns regarding appropriate payments for new technology services and device-dependent procedures, which we believe are furnished largely by teaching hospitals. In addition, the application of the wage index adjustment to 60 percent of the APC payment package (especially for APCs into which expensive devices are packaged) tends to benefit teaching hospitals, which are predominantly located in hgh-cost areas. These and other payment changes should help ensure equitable payment for all hospitals within the constraints of the statute.

I. Public Comments Received on the November 15, 2004 Final Rule With Comment Period

We received approximately 55 timely pieces of correspondence on the November 5, 2004 final rule with comment period, some of which contained multiple comments on the APC assignment of HCPCS codes identified with the NI comment indicator in Addendum B of that final rule with comment period and on the surgical insertion and implantation device criterion. Summaries of those public comments and our responses to those comments are set forth in the various sections under the appropriate headings.

II. Updates Affecting Payments for CY 2006

A. Recalibration of APC Relative Weights for CY 2006

1. Database Construction

a. Database Source and Methodology. Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS 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 a small number of APC changes, these relative payment weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).

In the CY 2005 OPPS proposed rule (70 FR 42680), we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the APC relative payment

weights for services furnished on or after January 1, 2006, and before January 1, 2007. That is, we would recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative payment weights for CY 2006, we used approximately 137 million final action claims for hospital OPD services furnished on or after January 1, 2004, and before January 1, 2005. Of the 137 million final action claims for services provided in hospital outpatient settings, 109 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 109 million claims, we were able to use 52.7 million whole claims to set the proposed OPPS APC relative weights for CY 2006 OPPS. From the 52.7 million whole claims, we created 87.9 million single records, of which 54.9 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section).

As we proposed, the final APC relative weights and payments for CY 2006 in Addenda A and B to this final rule with comment period were calculated using claims from this period that had been processed before June 30, 2005, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data.

We received numerous public comments concerning our proposed data source and methodology for recalibrating the APC relative weights for CY 2006. A summary of the comments and our responses are discussed below.

Comment: Commenters stated that many APC rates fluctuate dramatically, and the instability in the system makes it very hard for hospitals to budget and plan services from year to year. Among the services identified as issues of specific concern were clinic visits, application of brachytherapy sources, drugs and biologicals, and device-intensive APCs. Some commenters recommended that CMS limit increases and decreases for all APCs to no more than a 5-percent shift (increase or decrease) from one year to another. Commenters emphasized that fluctuations in payment rates for device-dependent procedures from year to year impact manufacturers' abilities to contract effectively with hospitals to provide a stable purchasing environment and, thereby, impede innovation and adversely impact beneficiaries.

Response: We understand the commenters' concerns about the need for sufficient stability in the OPPS so that hospitals can plan and budget. We have given this issue much consideration. We recognize that reliance on single procedure claims may result in fewer claims for some services than for others. For example, median costs for services such as office visits, for which the volume of single bills is very high, would generally be more stable than the median costs for services for which we have very few single procedure claims. We will continue to explore changes we could effectuate to enable us to use even more claims on the premise that using more claims data will enhance stability.

However, we note that the statutory design of the OPPS and the rapid evolution in the delivery of outpatient hospital services include many elements that may be responsible for some of the fluctuation in rates from year to year. For example, the ''2 times rule'' imposed by the law requires the movement of some procedures from one APC to another each year. Moreover, the OPPS is based on procedure coding for which there are hundreds of changes each year. In addition, the entry of new technology into a budget neutral payment system results in a shift of funds away from previously existing services to provide payments for new services. These systemic factors are valid reflections of the changes in services in the outpatient department, and shifts in payment legitimately mirror those changes.

Comment: Commenters stated that the entire OPPS is underfunded because it pays only 87 percent of the costs of services to Medicare beneficiaries. One commenter indicated that the underfunding of services to Medicare patients is particularly severe for disproportionate share hospitals and hospitals with level I trauma centers and, therefore, will inhibit access to care for Medicare beneficiaries and other individuals.

Response: Our early analyses indicated that the OPPS was, in its inception, based on payment that was less than cost due to statutory reductions in payment for hospital outpatient costs prior to the enactment of the BBA, which authorized the current OPPS. Certain fundamental statutory features of the OPPS dictate such a finding. For example, the base amounts upon which the OPPS was established, the rules concerning budget neutrality, and subsequent out-year adjustments such as annual reductions in coinsurance and adjustments to outlier and pass-through payment allocations are established in statute and, as such, would require legislation to amend.

Comment: Commenters supported use of the most recent claims data for recalibrating the APC relative weights but in many cases wanted CMS to adjust the claims data for particular services of interest to them in ways that will result in higher payment for those specified services. Other commenters supported use of proprietary, confidential external data in lieu of claims data to set the median costs on which the rates are based for selected services because they believe that the use of claims data results in median costs that are less than the costs of the services being furnished. Some commenters asked CMS to establish a representative sample of hospitals from which data would be collected for use in place of claims data or to validate the data derived from claims.

Response: We believe that, in a budget neutral relative payment system such as the OPPS, it is important that the relative weights be based on a uniform source of data processed in a standardized way. We believe that Medicare claims data are the most uniform data source available to us. Moreover, the weights derived from such a system are the vehicles for distributing Medicare payments for outpatient hospital services fairly among all hospitals that furnish outpatient hospital services to Medicare beneficiaries. We are committed to using claims data in a uniform manner, to the maximum extent possible, to develop the relative weights from which payment rates are calculated. We do not see a compelling need to use external data to set or adjust median costs for device-dependent APCs for the CY 2006 OPPS. Therefore, for the CY 2006 OPPS, we have not substituted external data for Medicare claims data for the purpose of setting the median costs on which the relative weights are based.

After carefully considering all comments received, we are finalizing our data source and methodology for the recalibration of CY 2006 APC relative weights as proposed without modification.

b. Use of Single and Multiple Procedure Claims. For CY 2006, we proposed to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based. As noted in the November 15, 2004 final rule with

comment period, 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 relative payment weights (69 FR 65730 through 65731). Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least costly services, thereby introducing downward bias to the medians on which the weights are based.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those with multiple procedures. We generally use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. However, by bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. We have used the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims the same as we did in recalibrating the CY 2005 APC relative payment weights. We refer to these newly created single procedure claims as ''pseudo'' singles because they were submitted by providers as multiple procedure claims.

For CY 2003, we created ''pseudo'' single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created ''pseudo'' single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs. We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating ''pseudo'' single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and Level I plain film x-rays. To derive more ''pseudo'' single claims, we also split the claims where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

As in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median costs for those APCs. For CY 2004, from about 16.3 million otherwise unusable claims, we used about 9.5 million multiple procedure claims to create about 27 million ''pseudo'' single claims. For CY 2005, we identified 383 bypass codes and from approximately 24 million otherwise unusable claims, we used about 18 million multiple procedure claims to create about 52 million ''pseudo'' single claims.

For CY 2006, we proposed to continue using date of service matching as a tool for creation of ''pseudo'' single claims and to continue the use of a bypass list to create ''pseudo'' single claims. The process we proposed for CY 2006 OPPS resulted in our being able to use some part of 90 percent of the total claims that are eligible for use in OPPS rate-setting and modeling in developing this final rule with comment period. This process enabled us to use, for CY 2006, 88 million single bills for rate-setting: 55 million ''pseudo'' singles and 34 million ''natural'' single bills (bills that were submitted containing only one separately payable major HCPCS code). (These numbers do not sum to 88 million because more than 800,000 single bills were removed when we trimmed at the HCPCS level at +/−3 standard deviations from the geometric mean.)

We proposed to bypass the 404 codes identified in Table 1 of the proposed rule (70 FR 42682) to create new single claims and to use the line-item costs associated with the bypass codes on these claims in the creation of the median costs for the APCs into which they are assigned. Of the codes on that list, 385 were used for bypass in CY 2005. For CY 2006, we proposed to continue the use of the codes on the CY 2005 OPPS bypass list and expand it by adding those codes that, using data presented to the APC Panel at its February 2005 meeting, met the same empirical criteria as those used in CY 2005 to create the bypass list. Our examination of the data against the criteria for inclusion on the bypass list, as discussed below for the addition of new codes, shows that the empirically selected codes used for bypass for the CY 2005 OPPS generally continue to meet the criteria or come very close to meeting the criteria, and we have received no comments against bypassing them.

As we proposed, in this final rule with comment period, we used the following empirical criteria that were developed by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We assumed that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There were 100 or more single claims for the code. This number of single claims ensured that observed outcomes were sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claim was equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

As stated in the proposed rule (70 FR 42681), we also added to the bypass list three codes (CPT codes 51701, 51702, and 51703 for bladder catheterization) which do not meet these criteria. These codes have been packaged and have never been paid separately. For that reason, when these were the only services provided to the beneficiary, no payment was made to the hospital. The APC Panel's Packaging Subcommittee recommended that we make separate payment when they are the only service on the claim. See section II.A.4. of this preamble for further discussion of our policy to pay these services separately. We added these codes to the bypass list because changing them from packaged to separately paid would result in a reduction of the number of single bills on which we could base median costs

for other major separately paid procedures that are billed on the same claim with these procedure codes. Single bills which contain other procedures would become multiple procedure claims when these bladder catheterization codes were converted from packaged to separately paid status.

As explained in the CY 2006 proposed rule (70 FR 42682), we examined the packaging on the single procedure claims in the CY 2004 data for these codes. We found that none of these three codes met the empirical standards for the bypass list. However, we believe that when these services are performed on the same date as another separately paid procedure, any packaging that appears on the claim would appropriately be associated with the other procedures and not with these codes. Therefore, we believe that bypassing them does not adversely affect the medians for other procedures. Moreover, future separate payment for these codes does not harm the hospitals that furnish these services, in view of the historical absence of separate payment for them under the OPPS in the past. Hence, we proposed to pay separately for these codes and to add them to the bypass list for the CY 2006 OPPS.

In the CY 2006 proposed rule, we specifically invited public comments on the proposed ''pseudo'' single process, including the bypass list and the criteria. A summary of the many comments we received and our responses follow:

Comment: Some commenters supported use of multiple procedure claims through application of the bypass list and date of service stratification. Other commenters stated that these processes may result in more claims but not necessarily better data for rate-setting. Many commenters objected to the use of single procedure claims as the basis for setting the relative weights because they believed that using single procedure claims limits the claims data to the simplest and least costly cases. They proposed CPT code or APC specific strategies for using multiple procedure claims in ways that would apply only to the services of interest to them that could not be generalized across multiple procedure claims for all services. The commenters indicated that the use of single procedure claims greatly limits the number of claims that are used for setting median costs and weights, and that the OPPS relative weights would be greatly improved if we could use all of the claims data. They indicated that the use of single procedure claims causes medians to be set based on incorrectly coded claims for the many add-on codes that can only be billed properly when they are billed with the base code to which they are attached. In addition, they indicated that many services are so routinely furnished in combination with other services that use of single procedure claims will never result in appropriate median costs for these procedures.

Response: We share the commenters' desire to use as much claims data as possible to set the relative weights for the OPPS services. We continue to explore ways to use more data from multiple procedure claims. Specifically, we are looking at the extent to which the many add-on codes (codes that are reported for services furnished only as an adjunct to another service) can be packaged to create more single claims. We are also exploring strategies for using data from correctly coded multiple procedure claims containing both base and add-on codes to ascertain the incremental costs of the add-on services. We also expect to explore other generally applicable strategies, such as apportioning packaging based on submitted charges that would enable us to use multiple procedure claims.

We are disinclined to focus on service-specific strategies for using multiple procedure claims because those that have been suggested to us are not generally applicable to multiple procedure claims across all services, but rather are focused on increasing the median costs of particular services to the exclusion of all other services. As we indicated above, we believe that it is important in a relative weight system that, to the maximum extent possible, the same claims and the same processing rules apply to all services so that the resulting relative weights are uniformly created and serve all hospitals fairly.

Comment: One commenter asked why only some of the office visit and consultation services are included in the bypass list (for example, CPT codes 99213 and 99214 are on the list) but CPT codes 99211, 99212 and 99215 are not. The commenter believed that the cited unlisted codes should also be on the list. Other commenters did not believe that CPT codes 99213 and 99214 met the criteria for inclusion as bypass codes and believed that they should be removed from the list.

Response: We have included below data calculated from the APC Panel data for use in setting the bypass list for the CY 2006 proposed rule and this final rule with comment period. These data show that CPT codes 99213 and 99214 meet the criteria for inclusion as bypass codes, and that CPT codes 99211, 99212 and 99215 exceed the 5-percent limit for single bills containing packaging:

HCPCS	Short descriptor	Median amount of packaging on single bills	Percent of single bills for the code containing packaging
99211	Office/outpatient visit, est	$11.98	6.15
99212	Office/outpatient visit, est	10.88	5.43
99213	Office/outpatient visit, est	11.72	3.87
99214	Office/outpatient visit, est	12.76	3.63
00215	Office/outpatient visit, est	12.76	8.62

Comment: Commenters supported the use of the bypass list but were concerned that the inclusion of services on the bypass list may systematically result in lower costs for the procedures that are included on the list than if they had not been included on the list.

Response: We established the bypass list criteria for the purpose of limiting any potential adverse impact on the medians for the services on the bypass list. We believe that the requirement that a code cannot be placed on the bypass list if more than 5 percent of the single bills for that code contain packaging or if the median packaging for the code exceeds $50, is a strong deterrent to systematic reduction of medians for services on the bypass list. We have received no comments on the appropriateness or inappropriateness of the bypass criteria, and thus, we have not changed them for the CY 2006 OPPS.

Comment: Commenters asked CMS to carefully consider the impact of add-on codes on the creation of multiple

procedure claims and urged CMS to not disqualify a claim because of the presence of an add-on code that is packaged. In the case of add-on codes that are separately paid, one commenter urged CMS to apportion the packaged charges between the base code and the add-on code so that the data from the multiple procedure claim can be used. Some commenters asked CMS to place all add-on codes, both packaged and separately paid, on the bypass list to create more single procedure claims.

Response: The presence of an add-on code with a status indicator of ''N'' because it is a packaged service does not currently disqualify the claim as a multiple procedure claim. The claim is considered to be a single procedure claim and the cost of the packaged add-on code is treated like any other packaged drug, device, or supply or other packaged cost. However, the presence of an add-on code that is separately paid but not on the bypass list does currently cause the claim to be a multiple procedure claim that is not used because of the difficulties in determining how to apportion the packaging on the claim between the two separately paid procedure codes.

We disagree that all add-on codes could safely be added to the bypass list. Many add-on codes use significant resources that are reported as packaged charges in support of the add-on code. For example, CPT code 33225 (Left ventricular lead add-on) requires more than an hour of additional operating room time and also requires a device with significant cost when the service is furnished in conjunction with a base service. If we were to include CPT code 33225 on the bypass list, only the line-item charge for the CPT code would be attributed to the procedure code. Neither the device cost (which is packaged), nor the share of other costs attributable to the service (for example, drugs, supplies, and extended operating room time) would be attributed to CPT code 33225. They would both be packaged into the base code. The single procedure claims for CPT code 33225 would not reflect the costs of the device or extended operating room time. In addition, the single procedure claims for the base code would reflect packaging that is not properly associated with that procedure.

However, we recognize that the add-on codes present a significant data problem because they can never be correctly billed unless they are also billed on the same claim with a base code to which they add services. We are undertaking a study of add-on codes to determine whether there are add-on codes that are now separately paid that should become packaged, and thus would provide more single procedure claims. With respect to the add-on codes for which packaging is not appropriate, we will be exploring methods that would enable us to systematically calculate valid median costs for the add-on codes from multiple procedure claims and thus create a more robust set of valid claims for rate-setting. We anticipate working with the APC Panel members on this issue.

Comment: Commenters asked CMS to assign a flag to claims that became pseudo singles in the claims included in the public use files so that it would be easier for commenters to model future proposed policies.

Response: The public use files (the limited data set and the beneficiary encrypted data set) contain claims as submitted to CMS. Therefore, to flag the pseudo single claims in the public use file is not possible because the pseudo single claims may be part, but not all, of the submitted claim. Even if we did flag the claim, the user would still have to replicate the process to create pseudo single claims. We note that we have greatly increased the information we issued regarding how we process the claims to acquire the median costs, and we understand that outside replication of our medians has improved.

Comment: Commenters asked whether CMS disregards line item charges for drugs, biologicals, and radiopharmaceutical agents and items with status indicators ''K'' and ''G'' for purposes of creating pseudo singles claims.

Response: The presence on a claim of a code and charge for a drug, biological, or radiopharmaceutical agent, whether separately paid or packaged, has no impact on determining whether the claim is a single procedure claim.

After carefully considering all public comments received, we are adopting as final the proposed ''pseudo'' single process and the bypass codes listed in Table 1 without modification.

BILLING CODE 4120–01–P

Table 1.--CY 2006 HCPCS Bypass Codes for Creating "Pseudo" Single Claims for Calculating Median Costs

HCPCS Code	Short Description	Status Indicator
11056*	Trim skin lesions, 2 to 4	T
11057*	Trim skin lesions, over 4	T
11719	Trim nail(s)	T
11720	Debride nail, 1-5	T
11721	Debride nail, 6 or more	T
17003*	Destroy lesions, 2-14	T
31231*	Nasal endoscopy, dx	T
31579	Diagnostic laryngoscopy	T
51701*	Insert bladder catheter	X
51702*	Insert temp bladder catheter	X
51703*	Insert bladder catheter, complex	X
51798*	Us urine capacity measure	X
54240	Penis study	T
67820*	Revise eyelashes	S
70030*	X-ray eye for foreign body	X
70100	X-ray exam of jaw	X
70110	X-ray exam of jaw	X
70130	X-ray exam of mastoids	X
70140	X-ray exam of facial bones	X
70150	X-ray exam of facial bones	X
70160	X-ray exam of nasal bones	X
70200	X-ray exam of eye sockets	X
70210	X-ray exam of sinuses	X
70220	X-ray exam of sinuses	X
70250	X-ray exam of skull	X
70260	X-ray exam of skull	X
70328	X-ray exam of jaw joint	X
70330	X-ray exam of jaw joints	X
70336*	Magnetic image, jaw joint	S
70355	Panoramic x-ray of jaws	X
70360	X-ray exam of neck	X
70370*	Throat x-ray & fluoroscopy	X
70371	Speech evaluation, complex	X
70450	Ct head/brain w/o dye	S
70480	Ct orbit/ear/fossa w/o dye	S
70486	Ct maxillofacial w/o dye	S
70544	Mr angiography head w/o dye	S
70551*	Mri brain w/o dye	S
71010	Chest x-ray	X
71015	Chest x-ray	X
71020	Chest x-ray	X

HCPCS Code	Short Description	Status Indicator
71021	Chest x-ray	X
71022	Chest x-ray	X
71023*	Chest x-ray and fluoroscopy	X
71030	Chest x-ray	X
71034	Chest x-ray and fluoroscopy	X
71090	X-ray & pacemaker insertion	X
71100	X-ray exam of ribs	X
71101	X-ray exam of ribs/chest	X
71110	X-ray exam of ribs	X
71111	X-ray exam of ribs/ chest	X
71120	X-ray exam of breastbone	X
71130	X-ray exam of breastbone	X
71250	Ct thorax w/o dye	S
72040	X-ray exam of neck spine	X
72050	X-ray exam of neck spine	X
72052	X-ray exam of neck spine	X
72069*	X-ray exam of trunk spine	X
72070	X-ray exam of thoracic spine	X
72072	X-ray exam of thoracic spine	X
72074	X-ray exam of thoracic spine	X
72080	X-ray exam of trunk spine	X
72090	X-ray exam of trunk spine	X
72100	X-ray exam of lower spine	X
72110	X-ray exam of lower spine	X
72114	X-ray exam of lower spine	X
72120	X-ray exam of lower spine	X
72125	Ct neck spine w/o dye	S
72128*	Ct chest spine w/o dye	S
72141	Mri neck spine w/o dye	S
72146	Mri chest spine w/o dye	S
72148	Mri lumbar spine w/o dye	S
72170	X-ray exam of pelvis	X
72190	X-ray exam of pelvis	X
72192	Ct pelvis w/o dye	S
72220	X-ray exam of tailbone	X
73000	X-ray exam of collar bone	X
73010	X-ray exam of shoulder blade	X
73020	X-ray exam of shoulder	X
73030	X-ray exam of shoulder	X
73050	X-ray exam of shoulders	X
73060	X-ray exam of humerus	X
73070	X-ray exam of elbow	X
73080	X-ray exam of elbow	X
73090	X-ray exam of forearm	X
73100	X-ray exam of wrist	X

HCPCS Code	Short Description	Status Indicator
73110	X-ray exam of wrist	X
73120	X-ray exam of hand	X
73130	X-ray exam of hand	X
73140	X-ray exam of finger(s)	X
73218	Mri upper extremity w/o dye	S
73221	Mri joint upr extrem w/o dye	S
73510	X-ray exam of hip	X
73520	X-ray exam of hips	X
73540	X-ray exam of pelvis & hips	X
73550	X-ray exam of thigh	X
73560	X-ray exam of knee, 1 or 2	X
73562	X-ray exam of knee, 3	X
73564	X-ray exam, knee, 4 or more	X
73565	X-ray exam of knees	X
73590	X-ray exam of lower leg	X
73600	X-ray exam of ankle	X
73610	X-ray exam of ankle	X
73620	X-ray exam of foot	X
73630	X-ray exam of foot	X
73650	X-ray exam of heel	X
73660	X-ray exam of toe(s)	X
73700	Ct lower extremity w/o dye	S
73718*	Mri lower extremity w/o dye	S
73721	Mri jnt of lwr extre w/o dye	S
74000	X-ray exam of abdomen	X
74010*	X-ray exam of abdomen	X
74210	Contrst x-ray exam of throat	S
74220	Contrast x-ray, esophagus	S
74230	Cine/vid x-ray, throat/esoph	S
74235	Remove esophagus obstruction	S
74240	X-ray exam, upper gi tract	S
74245	X-ray exam, upper gi tract	S
74246	Contrst x-ray uppr gi tract	S
74247	Contrst x-ray uppr gi tract	S
74249	Contrst x-ray uppr gi tract	S
74250	X-ray exam of small bowel	S
74300	X-ray bile ducts/pancreas	X
74301	X-rays at surgery add-on	X
74305	X-ray bile ducts/pancreas	X
74327	X-ray bile stone removal	S
74340	X-ray guide for GI tube	X
74350	X-ray guide, stomach tube	X
74355	X-ray guide, intestinal tube	X
74360	X-ray guide, GI dilation	S
74363	X-ray, bile duct dilation	S

HCPCS Code	Short Description	Status Indicator
74475	X-ray control, cath insert	S
74480	X-ray control, cath insert	S
74485	X-ray guide, GU dilation	S
74742	X-ray, fallopian tube	X
75894	X-rays, transcath therapy	S
75898	Follow-up angiography	X
75901	Remove cva device obstruct	X
75902	Remove cva lumen obstruct	X
75945	Intravascular us	S
75946	Intravascular us add-on	S
75960	Transcatheter intro, stent	S
75961	Retrieval, broken catheter	S
75962	Repair arterial blockage	S
75964	Repair artery blockage, each	S
75966	Repair arterial blockage	S
75968	Repair artery blockage, each	S
75970	Vascular biopsy	S
75978	Repair venous blockage	S
75980	Contrast xray exam bile duct	S
75982	Contrast xray exam bile duct	S
75984	Xray control catheter change	X
75992	Atherectomy, x-ray exam	S
75993	Atherectomy, x-ray exam	S
75994	Atherectomy, x-ray exam	S
75995	Atherectomy, x-ray exam	S
75996	Atherectomy, x-ray exam	S
76012	Percut vertebroplasty fluor	S
76013	Percut vertebroplasty, ct	S
76040	X-rays, bone evaluation	X
76061	X-rays, bone survey	X
76062	X-rays, bone survey	X
76066	Joint survey, single view	X
76070*	CT scan, bone density study	S
76075	Dexa, axial skeleton study	S
76076	Dexa, peripheral study	S
76078	Radiographic absorptiometry	X
76095	Stereotactic breast biopsy	T
76096	X-ray of needle wire, breast	X
76100	X-ray exam of body section	X
76101	Complex body section x-ray	X
76360	Ct scan for needle biopsy	S
76380	CAT scan follow-up study	S
76393	Mr guidance for needle place	S
76511	Echo exam of eye	S
76512	Echo exam of eye	S

HCPCS Code	Short Description	Status Indicator
76516	Echo exam of eye	S
76519	Echo exam of eye	S
76536	Us exam of head and neck	S
76645	Us exam, breast(s)	S
76700	Us exam, abdom, complete	S
76705	Echo exam of abdomen	S
76770	Us exam abdo back wall, comp	S
76775	Us exam abdo back wall, lim	S
76778*	Us exam kidney transplant	S
76801*	Ob us < 14 wks, single fetus	S
76811*	Ob us, detailed, sngl fetus	S
76817*	Transvaginal us, obstetric	S
76830	Transvaginal us, non-ob	S
76856	Us exam, pelvic, complete	S
76857	Us exam, pelvic, limited	S
76870	Us exam, scrotum	S
76880	Us exam, extremity	S
76941	Echo guide for transfusion	S
76945	Echo guide, villus sampling	S
76946	Echo guide for amniocentesis	S
76948	Echo guide, ova aspiration	S
76950*	Echo guidance radiotherapy	S
76970*	Ultrasound exam follow-up	S
76977	Us bone density measure	X
77280	Set radiation therapy field	X
77285	Set radiation therapy field	X
77295*	Set radiation therapy field	X
77300	Radiation therapy dose plan	X
77301	Radiotherapy dose plan, imrt	X
77315	Teletx isodose plan complex	X
77326	Radiation therapy dose plan	X
77327	Brachytx isodose calc interm	X
77328	Brachytx isodose plan compl	X
77331	Special radiation dosimetry	X
77332	Radiation treatment aid(s)	X
77333	Radiation treatment aid(s)	X
77334	Radiation treatment aid(s)	X
77336	Radiation physics consult	X
77370	Radiation physics consult	X
77402*	Radiation treatment delivery	S
77403	Radiation treatment delivery	S
77404*	Radiation treatment delivery	S
77408*	Radiation treatment delivery	S
77409	Radiation treatment delivery	S
77411	Radiation treatment delivery	S

HCPCS Code	Short Description	Status Indicator
77412	Radiation treatment delivery	S
77413	Radiation treatment delivery	S
77414	Radiation treatment delivery	S
77416	Radiation treatment delivery	S
77417	Radiology port film(s)	X
77418	Radiation tx delivery, imrt	S
77470	Special radiation treatment	S
78350	Bone mineral, single photon	X
80502	Lab pathology consultation	X
85060	Blood smear interpretation	X
86585	TB tine test	X
86850	RBC antibody screen	X
86870	RBC antibody identification	X
86880	Coombs test, direct	X
86885	Coombs test, indirect, qual	X
86886	Coombs test, indirect, titer	X
86890	Autologous blood process	X
86900	Blood typing, ABO	X
86901	Blood typing, Rh (D)	X
86905	Blood typing, RBC antigens	X
86906	Blood typing, Rh phenotype	X
86930	Frozen blood prep	X
86970	RBC pretreatment	X
88104	Cytopathology, fluids	X
88106	Cytopathology, fluids	X
88107	Cytopathology, fluids	X
88108	Cytopath, concentrate tech	X
88160	Cytopath smear, other source	X
88161	Cytopath smear, other source	X
88172	Cytopathology eval of fna	X
88182	Cell marker study	X
88300	Surgical path, gross	X
88304	Tissue exam by pathologist	X
88305	Tissue exam by pathologist	X
88311	Decalcify tissue	X
88312	Special stains	X
88313	Special stains	X
88321	Microslide consultation	X
88323	Microslide consultation	X
88325	Comprehensive review of data	X
88331	Path consult intraop, 1 bloc	X
88342	Immunohistochemistry	X
88346	Immunofluorescent study	X
88347	Immunofluorescent study	X
90801	Psy dx interview	S

HCPCS Code	Short Description	Status Indicator
90804*	Psytx, office, 20-30 min	S
90805	Psytx, off, 20-30 min w/e&m	S
90806	Psytx, off, 45-50 min	S
90807	Psytx, off, 45-50 min w/e&m	S
90808	Psytx, office, 75-80 min	S
90809	Psytx, off, 75-80, w/e&m	S
90810	Intac psytx, off, 20-30 min	S
90818	Psytx, hosp, 45-50 min	S
90826	Intac psytx, hosp, 45-50 min	S
90845	Psychoanalysis	S
90846	Family psytx w/o patient	S
90847	Family psytx w/patient	S
90853	Group psychotherapy	S
90857	Intac group psytx	S
90862	Medication management	X
92002	Eye exam, new patient	V
92004	Eye exam, new patient	V
92012	Eye exam established pat	V
92014	Eye exam & treatment	V
92020*	Special eye evaluation	S
92081*	Visual field examination(s)	S
92082	Visual field examination(s)	S
92083	Visual field examination(s)	S
92135	Opthalmic dx imaging	S
92136	Ophthalmic biometry	S
92225	Special eye exam, initial	S
92226	Special eye exam, subsequent	S
92230	Eye exam with photos	T
92250	Eye exam with photos	S
92275	Electroretinography	S
92285	Eye photography	S
92286	Internal eye photography	S
92520	Laryngeal function studies	X
92541*	Spontaneous nystagmus test	X
92546	Sinusoidal rotational test	X
92548	Posturography	X
92552	Pure tone audiometry, air	X
92553	Audiometry, air & bone	X
92555	Speech threshold audiometry	X
92556	Speech audiometry, complete	X
92557*	Comprehensive hearing test	X
92567	Tympanometry	X
92582	Conditioning play audiometry	X
92585	Auditor evoke potent, compre	S
92604*	Reprogram cochlear implt 7 >	X

HCPCS Code	Short Description	Status Indicator
93005	Electrocardiogram, tracing	S
93225	ECG monitor/record, 24 hrs	X
93226	ECG monitor/report, 24 hrs	X
93231	Ecg monitor/record, 24 hrs	X
93232	ECG monitor/report, 24 hrs	X
93236	ECG monitor/report, 24 hrs	X
93270	ECG recording	X
93278	ECG/signal-averaged	S
93303	Echo transthoracic	S
93307	Echo exam of heart	S
93320	Doppler echo exam, heart	S
93731	Analyze pacemaker system	S
93732*	Analyze pacemaker system	S
93733	Telephone analy, pacemaker	S
93734	Analyze pacemaker system	S
93735*	Analyze pacemaker system	S
93736	Telephonic analy, pacemaker	S
93741*	Analyze ht pace device sngl	S
93743	Analyze ht pace device dual	S
93797	Cardiac rehab	S
93798	Cardiac rehab/monitor	S
93875	Extracranial study	S
93880	Extracranial study	S
93882	Extracranial study	S
93886	Intracranial study	S
93888	Intracranial study	S
93922	Extremity study	S
93923	Extremity study	S
93924	Extremity study	S
93925	Lower extremity study	S
93926	Lower extremity study	S
93930*	Upper extremity study	S
93931	Upper extremity study	S
93965	Extremity study	S
93970	Extremity study	S
93971	Extremity study	S
93975	Vascular study	S
93976	Vascular study	S
93978	Vascular study	S
93979	Vascular study	S
93990	Doppler flow testing	S
94015	Patient recorded spirometry	X
95115	Immunotherapy, one injection	X
95117*	Immunotherapy injections	X
95165	Antigen therapy services	X

HCPCS Code	Short Description	Status Indicator
95805	Multiple sleep latency test	S
95806*	Sleep study, unattended	S
95807	Sleep study, attended	S
95812	Electroencephalogram (EEG)	S
95813	Eeg, over 1 hour	S
95816	Electroencephalogram (EEG)	S
95819	Electroencephalogram (EEG)	S
95822	Sleep electroencephalogram	S
95864	Muscle test, 4 limbs	S
95867*	Muscle test, head or neck	S
95872	Muscle test, one fiber	S
95900	Motor nerve conduction test	S
95921	Autonomic nerv function test	S
95925*	Somatosensory testing	S
95926	Somatosensory testing	S
95930	Visual evoked potential test	S
95937	Neuromuscular junction test	S
95950	Ambulatory eeg monitoring	S
95953	EEG monitoring/computer	S
95970*	Analyze neurostim, no prog	S
95972*	Analyze neurostim, complex	S
95974*	Cranial neurostim, complex	S
96000	Motion analysis, video/3d	S
96100	Psychological testing	X
96115	Neurobehavior status exam	X
96117*	Neuropsych test battery	X
96900	Ultraviolet light therapy	S
96910	Photochemotherapy with UV-B	S
96912	Photochemotherapy with UV-A	S
96913	Photochemotherapy, UV-A or B	S
98925*	Osteopathic manipulation	S
98940	Chiropractic manipulation	S
99213	Office/outpatient visit, est	V
99214	Office/outpatient visit, est	V
99241	Office consultation	V
99242*	Office consultation	V
99243	Office consultation	V
99244	Office consultation	V
99245	Office consultation	V
99273	Confirmatory consultation	V
99274	Confirmatory consultation	V
99275	Confirmatory consultation	V
D0473	Micro exam, prep & report	S
G0101	CA screen;pelvic/breast exam	V
G0127	Trim nail(s)	T
G0166	Extrnl counterpulse, per tx	T
G0175	OPPS Service,sched team conf	V
Q0091	Obtaining screen pap smear	T

HCPCS codes shown with an asterisk are bypass codes added to the list for CY 2006.

BILLING CODE 4120–01–C

2. Calculation of Median Costs for CY 2006

In this section of the preamble, we discuss the use of claims to calculate the OPPS payment rates for CY 2006. The hospital outpatient prospective payment page on the CMS Web site on which this final rule with comment period is posted provides an accounting of claims used in the development of the final rates: *http://www.cms.hhs.gov/providers/hopps*. The accounting of claims used in the development of this final rule with comment period is included on the Web site under supplemental materials for the CY 2006 final rule with comment period. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/providers/hopps*, includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.''

As we proposed, we used the following methodology to establish the relative weights to be used in calculating the OPPS payment rates for CY 2006 shown in Addendum A and in Addendum B to this final rule with comment period. This methodology is as follows:

We used outpatient claims for the full CY 2004 to set the relative weights for CY 2006. To begin the calculation of the relative weights for CY 2006, we pulled all claims for outpatient services furnished in CY 2004 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, and the U.S. Virgin Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 109 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Claims that were bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

3. Claims that were bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

For the cost-to-charge ratio (CCR) calculation process, we used the same approach as we used in developing the final APC rates for CY 2005 (69 FR 65744). That is, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2004 before determining whether the CCRs for such hospitals were valid. This initial limitation changed the distribution of CCRs used during the trimming process discussed below.

We then calculated the CCRs at a departmental level and overall for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2002 or CY 2003. For this final rule with comment period, we used the most recent cost report available, whether submitted or settled. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost, and we then adjusted the most recent available submitted but not settled cost report using that ratio.

The overall hospital-specific CCR is the total of costs and charges in those cost centers where we believe that a significant portion of the costs and charges are for services paid under the OPPS. We have included the list of the cost centers that we use in our overall CCR calculation on our Web site along with our cost center to revenue code crosswalk, which we discuss below. We do not include the costs and charges generated by nursing schools or paramedical education programs in our cost and charge totals.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the departmental level by removing the CCRs for each cost center as outliers if they exceeded +/−3 standard deviations of the geometric mean. This is the same methodology that we used in developing the final CY 2005 CCRs. For CY 2006, as proposed, we trimmed at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to a revenue code, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's departmental CCR was deleted by trimming, we set the departmental CCR for that cost center to ''missing,'' so that another departmental CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. The hierarchy of CCRs is available for inspection and comment at the CMS Web site: *http://www.cms.hhs.gov/providers/hopps/default.asp.*

We then converted the charges on the claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 2 of the proposed rule (70 FR 42690) contained a list of the allowed revenue codes. Revenue codes not included in Table 2 are those not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges) and, thus charges with those revenue codes were not packaged for creation of the OPPS median costs. If a hospital did not have a CCR that was appropriate to the revenue code reported for a line-item charge (for example, a visit reported under the clinic revenue code, but the hospital did not have a clinic cost center), we applied the hospital-specific overall CCR, except as discussed in section X. of this preamble for calculation of costs for blood.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, and the U.S. Virgin Islands, and claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of CMHCs and moved them to

another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We also moved claims for observation services to another file. We moved to another file claims that contained nothing but flu and pneumococcal pneumonia (''PPV'') vaccine. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the two above mentioned separate files containing partial hospitalization claims and the observation services claims are included in the files that are available for purchase as discussed above.

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim, but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate the per unit median for drugs, radiopharmaceutical agents, and blood and blood products. The line-item costs were also used to calculate the per administration cost of drugs, biologicals (other than blood and blood products), and radiopharmaceutical agents.

We then divided the remaining claims into five groups.

1. *Single Major Claims:* Claims with a single separately payable procedure, all of which would be used in median setting.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure or multiple units for one payable procedure. As discussed below, some of these can be used in median setting.

3. *Single Minor Claims:* Claims with a single HCPCS code that is not separately payable. These claims may have a single packaged procedure or a drug code.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are not separately payable without examining dates of service. For example, pathology codes are not used unless the pathology service is the single code on the bill or unless the pathology code is on a separate date of service from the other procedure on the claim. The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathology codes. However, by matching dates of service for the code and the reported costs through the ''pseudo'' single creation process discussed earlier, a claim with multiple pathology codes may become several ''pseudo'' single claims with a unique pathology code and its associated costs on each day. These ''pseudo'' singles for the pathology codes would then be considered a separately payable code and would be used the same as claims in the single major claim file.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS. These claims are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory.

We note that the claims listed in numbers 1, 2, 3, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor claims and the non-OPPS claims (numbers 3 and 5 above) because we did not use either in calculating median cost. We then examined the multiple major and multiple minor claims (numbers 2 and 4 above) to determine if we could convert any of them to single major claims using the process described previously. We first grouped items on the claims by date of service. If each major procedure on the claim had a different date of service and if the line-items for packaged HCPCS and packaged revenue codes had dates of service, we split the claim into multiple ''pseudo'' single claims based on the date of service.

After those single claims were created, we used the list of ''bypass codes'' listed in Table 1 of the proposed rule and this final rule with comment period to remove separately payable procedures that we determined contain limited costs or no packaged costs from a multiple procedure bill. A discussion of the creation of the list of bypass codes used for the creation of ''pseudo'' single claims is contained in section II.A.1.b. of this preamble.

When one of the two separately payable procedures on a multiple procedure claim was on the bypass code list, we split the claim into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS charges. This enables us to use a claim that would otherwise be a multiple procedure claim and could not be used.

We excluded those claims that we were not able to convert to singles even after applying both of the techniques for creation of ''pseudo'' singles. We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this final rule with comment period) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes is shown below in Table 2. These are the same as those published in Table 2 of the proposed rule (70 FR 42690).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, 58.4 million claims were left. Of these million claims, we were able to use some portion of 52.7 million whole claims (90.24 percent of the potentially usable claims) to create the 88 million single and ''pseudo'' single claims for use in the CY 2006 median payment rate-setting.

We also excluded (1) claims that had zero costs after summing all costs on the claim and (2) claims containing token charges (charges of less than $1.01) or for which intermediary systems had allocated charges as if the charges were submitted on the claim. We deleted claims containing token charges because we do not believe that a charge of less than $1.01 would yield a cost that would be valid to set weights for a significant separately paid service. Moreover, effective for services furnished on or after July 1, 2004, the OCE assigns payment flag number 3 to claims on which hospitals submitted token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under OPPS) for which the intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims.

For the remaining claims, we then wage adjusted 60 percent of the cost of the claim (which we have previously determined to be the labor-related portion), as has been our policy since the initial implementation of the OPPS, to adjust for geographic variation in labor-related costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-

reclassification wage indices, and would result in the most accurate adjusted median costs.

We then excluded claims that were outside 3 standard deviations from the geometric mean cost for each HCPCS code. We used the remaining claims to calculate median costs for each separately payable HCPCS code; first, to determine the applicability of the ''2 times'' rule, and second, to determine APC medians based on the claims containing the HCPCS codes assigned to each APC. As stated previously, 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 (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs as deemed appropriate. Section III.B. of this preamble includes a discussion of the HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes.

A detailed discussion of the medians for blood and blood products is included in section X. of this preamble. A discussion of the medians for APCs that require one or more devices when the service is performed is included in section IV.A. of this preamble. A discussion of the median for observation services is included in section XI. of this preamble and a discussion of the median for partial hospitalization is included below in section II.B. of this preamble.

We received a number of public comments concerning our proposed data processes for calculating the CY 2006 OPPS relative weights and median costs. A summary of the comments and our responses follow:

Comment: Commenters stated that the proposed rule did not provide adequate information for hospitals to evaluate the impact of each of the proposed policy changes independently or in combination. They requested that CMS provide a public use file that shows the impact of each individual proposed change in methodology so that providers can determine how the changes would affect their own operations and provide a basis for comments.

Response: We currently provide provider-specific tables that we understand are very accurate in estimating the payments individual hospitals will receive. While we wish to make available to the public as much hospital-specific information as possible, there are limits to the resources available to us to provide hospital-specific information. Generally, we provide a broad range of information to the public. We make available our claims data in the form of both a limited data set and a beneficiary encrypted data set for use by the public, including hospitals. In addition, in both the OPPS proposed and final rules each year, we give a detailed description of how we process the paid claims to derive the median costs and how we create relative weights from the median costs. Many different organizations with a broad range of divergent interests currently use this information provided to the public to generate extraordinarily detailed reports and data of interest to them. As this is public information, we would expect that hospital associations and hospitals could do the same, either directly or using alternative sources to determine the impact of various policy options.

Comment: One commenter strongly opposed the requirement that all OPPS encounters furnished on the same day must be billed on a single claim. Some commenters believed that this increases the number of claims that cannot be used for ratesetting by creating multiple procedure claims and creates a needless burden on hospitals to ensure that all encounters on the same date of service are billed on the same claim.

Response: We agree and we have revised our policy governing how services on the same date of service must be billed. See Change Request 4047, Transmittal 711, dated October 14, 2005 for a complete discussion of our current policy. Under this change in policy, there are instances where nonrepetitive OPPS services that are furnished on the same date of service may be billed on different claims as long as all charges that pertain to each service are also reported on the same claim as the HCPCS code that describes that service. We emphasize that it is vitally important to us that all of the charges that pertain to a separately paid service be included on the same claim with the service being billed so that the claim will accurately reflect the full cost of the service. If, for example, charges for a packaged drug, recovery room time, and sterile supplies that were used in providing a surgical service are not included on the claim with the HCPCS code and line-item charge for the use of the operating room for the surgical procedure, those charges for drugs, recovery room, and supplies will not be packaged with the charge for the OR time for the surgical procedure and that claim will incorrectly and inadvertently lower the median cost for that surgical procedure. This is especially the case if the service is a low volume service. Also, this revised billing policy cannot apply to services for which we use claim-specific OCE logic to determine payments, such as drug administration and observation services, because the OCE claim-by-claim logic cannot function properly if all services provided by a hospital that are related to the services subject to the OCE logic are not reported on the same claim.

Comment: One commenter supported deletion of claims with token or nominal charges (for example, a very small charge such as $1) but was concerned about exclusion of claims containing multiple surgical or cardiac catheterization services because such exclusions may significantly reduce the number of claims used for rate-setting. The commenter noted that CMS has long permitted hospitals to show a token charge on the line-item with separately paid procedures when they were performed at the same session as a surgical procedure for which a charge is shown as operating room time. Another commenter wanted claims that contain a single payable APC line to be included even if there are token charges on other nonpayable lines on the claim.

Response: The submission of claims for multiple separately paid procedures with the same date of service on which there is a charge for operating room time for one of the HCPCS codes and token charges on the lines for the other separately paid HCPCS codes reflects a difficulty with using multiple procedure claims. (For example, a claim contains three separately paid surgical services, with a charge of $2,000 for one and charges of $1 for each of the others, plus a single charge each for drugs, sterile supplies, and recovery room time.) We note if we were to use such claims and allocate packaging to each separately paid procedure (on some basis yet to be determined) and then divide the claim into multiple claims, we would be using claims records that would contain nothing but packaged costs and a token charge for some of those services. Similarly, if we were to focus solely on the procedure with the line charge of $2,000 and attribute all the packaging to it, we would be overstating the packaging for that service because some of it rightfully belongs with the other two separately paid procedures for which there was a token charge. We acknowledge the commenters' concern and we will continue to pursue an

appropriate way to allocate the costs on these types of claims.

After carefully reviewing all public comments received, we are finalizing the process for calculating median costs and the list of packaged services shown in Table 2 for OPPS services furnished on or after January 1, 2006, as proposed without modification. Table 2 contains the list of packaged services by revenue code that we used in developing the APC relative weights listed in Addenda A and B of this final rule with comment period.

We note that comments and responses regarding aspects of median cost and relative weight calculations specific to particular services or particular categories of services are also found in specifically identified sections of this preamble.

BILLING CODE 4120–01–C

Table 2.--CY 2006 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
343	DIAGNOSTIC RADIOPHARMS
344	THERAPEUTIC RADIOPHARMS
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
681	TRAUMA RESPONSE, LEVEL I
682	TRAUMA RESPONSE, LEVEL II
683	TRAUMA RESPONSE, LEVEL III
684	TRAUMA RESPONSE, LEVEL IV
689	TRAUMA RESPONSE, OTHER
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

BILLING CODE 4120–01–P

3. Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the final relative payment weights for each APC for CY 2006 shown in Addenda A and B to this final rule with comment period. 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 CY 2004 data, the median cost for APC 0601 is $60.19 for CY 2006.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2006 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2005 relative weights to aggregate payments using the CY 2006 final relative weights. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by 1.012508103 for budget neutrality. The final relative payment weights are listed in Addenda A and B to this final rule with comment period. The final relative payment weights incorporate the recalibration adjustments discussed in sections II.A.1. and 2. of this preamble.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this preamble) is included in the budget neutrality calculations for CY 2006 OPPS.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004, and before January 1, 2006. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources will not be used in determining outlier payments and payments for these items will be excluded from budget neutrality calculations for the CY 2006 OPPS. (We provide a discussion of brachytherapy payment issues at section VII. of this final rule with comment period.)

Comment: One commenter indicated that CMS should convene a panel to look at additional data submission requirements that the panel believes would greatly enhance both the reliability of the data and its subsequent use for ratesetting. Specifically, the commenter urged CMS to consider whether to require hospitals to identify the APCs that apply to multiple procedure claims or develop a system that groups multiple procedure claims in a fashion that is analogous to the inpatient prospective payment system.

Response: We fail to understand how hospital reporting of the APCs that apply to services on claims would resolve the issue of how to distribute packaged costs, such as drugs and recovery room time, among multiple procedures billed on the same claim. Therefore, we do not support imposing this reporting burden on hospitals. With respect to grouping procedures into combination APCs for purposes of dealing effectively with services that commonly appear in specific combinations together on claims, we proposed creation of combination APCs for the CY 2004 OPPS to deal with very frequent combinations of services. While we chose not to implement this approach for the CY 2004 OPPS, largely in response to public comments, we have not ruled out such an approach in the future as a way to effectively calculate median costs and set payment rates for services for which the norm is provision in combinations with other services.

4. Changes to Packaged Services

a. Background. Payments for packaged services under the OPPS are bundled into the payments providers receive for separately payable services provided on the same day. Packaged services are identified by the status indicator ''N.'' Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on the claims for purposes of median cost calculations. Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines.

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of ''N.'' Providers have often suggested that many packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator ''N.'' As stated in the proposed rule, the Packaging Subcommittee reviewed every code that was packaged in the CY 2004 OPPS (70 FR 42691). Based on comments we have received and their own expert judgment, the subcommittee identified a set of packaged codes that are often provided separately and subsequently reviewed utilization and median cost data for these codes. One of the main criteria utilized by the Packaging Subcommittee to determine whether a code should become unpackaged was how likely it was for the code to be billed without any other separately payable services on the claim. Another criterion used to determine whether a code should become unpackaged was how likely it was for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed. The Packaging Subcommittee also examined median costs from hospital claims for packaged services.

The Packaging Subcommittee identified areas for change for some packaged CPT codes that they believed could frequently be provided to patients as the sole service on a given date and that required significant hospital resources as determined from hospital claims data. During the February 2005 meeting, the APC Panel accepted the report of the Packaging Subcommittee and recommended:

(1) That packaged codes be reviewed by the Panel individually.

(2) That the Packaging Subcommittee continue to meet throughout the year to discuss problematic packaged codes.

(3) That CMS assign a modifier to CPT codes 36540 (Collect blood, venous device); 36600 (Withdrawal of arterial blood); and 51701 (Insertion of non-indwelling bladder catheter), for use when there are no other separately payable codes on the claim. The modifier would flag the OCE to assign payment to the claim.

(4) That CMS maintain the current packaged status indicator for CPT code 76937 (Ultrasound guidance for vascular access).

(5) That CMS change the status indicators for CPT immunization administration codes 90471 and 90472 to allow separate payment and ensure consistency with other injection codes.

(6) That CMS gather more data on CPT code 94762 (Overnight pulse oximetry) to determine how often this code is billed without any other separately payable codes and whether it is performed more frequently alone in rural settings than other settings.

(7) No changes to the packaged status of CPT codes 77790 (Radiation source handling) and 94760 and 94761 (both codes are for procedures to measure blood oxygen levels).

(8) That CMS provide education and consistent guidelines to providers and fiscal intermediaries on correct billing for packaged codes in general, and in particular for CPT codes 36540, 36600, 51701, and the recommended modifier, if approved.

(9) That the Packaging Subcommittee review CPT codes 42550 (Injection for salivary x-ray) and 38792 (Sentinel node imaging).

(10) That CPT code 97602 (Nonselective wound care) be referred to the Physician Payment Group within CMS for evaluation of its bundled status as it relates to services provided under the OPPS and that the Physician Payment Group report its conclusions back to the Panel.

In addition, during its August 2005 meeting, the APC Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

(1) No change to the CY 2005 status indicator of 76937 (N-packaged), ultrasound guidance for vascular access, but requested that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee at the next available meeting.

(2) No change to the CY 2005 status indicator of CPT code 38792 (N-packaged), sentinel node identification, but requested that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee by the next scheduled meeting.

(3) No change to the CY 2005 status indicator of CPT code 42550 (N-packaged), injection for salivary x-ray.

(4) That CMS collect additional data on CPT code 36500, venous catheterization for selective blood organ sampling, and the corresponding radiological supervision and interpretation code, 75893, including a list of other codes with which these codes are most frequently billed, for consideration by the Packaging Subcommittee.

(5) No change to the CY 2005 status indicator of CPT code 0069T (N-packaged), acoustic heart sound services.

(6) That CMS collect additional data on CPT 94762, overnight pulse oximetry, including a list of other codes with which this code is most frequently billed, for consideration by the Packaging Subcommittee.

b. Responses to the APC Panel Recommendations

For CY 2006, we proposed to maintain CPT codes 36540 (Collect blood venous device) and 36600 (Withdrawal of arterial blood) as packaged services and not adopt the APC Panel's recommendation to assign a modifier to the codes. We noted in our proposed rule that CPT code 36540 was also bundled under the Medicare Physician Fee Schedule (MPFS), and our data demonstrated that the service was generally billed with other separately payable services (70 FR 42691). We also had relatively few single claims for CPT code 36600, compared to the procedure's overall frequency. Both of these codes had relatively low hospital resource utilization. As these procedures were almost always provided with other separately payable services, hospitals' payments for those other services included the costs of CPT codes 36540 and 36600. With respect to the APC Panel's recommendation that the OPPS make payment for one of these services if the code had a modifier appended signifying that it was the only service provided on a day, there is currently no appropriate CPT modifier that could be appended to signal this circumstance. A new HCPCS modifier would not be appropriate because the packaged codes recommended by the APC Panel for separate payment when billed alone are CPT codes.

We received a few public comments concerning this proposal.

Comment: Commenters stated that CPT 36540 should not be assigned status indicator ''N'' because drawing blood for laboratory work from a venous access device requires that a registered nurse assess the patient and then use a sterile kit to perform the blood draw. They objected to having to report an E/M visit code in order to receive payment for the service when it is the only service provided. The commenters requested that CMS assign the proposed status indicator ''Q'' for CPT code 36540 so that the OPPS could make payment when it is the only service provided. Similarly, at least one commenter asked that CMS assign the ''Q'' status indicator to CPT code 36600.

Response: We continue to believe that the services described by CPT codes 36540 and 36600 are almost always provided in conjunction with other separately payable services in the hospital outpatient department setting. Our data do not support making these services separately payable. We proposed the new ''Q'' status indicator for services that may be separately payable or packaged depending on special circumstances for CY 2006 only for observation services. Codes assigned this status indicator will require the application of OCE logic to determine the codes' payment status and identify separate payment if appropriate, and then application of the same logic in our data processing to develop median costs for those services for future OPPS updates. We seek to gain some experience with such logic in the OCE and our data processing for observation services prior to considering any expansion of the use of status indicator ''Q.'' Use of the ''Q'' modifier for procedures that are sometimes packaged would require ongoing maintenance of a list of codes for which this status indicator may be used and their APC assignments if separately paid, as well as additional claims and data processing activities.

After carefully reviewing all comments received, for CY 2006 we are adopting as final without modification our proposal to retain CPT codes 36540 and 36600 as packaged services and not adopt the APC Panel's recommendation to assign a modifier for use when the services are provided with no other separately payable services on the same day.

For CY 2006, we proposed to pay separately for CPT code 51701 (Insertion of non-indwelling bladder catheter), and to map it to APC 0340 (Minor Ancillary Procedures), with status indicator ''X'', and a median cost of $39.00. The APC Panel recommended that we pay separately for this code only when there are no other separately payable services on the claim. However, we proposed to pay separately for this code every time it is billed. We believed that it was more appropriate to make payment for each procedure, rather than increase hospitals' administrative burden by requiring specific coding changes to indicate that there were no other separately payable procedures on the claim. Based on our review of the data, the cost for this procedure was not insignificant, and the volume of single and multiple claims was modest. When we reviewed related codes, including CPT code 51702 (Insertion of temporary

indwelling bladder catheter, simple) and CPT code 51703 (Insertion of temporary indwelling bladder catheter, complicated), we noted that these codes also had substantial median costs and a moderate volume of single claims. Therefore, for CY 2006, we proposed to pay separately for CPT codes 51702 and 51703, mapping them to APC 0340 with a median cost of $39.00 and APC 0164 (Level I Urinary and Anal Procedures) with a median cost of $72.00, respectively. We proposed that CPT codes 51701, 51702, and 51703 be placed on the bypass list, as discussed in section II.A.1.b. of this final rule with comment period.

The comments we received supported our proposal. Accordingly, we are finalizing our proposal to pay separately for CPT codes 51701 and 51702, and to assign them to APC 0340 with status indicator ''X,'' and a median cost of $36.00 for CY 2006. We are also finalizing our proposal to pay separately for CPT code 51703, and to assign it to APC 0164 with status indicator ''T,'' and a median cost of $69.00 for CY 2006.

For CY 2006, we proposed to accept the APC Panel recommendation that CPT code 76937 (Ultrasound guidance for vascular access) remain packaged. We were concerned that there might be unnecessary overuse of this procedure if it were separately payable. In addition, we believed that the service would always be provided with another separately payable procedure, so its costs would be appropriately bundled with the definitive vascular access service. As stated in the CY 2005 final rule with comment period (69 FR 65697), CMS and the Packaging Subcommittee reviewed CY 2004 claims data for CPT code 76937 and determined that this code should remain packaged.

We received several public comments in response to our proposal.

Comment: A few commenters requested that some radiologic guidance codes, such as CPT code 76937 for ultrasound guidance for vascular access and CPT code 75998 for fluoroscopic guidance for central venous access device placement, become separately payable instead of packaged. The commenters stated that each guidance code could be reported with several separately payable procedure codes, thereby skewing the median costs for the procedures and not providing appropriate payment for the procedures when radiologic guidance was used. In addition, one commenter expressed concern that the codes have been packaged due to concern over unnecessary utilization. The commenter stated that an audit is a more appropriate way to prevent unnecessary utilization. In addition, the commenters cited a finding published in a June 2001 report by the Agency for Healthcare Research and Quality, that use of ultrasound guidance reduces relative risk for complications during a central venous catheter insertion by 78 percent, as a reason that separate payment should be made for CPT code 76937. The commenters also stated that assignment of packaged status to these codes conflicts with CMS' policy as stated in its CY 2003 OPPS final rule, to pay separately for all radiology guidance codes.

Response: OPPS hospital claims data reveal that out of the total instances of CPT code 76937 appearing on claims used for setting payment rates for CY 2006, CPT code 76937 was billed with four separately payable codes for insertion of central venous access devices 84 percent of the time. This indicates, as might be expected, that the costs for CPT code 76937 are typically packaged into four CPT codes, 36556, 36558, 36561, and 36569, the most commonly billed codes under the OPPS for vascular access device insertion. The data for CPT code 75998 reveal similar patterns of utilization and packaging. Of the total instances of CPT code 75998 appearing on claims used for setting payment rates for CY 2006, code 75998 was billed with the same four separately payable codes for insertion of central venous access devices 70 percent of the time. This indicates that the costs for fluoroscopic guidance for central venous access device placement are typically packaged into the same CPT codes as the costs for ultrasound guidance for vascular access. Of single claims used for setting payment rates for CY 2006 for those four CPT codes describing the insertion of vascular access devices, ultrasound guidance was reported from 16 to 34 percent of the time, and fluoroscopic guidance was billed from 29 to 52 percent of the time. For the same four CPT codes, one or more forms of guidance (fluoroscopic and/or ultrasound) were reported on 41 to 64 percent of the single claims utilized for rate-setting. Thus, overall for these vascular access device insertion services, guidance was used in at least 41 percent of the single claim cases, a very significant proportion of the time. If anything, this percentage may underestimate the utilization of guidance for the insertion of vascular access devices, as we have been told that hospitals may not always code separately for packaged services for which no separate payment is made.

Hospital claims data from CY 2004 yield a median cost of $61.00 for ultrasound guidance and $73.00 for fluoroscopic guidance for vascular access. The costs for these guidance procedures are relatively low compared with the CY 2006 payment rates for the separately payable services they most frequently accompany, which range from almost $500 to about $1,600. We note that, in general, our payment rates for vascular access device services for CY 2006 are significantly greater than our CY 2005 payment rates for the same services because more specific CY 2004 data available for CPT codes that were new in CY 2004 permitted us to reconfigure the APCs containing vascular access device procedures to improve clinical and resource coherence. In addition, our hospital claims data demonstrate that in CY 2004 guidance services were used frequently for the insertion of vascular access devices, and we have no evidence that patients lacked appropriate access to guidance services necessary for the safe insertion of vascular access devices in the hospital outpatient setting. We believe the increased CY 2006 payment rates for insertion of vascular access devices should result in preservation of appropriate access to medically reasonable and necessary ultrasound and fluoroscopic guidance procedures used to facilitate the insertion of the devices.

If we were to unpackage CPT codes 76937 and 75998, single bills available to develop median costs for vascular access device insertion services would be significantly reduced. In addition, separate payment for an ancillary guidance service always performed in conjunction with other separately payable services could lead to overutilization of the ancillary service, for which payment is more appropriately bundled into the prospectively established payment for the procedure to insert the vascular access device. Our statement regarding paying separately for radiology guidance services in the CY 2003 final rule with comment period was made in the context of our explanation regarding our decision to unpackage certain radiology guidance procedures that had first been packaged for CY 2002, and does not necessarily apply to all radiology guidance services. As for all HCPCS codes, we will continue to evaluate each service, including radiology guidance services, for its most appropriate OPPS payment status, including packaged versus separately payable designation, on a case-by-case basis according to the clinical and resource characteristics of the procedure and the other services with which it would likely be billed.

We will share the CY 2004 and early CY 2005 hospital claims data concerning these vascular access guidance services with the APC Panel Packaging Subcommittee, as recommended by the APC Panel, for their review prior to the next biannual APC Panel meeting.

After carefully considering the public comments received, we are adopting as final without modification our proposal to accept the APC Panel's recommendation that CPT code 76937 remains a packaged service for CY 2006. In addition, we are finalizing our proposal to continue to package CPT code 75998 for CY 2006.

We refer the reader to section VIII. of this preamble on drug administration regarding the APC Panel's recommendation concerning CPT codes 90471 and 90472.

For CY 2006, we proposed to accept the APC Panel recommendation to gather data and review CPT code 94762 to determine how often this code was billed without any other separately payable codes on the same date of service and whether it was performed more frequently alone in rural settings than other settings. During the August 2005 APC Panel meeting, we presented data to the APC Panel regarding CPT code 94762. CY 2004 OPPS hospital claims data indicated at that time that CPT code 94762 was billed only 1,145 times without any separately payable codes on the claim, which was only 1.5 percent of all units of code 94762 billed. Fifty-two percent of the 1,145 single occurrences of CPT code 94762 were provided by rural hospitals. Fifty-two percent was particularly high considering that, when reviewing both single and multiple procedure claims, the data indicated that CPT code 94762 was provided by rural hospitals only 12 percent of the time. The data revealed that rural hospitals were more likely than urban hospitals to bill CPT code 94762 without any separately payable codes on the claim. For purposes of this analysis, a rural hospital was defined as any hospital that is considered rural for payment purposes. In general, this included geographically rural providers as well as providers that were reclassified to rural areas for wage index classification.

We recognize that the data used in the analysis are somewhat limited. Because CPT 94762 is a packaged code and does not receive separate payment, it is possible that an unknown number of hospitals chose not to submit claims to CMS when CPT code 94762 was provided without other separately payable services on their claims.

Comment: Several comments requested that CMS change the status indicator for CPT code 94762 from ''N'' to ''X'' and that the service be assigned to APC 0369, (Level III Pulmonary Tests). They stated that because noninvasive ear or pulse oximetry for oxygen saturation, by continuous overnight monitoring, is a prerequisite for proving the medical necessity for home oxygen therapy, this is often the only service provided to beneficiaries during their hospital outpatient visits. The commenters stated that no E/M service is necessary and that it should be possible to receive payment for CPT code 94762 when it is the only service provided.

Response: We continue to believe that the packaged status of CPT code 94762 is appropriate. As discussed during the August 2005 APC Panel meeting, our data do not support separate payment for this service because 98.5 percent of the time, it is provided with separately payable services, and is rarely the only service provided in hospital settings on a single date of service to a Medicare beneficiary.

After carefully considering the public comments received, for CY 2006 we are accepting the APC Panel's recommendations to retain as a packaged service CPT code 94762. We will share the CY 2004 and early CY 2005 hospital claims data concerning CPT code 94762 with the APC Panel Packaging Subcommittee as recommended by the APC Panel, for its review during the next biannual APC Panel meeting.

For CY 2006, we proposed to accept the APC Panel recommendations that CPT codes 77790 (Radiation handling), 94760 (Pulse oximetry for oxygen saturation, single determination), and 94761 (Pulse oximetry for oxygen saturation, multiple determinations) remain packaged. We state our belief that CPT code 77790 was integral to the provision of brachytherapy and should always be billed on the same day with brachytherapy sources and their loading, ensuring that the provider would receive appropriate payment for the radiation source handling bundled with the payment for the brachytherapy service. The small number of single claims for this code in our data verified that this code was rarely billed alone without other payable services on the claim, and those few single claims might be miscoded claims. Our data review of CPT codes 94760 and 94761 revealed that these codes had low resource utilization, and were most frequently provided with other services. Similar to CPT code 77790, there were many fewer single claims for CPT codes 94760 and 94761 than multiple procedure claims that included CPT codes 94760 and 94761. CPT codes 94760 and 94761 describe services that were very commonly performed in the hospital outpatient setting, and unpackaging these codes would likely significantly decrease the number of single claims available for use in calculating median costs for other services.

We did not receive any public comments concerning our proposal. Therefore, for CY 2006 we are finalizing, without modification, our proposal to accept the APC Panel's recommendations to retain as packaged services CPT codes 77790, 94760, and 94761.

For CY 2006, we proposed to accept the APC Panel recommendation to gather data and review CPT codes 42550 (injection for salivary x-ray), and 38792 (sentinel node identification) with the Packaging Subcommittee. In the proposed rule, we stated that this would include analyzing single and multiple procedure claims volume and resource utilization data, and reviewing those studies with the Packaging Subcommittee. During the August 2005 APC Panel meeting, the Panel recommended that we continue to package CPT codes 42550 and 38792 for CY 2006. We believed that CPT code 42550 was appropriately packaged, as were other injection codes that were integral to the provision of some separately payable procedures. In addition, we agreed with the APC Panel that CPT code 38792 was appropriately packaged because we believed that it would almost always be provided with other separately payable procedures on the same date of service, such as nuclear medicine services or surgical procedures.

We received a few public comments regarding our proposal to retain as packaged CPT code 38792.

Comment: The commenters stated that CPT 38792 is sometimes the only service provided in the hospital outpatient department, and that separate payment under the OPPS should be allowed. They stated that there are instances in which the injection for the X-ray is provided in the hospital outpatient department, and then the beneficiary goes to a different setting outside the hospital for the surgery. The commenters requested that CMS assign the proposed ''Q'' status indicator to this procedure code to make separate payment possible under the OPPS.

Response: We believe that the most appropriate course of action with regard to CPT code 38792 is to retain its packaged status and to collect

additional data and, as recommended by the APC Panel, to then present those data to the Packaging Subcommittee during our next meeting with them. Based on our CY 2004 claims data, we had only four single claims for CPT code 38792. We continue to believe that payment for the injection service is most appropriately packaged with other separately payable services provided on the same date of service, most likely imaging or surgical procedures.

After carefully reviewing and considering the public comments received for CY 2006, we are accepting the APC Panel's recommendations to retain as packaged services CPT codes 38792 and 42550. Payment for those injection services is most appropriately bundled with the payments for other separately payable services provided on the same day.

We will share the CY 2004 and early CY 2005 hospital claims data concerning CPT 38792 with the APC Panel Packaging Subcommittee as recommended by the APC Panel, for its review during the next biannual APC Panel meeting.

As we proposed, we referred CPT code 97602 (Nonselective wound care) for MPFS evaluation of its bundled status as CPT code 97602 relates to services provided under the OPPS.

We received several public comments concerning our proposed treatment of CPT code 97602 for CY 2006, with assignment of status indicator ''A.''. Those comments and others related to wound care services are addressed in section III.D.5.j. of this preamble.

During the August 2005 APC Panel meeting, the Panel recommended that CMS collect additional data on CPT code 36500 (Venous catheterization for selective blood organ sampling) and the corresponding radiological supervision and interpretation code, 75893. We received several clinical scenarios from a provider, indicating that CPT codes 36500 and 75893, both packaged services, were frequently provided on a claim without any separately payable codes. In those cases, the provider did not receive any payment. We believed it was unlikely that these two procedures would be reported without any other separately payable codes on the claim. Our early review of several clinical scenarios revealed that other separately payable codes would likely be provided on the same claim.

We received one comment in response to our proposal to retain packaged status for CPT codes 36500 and 75893.

Comment: One commenter requested that CMS allow separate payment for CPT codes 36500 and 75893 when these services are the only services on the claim. The commenter stated that there are many times that these are the only procedures performed during a hospital outpatient encounter.

Response: Our data do not support separate payment for these procedures at this time. After considering the comment and the APC Panel's recommendation, we will collect and review additional data to determine which codes are most frequently billed on claims with CPT codes 36500 and 75893. We will share the CY 2004 and early CY 2005 hospital claims data for these venous catheterization and radiological supervision services as recommended by the APC Panel, for its review prior to the next biannual APC Panel meeting.

During the August 2005 APC Panel meeting, the Panel recommended that CMS maintain the packaged status of CPT 0069T (Acoustic heart sound recording and computer analysis only). This code is indicated as an add-on code to an electrocardiography service, according to the American Medical Association's CY 2005 CPT book. Therefore, we believed this code was appropriately packaged because it was integrally related to the provision of electrocardiography, and should never be performed alone.

We received several comments regarding CPT 0069T in response to the code's new interim designation in the CY 2005 final rule with comment period and to our proposal for CY 2006.

Comment: Several commenters requested that CMS change the status indicator for CPT code 0069T (Acoustic heart sound recording and computer analysis only). The commenters requested that CMS assign the procedure to APC 0099 with an ''S'' status indicator rather than ''N,'' as was the CY 2005 and proposed CY 2006 status indicator for code 0069T. The commenters indicated that the test's status as a packaged procedure results in inequitable payment to hospitals. They stated that the cost of an EKG with the acoustic heart sound recording is $55, whereas the cost of an EKG without such recording is only $31. They added that because CMS has packaged the procedure, the hospital is underpaid by $24 for each test it performs.

Response: It is our understanding that the acoustic heart sound recording and analysis is intended for a specific, targeted group of patients to enhance the provider's ability to diagnose heart failure. The technology always is performed in conjunction with an EKG and as such is ideal for packaging. It is up to hospitals to increase their charges to reflect the additional costs for those EKGs that include the acoustic heart sound recording. If the hospital uses the test according to the manufacturer's guidelines, the costs will be distributed over the large number of EKGs that are performed in the hospital outpatient department and, over time, the additional costs will be recognized in the OPPS rates as increased payments for other services provided on the same day, likely EKGs. We are accepting the Panel's recommendation that we maintain the packaged status of CPT code 0069T for CY 2006. We will review claims data as they become available for the CY 2007 OPPS update.

We also received several comments that requested status indicator changes for other CPT codes, not previously brought before the Packaging Subcommittee.

Comment: Commenters suggested that the following packaged procedures should be made separately payable: CPT code 96523 (Irrigation of implanted venous access device for drug delivery systems (new code for CY 2006)); CPT code 76001 (Fluoroscopy, physician time more than one hour); CPT code 76003 (Fluoroscopic guidance for needle placement); CPT code 76005 (Fluoroscopic guidance and location of needle or catheter tip); CPT code 74328 (Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation); CPT code 74329 (Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation); CPT code 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation); HCPCS code P9612 (Catheterization for collection of specimen); and HCPCS code G0269 (Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure).

Response: We believe that the commenters' suggestions bear closer examination. We will not make any changes to the packaged status of these services at this time. Rather, we will collect data related to the costs and utilization of these services for presentation to the Packaging Subcommittee of the APC Panel. We note that the status indicator of CPT code 96523, a new CPT code for CY 2006, is subject to comment in this final rule with comment period. We will discuss with the Packaging Subcommittee, on an ongoing basis, packaged procedures for which status indicator changes have been suggested by the public. The ongoing process allows members some additional time to

consider the issues we bring to them prior to the twice yearly meetings where the subcommittee makes its recommendations to the full APC Panel.

Additional issues and new data concerning the packaging status of codes will be shared with the APC Panel Packaging Subcommittee for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov*, with ''Packaging Subcommittee'' in the subject line.

B. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. 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. For a detailed discussion, refer to the April 7, 2000 OPPS final rule (65 FR 18452).

2. PHP APC Update for CY 2006

To calculate the final CY 2006 PHP per diem payment, we initially used the same methodology that was used to compute the CY 2005 PHP per diem payment. For CY 2005, the per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1, 2003 through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs 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 services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we used CCRs from the outpatient provider specific file.

Historically, the median per diem cost for CMHCs has greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly from year to year while the median per diem cost for hospital-based PHPs has remained relatively constant ($200–$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in the next section and in the final rule establishing the CY 2004 OPPS (68 FR 63470), we believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

In the CY 2003 update, the difference in median per diem cost for CMHCs and hospital-based PHPs was so great, $685 for CMHCs and $225 for hospital-based PHPs, that we applied an adjustment factor of .583 to CMHC costs to account for the difference between ''as submitted'' and ''final settled'' cost reports. By doing so, the CMHC median per diem cost was reduced to $384, resulting in a combined hospital-based and CMHC PHP median per diem cost of $273. As with all APCs in the OPPS, the median cost for each APC was scaled to be relative to the cost of a mid-level office visit and the conversion factor was applied. The resulting per diem rate for PHP for CY 2003 was $240.03.

In the CY 2004 OPPS update, the median per diem cost for CMHCs grew to $1038, while the median per diem cost for hospital-based PHPs was again $225. After applying the .583 adjustment factor to the median CMHC per diem cost, the median CMHC per diem cost was $605. Since the CMHC median per diem cost exceeded the average per diem cost of inpatient psychiatric care, we proposed a per diem rate for CY 2004 based solely on hospital-based PHP data. The proposed PHP per diem for CY 2004, after scaling, was $208.95. However, by the time we published the OPPS final rule with comment period for CY 2004, we had received updated CCRs for CMHCs. Using the updated CCRs significantly lowered the CMHC median per diem cost to $440. As a result, we determined that the higher per diem cost for CMHCs was not due to the difference between ''as submitted'' and ''final settled'' cost reports, but were the result of excessive increases in charges which may have been done in order to receive higher outlier payments. Therefore, in calculating the PHP median per diem cost for CY 2004, we did not apply the .583 adjustment factor to CMHC costs to compute the PHP APC. Using the updated CCRs for CMHCs, the combined hospital-based and CMHC median per diem cost for PHP was $303. After scaling, we established the CY 2004 PHP APC of $286.82.

Then, in the CY 2005 OPPS update, the CMHC median per diem cost was $310 and the hospital-based PHP median per diem cost was $215. No adjustments were determined to be necessary and, after scaling, the combined median per diem cost of $289 was reduced to $281.33. We believed that the reduction in the CMHC median per diem cost indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges, and represented a more accurate estimate of CMHC per diem costs for PHP.

As discussed in the proposed rule (70 FR 42693), for CY 2006, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2004, and December 31, 2004. The data indicated that the median per diem cost for CMHCs had dropped to $143, while the median per diem cost for hospital-based PHPs was $209. It appears that CMHCs significantly reduced their charges in CY 2004 compared to CY 2003. The average charge per day for CMHCs in CY 2003 was $1,184 and in CY 2004, the CMHC average charge per day dropped to $765. We have determined that a combination of lower charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost.

Following the methodology used for the CY 2005 OPPS update, the combined hospital-based and CMHC median per diem cost would be $149, a decrease of 48 percent compared to the CY 2005 combined median per diem amount. We believed that after scaling this amount to the cost of a mid-level office visit, the resulting APC rate would be too low to cover the per diem cost for all PHPs.

As stated in the proposed rule (70 FR 42693), we considered three alternatives to our update methodology for the PHP APC for CY 2006 that would mitigate this drastic reduction in payment for PHP. One alternative was to base the PHP APC on hospital-based PHP data alone. The median per diem cost of hospital-based PHPs has remained in the $200–225 range over the last 5 years, while the median per diem cost for CMHC PHPs has fluctuated significantly from a high of $1,037 to a low of $143. Under this alternative, we would have used $209, the median per diem cost for hospital-based PHPs during CY 2004 to establish the PHP APC for CY 2006. However, we believed using this amount would also result in an unacceptable drop in Medicare payments for all PHPs in CY 2006 compared to payments in CY 2005.

The second alternative we considered was to apply a different trimming methodology to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments. We compared CMHC per diem costs in CY 2003 to CMHC per diem costs in CY 2004 and determined the percentage change. Initially, we trimmed CMHCs claims where the CMHC's per diem costs changed by 50 percent or more from CY 2003 to CY 2004. After combining the remaining CMHC claims with the hospital-based PHP claims, we calculated a median per diem cost of $160.75. We then analyzed the resulting median per diem cost if we trimmed CMHC claims where the difference in CMHC per diem costs from 2003 to 2004 was 25 percent. This trimming approach resulted in a combined CMHC and hospital-based PHP median per diem cost of $176. We also trimmed the CMHC claims from the CY 2003 data to see how trimming aberrant data would have affected the combined hospital/CMHC median per diem cost. We found that trimming the claims from the CMHCs with a 25 percent difference in per diem cost from CY 2003 to CY 2004 reduced the $289 median per diem cost to $218.

We believe it is important to eliminate aberrant data and we believe trimming certain CMHC data will provide an incentive for CMHCs to stabilize their charges so that we can use their data in future updates of the PHP APC. However, we believe that the trimming methods described above will also result in an unacceptably large decrease in payment. In addition, the trimming method we used was based on percentage change in cost per day, and may not have identified all the CMHCs that may have manipulated their charges in order to receive more outlier payments, for example, CMHCs with high charges and no reduction in charges compared to CY 2003.

Although we prefer to use both CMHC and hospital data to establish the PHP APC, as stated in the proposed rule (70 FR 42693) we continue to be concerned about the volatility of the CMHC data. The analyses we conducted for the proposed rule seem to indicate that eliminating aberrant CMHC data results in a median per diem cost more in line with hospital data. We stated in the proposed rule that we would continue to analyze the CMHC data in developing payment rates, and cautioned that we may use only hospital data in the future if the data continue to be unstable.

In the proposed rule, we stated that we considered a third alternative that would lessen the PHP payment reduction for CY 2006, yet provide an adequate payment amount to promote access to the partial hospitalization benefit for Medicare beneficiaries (70 FR 42694). Using this approach, for CY 2006, we proposed to apply a 15-percent reduction in the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. We scaled that amount relative to the cost of a mid-level office visit to establish the PHP APC for CY 2006. We believed a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a day. We believed 15 percent was an appropriate reduction because it recognizes decreases in median per diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we proposed that the reduction in payments for PHP be a transitional measure, and proposed to continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS.

We received 58 public comments in response to this proposal. A summary of the comments is provided below along with our responses.

Comment: In general, the commenters expressed concern that a reduction in the PHP rate of 15 percent would lead to the closure of many PHPs and that limited access to this crucial service would result in more costly inpatient hospital care as the only alternative. CMHCs commented that their costs are higher than hospitals', with most in the $300 to $400 range. Another commenter indicated that a per diem rate of $300 to $350 was more appropriate than our proposed amount.

A few commenters also suggested alternatives such as including prior years' CMHC data trended forward based on medical inflation, using a rolling-average or maintaining the CY 2005 payment rate for PHP services furnished in CY 2006.

Response: For the final rule, we analyzed 12 months of more current data for hospital and CMHC PHP claims for services furnished between January 1, 2004 and December 31, 2004. This claims data is more current in that it includes claims paid through June 30, 2005. We also used the most currently available cost-to-charge ratios to estimate costs. Using this updated data, we recreated the analysis performed for this year's proposed rule to determine if the significant factors we used in determining the proposed PHP rate had changed. The median per diem cost for CMHCs increased slightly to $154, while the median per diem cost for hospital-based PHPs decreased slightly to $201. The CY 2004 average charge per day for CMHCs was $760 similar to the figure noted in the proposed rule ($765) but still significantly lower than what is noted for CY 2003 ($1,184). We continue to believe that a combination of reduced charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost between CY 2003 and CY 2004.

Following the methodology used for the CY 2005 OPPS update, the combined hospital-based and CMHC median per diem cost would be $161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount. While this figure is somewhat higher than the $149 combined median in the proposed rule, we believe that this amount is still too low to cover the cost for all PHPs.

As we did in the proposed rule, we again considered three alternatives to our update methodology for the PHP

APC for CY 2006 that would mitigate the payment differences for PHP services. The first alternative was to base the PHP APC on hospital-based PHP data alone. Using the most recent years available data, the median per diem cost of hospital-based PHPs for CY 2004 is $201, somewhat less than the $209 median per diem cost of hospital-based PHP using the proposed rule CY 2004 data. We continue to believe that using $201 would be too low for all PHPs in CY 2006. However, we do believe the decrease from $209 to $201 from the proposed rule to this final rule with comment continues the trend in lower per diem costs for hospital-based PHPs.

The second alternative we considered was to apply the same trimming methodology noted in the proposed rule to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments. Again, using the most recent available data, we compared CMHC per diem costs in CY 2003 to CMHC per diem cost in CY 2004 and determined the percentage change. Initially, we trimmed CMHC claims where the CMHC's per diem costs changed by 50 percent or more from CY 2003 to CY 2004. After combining the remaining CMHC claims with the hospital-based PHP claims, we calculated a median per diem cost of $165, slightly more than noted in the proposed rule. Again, this approach still produced a per diem cost we believe is too low. We then trimmed CMHC claims where the difference in CMHC per diem costs from 2003 to 2004 were 25 percent or more. This trimming variant produced a CMHC median per diem cost of $172 for CY 2004.

We continue to believe that trimming certain aberrant CMHC data will provide an incentive for CMHCs to stabilize their charges so that we can use their data in future updates of the PHP APC. However, the two trimming methods described above produce median per diem costs that we believe are too low for the CY 2006 PHP APC rate.

The CY 2004 claims data coincides with the effective date of the separate CMHC outlier threshold policy which became effective January 1, 2004. We believe that this policy may have, in part, contributed to the rapid decreases in CMHC's per diem charges in CY 2004. If so, we may see charges stabilize in the CY 2005 claims data which would enable us to use the CMHC data to compute the CY 2007 rate.

We proposed a 15 percent reduction to the combined hospital-based and CMHC median per diem cost for CY 2006. We have conducted further analysis of more complete CY 2004 claims data combined with more recently available cost-to-charge ratios. The newer data continue to produce a combined hospital-based and CMHC median per diem cost that is an unacceptable decrease from CY 2005 PHP APC rate. We continue to believe that 15 percent is an appropriate reduction because it recognizes decreases in median per diem costs in the hospital data and the CMHC data, and also reduces the risk of adverse impact on access to these services that might result from a large single-year rate reduction.

To apply this methodology, we reduce $289 (the CY 2005 combined hospital-based and CMHC median per diem cost) by 15 percent, resulting in a combined median per diem cost of $245.65. After scaling, the resulting APC final rate for PHP of $246.04 for CY 2006, of which $49.21 is the beneficiary's coinsurance.

Comment: A few commenters stated that CMHC facility costs increased in virtually every area including salaries, benefits, supplies, insurance, dietary support, transportation, communications and administrative support and that they experienced overall increases in expenses of more than 5 percent in most areas. These commenters requested that CMS increase the per diem rate paid for PHP services consistent with the inflation rate for the medical industry. Another commenter suggested we use inpatient costs per day as the basis for the PHP median per diem cost. This commenter suggested that CMS develop an adjustment factor relative to the inpatient psychiatric facility prospective payment system per diem base rate to form the basis for the PHP per diem rate.

Response: The statute does not provide for the update strategies suggested by these commenters and is specific as to the update methdology.

Comment: A few commenters indicated that the methodology used to compute the PHP APC distorts per diem costs because the claims include non-paid days.

Response: If a provider has charges on a bill for which they do not receive payment, this will be reflected in that provider's cost-to-charge ratio. This lower cost-to-charge ratio will be applied to the larger charges and will result in the appropriate cost per diem.

Comment: A few commenters stated that they are unable to collect coinsurance from their patients, that Medicaid cuts have made it more difficult to stay viable, and that the proposed rate reduction would cause PHP programs to close.

Response: The Medicare bad debt policy and Medicaid payment policies are beyond the scope of the July 25, 2005 OPPS proposed rule. We note the bad debt policy can be located in the Medicare Provider Reimbursement Manual, Pub. 15, Chapter 3 or through the following link: *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp.*

Comment: With respect to the methodology used to establish the PHP APC amount, commenters expressed concern that data from settled cost reports fails to include costs reversed on appeal and that there are inherent problems in using claims data from a different time period like available cost-to-charge ratios on settled cost reports.

These commenters also stated that this can only artificially lower the actual median costs. The commenters claims that when cost reports are settled, generally 2 years or more after the actual year of services, they have operated on actual revenues of 80 percent of the per diem.

Response: We use the best available data in computing the APCs. With respect to PHP services, we specifically issued a Program Memorandum on January 17, 2003 directing FIs to update the cost-to-charge ratios on an on-going basis whenever a more recent full year cost report is available. In this way, we hoped to minimize the time lag between the cost-to-charge ratios and claims data.

Comment: One commenter related that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. Medicare does not cover transportation to and from programs and does not cover meals. Almost all programs offer transportation because in most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation.

Response: The services that are covered as part of a PHP are specified in section 1861(ff) of the Act. Meals and transportation are specifically excluded under section 1861(ff)(2)(I) of the Act.

Comment: Several commenters simply summed the payment rates for three Group Therapy Sessions (APC 0325) and one Extended Individual Therapy Session (APC 0323) and requested that amount as the minimum for a day of PHP. These same commenters then questioned why the per diem amount is considerably less than the combined cost of these services.

Response: We do not believe this is an appropriate comparison. It is important to note that the APC services cited by

the commenter (APC 0325 and APC 0323) are not PHP services, but rather single outpatient therapeutic sessions. PHP is a complete program of services with efficiencies and economies of scale provided in contrast to individual psychotherapy services. We also believe that the commenters used only the median cost from single bills, for example, where group psychotherapy was the only service furnished. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a complete program of services with efficiencies and economies of scale provided in contrast to individual psychotherapy services.

The PHP APC (0033) reflects the program of services provided in that it consists of the cost of all services provided each day and does not reflect a sole service. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and have focused our analysis on the cost per day rather than the cost of each service furnished within the day.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and sole community hospitals in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHC providers.

Comment: We received several comments from CMHCs stating that their costs are higher as hospitals can share and spread their costs to other departments. These commenters also indicated that the CMHC patient acuity level is more intense than the hospital patients as hospital outpatient departments need only provide 1 or 2 therapies, yet still receive the full per diem.

Response: By definition, a PHP bill must have at least 3 partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS code (other than brief psychotherapy). This requirement is applied to all partial hospitalization bills, whether provided in an outpatient hospital department or in a CMHC. Therefore, hospital outpatient departments must provide the same level of program intensity and must provide for the same level of patient acuity as CMHCs in order to receive payment.

Comment: A few commenters requested that CMS revise the CMHC cost report form (CMS–2088) to include a field which allows the CMHC to report its Medicare PHP days. They also recommended that we revise settlement worksheet D on the CMS–2088 to include new fields that display the Medicare PHP cost per day and separate PHP reimbursement between outlier and non-outlier reimbursement (since the current cost report form commingles both types of reimbursement). Finally, the commenters recommended that we revise the CMHC Provider Statistical & Reimbursement Report Type: 76P to include a field which reports actual paid Medicare PHP days.

Response: We appreciate the commenters suggestions for improving the Medicare cost report for CMHCs. We plan to explore these and other modifications to improve CMHC cost reporting so that we may use CMHC data in future ratesetting.

Comment: A few commenters stated that hospitals that offer partial hospitalization services should not be penalized for the instability in data reporting that stems from CMHCs.

Response: We believe hospitals-based PHPs have actually benefited from our combining hospital and CMHC data to compute the PHP APC rate. The median calculated from hospital outpatient department PHPs has consistently been far less then the median amount that is computed for CMHCs.

Comment: One commenter who represents CMHCs expressed frustration over several unsuccessful attempts at becoming a member of the APC panel.

Response: The qualifications and selection of the APC Panel members is outside the scope of this regulation. We refer the commenter to *http://www.cms.hhs.gov/faca/apc/default.asp* for information on the APC panel.

3. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of OPPS outlier payments for CMHCs was contrary to the intent of the general OPPS outlier policy. Therefore, for CYs 2004 and 2005, we established a separate outlier threshold for CMHCs. We designated 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 each of those years, excluding outlier payments.

As stated in the November 15, 2004 final rule with comment period, CMHCs were projected to receive 0.6 percent of the estimated total OPPS payments in CY 2005 (69 FR 65848). The CY 2005 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.5 times the PHP APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. As previously stated, we used CY 2004 claims data to calculate the CY 2006 per diem payment. These data show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. During CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs, within the 2.0 percent of total OPPS payments identified for CMHCs. In contrast, for CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

In the proposed rule, CMHCs were projected to receive 0.6 percent of the estimated total OPPS payments in CY 2006. As noted in section II.H. of this preamble, for CY 2006, we proposed to set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We also proposed allocate a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. As discussed in section II.G. below, we proposed to set a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we did not set a dollar threshold for CMHC outliers. We proposed to set the outlier threshold for CMHCs for CY 2006 at 3.45 percent times the APC payment amount and the CY 2006 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. As we did with the hospital

outlier threshold, we used hospital charge inflation factor to inflate charges to CY 2006.

We received no comments on our proposal. As discussed in section II.H, using more recent data for this final rule, we set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We also allocate a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. As we proposed, we set a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we did not set a dollar threshold for CMHC outliers. For CY 2006, we set the outlier threshold for CMHCs at 3.40 percent times the APC payment amount and the CY 2006 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. As we did with the hospital outlier threshold, we used hospital charge inflation factor to inflate charges to CY 2006.

C. Conversion Factor Update for CY 2006

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 CY 2006, 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 2006 published in the IPPS final rule on August 12, 2005, is 3.7 percent (70 FR 47392), rather than the 3.2 percent forecast published in the IPPS proposed rule on May 4, 2005 (70 FR 23384) and referenced in the CY 2006 OPPS proposed rule. To set the OPPS proposed conversion factor for CY 2006, we increased the CY 2005 conversion factor of $56.983, as specified in the November 15, 2004 final rule with comment period (69 FR 65842), by 3.7 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2005 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget neutral basis. We calculated a budget neutrality factor of 1.001485209 for wage index changes by comparing total payments from our simulation model using the FY 2006 IPPS final wage index values to those payments using the current (FY 2005) IPPS wage index values. In addition, to accommodate the rural adjustment discussed in section II.G. of this preamble, we calculated a budget neutrality factor of 0.99614506 by comparing payments with the rural adjustment to those without. For CY 2006, we estimate that allowed pass-through spending will equal approximately $45.5 million, which represents 0.17 percent of total OPPS projected spending for CY 2006. The conversion factor is also adjusted by the difference between the 2.0 percent pass-through set-aside and the 0.17 percent estimate of pass-through spending. Finally, decreasing payments for outliers to 1.0 percent of total payments, as proposed, returned 1.0 percent to the conversion factor.

The market basket increase update factor of 3.7 percent for CY 2006, the required wage index budget neutrality adjustment of approximately 1.001485209, the return of 1.0 percent in total payments from a reduced outlier target, the return of 1.83 percent of the pass-through set-aside, and the adjustment for the rural payment adjustment of 0.99614506 result in a conversion factor for CY 2006 of $59.511.

We received several public comments on the proposed conversion factor update for CY 2006.

Comment: Several commenters requested CMS to revise the market basket update included in the final OPPS rule to include a 3.7 percent market basket update, consistent with the IPPS final rule.

Response: We have used a 3.7 percent market basket increase update factor in our conversion factor calculation for the CY 2006 OPPS update.

Comment: One commenter suggested that CMS increase total payments to hospitals by 3.2 percent and not the 1.9 percent total payment increase indicated in the regulatory impact analysis section of the proposed rule.

Response: The 1.9 percent reported in column 6 of Table 33 in the regulatory analysis section of the proposed rule is not the 3.2 percent that appears in column 5 because it models all payments to hospitals. The 1.9 percent reflects the loss of payment for drugs outside of OPPS authorized by Pub. L. 108–173, that expires in CY 2006. The statute requires CMS to take into account, for purposes of establishing a budget neutral CY 2006 update, the additional costs associated with payments for specified covered outpatient drugs. The regulatory impact analysis accompanying this final rule with comment period demonstrates a similar loss. The market basket increase update factor of 3.7 percent is offset by the drug payments in CY 2006 that were made outside the system in CY 2005, to result in an overall increase of 2.2 percent.

Accordingly, we are finalizing the conversion factor update for CY 2006 of $59.511.

D. Wage Index Changes for CY 2006

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we proposed to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in section II.A. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the CY 2006 OPPS proposed rule, in accordance with our established policy, we proposed to use the FY 2006 final version of these wage indices with any corrections posted on the CMS Web site, to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that we will publish in our final rule for CY 2006.

We note that the FY 2006 IPPS wage indices continue to reflect a number of changes implemented in FY 2005 as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index,

and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the proposed changes in the FY 2005 IPPS wage indices, continued for FY 2006, and any adjustments that we are applying to the OPPS for CY 2006. We refer the reader to the FY 2006 IPPS final rule (70 FR 47363 through 47387, August 12, 2005) for a detailed discussion of the changes to the wage indices. In this final rule with comment period, we are not reprinting the FY 2006 IPPS wage indices referenced in the discussion below, with the exception of the out-migration wage adjustment table (Addendum L of this final rule with comment period). We refer readers to the CMS Web site for the OPPS at *http://www.cms.hhs.gog/providers/hopps.* At this Web site, the reader will find a link to the FY 2006 IPPS wage indices tables and any corrections made to them.

1. The continued use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2006 IPPS final rule, we again stated that hospitals located in MSAs will be urban and hospitals that are located in Micropolitan Areas or Outside CBSAs will be rural. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent with IPPS, we will continue the policy we began in CY 2005 of applying the same criterion to TEFRA hospitals paid under the OPPS but not under the IPPS and to maintain that MSA designation for determining a wage index for the specified period. Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although those hospitals paid under the IPPS will be eligible to apply for reclassification. In addition to this ''hold harmless'' provision, the FY 2005 IPPS final rule implemented a 1-year transition for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. In the FY 2006 IPPS final rule, we discussed the cessation of the 1-year transition and announced that hospitals will receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006. Again, for the sake of consistency with IPPS, TEFRA hospitals will receive 100 percent of their wage index based upon the new CBSA configurations beginning in CY 2006.

2. We are applying the occupational mix adjustment for FY 2006 IPPS to 10 percent of the average hourly wage and leave 90 percent of the average hourly wage unadjusted for occupational mix. As noted in the FY 2006 IPPS final rule, we are, essentially, using the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics data to calculate the adjustment. Because there are no significant differences between the FY 2005 and the FY 2006 occupational mix survey data and results, we believe it is appropriate to adopt the IPPS rule and apply the same occupational mix adjustment to 10 percent of the FY 2006 wage index.

3. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPPS wage index, we are adopting all of the IPPS reclassifications for FY 2006, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173. We note that section 508 reclassifications will terminate March 31, 2007.

4. We are continuing to apply an adjustment to the wage index to reflect the ''out-migration'' of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (FY 2006 IPPS final rule (70 FR 47383 and 47384, August 12, 2005)). Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties receive a wage index increase unless they have already been reclassified under section 1886(d)(10) of the Act, redesignated under section 1886(d)(8)(B) of the Act, or reclassified under section 508. As discussed in the FY 2006 IPPS final rule, we finalized our policy that reclassified hospitals not receive the out-migration adjustment unless they waive their reclassified status. For OPPS purposes, we are continuing our policy from CY 2005 to apply the same 505 criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Because TEFRA hospitals cannot reclassify under sections 1886(d)(8) and 1886(d)(10) of the Act or section 508, they are eligible for the out-migration adjustment. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPPS. Addendum L to this final rule with comment period lists all hospitals that will receive an out-migration adjustment to their wage index in 2006 including TEFRA hospitals that will receive an out-migration adjustment under this OPPS final rule with comment period. (See also Table 4J of the Addendum to the FY 2006 IPPS final rule).

We used the final FY 2006 IPPS indices to adjust the payment rates and coinsurance amounts that are included in this OPPS final rule with comment period for CY 2006. With the exception of reclassifications resulting from the implementation of the one-time appeal process under section 508 of Pub. L. 108–173, all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2006, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the FY 2006 IPPS final rule, such as the hold harmless provision for hospitals changing status from urban to rural under the new CBSA geographic statistical area definitions. However, section 508 set aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already counted against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

We received two public comments on the application of the FY 2006 IPPS wage indices under the OPPS.

Comment: One commenter supported our proposal to extend the IPPS wage indices to OPPS because this simplifies payment for hospitals.

One commenter suggested that OPPS use different labor share percentages for hospitals with a wage index below 1.0

and hospitals with a wage index above 1.0. The commenter specifically cited the requirement in Pub. L. 108–173 that IPPS use a larger labor share percentage for hospitals with wage indexes over 1.0 and a relatively smaller labor share percentage for hospitals with wage indexes less than 1.0. This commenter specifically requested that CMS use a labor share of 50 percent for hospitals with wage indexes less than 1.0.

Response: Section 403 of Pub. L. 108–173 requires that IPPS hospitals be paid using a labor-related share of 62 percent unless this labor-related share would result in lower payments than would otherwise be made. Unlike IPPS, OPPS has no mandate to reduce the labor-related share. The OPPS labor-related share was determined through regression analyses conducted for the initial OPPS proposed rule (63 FR 47581, September 8, 1998). Those analyses identified 60 percent as the appropriate labor share for outpatient services. We confirmed that this labor-related share is still appropriate during our regression analysis for the payment adjustment for rural hospitals in this final rule. In these regression equations, the coefficient of the hospital wage index is the estimated percentage change in unit costs attributable to a 1 unit percent increase in the wage index, which is an estimate of the share of outpatient unit costs attributable to labor. Both Table 5 and Table 6 in section II.G. of this preamble indicate a coefficient of 63 percent for the wage index. In light of both analyses, we believe that the current 60 percent labor-related share remains appropriate for OPPS payment purposes.

After carefully considering the public comments received, we are finalizing our wage index adjustment policy for CY 2006 OPPS as proposed without modification.

E. Statewide Average Default Cost-to-Charge Ratios (CCRs)

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2005 in our final rule, published on November 15, 2004 (69 FR 65821 through 65825). As we proposed, in this final rule with comment period, we have updated the default ratios using the most recent cost report data for CY 2006.

We calculated the statewide default CCRs using the same CCRs that we use to adjust charges to costs on claims data. Table 3 of the proposed rule (70 FR 42696) listed the proposed CY 2006 default urban and rural CCRs by State. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

For the proposed rule, 80.79 percent of the submitted cost reports represented data for CY 2003. We have since updated the cost report data we use to calculate cost to charge ratios with additional submitted cost reports for CY 2004. For the final rule, 51.66 percent, the majority of the submitted reports utilized in the default ratio calculation, were for CY 2003. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2003.

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2003, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the Nation as a substitute for Maryland CCRs, which appeared in Table 3. Very few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The overall decrease in default statewide CCRs can be attributed to the general decline in the ratio between costs and charges widely observed in the cost report data.

We did not receive any public comments concerning the proposed statewide average default CCRs. Therefore, we are finalizing them as shown in Table 3 below for OPPS services furnished on or after January 1, 2006.

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Table 3.--Statewide Average Cost-to-Charge Ratios (CCRs)

State	Urban/Rural	Previous Default CCR	Default CCR
ALABAMA	RURAL	0.31552	0.23418
ALABAMA	URBAN	0.2986	0.21741
ALASKA	RURAL	0.59388	0.54605
ALASKA	URBAN	0.38555	0.39832
ARIZONA	RURAL	0.39748	0.30658
ARIZONA	URBAN	0.30922	0.24132
ARKANSAS	RURAL	0.35936	0.29108
ARKANSAS	URBAN	0.38278	0.27611
CALIFORNIA	RURAL	0.40335	0.26409
CALIFORNIA	URBAN	0.32427	0.22126
COLORADO	RURAL	0.51041	0.39223
COLORADO	URBAN	0.41863	0.28236
CONNETICUT	RURAL	0.42702	0.38081
CONNETICUT	URBAN	0.46592	0.38571
DELAWARE	RURAL	0.36289	0.35359
DELAWARE	URBAN	0.45061	0.42436
DISTRICT OF COLUMBIA	URBAN	0.3869	0.34874
FLORIDA	RURAL	0.31782	0.22179
FLORIDA	URBAN	0.28363	0.20998
GEORGIA	RURAL	0.39829	0.30927
GEORGIA	URBAN	0.40262	0.29195
HAWAII	RURAL	0.4442	0.34871
HAWAII	URBAN	0.34815	0.32641
IDAHO	RURAL	0.49682	0.41757
IDAHO	URBAN	0.51942	0.46269
ILLINOIS	RURAL	0.41825	0.31279
ILLINOIS	URBAN	0.36825	0.27474
INDIANA	RURAL	0.44596	0.35138
INDIANA	URBAN	0.44205	0.3498
IOWA	RURAL	0.50166	0.40375
IOWA	URBAN	0.46963	0.34645
KANSAS	RURAL	0.48065	0.34407
KANSAS	URBAN	0.34698	0.26461
KENTUCKY	RURAL	0.36987	0.28358
KENTUCKY	URBAN	0.37381	0.29116
LOUISIANA	RURAL	0.34317	0.27617
LOUISIANA	URBAN	0.34357	0.25738
MAINE	RURAL	0.47857	0.385
MAINE	URBAN	0.54084	0.43839
MARYLAND	RURAL	0.7038	0.3362
MARYLAND	URBAN	0.68104	0.30235
MASSACHUSETTS	URBAN	0.44439	0.34321
MICHIGAN	RURAL	0.4489	0.36976
MICHIGAN	URBAN	0.41143	0.33319
MINNESOTA	RURAL	0.48514	0.46788
MINNESOTA	URBAN	0.45259	0.34301
MISSISSIPPI	RURAL	0.34264	0.28672
MISSISSIPPI	URBAN	0.37097	0.25325
MISSOURI	RURAL	0.42187	0.30823
MISSOURI	URBAN	0.38128	0.2907
MONTANA	RURAL	0.51173	0.45445
MONTANA	URBAN	0.49396	0.41281
NEBRASKA	RURAL	0.49386	0.39625
NEBRASKA	URBAN	0.42043	0.29024
NEVADA	RURAL	0.42878	0.46867
NEVADA	URBAN	0.22854	0.21197
NEW HAMPSHIRE	RURAL	0.50083	0.37552
NEW HAMPSHIRE	URBAN	0.39954	0.32278
NEW JERSEY	URBAN	0.49024	0.28231
NEW MEXICO	RURAL	0.44932	0.29838
NEW MEXICO	URBAN	0.50857	0.37082
NEW YORK	RURAL	0.52062	0.43021
NEW YORK	URBAN	0.54625	0.41179
NORTH CAROLINA	RURAL	0.37776	0.32018

State	Urban/Rural	Previous Default CCR	Default CCR
NORTH CAROLINA	URBAN	0.42726	0.35682
NORTH DAKOTA	RURAL	0.52829	0.37434
NORTH DAKOTA	URBAN	0.47341	0.36945
OHIO	RURAL	0.42562	0.38349
OHIO	URBAN	0.42718	0.30535
OKLAHOMA	RURAL	0.40628	0.31287
OKLAHOMA	URBAN	0.36264	0.27113
OREGON	RURAL	0.47915	0.38707
OREGON	URBAN	0.49958	0.3986
PENNSYLVANIA	RURAL	0.40582	0.32748
PENNSYLVANIA	URBAN	0.33807	0.25961
PUERTO RICO	URBAN	0.42208	0.42501
RHODE ISLAND	URBAN	0.4393	0.30402
SOUTH CAROLINA	RURAL	0.35996	0.25726
SOUTH CAROLINA	URBAN	0.36961	0.25645
SOUTH DAKOTA	RURAL	0.49599	0.37687
SOUTH DAKOTA	URBAN	0.44259	0.31324
TENNESSEE	RURAL	0.36663	0.28343
TENNESSEE	URBAN	0.36464	0.2595
TEXAS	RURAL	0.41763	0.30769
TEXAS	URBAN	0.33611	0.27468
UTAH	RURAL	0.49748	0.47797
UTAH	URBAN	0.46733	0.43421
VERMONT	RURAL	0.47278	0.44428
VERMONT	URBAN	0.54533	0.39407
VIRGINIA	RURAL	0.39408	0.29042
VIRGINIA	URBAN	0.38604	0.2976
WASHINGTON	RURAL	0.54246	0.40571
WASHINGTON	URBAN	0.54658	0.381
WEST VIRGINIA	RURAL	0.42671	0.32565
WEST VIRGINIA	URBAN	0.45616	0.38024
WISCONSIN	RURAL	0.50126	0.39136
WISCONSIN	URBAN	0.46268	0.3672
WYOMING	RURAL	0.54596	0.4687
WYOMING	URBAN	0.41265	0.38414

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F. Expiring Hold Harmless Provision for Transitional Corridor Payments for Certain Rural Hospitals

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (transitional corridor payment) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system (section 1833(t)(7) of the Act). Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers, with two exceptions, to ease their transition from the prior reasonable cost-based payment system to the OPPS system. Cancer hospitals and children's hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to SCHs located in rural areas for services

furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, will expire for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005. For CY 2006, transitional corridor payments will continue to be available to cancer and children's hospitals. (We note that the succeeding section II.G. of this preamble discusses an additional provision of section 411 of Pub. L. 108–173 that related to a study to determine appropriate adjustment to payments for rural hospitals under the OPPS beginning January 2006.)

We received four public comments concerning this hold harmless policy.

Comment: The commenters expressed concern about the impact that the expiration of the transitional corridor hold harmless payments would have on small rural hospitals because these are vulnerable facilities that provide important access to care in their communities.

One commenter recommended that the provision be expanded to permanently extend the hold harmless payments to small rural hospitals and rural SCHs, as is currently the case for cancer hospitals and children's hospitals. Two commenters referenced efforts by a large hospital association to work with Congress on legislation to provide for this expansion.

Response: We appreciate the comments that were submitted and we have carefully reviewed each of them. As the commenters acknowledge, section 1833(t)(7)(D) of the Act, as amended by section 411 of Pub. L. 108–173, provides that OPPS transitional corridor payments will expire for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005. Therefore, we are providing for the termination of these payments in this final rule with comment period. However, as noted in section II.G. of this final rule with comment period, we are providing a 7.1 percent adjustment for rural sole community hospitals in accordance with section 411 of Pub. L. 108–173.

G. Adjustment for Rural Hospitals

Section 411 of Pub. L. 108–173 added a new paragraph (13) to section 1833(t) of the Act. New section 1833(t)(13)(A) specifically instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient costs. Moreover, under new section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

As described in our CY 2006 OPPS proposed rule, we used regression analysis to study the differences in outpatient cost per unit between rural and urban hospitals because we believed that a simple comparison of unit costs would not capture the myriad of factors that contribute to observed costs, including labor supply, complexity, and volume of services. For this final rule with comment period, we reran these regression analyses that we conducted in the proposed rule and conducted additional analyses in response to issues raised in public comments.

For this final rule with comment period, our regression analysis included all 4,088 hospitals billing under OPPS for which we could model accurate cost per unit estimates. For each hospital, total outpatient costs and descriptive information were derived from a more complete set of CY 2004 Medicare claims than was used in the analysis for the proposed rule and the hospital's most recently submitted cost report. The description of claims used, our methodology for creating costs from charges, and a description of the specific hospitals included in our modeling are discussed in section II. A. of this preamble. We excluded separately payable drugs and biologicals, services receiving pass-through payments, and any service paid under a separate payment system from our analysis. We excluded the 49 hospitals in Puerto Rico because their wage indices and unit costs are so different that they would have skewed results. Finally, we excluded facilities whose unit outpatient costs were outside of 3 standard deviations from the geometric mean unit outpatient cost.

We calculated the total unit outpatient cost for each hospital by dividing total outpatient cost by the total number of APC units discounted for the joint performance of multiple surgical procedures. (See section II.G.1. below for a definition of discounted units.) As in the analysis for the proposed rule, we modeled both explanatory and payment regression models. In an ''explanatory model'' approach, all variables that are hypothesized to be important determinants of cost are included in the cost regression, whether or not they are going to be used as payment adjustments. We used the explanatory regression models to assess which class of rural hospitals, if any, is significantly more costly than urban hospitals. In a ''payment model'' approach, the only independent variables included in the cost regression are those variables considered for payment adjustments. We used the payment model to determine the amount of the adjustment for any class of hospitals identified as significantly more costly in the explanatory model. The regression equations for both models were specified in double logarithmetic form. The dependent variable in the explanatory regression equation was unit outpatient cost. The dependent variable in the payment regressions was standardized unit outpatient costs, that is, unit outpatient costs adjusted to reflect unit payment by dividing through by the provider's service-mix index which was adjusted by the provider's wage index. The service-mix index is a measure of the resource intensity of services provided by each hospital. Both regression equation models included quantitative independent variables transformed into natural logarithms and categorical independent variables. Categorical independent (dummy) variables included hospital characteristics such as rural location or type of hospital (short stay or specialty hospital). In regression analysis, dummy variables capture the difference in means of the dependent variable in the class of hospitals of interest and all other hospitals, holding all other variables in the equation constant.

1. Factors Contributing to Unit Cost Differences Between Rural Hospitals and Urban Hospitals and Associated Explanatory Variables

For this final rule with comment period, we retained the same set of explanatory variables as used in the regression analysis for the proposed rule because we believe that these variables capture the most important factors contributing to differences in unit costs between rural and urban hospitals.

- First, unit outpatient costs are expected to vary directly with the prices of inputs used to produce outpatient services, especially labor. Wage rates tend to be lower in rural areas than in urban areas. We used the OPPS hospital wage index for CY 2006 as our measure of relative differences in labor input costs.
- Second, there may be economies of scale in producing outpatient services, which imply that unit costs will vary inversely with the volume of outpatient services provided. We used the total number of discounted units as our indicator of volume. Discounted units

are the total number of units after we adjust for the multiple procedure reduction of 50 percent that applies to payment for surgical services when two surgical procedures are performed during the same operative session. For example, if a procedure is paid at 100 percent of payment 1,000 times and the same procedure is paid at 50 percent of payment 100 times, the discounted units for that procedure equal 1,050 units (the sum of 1,000 units at full payment plus 100 units at 50 percent payment).

• Third, independent of the volume of outpatient services, hospitals that provide more complex outpatient services are expected to have higher unit costs than hospitals with less complex service-mixes. Typically, greater complexity involves a combination of higher equipment and labor costs. Rural hospitals usually have less volume and perform less complex services than urban hospitals. We used a service-mix index defined as the ratio of the number of discounted units weighted by APC relative weights divided by the number of unweighted discounted units as our measure of complexity. The service-mix index reflects the average APC weight of each facility's outpatient services. From our analysis, we also believe that the number of beds captures variation in unit costs attributable to the additional complexity of services performed by a hospital that is not explained by their service mix index.

• Fourth, the size of a hospital may influence the volume and service-mix of outpatient services. Large hospitals generally provide a wider range of more complex services than do small hospitals. Large hospitals may also have larger volumes in ancillary departments that are shared between outpatient and inpatient services, and as a result, benefit from greater economies of scale than do small hospitals. Rural hospitals tend to be smaller than urban hospitals. Our primary measure of outpatient volume is discounted units of APCs, which only reflects the volume of Medicare services paid under the outpatient PPS. This measure does not include the inpatient utilization of shared ancillary departments or non-Medicare outpatient services. For all of these reasons, it seems appropriate to include a broader measure of facility size in the explanatory regression model. Therefore, as explained below, we used the total number of facility beds to measure facility size. Unit outpatient costs may be positively or negatively related to facility size depending on whether complexity effects, noted above, or scale economies are more important.

• In addition to the above factors, we included additional categorical variables to indicate the types of specialty hospitals that participate in OPPS, specifically cancer, children's, long-term care, rehabilitation, and psychiatric hospitals because we do not believe that the costs, volume, and service-mix associated with these hospitals looks like the costs, volume, and service mix of a typical OPPS provider.

• Finally, we included several categorical variables for rural/urban location and type of rural hospital to capture variation unexplained by the other independent variables in the model. Urban hospitals are the reference group for all of the different types of hospitals examined included in the regressions equations below. Table 4 provides descriptive statistics for the dependent variables and key independent variables by urban and rural status. Without controlling for the other influences on per unit cost, rural hospitals have a lower cost per unit than urban hospitals. However, when standardized for the service-mix wage indices, average unit costs are nearly identical between urban and rural hospitals.

TABLE 4.—MEANS AND STANDARD DEVIATIONS (IN PARENTHESIS) FOR KEY VARIABLES BY RURAL AND URBAN LOCATION

Variable	Rural		Urban	
	Means	Standard Deviation	Means	Standard Deviation
Unit Outpatient Cost	$157.57	($64.94)	$188.76	($93.53)
Standardized Unit Outpatient Cost	$75.51	($55.70)	$73.54	($40.98)
Wage Index	0.8807	(0.1012)	1.0212	(0.1479)
Service-Mix Index	2.3636	(0.9357)	2.7544	(1.6037)
Outpatient Volume	21,021	(21,770)	38,469	(46,925)
Beds	78	(56)	196	(170)
Number of Hospitals	1,206	.....	2,882	

2. Results

For this final rule with comment period, we began our analysis by rerunning the regression models that we had examined for the proposed rule. As a group, all rural hospitals continue to demonstrate weak evidence of slightly higher unit costs than urban hospitals, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. In the explanatory model, regressing unit costs on all of the independent variables discussed above, the coefficient for the rural categorical variable was 0.024 (p=0.0613). If the unit costs of rural hospitals are the same as the unit costs of urban hospitals, the probability of observing a value as extreme as or more extreme than 2.4 percent would be approximately 6 percent or less. This suggests that rural hospitals are approximately 2.4 percent more costly than urban hospitals after accounting for the impact of other explanatory variables. This is the same coefficient observed in the regression analyses for the proposed rule. The results of this regression appear in Table 5. This regression demonstrated reasonably good explanatory power with an adjusted R2 of 0.54 (rounded). Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. The regression coefficients of the key explanatory variables all move in the expected direction: positive for the wage index, indicating that rural hospitals can be expected to have lower unit outpatient costs because they tend to be located in areas with lower wage rates; positive for the outpatient service-mix index, consistent with the hypothesis that rural hospitals' less complex outpatient service-mixes result in lower unit costs than those of the typical urban hospital; negative for outpatient service volume, implying that, on average, rural hospitals' lower service volumes are a source of higher unit cost compared to urban hospitals; and positive for the

facility size variable (beds), suggesting that facility size is more reflective of complexity than any economies of scale. The payment regression that accompanies this explanatory model indicates an adjustment for all rural hospitals of 4.3 percent.

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Table 5.--Regression Results for Unit Outpatient Cost: Rural Versus Urban

Variable	Explanatory			Payment		
	Regression Coefficient	t Value[1]	p Value[2]	Regression Coefficient	t Value[1]	p Value[2]
Intercept	4.96886	127.93	<.0001	4.22095	664.32	<0.0001
Wage Index	0.62958	17.53	<.0001			
Service-Mix Index	0.73528	59.98	<.0001			
Outpatient Volume	-0.07419	-16.66	<.0001			
Beds	0.04851	6.80	<.0001			
All Rural Hospitals	0.02394	1.87	0.0613	0.04212	3.60	0.0003
Children's Hospitals	0.02866	0.60	0.5483			
Psychiatric Hospitals	-0.48134	-16.85	<.0001			
Long-Term Care Hospitals	-0.12577	-4.21	<.0001			
Rehabilitation Hospitals	-0.30148	-9.57	<.0001			
Cancer Hospitals	0.31344	3.50	0.0005			
Adj. R2[3]	0.5383					

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variable, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e, the base of natural logarithms.

[1]A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

[2]A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than -2 indicate a probability less than 5 percent, p-value<0.05, that the estimated coefficient is zero.

[3] Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. No adjusted R2 is reported for the payment regression because the purpose of this model is not to explain all variation in the dependent variable but to determine the amount of the payment adjustment. The dependent variable reflects unit payment not unit cost.

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As we did for our proposed rule, we divided rural hospitals into categories that reflected their eligibility for the expiring hold harmless provision under section 1833(t)(7)(D) of the Act in order to determine whether the small difference in costs was uniform across classes of rural hospitals or whether all of the variation was attributable to a specific type of rural hospitals. Specifically, we divided rural hospitals into rural SCHs, rural hospitals with 100 or fewer beds that are not rural SCHs, and other rural hospitals. The first two categories of rural hospitals are currently eligible for payments under the expiring hold harmless provision.

As indicated in the proposed rule, we found that rural SCHs demonstrated significantly higher cost per unit than urban hospitals after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. The results of this regression appear in Table 6. With the exception of the new rural variables, the independent variables have the same sign and significance as in Table 5. Rural SCHs have a positive and significant coefficient. The rural SCH variable has an explanatory regression coefficient of 0.06044 and an observed probability of 0.0003. If the unit costs of rural SCHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 6.2 percent would be less than 0.1 percent. This is sufficient evidence to accept that rural SCHs are more costly than urban hospitals, holding all other variables constant.

Notably, we observe no significant difference between all small rural hospitals with 100 or fewer beds and urban hospitals or between other rural hospitals and urban hospitals. In the explanatory regression presented in Table 6, the dummy variable for small rural hospitals has an observed coefficient of 0.01203 and an associated probability of 0.4748. If the unit costs of small rural hospitals are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 1.2 percent would be less than 50 percent. With such a high probability, there is insufficient evidence to conclude that rural hospitals with 100 or fewer beds are more costly than urban hospitals, holding all other variables constant. The results are almost identical when

volume and facility size are not included in the equation. Finally, the dummy variable for other rural hospitals has an observed coefficient of −0.01646 and an associated probability of 0.4545. If the unit costs of other rural hospitals are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than −1.7 percent would be less than 50 percent. These results are also present when facility size and volume are not included in the equation. As with small rural hospitals, this is insufficient evidence to conclude that other rural hospitals are more costly than urban hospitals. Further, for this group of rural hospitals, the coefficient is negative, indicating lower cost per unit.

Table 6.--Regression Results for Unit Outpatient Cost: Rural Sole Community Hospitals

Variable	Explanatory			Payment		
	Regression Coefficient	t Value[1]	p Value[2]	Regression Coefficient	t Value[1]	p Value[2]
Intercept	4.95656	124.68	<.0001	4.22555	745.89	<.0001
Wage Index	0.62700	17.45	<.0001	--	--	--
Service-Mix Index	0.73640	59.60	<.0001	--	--	--
Outpatient Volume	-0.07424	-16.69	<.0001	--	--	--
Beds	0.05079	6.98	<.0001	--	--	--
Rural SCH	0.06044	3.61	0.0003	0.06865	4.09	<.0001
Small Rural Hospitals	0.01203	0.71	0.4748	--	--	--
Other Rural Hospitals	-0.01646	-0.75	0.4545	--	--	--
Children's Hospitals	0.02882	0.60	0.5456	--	--	--
Psychiatric Hospitals	-0.47873	-16.76	<.0001	--	--	--
Long-Term Care Hospitals	-0.12229	-4.09	<.0001	--	--	--
Rehabilitation Hospitals	-0.29848	-9.47	<.0001	--	--	--
Cancer Hospitals	0.31883	3.57	0.0004	--	--	--
R2[3]	0.5394			--	--	--

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variables, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e, the base of natural logarithms.

[1]A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

[2]A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than -2 indicate a probability less than 5 percent, p-value <0.05, that the estimated coefficient is zero.

[3] Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. No adjusted R2 is reported for the payment regression because the purpose of this model is not to explain all variation in the dependent variable but to determine the amount of the payment adjustment. The dependent variable reflects unit payment not unit cost.

Based on the above analysis, we continue to believe that a payment adjustment for rural SCHs is warranted. The accompanying payment regression, also appearing in Table 6, indicates a cost impact of 7.1 percent. Thus, in accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108–173, we are implementing a 7.1 percent payment increase for rural SCHs for CY 2006. This adjustment will apply to all services and procedures paid under the OPPS, excluding drugs, biologicals, and services paid under the pass-through payment policy. As stated in the proposed rule, this adjustment is budget neutral, and will be applied before calculating outliers and coinsurance. We will not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future, and if appropriate, may revise the adjustment. Additional descriptive statistics are available on the CMS Web site.

We received 19 public comments concerning these results.

Comment: Several commenters supported our proposed payment increased for rural SCHs of 6.6 percent.

Response: We appreciate the commenters' support. As we discussed above, based on our most recent analysis, we are implementing an adjustment of 7.1 percent in this final rule with comment period. We believe that an adjustment at this level remains consistent with the views expressed by the commenters.

Comment: Several commenters expressed concern that the regression analysis, as presented, does not separately set out the regression results for rural hospitals with 100 or fewer beds that are not rural SCHs. They indicate that, while CMS stated that this class of hospitals did not demonstrate significance in the explanatory regression analyses, it did not definitively display these results. The

commenters highlighted the importance of showing these results because these are the facilities that will be losing their hold harmless protection in CY 2006. One of the commenters cited MedPAC's 2005 Report to Congress, which noted that previous MedPAC research indicated higher costs for low-volume hospitals which are predominantly rural. The commenters urged CMS to specifically report the regression results with small rural hospitals with 100 or fewer beds identified separately.

Response: We agree with the commenters that we should identify small rural hospitals with 100 or fewer beds separately in the analysis. The results in Table 6 demonstrate that small rural hospitals with 100 or fewer beds do not appear to have unit costs different from those of urban hospitals after controlling for other contributors to unit cost, including volume.

Comment: Several commenters requested clarification on the definition of rural in order to assess which hospitals would be eligible for the rural adjustment. The commenters asked: Would a SCH located in a rural area that has been reclassified for wage index purposes into an urban area be eligible for the SCH adjustment? Would a SCH located in an urban area that has been reclassified for wage index purposes into a rural area be eligible for the SCH adjustment?

Response: SCHs will be considered rural for the rural adjustment, and for purposes of the OPPS rural adjustment only, under section 1833(t)(13)(B) of the Act if a hospital is geographically located in a rural area or has been reclassified to a rural area for wage index purposes. Therefore, a SCH located in a rural area that has been reclassified for wage index purposes into an urban area will be eligible for the adjustment, regardless of whether the SCH has been reclassified to an urban area for wage index purposes. In addition, a SCH located in an urban area that has been reclassified for wage index purposes into a rural area also will be eligible for the adjustment. New § 419.43(g)(1)(ii) of the regulations, which we are finalizing in this final rule with comment period, will provide that an SCH is eligible for the adjustment if the hospital is ''located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under § 412.103.'' To clarify the text in response to the comments received, we are referencing § 412.103 in the final regulation text instead of the reference to section 1886(d)(8)(E) of the Act. This definition of a ''SCH located in a rural area'' only will apply for the purposes of the rural adjustment in this rule.

Comment: One commenter asked if rural SCHs that are participating in the Rural Community Hospital Demonstration Program would be eligible for the rural adjustment.

Response: Rural SCHs participating in the Rural Community Hospital Demonstration Program are eligible to receive this rural adjustment. The Rural Community Hospital Demonstration Program, authorized under section 410A of Pub. L 108–173, assesses whether rural hospitals will benefit from cost-based reimbursement and is limited to payment for inpatient services. Although SCHs participating in the demonstration program are not eligible to receive traditional SCH payments made under the IPPS, these hospitals retain their SCH status.

Comment: Several commenters requested clarification of whether CMS intends to make this adjustment available beyond CY 2006, and whether it intends to reestablish the adjustment amount on an annual basis.

Response: We will not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future and, if appropriate, revise the adjustment.

Comment: A few commenters requested that CMS extend the rural adjustment to CMHCs or make some other special allowance or provision for their rural location.

Response: Section 1833(t)(13)(A) of the Act limits the scope of this analysis and any adjustment to comparing rural and urban hospitals costs.

Comment: Several commenters requested that CMS extend the proposed rural adjustment to all SCHs, not just rural hospitals, under its equitable adjustment authority in section 1833(t)(2)(E) of the Act. The commenters described the necessary access to services that urban SCHs provide and highlighted that both urban and rural SCHs have been recognized for special protections by Congress in other payment systems because they are the sole source of inpatient hospital services reasonably available to Medicare beneficiaries.

One commenter used the public use file that CMS provided on its Web site and conducted detailed analyses to assess the appropriateness of an adjustment for urban SCHs. The commenter compared urban SCHs, rural SCHs, other urban hospitals, and other rural hospitals on the number of beds, their service mix, and wage index. The commenter also conducted regression analysis. The first model the commenter examined included a variable for rural location and a variable for SCH status in addition to the other variables used in CMS' explanatory model. The commenter reported that the SCH variable is significant, suggesting that SCHs are more costly than other non-SCHs controlling for rural or urban status. The commenter concluded that the results indicated SCHs are significantly more costly than hospitals that are not SCHs and that geographic location does not influence this finding.

The same commenter also examined an explanatory model that resembled CMS' explanatory model. The commenter indicated that this model included separate variables for urban SCHs, rural SCHs, and all other rural hospitals in order to isolate the unit cost differences between urban SCHs and other hospitals. The commenter reported that, in this model, the unit costs of urban SCHs were not significantly different from urban, non-SCH unit costs. With regard to this last finding, the commenter suggested that the lack of significance is less important than the comparability in the magnitude of the coefficient for rural and urban SCHs, and that both types of hospitals have coefficients at 6 percent. Finally, the commenter examined the significance of the rural indicator in an explanatory regression model conducted only with SCH hospitals. Within this population, the commenter reported that all explanatory variables are statistically significant, except an indicator for rural status, and suggested that this finding further supports extending the adjustment to urban SCHs. The commenter concluded by requesting that CMS repeat its regression to confirm that SCH status, and not geographic location, is indicative of higher costs, and if it finds this to be true, to appropriately adjust for higher costs.

Response: We do not believe it is sufficient to confirm that all SCHs are significantly more costly than non-SCHs, as the commenter demonstrated in its first regression model because the statutory authority for this adjustment is to be based upon the comparison between urban and rural hospitals. The regression model that includes a variable for SCH status and a variable for rural location only confirms that all SCHs have higher costs than hospitals that are not SCHs and that, having controlled for SCH status, rural and urban hospitals are not different. Rural SCHs comprise 90 percent of all SCH, and are the basis for the observed significance on the SCH variable. Notwithstanding the mandate for this rural adjustment, we believe that urban SCHs would have to demonstrate strong

empirical evidence that they are significantly more costly than other urban hospitals. We do not find the strong empirical evidence supporting an adjustment for urban SCHs, as we do for rural SCHs.

In many respects, urban SCHs look like urban hospitals on some of the key variables presented in Table 4. Urban SCHs have a mean cost per unit of $183.89, and urban hospitals have a mean cost per unit of $188.76. Urban SCHs have a mean standardized unit cost of $74.01, and all urban hospitals have a mean standardized cost of $73.54. Finally, urban SCHs have a mean volume of 36,714, and urban hospitals have a mean volume of 38,469. Similar to the commenter, we also ran an explanatory regression analysis that included urban SCHs as a separate class of hospitals in addition to rural SCHs, small rural hospitals, and other rural hospitals. In these results, the coefficient associated with urban SCHs was 0.05960 and the associated probability was 0.1624. If the unit costs of urban SCHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 6.1 percent would be less than 20 percent. We acknowledge the commenter's statement that the size of the coefficient on the urban SCH dummy variable is comparable to that on the dummy variable for rural SCHs. However, we do not believe that the size of the coefficient is sufficient evidence. The lack of significance associated with such a large coefficient is attributable to the much higher standard error accompanying urban SCHs compared to rural SCHs. Higher standard error indicates that there is large variability in unit costs for urban SCHs after controlling for all other variables in the equation. Some urban SCHs may have unit costs as high as rural SCHs, but clearly many do not. We believe that this observation accounts for the lack of significance on the rural variable in the commenter's regression analyses, which was limited to the population of SCHs.

Comment: One commenter requested that CMS examine whether the outpatient costs of Medicare-Dependent Small Rural Hospitals (MDHs), a subgroup of rural hospitals, are higher than urban hospitals' outpatient costs, and provide an adjustment to payments if appropriate.

Response: We did not find any evidence that rural MDHs are more costly than urban hospitals. We ran an explanatory regression analysis that included rural MDHs as a separate class of small rural hospitals from other small rural hospitals because 90 percent of rural MDHs were also small rural hospitals. We also included all of the other variables in Table 6 above, including rural SCHs and other rural hospitals. In these results, the coefficient associated with rural MDHs was −0.01955, with an associated probability of 0.4438. If the unit costs of MDHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 2 percent would be less than 50 percent.

Comment: One commenter argued that CMS excluded variables from the regression model that control for ''financial pressure'' and ''market structure.'' The commenter argued that higher costs can be the result of inefficient operations as much as they could also be the result of higher input costs created by rural location, and that measures of financial pressure or market structure would capture any variation in unit cost attributable to a lack of local competition. The commenter suggested that SCHs may be inefficient because they already have special payment status under the IPPS and the OPPS. Finally, the commenter suggested that, because beneficiaries' access to care is the central objective of any payment policy, CMS should consider a low-volume adjustment that better captures higher costs that the hospital cannot control. At the same time, the commenter acknowledged that section 1833(t)(13)(A) of the Act specifically requires an analysis of urban and rural costs.

Response: While it is not inappropriate to include additional variables in the explanatory regression analysis, we first note that section 1833(t)(13)(A) of the Act specifically calls a determination of whether costs faced by rural hospitals are higher than those faced by urban hospitals. For this reason, we believe that the model in Table 6 ably controls for scale efficiencies in a comparison of urban and rural costs. Our adjusted R2 of 54 percent also demonstrates a relatively good fit. We acknowledge that some of the SCHs eligible for the adjustment may also be more costly because of inefficiencies due to limited competition or because they currently receive special payment status under the IPPS and the OPPS. However, we also agree with the commenter that beneficiary access is an important goal. We believe that the current model is sufficiently robust to identify hospitals with significantly higher costs such that payment under the OPPS alone might impact beneficiary access. The SCH status of these hospitals suggests that they are important to beneficiary access. Rural SCHs receive their designation because they are the only, or one of a few, sources of care for beneficiaries. For example, these hospitals may be the only immediately available source of emergency services for Medicare beneficiaries.

In accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108–173, we are finalizing our policy by including a payment adjustment for rural SCHs of 7.1 percent and finalizing the regulation text at § 419.43(g) as noted above.

H. Hospital Outpatient Outlier Payments

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2005, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,175 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. For a discussion on CMHC outliers, see section II.B.3. of this final rule with comment period.

As explained in our CY 2005 final rule with comment period (69 FR 65844), we set our projected target for aggregate outlier payments at 2.0 percent of aggregate total payments under the OPPS. Our outlier thresholds were set so that estimated CY 2005 aggregate outlier payments would equal 2.0 percent of aggregate total payments under the OPPS.

For CY 2006, we proposed to set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS. A portion of that 1.0 percent, an amount equal to 0.6 percent of outlier payments, would be allocated to CMHCs for partial hospitalization program service outliers. In support of this decision, we cited MedPAC's March 2004 Report to Congress, in which MedPAC recommended that Congress pursue the statutory change needed to eliminate the outlier policy under the OPPS. We specifically highlighted several of the reasons given by MedPAC for the elimination of the outlier policy because they are equally applicable to any

reduction in the size of the percentage of OPPS payments dedicated to outlier payments. One of MedPAC's arguments included the very narrow definition of many APCs with limited packaging frequently resulting in multiple service payments for any given claim. In addition, we noted that outlier policies are susceptible to ''gaming'' through charge inflation and that the OPPS is the only ambulatory payment system with an outlier policy. Finally, we cited MedPAC's observation that the distribution of outlier payments benefits some hospital groups more than others.

In order to ensure that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we proposed that the outlier threshold be modified so that outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,575 fixed-dollar threshold. Ultimately, we chose to modify the fixed dollar threshold to target 1.0 percent of estimated aggregate total payment under the OPPS and not to modify the current 1.75 multiple in order to further our policy of targeting outlier payments to complex and expensive procedures with sufficient variability to pose a financial risk for hospitals. We note that modifying the multiple threshold would have done less to target outlier payments to complex and expensive procedures.

We calculated the fixed-dollar threshold for the proposed rule using the same methodology as we did in CY 2005. The claims that we use to model each OPPS lag by 2 years. For this final rule with comment period, we used CY 2004 claims to model the CY 2006 payment system. In order to estimate CY 2006 outlier payments for the proposed rule, we inflated the charges on the CY 2004 claims using the same inflation factor of 1.0865 that we used to estimate the IPPS fixed-dollar outlier threshold for the IPPS FY 2006 proposed rule. For 2 years, the inflation factor is 1.1804. The methodology for determining this charge inflation factor was discussed at length in the IPPS proposed rule (70 FR 47493, August 12, 2005). As we stated in our final rule for 2005, we believe that the use of this charge inflation factor is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845, November 15, 2004). As also noted in the IPPS final rule, we believe that a charge inflation factor is more appropriate than an adjustment to costs because this methodology closely captures how actual outlier payments are made and calculated (70 FR 47495, August 12, 2005). We then applied the overall cost-to-charge ratio (CCR) that we calculate from each Hospital's Cost Report (CMS–2552–96) as part of our process for estimating median APC costs. The calculation of this overall CCR is discussed in greater detail in section II.A. of this preamble. We estimated outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple constant until the aggregated outlier payments equaled 1.0 percent of aggregated total payments under the OPPS. In addition, for CY 2006, we proposed an outlier threshold for CMHCs of 3.45 times the APC payment rate.

For this final rule with comment period, we recalculated the fixed-dollar threshold in light of updated claims data, a revised charge inflation estimate, and more timely CCRs. As in the proposed rule, we did not change the multiple threshold of 1.75 times the APC payment rate, but concentrated on adjusting the fixed-dollar threshold. We again used the same inflation factor that we used to estimate the IPPS fixed-dollar threshold. Because the charge inflation factor for the IPPS was revised to 14.94 percent for 2 years in the IPPS FY 2006 final rule (70 FR 47493, August 12, 2005), we inflated charges on all CY 2004 OPPS claims by 1.1494.

We then applied the hospital specific overall CCR which we calculated for purposes of our APC cost estimation. We simulated aggregated outlier payments using these costs for several different fixed dollar thresholds holding the 1.75 multiple constant until the total outlier payments equaled 1.0 percent of aggregated total OPPS payments. We estimate that a threshold of $1,250 combined with the multiple threshold of 1.75 times the APC payment rate will allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We used a lower charge inflation factor of 14.94 percent to increase charges to reflect 2006 dollars. The proposed fixed dollar threshold declined to $1,250 from $1,575 in the proposed rule primarily because we used the lower charge inflation factor of 1.1494.

The following is an example of an outlier calculation for CY 2006 under our final policy. A hospital charges $26,000 for a procedure. The APC payment for the procedure is $3,000, including a rural adjustment, if applicable. Using the provider's CCR of 0.30, the estimated cost to the hospital is $7,800. To determine whether this provider is eligible for outlier payments for this procedure, the provider must determine whether the cost for the service exceeds both the APC outlier cost threshold (1.75 × APC payment) and the fixed-dollar threshold ($1,250 + APC payment). In this example, the provider meets both criteria:

(1) $7,800 exceeds $5,250 (1.75 × $3,000)

(2) $7,800 exceeds $4,250 ($1,250 + $3,000)

To calculate the outlier payment, which is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate, subtract $5,250 (1.75 × $3,000) from $7,800 (resulting in $2,550). The provider is eligible for 50 percent of the difference, in this case $1,275 ($2,550/2). The formula is (cost − (1.75 × APC payment rate))/2.

For CMHCs, in CY 2005, the outlier threshold is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.5 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.5 times the APC payment rate. For this final rule with comment period, updated data reduces the multiple outlier threshold for CMHCs to 3.4. The outlier threshold for a CMHC is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.4 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.4 times the APC payment rate.

We received 25 public comments concerning our proposed outlier policy.

Comment: One commenter supported CMS' decision to reduce the percentage of total payments set aside for outlier payments from 2.0 percent to 1.0 percent.

Response: We appreciate the commenter's support. Although the fixed-dollar threshold has changed due to more accurate data than in the proposed rule, we do not believe that this change would impact the views expressed by the commenter.

Comment: Several commenters expressed concern that, in light of an increase in the threshold from $1,175 to $1,575, CMS may have set the threshold for outlier payments too high. They requested clarification as to how CMS determined that a $400 increase in the fixed-dollar threshold was appropriate and how the $1,575 fixed-dollar threshold was calculated. The commenters specifically noted that in the IPPS final rule CMS reduced the charge inflation factor used to set the fixed-dollar threshold from 18.04

percent to 14.94 percent, and suggested that CMS make a similar adjustment to the OPPS methodology.

Response: As discussed above, for the proposed rule, we used a charge inflation factor of 1.1804 to inflate the charges on CY 2004 claims to CY 2006 dollars. We then applied the overall CCR that we calculate as part of our APC median estimation process to those inflated charges to estimate costs. We compared these estimated costs to 1.75 times the proposed APC payment amount and to the APC payment amount plus a number of fixed-dollar thresholds until we identified a threshold that produced total outlier payments equal to 1.0 percent of total aggregated OPPS payments. This methodology increased the fixed-dollar threshold by $400.

We repeated the same estimation process for this final rule, using a complete set of CY 2004 claims, the updated charge inflation estimate of 14.94 percent from the IPPS final rule, as requested by commenters, and each hospital's overall CCR, as calculated for our APC median setting process. The final fixed dollar threshold for OPPS 2006 is $1,250 plus the APC payment rate, and the final multiple threshold is 1.75 times the APC payment rate.

Comment: Commenters expressed concern that CMS has never reported the actual amount of outlier payments for the OPPS made in past years. They noted that CMS routinely reports prior year outlier payments for the IPPS. The commenters also expressed concern that CMS may not spend the percentage of total aggregated OPPS payment set aside each year for outlier payments. One commenter hypothesized that outlier payments had been underspent in previous years, and that the proposed reduction in outlier payments was designed to realign the policy with actual payment. The commenters urged CMS to publish data on actual outlier payments made in CY 2004 and prior years in the final rule. They also recommended that actual outlier payments for CY 2005 OPPS be reported as soon as CMS is able to obtain accurate data and that CMS continue to report these data in the future.

Response: As we have stated in prior rules (see for example 69 FR 65847, November 15, 2004), we have not provided aggregate outlier payments for past years because we do not use those estimates to set the outlier thresholds and because we make outpatient claims available. However, we understand that providers might wish to know this information, especially in light of recent changes in the OPPS outlier policy. In the final set of CY 2004 OPPS claims, aggregated outlier payments were 2.5 percent of aggregated total OPPS payments. In the final set of CY 2003 OPPS claims, aggregated outlier payments were 3.1 percent of aggregated total OPPS payments. For both years, the estimated outlier payments were set at 2 percent of total aggregated OPPS payments. At this time, we cannot make accurate estimates about aggregated total outlier payments for CY 2005, but we intend to provide this information in our proposed rule for CY 2007. We intend to continue reporting the percentage of total payments made in outlier payments for the most recent and complete set of claims in future rules. We note above our reasons for proposing to reduce the projected target percent of total aggregated OPPS payments attributable to outlier payments.

Comment: Several commenters suggested that CMS did not provide sufficient analytic support to justify a reduction in outlier payments from 2.0 percent to 1.0 percent, relying only on MedPAC's recommendations. The commenters urged CMS not to change its outlier policy or to delay implementation until greater technical analyses could be conducted. One commenter suggested that, without CMS' technical analyses, stakeholders cannot conduct their own analyses. The commenters frequently questioned our reference to the March 2004 MedPAC Report to Congress and stated that outlier payments are not evenly distributed among hospitals as justification for reducing the percentage of total payments dedicated to outlier payments. They noted that differences in outlier payments would be expected for hospitals serving different populations. Several commenters cited the continued instability in rates as a reason for continuing at 2.0 percent. One commenter specifically hypothesizes that instability in payment rates may be attributable to a lack of stability in unit costs, suggesting a continued need for outlier payments. Another commenter acknowledged that the variability in costs for APCs was clearly less than that for DRGs, but that the current policy of setting aside two percent of total payments, already accounted for this difference.

Response: Our decision to reduce the projected target amount of total payments set aside for outlier payments is based on the technical analyses that MedPAC conducted in its March 2004 Report to Congress demonstrating that the CY 2004 OPPS outlier policy was ineffective at addressing complex cases of financial risk and on the arguments that MedPAC made against outlier payments. As noted above, MedPAC argued that the fairly narrow definition of the APC groups makes outlier payments less necessary for the OPPS, that the limited packaging in OPPS frequently resulting in multiple service payments for any given claim, and that the susceptibility to ''gaming'' through charge inflation continues. MedPAC's 2004 Report to Congress also suggested that our outlier policy could be redistributing outlier payments among hospitals based on cost structures or charging patterns rather than differences in case-mix. We agree with the commenters that an unequal distribution of outlier payments according to differences in case mix is appropriate, the concern is that different case mix does not account for outlier payment distributions.

We do not believe that the moderate fluctuation in APC payment rates that continues to be present in the OPPS is an adequate argument against reducing the percentage of aggregated total OPPS payments set aside for outlier payments for several reasons: changes in payment rates appropriately reflect changes in costs, the variability of costs is less for complex and expensive procedures, and outlier payments in OPPS target services not cases. As discussed in section II.A. of this preamble, we believe that the moderate changes in the payment rates remaining after the system has been operating for several years is, in large part, a function of the small APC group size and service basis. The small group size of the APCs makes changes in service costs more transparent than if groups were larger. Aggregation generally reduces variation. Changes in payment rates from year to year appropriately reflect true changes in the cost of a specific service. Changes in cost and charging patterns captured in a provider's cost report will lead to changes in the median cost of services from year to year. In addition, we are required to adjust the APCs each year to ensure that groups are comparable with ''respect to the use of resources.'' The ''2 times'' rule requires that the highest median cost for an item or service within the group not be greater than two times the lowest median cost. The ''2 times'' rule specifically limits the amount of variability of unit costs in any group, forcing the APC payment rates to reflect changes in costs. It embeds some fluctuation into APC payment rates, but also reduces the need for an expansive outlier policy.

The observed variability in unit costs is greater for low cost and simple procedures and smaller for complex, expensive procedures. In its 2004 Report to Congress, MedPAC found that

the highest variability in estimated costs was associated with the lowest cost items. This observation continues to be true in the CY 2004 claims. On average, HCPCS codes with low median costs demonstrate greater variability, as measured by the coefficient of variation, than HCPCS codes with high median costs. The coefficient of variation is the percent of the standard deviation accounted for by the mean and enables a relative comparison of variation across groups. This trend also is evident in the APC coefficient of variation. The bottom 50 percent of APCs arrayed by median costs have an average coefficient of variation of 82 percent, whereas the top 50 percent of APCs, arrayed by median cost, have an average coefficient of variation of 63 percent.

Finally, OPPS outlier payments are targeted to services, rather than cases. Unlike the IPPS, outlier payments are not for extremely costly patients but extremely costly services. In many cases, an extremely costly case in the outpatient setting may not warrant an outlier payment because no specific service was excessively costly. The small number of services included in any APC group means that the provider will receive payment for most services billed on a claim. Reducing total outlier payments to 1.0 percent of total OPPS payments effectively raises the payment for all other services because the foregone 1.0 percent of total spending is returned to the conversion factor. We acknowledge the comment stating that the comparative difference in cost variability between the IPPS and the OPPS is already accounted for in the difference between the 5 to 6 percent estimated outlier target under IPPS and the 2 percent projected outlier estimate under OPPS. However, we believe that setting total outlier payments at 1.0 percent of total aggregated OPPS payments sets aside an appropriate amount of dollars for unexpected and costly services.

Comment: One commenter indicated concern that CMS proposed an additional change to the outlier payments before having one year of experience with the fixed-dollar threshold introduced in CY 2005.

Response: We do not believe that these two policies are related. The amount of total aggregated OPPS payments set aside for outlier payments is an entirely different policy from the manner in which those payments are distributed to hospitals. We did not institute the fixed-dollar threshold to reduce outlier payments, but rather to target payments to expensive and costly cases. The fixed-dollar threshold will continue to have this effect within a smaller amount of outlier payments.

Comment: Several commenters suggested that CMS did not sufficiently demonstrate the impact on hospitals of reducing the percentage of estimated total payments dedicated to outlier payments 2.0 percent to 1.0 percent and requested this analysis. The commenters expressed concern that hospitals providing sophisticated and expensive technologies to very sick patients would be placed at greater risk of financial loss. Most of the commenters suggested that the reduction in the outlier percentage be delayed until CMS can fully evaluate the impact, while other commenters simply urged for a return to the 2-percent target amount.

Response: For the proposed rule, we did not include a specific analysis of the redistributive impact of outliers because the fixed-dollar threshold policy did not change, only the aggregate amount of dollars paid. We did include outlier payments in our impact tables, and we made the amount of outlier payment estimated for each hospital available on our Web site. However, we appreciate commenters' desire to more fully view the impact of the outlier policy. For this final rule with comment period, we have provided a separate table in our regulatory impact analysis, section XIX of this preamble, showing the differences in total aggregated OPPS payment for CY 2006 attributable to the change in the outlier policy. We estimate that no class of hospital will experience more than a 1 percent change in total payments due to outlier payments and many classes of hospitals receive greater payments.

Comment: Several commenters suggested that CMS pay outlier claims at the same rate at which inpatient outlier claims are paid, that is, 80 percent of cost. Various rationales were provided, including consistency with the IPPS, ensuring that hospitals can recoup the variable costs of providing expensive care, and improving the adequacy of payments.

Response: We believe that the payment percentage of 50 percent is appropriate for the OPPS because, in general, a costly OPPS service poses less of a financial risk for hospitals than a costly case under the IPPS. If we did increase the payment percentage to 80 percent, we would have to compensate elsewhere to maintain the 1.0 percent set aside for outlier payments, probably by raising the fixed-dollar threshold. Changing the payment percentage to 80 percent would merely concentrate a more generous outlier payment on a much smaller number of extremely costly services each year.

Comment: One commenter recommended a new methodology for estimating the fixed-dollar outlier threshold for both the OPPS and the IPPS. The commenter suggested that, in addition to inflating charges from CY 2004 to CY 2006, CMS also should adjust CCRs to reflect proportionally slower inflation in costs. The commenter believed that this would result in deflating overall CCRs. The commenter specifically recommended that CMS update the CCRs for the OPPS to the latest available hospital-specific data.

Response: We agree with the commenter that the CCRs that we use to set the outlier thresholds should be as recent as possible. We also believe that these CCRs should reflect, as closely as possible, the actual CCRs that the fiscal intermediary will use to determine outlier payments in CY 2006. As we did for the IPPS final rule (70 FR 47493, August 12, 2005), we used the overall CCRs from the most recent provider-specific file, in this case, the July 2005 OPSF, to estimate costs from inflated charges on CY 2004 claims. The OPSF contains CCRs from each provider's most recent tentatively settled cost report. Because of the time it takes to complete cost reports and upload them in the fiscal intermediaries' standard systems, for at least part of CY 2006, the CCRs on the OPSF are the same ones that the fiscal intermediaries will use to determine outlier payments. However, unlike the IPPS, the overall CCRs on the OPSF are higher than those that we use to estimate APC medians. The median overall CCR that we calculate from each hospital's cost report as a default CCR in estimating costs from charges in order to set relative weights is 0.305, whereas the median overall CCR on the OPSF is 0.32. Were we to use the CCRs from the OSPF, the fixed dollar threshold would increase, from $1,250 to $1,800.

We will consider using the CCRs found in the OSPF for the CY 2007 OPPS outlier calculations, similar to our calculations under IPPS. However, in view of the newness of a fixed-dollar threshold for OPPS outlier payments and our concern that using the OSPF CCRs for this final rule would result in an $1,800 fixed dollar threshold that is considerably higher than the proposed threshold, we have decided to use the CCRs that we calculated for the APC median setting process for our outlier calculations as we have in past years. These CCRs are timely, as the majority of them are created from cost reports with fiscal years beginning in 2004 and 2003.

Comment: One commenter requested that CMS reverse its decision to reduce

the percentage of total payments attributable to outlier payments to 1 percent and return outlier payments to the target level of 3 percent established under the Balanced Budget Act (BBA) of 1997.

Response: For all of the reasons stated above, we do not believe that outlier payments should be increased to 3 percent of total payments. We further note that the BBA, as revised by the Balanced Budget Refinement Act (BBRA) of 1999, set an upper limit of ''no more than'' 3.0 percent for outlier policies, giving the Secretary the discretion to set a lower estimated target percent.

Comment: One commenter expressed concern that decreasing the outlier pool and increasing the fixed dollar threshold may encourage greater packaging in order to increase procedure charges.

Response: We do not believe that greater packaging is an issue for the OPPS outlier policy. Should providers choose to package more services into the charges for payable procedures and not report packaged services, over time, those higher costs would lead to higher payment rates for payable procedures. This would, in turn, increase the fixed dollar outlier threshold. Further, rolling the charges for packaged services into the charges for payable procedures is expected under OPPS.

Comment: One commenter requested that CMS describe the services that qualify for outlier payments.

Response: The actual services that qualify for outlier payments under the fixed dollar threshold policy introduced in CY 2005 will likely be quite similar to those receiving payments under 2005 OPPS. As noted above, at this time, we do not have a complete set of CY 2005 claims. However, in our analysis replicating the analysis done by MedPAC in its March 2004 Report to Congress, we estimate that costly services such as APC 0246 (Cataract Procedures with IOL Insert), APC 0080 (Diagnostic Cardiac Catheterization), and APC 0131 (Level II Laparoscopy) would receive a large percentage of outlier payments under the fixed-dollar threshold policy.

Accordingly, after considering the public comments received, for CY 2006, we are finalizing the OPPS outlier policy of two thresholds for hospitals of a multiple threshold of 1.75 times the APC payment amount and a fixed dollar threshold of $1,250 plus the APC payment amount and one threshold for CMHCs of 3.4 times the APC payment amount.

I. Calculation of the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this final rule with comment period and the relative weight determined under section II.A. of this final rule with comment period. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this final rule with comment period and for HCPCS codes to which payment under the OPPS has been assigned in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the final CY 2006 scaled weight for the APC by the final CY 2006 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (Refer to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2006 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, section 1866(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. The wage index values include the occupational mix adjustment described in section II.D. of this final rule with comment period that was developed for the FY 2006 IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L contains the qualifying counties and the final wage index increase developed for the FY 2006 IPPS. This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

Step 6. If a provider is a SCH, as defined in § 419.92, and located in a rural area, as defined in § 412.63(b), or is treated as being located in a rural area under § 412.103 of the Act, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

We received no public comments concerning our proposal for calculating the national unadjusted Medicare payment rate. Therefore; we are adopting as final, for OPPS services furnished on or after January 1, 2006, our proposed methodology for calculating the national unadjusted Medicare payment amount.

J. Beneficiary Copayments for CY 2006

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2006, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

2. Copayment for CY 2006

For CY 2006, we proposed to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPPS final rule with comment period, 68 FR 63458). We used the same methodology to determine the final unadjusted copayment amounts for services payable under the OPPS that will be effective January 1, 2006. These copayment amounts are shown in Addendum A and Addendum B of this final rule with comment period.

3. Calculation of the Unadjusted Copayment Amount for CY 2006

To calculate the unadjusted copayment amount for an APC group, take the following steps:

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, $7.00 is 29 percent of $23.79.

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.I. of this preamble.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

We received two public comments concerning our proposed methodology for calculating the beneficiary unadjusted copayment amount.

Comment: One commenter recommended that CMS maintain the coinsurance amount above 40 percent of the APC payment amount as the proposed payment rate for CY 2006 is lower than the CY 2005 payment rate when adjusted for inflation.

Response: We appreciate the commenter's recommendation but note that the statute does not provide for this. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2006, and in calendar years thereafter, that specified percentage is 40 percent of the APC payment rate.

Comment: One commenter objected to beneficiaries being liable for more than 20 percent of the Medicare payment rate for services paid under the OPPS. The commenter acknowledged that the law limits the copayment for a single service to the amount of the inpatient deductible, but objected to there being no limit to the amount of coinsurance that a beneficiary can incur per year or even for a single outpatient encounter. The commenter acknowledged that the amount of beneficiary copayment liability is set in statute but urged CMS to work with Congress to restore beneficiary coinsurance of hospital outpatient services to the level it views as appropriate.

Response: As the commenter indicated, the level of beneficiary coinsurance is set based on specific statutory criteria.

Comment: One commenter recommended that CMS work with Congress to restore the beneficiary coinsurance for hospital outpatient services to the appropriate level. By ''appropriate,'' we assume the commenter means that coinsurance for all OPPS services should be 20 percent, which is the coinsurance rate for other services paid under Medicare Part B.

Response: We appreciate the commenter's recommendation and will take it into consideration. However, until the statute at section 1833(t)(8)(C)(ii) of the Act is revised, the Secretary must adhere to the current requirements of the law, which caps the beneficiary coinsurance payment at 40 percent of the APC payment rate. In addition, the law requires that the coinsurance amount be no less than 20 percent of the APC rate.

Accordingly, we are adopting as final, for OPPS services furnished on or after January 1, 2006, our proposed methodology for calculating the beneficiary unadjusted copayment amount.

III. Ambulatory Payment Classification (APC) Group Policies

A. Introduction

1. Treatment of New HCPCS Codes Discussed in the CY 2006 OPPS Proposed Rule

During the second quarter of CY 2005, we created 11 HCPCS codes that were not addressed in the November 15, 2004 final rule with comment period that updated the CY 2005 OPPS. (Table 14 of the CY 2006 OPPS proposed rule.) We have designated the payment status of those codes and added them to the April update of the CY 2005 OPPS (Transmittal 514). In the proposed rule, we also solicited public comments on the proposed APC assignments of these services.

TABLE 7.—NEW HCPCS CODES IMPLEMENTED IN APRIL 2005

HCPCS code	Description
C9127	Injection, paclitaxel protein-bound particles, per 1 mg.
C9128	Injection, pegaptamib sodium, per 0.3 mg.
C9223	Injection, adenosine for therapeutic or diagnostic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270).
C9440	Vinorelbine tartrate, brand name, per 10 mg.
C9723	Dynamic infrared blood perfusion imaging (DIRI).
C9724	Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy.
Q4079	Injection, natalizumab, 1 mg.
Q9941	Injection, Immune Globulin, Intravenous, Lyophilized, 1 g.
Q9942	Injection, Immune Globulin, Intravenous, Lyophilized, 10 mg.
Q9943	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1 g.
Q9944	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 10 mg.

Further, consistent with our annual APC updating policy, we proposed to assign the new HCPCS codes for CY 2006 to the appropriate APCs and incorporate them into our final rule with comment period for CY 2006.

We did not receive any public comments on the new procedural C codes, their status indicators, or their APC assignments for the two new OPPS procedures (C9723 and C9724) implemented in April 2005. Therefore, we are adopting as final our proposal to assign these HCPCS codes C9723 and

C9724 for CY 2006 to the appropriate APCs, as shown in Addendum B of this final rule with comment period, without modification.

We received a number of public comments related to drugs described by new HCPCS codes implemented in April 2005 in the OPPS; specifically, HCPCS codes C9127, C9128, C9223, C9440, Q4079, Q9941, Q9942, Q9943, and Q9944. See section V. of this preamble (Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents) for a discussion of these comments, including comment summaries, our responses and a description of our final OPPS payment policies. In addition, our final payment policy for CY 2006 is included in Addendum B of this final rule with comment period.

2. Treatment of New CY 2006 HCPCS Codes

In the proposed rule, we proposed that we would assign new HCPCS codes for CY 2006 to appropriate APCs and/or status indicators and that we would implement them in our final rule. However, we received some comments regarding individual new HCPCS codes that commenters expect to be implemented for the first time in the CY 2006 OPPS. We do not specifically respond to those comments in this final rule. We could not discuss APC and/or status indicator assignments for new CY 2006 HCPCS codes in the proposed rule because the new CY 2006 HCPCS codes were not available when we issued the proposed rule. Rather, as has been our practice in the past, we implement new HCPCS codes in the OPPS final rule, at which time we invite public comment about our treatment of the new codes. We subsequently respond to those comments in the final rule for the following year's OPPS update.

New 2006 HCPCS codes are designated in Addendum B with Comment Indicator ''NI.'' The status indicator and/or APC assignments for all HCPCS codes flagged with Comment Indicator ''NI'', which are new 2006 HCPCS codes, are subject to public comment.

3. Treatment of New Mid-Year Category III CPT Codes

Twice each year, the AMA issues Category III CPT codes, which the AMA defines as temporary codes for emerging technology, services, and procedures. The AMA established these codes to allow collection of data specific to the service described by the code which otherwise could only be reported using a Category I CPT unlisted code. The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. In the past, CMS has treated new Category III CPT codes implemented in July of the previous year or January of the OPPS update year in the same manner that new Category I CPT codes and new Level II HCPCS codes implemented in January of the OPPS update year are treated; that is, we provide APC and/or status indicator assignments in the final rule updating the OPPS for the following calendar year. New Category I and Category III CPT codes, as well as new Level II HCPCS codes, are flagged with Comment Indicator ''NI'' in Addendum B of the final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPPS update.

We are concerned that not recognizing for 6 months (from July to January) the Category III codes that the AMA releases each January for implementation in July may hinder timely collection of data pertinent to the services described by the codes. Moreover, delay in recognizing these codes could inhibit access to the services they describe because of provider reluctance to furnish a service that defaults to the OPPS payment assigned to unlisted codes. Also, we have on occasion found redundancy between Category III CPT codes and some of the C-codes, which are only payable under the OPPS and created by us in response to applications for New Technology services. Therefore, beginning in CY 2006, we are modifying this process and recognizing Category III CPT codes that are released by the AMA in January to be effective beginning July of the same calendar year in which they are issued, rather than deferring recognition of those codes to the following calendar year update of the OPPS. Adopting this approach means that new Category III CPT codes will be recognized under the OPPS biannually rather than annually.

Some of the new Category III CPT codes may describe services that our medical advisors determine to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes may describe services that our medical advisors determine are not compatible with an existing clinical APC, yet are appropriately provided in the hospital outpatient setting. In these cases, we may assign the Category III CPT code to what we estimate is an appropriately priced New Technology APC. In other cases, we may assign a Category III CPT code one of several non-separately payable status indicators, including N, C, B, or E, which we feel is appropriate for the specific code. We expect that we will already have received applications for New Technology status for some of the services described by new Category III CPT codes, which may assist us in determining appropriate APC assignments. If the AMA establishes a Category III CPT code for a service for which an application has been submitted to CMS for New Technology status, CMS may not have to issue a temporary Level II HCPCS code to describe the service, as has often been the case in the past when Category III CPT codes were only recognized by the OPPS on an annual basis.

Therefore, beginning in July 2006, CMS will implement in the regular quarterly update of the OPPS the Category III CPT codes that the AMA releases in January 2006 for implementation in July 2006. CMS will implement in the January 2007 update of the OPPS the Category III CPT codes that the AMA releases in July 2006, and so forth.

B. Variations Within APCs

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of surgical, diagnostic, partial hospitalization services, and medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and brachytherapy devices.

We have packaged into each procedure or service within an APC group the cost associated with those items or services that are directly related

and integral to performing a procedure or furnishing a service. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: use of an operating, treatment, or procedure room; use of a recovery room; use of an observation bed; anesthesia; medical/surgical supplies; pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V of this preamble); and incidental services such as venipuncture. Our packaging methodology is discussed in section II.A. of this final rule with comment period.

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 hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0601 (Mid-Level Clinic Visits). The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make 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, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for CY 2006 OPPS and our responses to them are discussed in sections III.B. and III.C.4. of this preamble).

Finally, as discussed earlier, 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.

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group (''2 times rule''). We make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. The statute provides no exception 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 because these drugs are assigned to individual APCs.

During the APC Panel's February 2005 meeting, we presented median cost and utilization data for the period of January 1, 2004, through September 30, 2004, concerning a number of APCs that violated the 2 times rule and asked the APC Panel for its recommendation. After carefully considering the information and data we presented, the APC Panel recommended moving a total of 65 HCPCS codes from their currently assigned APCs to different APCs to resolve the 2 times rule violations. Of the 65 HCPCS code reassignments recommended by the APC Panel, we concurred with 58 of the recommended reassignments. Therefore, we proposed to reassign the HCPCS codes as indicated in Table 7 of the proposed rule (70 FR 42703).

The seven HCPCS code movements that the APC Panel recommended, but upon further review we proposed not to accept, are discussed below. We include in our discussion the assignments we also proposed and the final assignments for CY 2006.

a. APC 0146: Level I Sigmoidoscopy, APC 0147: Level II Sigmoidoscopy, APC 0428: Level III Sigmoidoscopy. APCs 0146 and 0147 were exceptions to the 2 times rule in CY 2005. At the time of the proposed rule, our analysis of those two APCs based on partial year CY 2004 data revealed greater violations of the 2 times rule and changing relative frequencies of simple and complex procedures in these two APCs. Thus, for CY 2006 the APC Panel assisted us in reconfiguring these two APCs into three related APCs to resolve the two times violations and improve their clinical and resource homogeneity based on the partial CY 2004 hospital claims data and to remove these APCs from the list of exceptions. The APC Panel recommended maintaining CPT codes 45303 (Proctosigmoidoscopy, rigid; with dilation) and 45305 (Proctosigmoidoscopy, rigid; with biopsy, single or multiple) in APC 0146 because the median cost for these codes appeared too high, and they believed that the CY 2004 claims were aberrant. In addition, the APC Panel recommended that CMS move CPT code 45309 (Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique) from APC 0147 and assign it to a new proposed APC 0428. Based on the results of our review of several years of claims data and our study of hospital resource homogeneity, we disagreed that those claims data were aberrant. We proposed to move CPT codes 45303 and 45305 to APC 0147 and to keep CPT 45309 in APC 0147, to resolve the 2 times rule violation.

We received no public comments concerning our proposed APC assignments for CPT codes 45303, 45305 and 45309 and are making final our proposal, without modification.

b. APC 0342: Level I Pathology, APC 0433: Level II Pathology, APC 0343: Level III Pathology. To resolve a 2 times rule violation, the APC Panel recommended moving CPT codes 88108 (Cytopathology, concentration technique, smears and interpretation) and 88112 (Cytopathology, selective cellular enhancement technique with interpretation, except vaginal or cervical) from APC 0343 to a proposed new APC 0433. The APC Panel also recommended moving CPT codes 88319 (Determinitive histochemistry or cytochemistry to identify enzyme constituents) and 88321 (Consultation and report on referred slides prepared elsewhere) from APC 0342 to a proposed new APC 0433. Based on the results of our review of several years of hospital claims data and our study of hospital resource homogeneity, we proposed a different way to resolve the 2 times rule violation. We proposed to place CPT codes 88319 and 88112 in APC 0343 and to place CPT codes 88108 and 88321 in new APC 0433.

We received no public comments concerning our proposal.

We will finalize, without modification our proposal to assign CPT codes 88112 and 88319 to APC 0343 and to assign CPT codes 88108 and 88321 to new APC 0433.

c. Other Comments on the Proposed List of APC Assignments to Address 2 Times Violations. We received a few comments concerning our proposed reassignments for several of the other

HCPCS codes (for example, CPT codes 57155, 75790, and 88187) indicated in Table 7 of the proposed rule (70 FR 42703) and the responses are included in clinically relevant sections, elsewhere in this preamble.

After carefully reviewing our final data and all comments received concerning our proposed assignments of the 58 HCPCS codes, we are finalizing those assignments as proposed.

3. Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. At the time of the proposed rule, taking into account the APC changes that we proposed for CY 2006 based on the APC Panel recommendations discussed in section III.B.1. of this preamble and the use of CY 2004 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule criteria. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration
- Frequency of service (volume)
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, refer to the April 7, 2000 OPPS final rule with comment period (65 FR 18457).

Table 8 published in the proposed rule (70 FR 42705) listed the APCs that we proposed to exempt from the 2 times rule based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we proposed for CY 2006. The median costs for hospital outpatient services for these and all other APCs can be found on the CMS Web site: *http//www.cms.hhs.gov.*

We received a number of comments about some of the procedures assigned to APCs that we proposed to make exempt from the 2 times rule for CY 2006. Those discussions are elsewhere in the preamble, in sections related to the types of procedures that were the subject of the comments.

For the proposed rule the listed exceptions to the 2 times rule were based on data from January 1, 2004 through September 30, 2004. For this final rule with comment period, we used data from January 1, 2004 through December 31, 2004. Thus, after responding to all of the comments on the proposed rule and making changes to APCs based on those comments, we analyzed the full CY 2004 data to identify APCs with 2 times rule violations.

Based on those final data, we found that there were 41 APCs with 2 times violations. We were able to remedy two violations of the 2 times rule that appeared in the final data for APC 0363 (Level I Otorhinolaryngologic Function Tests) and APC 0010, (Level I Destruction of Lesion). We moved CPT code 92588 (Evoked otoacoustic emissions; comprehensive or diagnostic evaluation) from APC 0363 to APC 0660 (Level II Otorhinolaryngologic Function Tests) to address a 2-times violation in APC 0363. We applied the criteria as described earlier to finalize the APCs that are exceptions to the 2 times rule for CY 2006.

Listed below in Table 8 is the final revised list of APCs that are exceptions to the 2 times rule for CY 2006.

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Table 8.--APC Exceptions to the 2 Times Rule For CY 2006

APC	APC Description
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow
0010	Level I Destruction of Lesion
0019	Level I Excision/ Biopsy
0024	Level I Skin Repair
0043	Closed Treatment Fracture Finger/Toe/Trunk
0046	Open/Percutaneous Treatment Fracture or Dislocation
0047	Arthroplasty without Prosthesis
0060	Manipulation Therapy
0081	Non-Coronary Angioplasty or Atherectomy
0093	Vascular Reconstruction/Fistula Repair without Device
0099	Electrocardiograms
0105	Revision/Removal of Pacemakers, AICD, or Vascular
0120	Infusion Therapy Except Chemotherapy
0140	Esophageal Dilation without Endoscopy
0141	Level I Upper GI Procedures
0148	Level I Anal/Rectal Procedures
0164	Level I Urinary and Anal Procedures
0191	Level I Female Reproductive Proc
0203	Level IV Nerve Injections
0204	Level I Nerve Injections
0235	Level I Posterior Segment Eye Procedures
0245	Level I Cataract Procedures without IOL Insert
0251	Level I ENT Procedures
0252	Level II ENT Procedures
0262	Plain Film of Teeth
0274	Myelography
0297	Level II Therapeutic Radiologic Procedures
0303	Treatment Device Construction
0312	Radioelement Applications
0314	Hyperthermic Therapies
0325	Group Psychotherapy
0330	Dental Procedures
0341	Skin Tests
0353	Level II Injections
0397	Vascular Imaging
0409	Red Blood Cell Tests
0432	Health and Behavior Services
0600	Low Level Clinic Visits
0664	Level I Proton Beam Radiation Therapy
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver

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C. New Technology APCs

1. Introduction

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable 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. 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.

Every year we receive many requests for higher payment amounts for specific procedures under the OPPS because they require the use of expensive equipment. We are taking this opportunity to respond in general to the issue of hospitals' capital expenditures as they relate to the OPPS and Medicare.

Under the OPPS, our goal is to make payments that are appropriate for the services that are necessary for treatment of Medicare beneficiaries. The OPPS and most other Medicare payment systems are budget neutral and so, although we do not pay full hospital costs for procedures, we believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings. Further, we believe that our rates are adequate to assure access to services for most beneficiaries.

For many emerging technologies there is a transitional period during which utilization may be low, often because providers are first learning about the techniques and their clinical utility. Quite often, the requests for higher payment amounts are for new procedures in that transitional phase. The requests, and their accompanying estimates for expected Medicare beneficiary or total patient utilization, often reflect very low rates of patient use, resulting in high per use costs for which requestors believe Medicare should make full payment. Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on Medicare beneficiary projected utilization and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment. For the OPPS, we rely on hospitals to make their business decisions regarding acquisition of high cost capital equipment taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payors' payment policies.

As stated earlier, in a budget neutral environment we do not make payments that fully cover hospitals' costs, including those for the purchase and maintenance of capital equipment. We rely on providers to make their decisions regarding the acquisition of high cost equipment with the understanding that the Medicare program must be careful to establish its initial payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost efficient hospital outpatient settings. As the OPPS acquires claims data regarding hospital costs associated with new procedures, we will regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPPS payments remain appropriate for procedures as they transition into mainstream medical practice.

2. Refinement of New Technology Cost Bands

In the November 7, 2003 final rule with comment period, we last restructured the New Technology APC groups to make the cost intervals more consistent across payment levels (68 FR 63416). We established payment levels in $50, $100, and $500 intervals and expanded the number of New Technology APCs. We also retained two parallel sets of New Technology APCs, one set with a status indicator of ''S'' (Significant Procedure, Not Discounted When Multiple) and the other set with a status indicator of ''T'' (Significant Procedures, Multiple Reduction Applies). We did this restructuring because the number of procedures assigned to New Technology APCs had increased, and narrower cost bands were necessary to avoid significant payment inaccuracies for new technology services. Therefore, we dedicated two new series of APCs to the restructured New Technology APCs, which allowed us to narrow the cost bands and afforded us the flexibility to create additional bands as future needs dictated.

As the number of procedures that qualify for placement in the New Technology APCs has continued to increase over the past 2 years, we recognized that the $0 to $50 cost band represented by ''S'' status APC 1501 (New Technology, Level I, $0–$50) and ''T'' status APC 1538 (New Technology, Level I, $0–$50) spanned too broad of a cost interval to accurately represent the lower costs of an ever-increasing number of procedures that are appropriate for New Technology APC assignment. Therefore, we proposed to refine this cost band to five $10 increments, resulting in the creation of an additional 10 New Technology APCs to accommodate the two parallel sets of New Technology APCs, one set with a status indicator of ''S'' and the other set with a status indicator of ''T.'' We also proposed to eliminate the two $0 to $50 cost band New Technology APCs 1501 and 1538, so that the cost bands of all New Technology APCs would continue to be mutually exclusive. Table 9 published in the proposed rule (70 FR 42706) contained a listing of the 10 additional New Technology APCs that we proposed for CY 2006.

As we explained in the November 30, 2001 final rule (66 FR 59897), 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, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost. Therefore, we proposed to discontinue New Technology APCs 1501 and 1538, and reassign the procedures currently assigned to them to proposed New Technology APCs 1491 through 1500. Table 10 published in our proposed rule (70 FR 42707) summarized these proposed New Technology APC reassignments.

We received no public comments in response to our proposed refinement of the New Technology APC cost bands. Therefore, for CY 2006, we are finalizing our proposal to discontinue New Technology APCs 1501 and 1538, and reassign the procedures currently assigned to them to New Technology APCs 1491 through 1500. Table 9 lists the final New Technology APCs 1491 through 1500 for CY 2006.

TABLE 9.—NEW TECHNOLOGY APCS FOR CY 2006

APC	Descriptor	Status Indicator	Final CY 2006 payment rate
1491	New Technology—Level IA ($0–$10)	S	$5
1492	New Technology—Level IB ($10–$20)	S	15
1493	New Technology—Level IC ($20–$30)	S	25
1494	New Technology—Level ID ($30–$40)	S	35
1495	New Technology—Level IE ($40–$50)	S	45
1496	New Technology—Level IA ($0–$10)	T	5
1497	New Technology—Level IB ($10–$20)	T	15
1498	New Technology—Level IC ($20–$30)	T	25
1499	New Technology—Level ID ($30–$40)	T	35
1500	New Technology—Level IE ($40–$50)	T	45

3. Requirements for Assigning Services to New Technology APCs

In the April 7, 2000, final rule (65 FR 18477), we created a set of New Technology APCs to pay for certain new technology services under the OPPS. We described a group of criteria for use in determining whether a service is eligible for assignment to a New Technology APC. We subsequently modified this set of criteria in our November 30, 2001, final rule (66 FR 59897 to 59901), effective January 1, 2002. These modifications were based on changes in the data (we were no longer required to use CY 1996 data to set payment rates) and on our continuing experience with the assignment of services to New Technology APCs.

In the course of reviewing applications for New Technology APC assignments under the OPPS, we have encountered many situations in which there is extremely limited clinical experience with new technology services regarding their use and efficacy in the typical Medicare population. In some cases, there has been ambiguity regarding how the new technology services fit within the standard coding framework for established procedures, and there may be no specific coding available for the new technology services in other settings or for use by other payers. Nevertheless, applicants requesting assignment of services to New Technology APCs request that we provide billing and payment mechanisms under the OPPS for the new technology services through the establishment of codes, descriptors, and payment rates. As stated in section I.F. of this preamble, we remain committed to the overarching goal of ensuring that Medicare beneficiaries have timely access to the most effective new medical treatments and technologies in clinically appropriate settings. In the CY 2006 proposed rule, we indicated that we believed that our current New Technology APC assignment process helps to assure such access, and that an enhancement to the New Technology APC application process might further encourage appropriate dissemination of and Medicare beneficiary access to new technology services.

We are interested in promoting review of the coding, clinical use, and efficacy of new technology services by the greater medical community through our New Technology APC application and review process for the OPPS. Therefore, in addition to our current information requirements at the time of application, we proposed to require that an application for a code for a new technology service be submitted to the American Medical Association's (AMA's) CPT Editorial Panel before we accept a New Technology APC application for review. In making this proposal, we specifically indicated that we would not change our current criteria for assignment of a service to a New Technology APC. Rather, the intent of the proposed new requirement was to encourage timely review of a new service or procedure by the wider medical community as CMS is reviewing it for possible new coding and assignment to a New Technology APC under the OPPS. The AMA's CPT Editorial Panel has only one CPT code application that is used by applicants requesting consideration for either Category I or III codes. We indicated that we would accept either a Category I or Category III code application to the CPT Editorial Panel. The application requests relevant clinical information regarding new services, including their appropriate use and the patient populations expected to benefit from the services, which would provide us with useful additional information. CPT code applications are reviewed by the CPT Editorial Panel, whose members bring diverse clinical expertise to that review. In the proposed rule, we indicated our belief that consideration by the CPT Editorial Panel might facilitate appropriate dissemination of the new technology services across delivery settings and bring to light other needed coding changes or clarifications. We further proposed that a copy of the submitted CPT application be filed with us as part of the application for a New Technology APC assignment under the OPPS, along with CPT's letter acknowledging or accepting the coding application. We reminded the public that we do not consider an application complete until all informational requirements are provided. In addition, we reminded the public that when we assign a new service a HCPCS code and provide for payment under the OPPS, these actions do not imply coverage by the Medicare program, but indicate only how the procedure or service may be paid if covered by the program. Fiscal intermediaries must determine whether a service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment. CMS may also make National Coverage Determinations (NCDs) on new technology procedures.

We received a large number of public comments concerning our proposal.

Comment: Many commenters suggested that the AMA CPT Editorial Panel may not be the most appropriate forum for a federally mandated decision. Some of these commenters pointed out that meetings of the panel and the considerations on which it bases decisions are not open to the public. Other commenters questioned whether there is an inherent conflict in the proposal, as CMS and the AMA are distinctly separate organizations with different objectives and constituencies, so that it may not be in the interest of Medicare beneficiaries to tie CMS policy to proceedings of the AMA. Other commenters suggested that even the requirement that the AMA acknowledge receipt of the coding application suggests that the AMA has potential ''veto'' power over CMS authority and

may thus constitute an unlawful delegation of federal decision making.

Response: We wish to clarify that it was not our proposal to rely upon the decisions of the CPT Editorial Panel. Nor did we propose to adopt the objectives or policies of the AMA or the CPT Editorial Panel. Rather, we proposed only to require initiation of the process for obtaining a CPT code in order to foster the common objective of appropriately recognizing new technology services and properly coding those services. Under our proposal, we would continue to make determinations about the need for new HCPCS codes and about appropriate assignments to New Technology APCs to establish payment rates completely independently of the CPT Editorial Panel. We also proposed only that the applicant show us a letter of acknowledgement or receipt from the AMA, not that the AMA would send us such a letter or withhold such a letter as a way to exercise veto power.

Comment: One commenter stated that while it is possible for manufacturers to file CPT applications to the AMA, the AMA has usually discouraged this practice and specialty societies have been slow to support CPT applications not vetted through them. Another commenter indicated that manufacturers are often not in receipt of letters from the AMA indicating receipt of a CPT coding application, and hence may not be able to provide these letters with their application for New Technology APC assignment. Other commenters claimed that if a manufacturer waits to gather clinical and utilization information sufficient to support a Category I code, the application may no longer meet CMS's definition of ''truly new'' and may be ineligible for a New Technology APC assignment.

Response: Our proposal did not specifically require that manufacturers submit applications to the CPT Editorial Panel. In fact, we specifically proposed only that such an application ''be submitted,'' and did not stipulate the identity of the applicant. In addition, we were not proposing to require that manufacturers provide us with copies of letters they had received directly from the AMA. We understand, however, that manufacturers ordinarily work in concert with the actual applicants for new CPT codes, and expect that it is reasonable for a manufacturer to be able to obtain such a letter. We also specifically required only the initiation of the application process, not the receipt of a positive (or negative) decision by the CPT Editorial Panel, in order to prevent the process from delaying our decision beyond the point at which a New Technology APC assignment is appropriate. Our proposal was meant only to encourage the appropriate dissemination of information, data collection, and review by the wider medical community concerning new technologies. Finally, it is worth emphasizing that while our objective is to consider for assignment to New Technology APCs services that represent technologies that are ''truly new,'' for designation under the OPPS we specifically rely on our criteria which require that a service or procedure not be described by any existing HCPCS code or combination of codes, that it cannot be adequately represented in the claims data being used for the most current annual OPPS update, and that there is no appropriate clinical APC for its assignment. We do not believe that our proposal to require initiation of the CPT application process would result in delays beyond the point at which these criteria could still be met.

Comment: One commenter stated that there are only three submission deadlines per year for CPT applications, which do not comport to the quarterly schedule for filing New Technology applications to CMS.

Response: The filing dates for New Technology applications are informational dates published on our website as reference points for application receipt related to the earliest date for adding a new code for an approved service to a New Technology APC, that is, the beginning of the following quarter. The actual dates for adding new services, if approved, are often later than the next quarter, depending on specific issues related to comprehensive evaluation of a specific application, which often involves requests for additional information.

Comment: One commenter recommended as an alternative that CMS create codes for qualifying services and assign them to a New Technology APC and stipulate that those applicants must apply to the CPT Editorial Panel for a new code within one year.

Response: We do not believe that it would be advisable to accept this recommendation. First, we do not have a policy of making contingent approvals for payment. All requirements for Medicare payment must be met at the time a code and payment rate are established. In addition, this recommendation would require establishing a mechanism to monitor compliance with the condition of approval. Finally, the necessity of withdrawing some HCPCS codes from coding and payment because of non-compliance has great potential for causing confusion among providers.

Comment: One commenter stated that our concern about limited experience with new technologies in the Medicare population is more appropriately related to coverage of new procedures, rather than to coding issues. Assignment of a service to a New Technology APC is meant to create a mechanism for gathering utilization data, and does not guarantee coverage and payment of a technology. Coverage for new technologies remains the discretion of Medicare contractors, unless CMS makes a national coverage determination. This commenter claimed that the proposal to require a CPT coding application implies that CMS would be effectively removing the Medicare contractors from the coverage decision-making process.

Response: We do not believe that our proposal would have the effect of removing Medicare contractors from the process of making coverage decisions, or otherwise usurp the role of the coverage decision-making process. Rather, the proposal would serve merely to promote evaluation of new services by the wider medical community, so that the results of this evaluation could serve to assist in broader distribution of new clinical information, establishment of appropriate standard coding, and wider dissemination of promising technologies. Even when the CPT Editorial Panel establishes a new code, Medicare contractors have discretion to make local coverage decisions, and CMS retains the right to make national coverage determinations with regard to the procedure or service.

Comment: Some commenters indicated that there are unique payment concerns related to applying for a Category III CPT code, asserting that many Medicare contractors view Category III CPT codes as an indication that a technology is experimental or investigational. One commenter provided as an example a proposed and final policy of one CMS contractor not to cover any technologies described by Category III CPT codes, ''since these codes have been created to track new, unproven therapies and tests.'' Another commenter claimed that assignment of a Category III CPT code often results in non-coverage decisions by both local carriers and fiscal intermediaries.

Response: The example provided by commenters about the implications of Category III CPT codes for coverage decisions by Medicare contractors appears to be relevant outside the context of the OPPS, mainly within the physician payment context. We have been unable to identify any fiscal

intermediary that has adopted any such broad noncoverage policy regarding Category III CPT codes.

Comment: One group of commenters urged us not to adopt the proposed requirement that a CPT application submission to the AMA's CPT Editorial Panel be required before we accept a New Technology APC application for review. These commenters asserted that a CPT coding application, in and of itself, will not provide us with input from the greater medical community, unless we wait until the CPT Editorial Panel has made a coding decision and that decision has been made public. Because of the timing of the CPT code review process, it is not reasonable for CMS to wait until the CPT Editorial Panel has made a public coding decision, which can take 6–12 months for an internal decision, and 6–24 months before publishing a coding decision for a Category I code. These commenters also believed that this requirement would delay access to new services, asserting that applying for a CPT code is a lengthy process and involves months of gathering information on the technology and its use, working with relevant specialty societies to obtain support for a new code and to develop a clinical vignette, and consulting within the CPT Editorial Panel. In order to obtain a Category I code, the new technology must have widespread usage across the country and in multiple locations, and its efficacy must be documented in U.S. peer-reviewed journal articles. Other commenters stated that a number of issues regarding the CPT coding process make our proposal impractical, in addition to the lack of a guaranteed timely review by the CPT Editorial Panel. The AMA does not have ''official'' evidence and utilization thresholds for coding applications. However, commenters indicated that physician specialty societies often require certain thresholds of utilization or clinical evidence be met before a Category I CPT application for a new service is submitted, and there is considerable variation in such thresholds among the specialty societies. If a manufacturer submits an application without society support or before there is widespread utilization, the application is more likely to be denied or assigned a Category III CPT code, even if that was not requested. Some commenters indicated that there are payment concerns in applying for a Category III CPT code, asserting that most private payers view Category III CPT codes as indication that a technology is experimental or investigational, and therefore refuse to cover procedures or services described by Category III CPT codes. These commenters asserted that because of the risk of non-coverage of Category III CPT codes, manufacturers may forego applying for New Technology APC assignments, or will be hesitant to apply for both a New Technology APC assignment and CPT code simultaneously. Without unique service codes, it will be more difficult for CMS to track new services and eventually to assign them to clinically appropriate APCs. The result will be fewer New Technology APC applications, and less beneficiary access to new technologies. A few commenters asserted that little would be gained by the mere filing of a CPT application without a coding determination from the CPT Editorial Panel, because the information in both applications is similar. One commenter suggested that if there is information from the CPT application that CMS requires to evaluate the New Technology APC application, we should add such questions to our application.

In lieu of using the CPT coding process to encourage review by the wider medical community, a few commenters recommend that CMS appoint a standing advisory committee of clinical representatives, or another independent group of medical experts from specialties and hospitals, to review New Technology APC applications and provide input to CMS. Other commenters also suggested that we convene an independent group of medical experts to assist in the review of applications as necessary.

A number of other commenters, principally from hospitals and hospital associations, supported our proposal to require a CPT application prior to our consideration of a New Technology APC application because they favored less ambiguity in the coding framework. Some of these commenters said that there is a proliferation of C-codes and G-codes, which are burdensome to hospitals as such codes are often not recognized by other payers, and our proposal will minimize the need for expedited issuance of C-codes or G-codes. They asserted that hospitals would benefit by reduced duplication of codes for services recognized by Medicare and other payers. Other commenters claimed that the correct process for coding new services is to start by way of the CPT Editorial Panel review process rather than the New Technology APC application process. Other commenters also supported the requirement on the grounds that the CPT review process is rigorous, including input by physician specialty societies, which indicates the level of acceptance of a new technology in the medical community, relevant to the OPPS because physicians perform new technology procedures in the hospital setting. One commenter indicated that there may be specific occasions when it is necessary to submit applications to the CPT Editorial Panel and CMS simultaneously. Another commenter requested that we recognize potential delays resulting from this additional step and expedite our review of New Technology APC applications. Finally, one commenter indicated appreciation of the reasons for the proposal, but asked that this new requirement remain as stated, that an application needs to be submitted to the AMA CPT Editorial Panel, but that it did not necessarily need to be reviewed and processed by the CPT Editorial Panel prior to CMS's consideration of the New Technology APC application.

Response: In light of the strong division among the commenters on the merits of our proposal to require that a CPT coding request be submitted prior to submission of a New Technology APC application, we have decided not to adopt this proposal at this time. Many of the comments reflect confusion about the specifics of the proposal. Therefore, we are concerned that, because the commenters did not understand some specifics of this proposal during their review of the CY 2006 proposed rule, we may similarly not be in a position to understand all the implications of the concerns noted by the commenters. In particular, we did not intend to tie our decision-making regarding applications for New Technology APC assignment to the CPT Editorial Panel process, but wished to promote review of the coding, clinical use, and efficacy of new technology services by the wider medical community to facilitate the swift spread of promising new technologies into medical practice.

While we are deferring our proposal, we continue to believe that timely review of potential new services by the wider medical community is valuable, given our experience that many services that have requested OPPS coding and assignment to a New Technology APC have demonstrated limited clinical efficacy. We also continue to believe that new technology services deserve timely standard and comprehensive coding established through the CPT Editorial Panel review process to permit appropriate payment and data collection regarding their utilization patterns and clinical outcomes. We also do not agree with many of the criticisms directed against the proposal. For example, as stated previously, we do not agree that

our proposal to have applicants file a CPT coding request before submission of a New Technology APC application would make the CPT coding process a Federal decisionmaking forum. This is because we would not require a decision to be made by the CPT Editorial Panel. However, in light of the numerous and considered comments opposed to the proposal, we are not proceeding with it at this time.

At the same time, we remain committed to the general goal of promoting review of the coding, clinical use, and efficacy of new technology services by the wider medical community. We continue to believe that such broad and early review of new technology procedures would enhance our ability to make appropriate initial and subsequent decisions on assignments of new services to New Technology APCs and would facilitate the more rapid dissemination of promising new technologies to all service settings and appropriate patient populations. Therefore, we will continue to study how to best achieve these goals of timely review of new technologies by the general medical community to validate their clinical worth and distinctiveness in comparison with existing services and to promote more rapid dissemination of effective new procedures throughout standard medical practice. In doing so, we will continue to consider whether the proposal we advanced would serve that goal. We would specifically welcome further input on this proposal or alternatives to it. We may reintroduce this proposal or advance alternative approaches at a later date.

As a preliminary matter, we are not inclined to accept one alternative recommended by some commenters. Specifically, we are not inclined to establish a standing advisory committee to provide input on New Technology applications to the OPPS, as some have suggested. A standing committee involving outside experts would add additional review time that would impede upon our application process, as well as prevent us from evaluating New Technology applications for addition to the OPPS on a quarterly basis, as appropriate. We prefer to maintain the flexibility that our current process provides. In addition, the specific medical expertise required to evaluate new technologies would likely vary widely from application to application. This factor would render consultation with a standing advisory committee with fairly stable membership more difficult to maintain.

4. New Technology Services

a. Ablation of Bone Tumors

Comment: One commenter requested that we reassign CPT code 20982 (Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance) from New Technology Level XX, APC 1557 to New Technology Level XXII, APC 1559. The commenter stated that the procedure has been in New Technology APC 1557 for 2 years, and that the payment rate for that APC is not adequate to cover the hospitals' costs. The commenter asserted that assignment to that APC was based on inadequate information. The commenter used physician practice expense data to estimate costs to perform the ablation procedure, and stated that the costs far surpass the OPPS payment amount, largely due to the high cost of the necessary radiofrequency probe. Further, the commenter added that its analysis found that 2 of the 16 single claims CMS used to calculate the median cost for CPT code 20982 for the proposed rule were inaccurate because no charge for the ablation device, as indicated by the absence of a separate supply charge, was included. The commenter believed that those two claims had a significant effect on the median cost for CPT code 20982, because of the small number of claims for the procedure. The commenters' analysis further showed that the median cost for these procedures was $2,156 based on 14 claims that included a supply charge.

Response: As we have stated in this preamble, we are committed to relying on our claims data for making APC assignments as much as possible. While we appreciate the external data provided by the commenter regarding the costs of supplies associated with the practice expense inputs for the Medicare Physician Fee Schedule, that payment system utilizes a different methodology for establishing payment for services that is not directly applicable to payment rates under the OPPS. In the case of CPT code 20982, we believe that our hospital claims data are adequate to support our proposal to maintain the service in New Technology APC 1557 for CY 2006. CPT code 20982 was a new code for CY 2004 so we have 1 year of hospital data for this procedure. For CPT code 20982, we have 17 single claims from CY 2004 with a procedure-specific median cost of $1,578. As we do not require that hospitals bill a separate supply charge for the probe that is used for this service because there is no specific device C-code available, we have no reason to believe that claims for CPT code 20982 without a separate supply charge do not contain charges for all costs associated with the procedure. The catheter charges may be wrapped into the charge for the procedure itself. The code-specific median indicates that even the current New Technology APC payment at $1,850 may be too high, but given the information provided by the commenter and the relatively low number of CY 2004 claims available for calculating the median cost for CPT code 20982, we are finalizing our proposal for CY 2006 and are retaining CPT code 20982 for at least 1 more year in New Technology APC 1557.

b. Breast Brachytherapy

Comment: In response to the November 15, 2004 final rule with comment period (69 FR 65682), one commenter applauded our assignment of CPT codes 19296 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application) and 19298 (Placement of radiotherapy afterloading balloon catheters, multiple tube and button type, into the breast for interstitial radioelement application) to New Technology APC 1524 (Level XIV $3000–$3500), and CPT code 19297 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application; concurrent with partial mastectomy) to New Technology APC 1523 (Level XXIII $2500–$3000) for CY 2005. The commenter stated that these payment amounts adequately cover the costs of the applicator devices involved in the procedures.

Response: We agree with the commenter's acknowledgement that the payment amounts that we assigned to CPT codes 19296, 19297, and 19298 for CY 2005 adequately cover the resource costs associated with these procedures. Therefore, for CY 2006, we are maintaining CPT codes 19296 and 19298 in New Technology APC 1524 and CPT code 19297 in New Technology APC 1523.

c. Enteryx Procedure

A new CPT code, 0133T (Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with injection of implant material into and along the muscle of the lower esophageal sphincter (e.g., for treatment of gastroesophageal reflux disease)), was created for implementation January 1, 2006 to describe the procedure currently coded under the OPPS as HCPCS code C9704 (Injection or insertion of inert substance

for submucosal/intramuscular injections(s) into the upper gastrointestinal tract, under fluoroscopic guidance). For CY 2005, C9704 was assigned to New Technology APC 1556, with a payment rate of $1,750. As discussed below, we determined an appropriate APC assignment for this procedure for CY 2006. However, in the period between publication of the proposed rule and the end of the comment period, the product manufacturer recalled this product and the Food and Drug Administration has warned physicians about the danger of its use.

In our analyses to determine the most appropriate APC assignment for the new CPT code, we found that the most accurate payment will be made by retaining the procedure's current APC assignment. We did not automatically assign CPT code 0133T to APC 1556 because that CPT code explicitly includes the endoscopy that is integral to the service, whereas the current C-code does not. For that reason we calculated the claims-based median cost for the procedure by using single claims for HCPCS code C9704, on the premise that if the procedure required endoscopy and the endoscopy was not separately billed then the endoscopy charges were reflected in the charges for HCPCS code C9704 as well as claims for HCPCS code C9704 that had a charge for an endoscopy included to assure us that we were capturing the charges for the entire procedure from as many claims as possible. Thus, to determine an appropriate APC placement for CPT code 0133T we analyzed all single claims for HCPCS code C9704, as well as claims that had HCPCS code C9704 combined with either CPT code 43234 (Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible endoscope)), or CPT code 43235 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing).

The median cost from these claims which would crosswalk to the new CPT code is $1,660. Therefore, we believe that it is still appropriate to retain the procedure, coded for CY 2006 as CPT code 0133T, in New Technology APC 1556 rather than assigning it to a different New Technology APC or a clinical APC at this time. We will be deleting HCPCS code C9704. As with all procedures assigned to New Technology APCs, we will reevaluate it for next year to determine whether assignment to a clinical APC is more appropriate.

d. Extracorporeal Shock Wave Treatment

Comment: Several commenters to both the November 15, 2004 final rule with comment period and to our July 25, 2005 proposed rule opposed our placement of new HCPCS codes for high energy Extracorporeal Shock Wave Therapy (ESWT) services into New Technology APC 1547. In response to a New Technology application for ESWT, we created new codes for high energy ESWT for chronic lateral epicondylitis (C9720-tennis elbow) and for chronic plantar fasciitis (C9721) effective January 1, 2005, and placed them into New Technology APC 1547, with a payment rate of $850 for CY 2005. A number of commenters requested that these ESWT services be placed in New Technology APC 1559, which has a payment rate of $2,250. A manufacturer of ESWT equipment, who commented, cited our regulations (42 CFR § 419.31) in stating that APC groups ''must be'' comparable in terms of clinical use and resources required. This commenter, as well as another manufacturer, claimed that New Technology APC 1547 does not cover the costs of the ESWT procedures for chronic lateral epicondylitis and for chronic plantar fasciitis. The commenters provided their estimated costs of the procedure at about $2,300 per service for both clinical indications. One commenter also indicated that it understood that the AMA's CPT Editorial Panel intended to issue new codes for the two high energy ESWT services beginning in CY 2006. It stated that when these new CPT codes become effective, providers and payers will be faced with two different sets of codes for high energy ESWT, the CPT codes and the HCPCS C-codes, and this will cause difficulties with provider billing and reimbursement.

Commenting parties expressed their belief that our placement of ESWT did not cover the costs of ESWT for plantar fasciitis, claiming that the ESWT equipment costs between $250,000 and $400,000 for each unit, varying by manufacturer, and summarizing other additional costs, such as those for an annual maintenance contract, a specialized technician, and anesthesia, along with a specialized transport vehicle for the ESWT equipment. Commenters asserted that high energy ESWT is comparable to the resource costs of services in Level II Foot Musculoskeletal Procedures, APC 0056 with a CY 2005 payment rate of $2,380.72, except that ESWT includes the capital costs for the equipment, transport vehicle, and technician mentioned earlier. The commenters also stated that high energy ESWT has a similar technology and cost structure, including technological devices, maintenance contracts, and specialized technical personnel, to extracorporeal shock wave lithotripsy, for the fragmentation of kidney stones. These commenters proposed that high energy ESWT be placed in APC 1559. One hospital indicated that its average cost for ESWT is $2,100. Another commenter who compared high energy ESWT with lithotripsy stated that if we wished to compare ESWT with the costs of other procedures, then we should use lithotripsy, which also employs high energy extracorporeal shock waves, but for the treatment of kidney stones. The commenter claimed that many of the other costs associated with the two procedures were similar as well, with the exception of an imaging component used with lithotripsy. The commenter noted that lithotripsy's APC assignment, APC 0169, has a payment rate close to that of New Technology APC 1559. Another commenter, commenting only on HCPCS code C9721, recommended that high energy ESWT for treatment of chronic plantar fasciitis be placed in either clinical APC 0055 (Level I Foot Musculoskeletal Procedures) or APC 0056 (Level II Foot Musculoskeletal Procedures), claiming that it fits most closely clinically to procedures in APC 0055, and that high energy ESWT is more homogeneous to either APC 0055 or 0056 clinically and economically than to its assigned New Technology APC. The commenter also stated that any new CPT code beginning in CY 2006 for high energy ESWT for chronic plantar fasciitis should replace HCPCS code C9721 and should be placed in APC 0055 or 0056.

Response: When we determine that a new service is eligible for placement into a New Technology APC, we then perform our own cost analysis and cost estimate, in addition to taking the projected costs submitted in a New Technology APC application into consideration. As we stated in our November 30, 2001 final rule (66 FR 59900) concerning placement of new services into APCs, ''* * * we will not limit our determination of the cost of the procedure to information submitted by the applicant. Our staff will obtain information on cost from other appropriate sources before making a determination of the cost of the procedure to hospitals.'' We compared the necessary hospital resources such as procedure room time, personnel, anesthesia and other resources of the ESWT procedure to various other procedures for which we have historical

hospital claims data. Additionally, we took into consideration projected costs submitted in the New Technology APC application, including the capital costs and equipment utilization assumptions, concluding that HCPCS codes C9720 and C9721 should be assigned to New Technology APC 1547. New Technology APCs, by their very definition, do not contain services that are clinically homogeneous, but instead, based solely on hospital resource considerations, the services have estimated costs that place them into the same New Technology payment band. In contrast, services assigned to the same clinical APC are homogeneous with respect to both their clinical characteristics and hospital resource utilization.

There are new CPT codes for CY 2006 that describe high energy ESWT services, and hospitals providing these services in CY 2006 will use the CPT codes to report them instead of the two predecessor C codes. In particular, CPT code 0102T (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle) will replace HCPCS code C9720. In addition, CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia) will replace HCPCS code C9721. We have closely reviewed the hospital cost information provided by the commenters, along with our CY 2004 hospital claims data for other outpatient hospital services. We are not confident yet, in the absence of hospital claims data for the predecessor C codes or the new CPT codes, that we can appropriately place CPT codes 0102T and 28890 in clinical APCs where they would share clinical and resource homogeneity with other services. Therefore, for CY 2006 we are assigning CPT codes 0102T and 28890 to New Technology APC 1547 with a payment rate of $850. We believe that the payment rate is appropriate based on all cost and utilization information available to us regarding high energy ESWT and other services provided in a hospital outpatient setting.

Comment: One commenter, the applicant for assignment of high energy ESWT to a New Technology APC, claimed that our assignment of ESWT to a New Technology APC violates the Administrative Procedure Act (APA). The commenter asserted that the OPPS proposed rule published August 16, 2004 (69 FR 50448) failed to mention ESWT or its placement in an APC. Moreover, the commenter claimed that our lack of discussion of our methodology made proper comments difficult if not impossible. The commenting party claimed that finalizing a rule without explanation is unlawful. The commenter furthermore claimed that the placement of ESWT in APC 1547 was arbitrary, capricious, and in excess of statutory authority in violation of the Administrative Procedure Act. The commenter claimed that it appeared that CMS ignored the applicant's data that it submitted regarding resource use, instead comparing the resource costs for ESWT with entirely different procedures, resulting in inaccurate conclusions regarding the costs of ESWT services. Moreover, the commenter claimed that we have improperly classified ESWT into the same APC as endoscopic epidural lysis, which it claims violated the statutory requirement to group procedures based on both costs and clinical and resource comparability.

Response: We disagree that our assignment of ESWT to New Technology APC 1547 was arbitrary, capricious, and in violation of the APA or the Medicare statute. As stated in our response above, we perform our own cost analysis and estimate the cost of any eligible new service, while taking the projected hospital costs submitted in the New Technology APC application into consideration. As we have indicated above, our November 30, 2001 final rule concerning placement of new services into APCs states that we do not limit our determination of the cost of the procedure to information submitted by the applicant. We obtain information on costs from other appropriate sources before making a determination of the cost of the procedure to hospitals. In the case of the ESWT procedures, our clinical review team of physicians compared the resources such as procedure room time, anesthesia, and other resources of the ESWT procedure to the resources of various other outpatient hospital procedures for which we have historical hospital claims data. We believe that our claims data on other procedures in terms of hospital resource use yield relevant cost information for use in developing cost estimates for new procedures without a claims history. As explained above, we took the New Technology APC applicant's costs into account as we reviewed its projected hospital costs thoroughly and, in particular, utilized information regarding expected service frequency, capital equipment, and other costs in our total cost estimate for the procedures. As discussed earlier, assignment to a New Technology APC does not imply clinical homogeneity with other services assigned to the same New Technology APC. We also note that we could not have included these two C-codes in the proposed rule for CY 2005, since we had not yet completed our evaluation of the New Technology APC application and rendered a decision until well after that proposed rule was published. As we have announced numerous times elsewhere, we will add New Technology service codes and assign their payment rates in our quarterly updates, where applicable and available, to facilitate timely integration of new codes into the OPPS. The timing of the ESWT procedures decision made the addition of the codes and payment rates coincident with our CY 2005 final rule publication. In order to have provided a discussion of the codes in a proposed rule, implementation of the codes would have been delayed a full year.

e. GreenLight Laser

During the August 2005 APC Panel meeting, the Panel recommended accepting CMS' proposed creation of APC 0429 for CY 2006 and the inclusion of HCPCS C9713, which describes use of the GreenLight Laser System, in this APC. We received several public comments concerning the reassignment of HCPCS codes C9713, 52647, 52648, 50080, and 50081 to APC 0429.

Comment: Several commenters requested that CMS maintain HCPCS code C9713 in its New Technology APC for one more year, which would give hospitals more time to learn how to correctly code for this service. The commenters stated that our proposed reassignment of the procedure to a clinical APC was premature because the decision was based on only 9 months of claims data. They suggested that many hospitals may not even have known about the new HCPCS code C9713 because it was not implemented until April 5, 2004, and, therefore, CMS received even fewer correctly coded claims than the true number of outpatient hospital services actually described by HCPCS code C9713 that were performed on Medicare beneficiaries during the 9 month period.

The commenters pointed out that there is evidence that hospitals have not been using the HCPCS code properly and reminded us that some members of the APC Panel stated that their hospitals were not coding these procedures correctly.

The commenters stated that the short period of time for collection of claims data and the low median cost calculated for HCPCS code C9713 based on those claims support their conjecture that the claims are not correct, and that the

procedure should remain in its CY 2005 New Technology APC for at least one more year to allow for collection of more accurate claims data.

Response: For CY 2006, CPT revised the descriptors of two procedure codes for prostate laser procedures described by CPT codes 52647 and 52648. The revised CPT code descriptors are as follows: 52647 (Laser coagulation of prostate, including control of postoperative bleeding, complete (vasotomy, meatotomy, cystourethroscopy, urethral calibration and /or dilation, and internal urethrotomy are included if performed); and 52648 (Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation internal urethrotomy and transurethral resection of prostate are included if performed). These descriptors for the CPT codes will be implemented on January 1, 2006. Our policy in the OPPS is to maintain only one HCPCS code that describes a specific procedure, and to the extent possible adopt CPT coding for services provided under the OPPS. In this case we determined, based on our review of the new descriptors, that procedures reported using HCPCS code C9713 in CY 2005 could be appropriately billed with CPT codes for CY 2006.

We also concluded that the resource use and clinical aspects of the laser vaporization procedure reported with HCPCS code C9713 and of the prostate procedures reported using CPT codes 52647 and 52648 prior to revision were so similar that it was appropriate to move, as proposed, the CY 2004 hospital claims data for HCPCS code C9713 to APC 0429 to contribute to the APC's median cost calculation for CY 2006. In addition, there was no reason to postpone adoption of the revised CPT codes for use in the OPPS. Although we had less than a full year of hospital claims data available for HCPCS code C9713, we had well over 1,600 single claims upon which to calculate median costs for the procedure, and those claims data confirmed the resource similarity of this service to the services coded by CPT codes 52647 and 52648. The medians for these three procedures only range from $2,475 to $2,602 and the clinical indications for the procedures are also similar. For CY 2006 we are adopting the newly available revised CPT codes for reporting the procedure previously described by HCPCS code C9713 and deleting HCPCS code C9713, effective January 1, 2006.

Creation of a new Level V APC 0042 for Cystourethroscopy and Other Genitourinary Procedures, the level to which we assigned the CY 2004 data for the prostate laser procedures described by HCPCS code C9713 and CPT codes 52647 and 52648, along with cost data for two other procedures also reassigned to that APC, resulted in tighter median cost distributions within all levels of the APCs for cystouresthroscopy and other genitourinary procedures. We are confident in the median costs for all of these prostate procedures because we have over 1,000 single claims for each of those procedures.

Although HCPCS code C9713 was placed in a New Technology APC for only one year, assignment to an appropriate clinical APC is always our goal for procedures that spend time assigned to New Technology APCs. In this case, the creation of a Category I CPT code that describes the procedure reported by HCPCS code C9713 during CY 2004 and CY 2005 in the OPPS occurred more quickly than is often the case. We believe that the procedure's assignment with similar procedures to a new clinical APC is appropriate and will result in accurate payment. Also, we expect that adoption of a revised CPT code for reporting the noncontact laser vaporization of the prostate procedure will reduce hospitals' administrative burden as they will be able report CPT codes for prostate services provided in CY 2006, rather than C-codes specific to the OPPS.

After carefully considering all comments we received, we are finalizing, without modification, our proposal to assign CPT codes 52647, 52648, 50080, and 50081 to new APC 0429, Level V Cystourethroscopy and Other Genitourinary Procedures. The CY 2004 hospital claims data for HCPCS code C9713 have been assigned to APC 0429 for purposes of establishing the final CY 2006 payment rate for that APC.

f. Magnetoencephalography (MEG)

We proposed to reassign MEG procedures to clinical APC 0043, using CY 2004 claims data to establish median costs on which payments would be based.

We received a number of public comments concerning the reassignment of CPT codes 95965, 95966, 95967.

Comment: A number of commenters addressed our proposal to assign magnetoencephalography (MEG) procedures to APC 0430. There are three MEG procedures affected by our proposal: CPT code 95965, MEG recording and analysis for spontaneous brain magnetic activity; CPT code 95966, MEG for evoked magnetic fields, single modality; and CPT code 95967, MEG for evoked magnetic fields, each additional modality to be listed separately in addition to CPT code 95965 for primary procedure. Each of those procedures is currently assigned to a separate New Technology APC, and the commenters believed that they should remain in those APCs for CY 2006. The commenters believed that assignment to APC 0430 was inappropriate because the proposed payment level of $674 was inadequate to cover the costs of the procedures and because the procedures should not be assigned to only one level as their required hospital resources differ significantly.

The commenters stated that the median costs based on CMS' hospital claims data are erroneous because hospitals are not providing accurate charges for the procedures. Further, they stated that our data did not represent the true costs of the procedures because MEG procedures are performed on very few Medicare patients.

In addition to the written comments we received on our proposed rule, hospital and manufacturer representatives made presentations to the APC Panel during its August 2005 meeting. At that time, the Panel recommended that CMS retain the MEG procedures in their current New Technology APCs and that we collect more external data and provide a detailed review of the data for the Panel's consideration at its next meeting.

Response: The MEG procedures have been assigned to New Technology APCs for 4 years. In CY 2002, all three services were assigned a payment rate of $150 in a single New Technology APC. As these CPT codes were new for CY 2002 and, therefore, first open to comment in the CY 2002 final rule, we received several comments regarding the costs of the services. For CY 2003, all three services were assigned to higher paying New Technology APCs, with a rate of $2,250 for CPT code 95965, $1,375 for CPT code 95966, and $875 for CPT code 95967. For CY 2004 and CY 2005, the procedures were again assigned to higher paying New Technology APCs, with CPT code 95965 moving to a rate of $5,250; CPT code 95966 to a rate of $1,450; and CPT code 95967 to a rate of $950.

For CY 2006, we proposed to assign these procedures to one new clinical APC because assignment to New Technology APCs is generally temporary while we are gathering hospitals claims data, and we now have 3 years of data upon which to base clinical APC assignments. Over the entire 3-year period, the median costs

for all 3 services, especially CPT code 95965, have generally been far less than the OPPS payment rates. In fact, the CY 2005 median cost (based on CY 2003 claims data) for CPT code 95965 was only 16 percent of the payment rate, and for CY 2006 the median cost (based on CY 2004 claims) was only 12 percent of the rate.

These procedures are rarely performed on Medicare beneficiaries and, therefore, we have a small number of claims now and have no expectation that the volume will increase. Patients targeted for MEG investigation procedures are typically between 17 and 32 years old. Furthermore, industry expectations are that the technology's growth will be in installations outside of hospitals. Nevertheless, almost all services with ongoing expectations of low volume for Medicare beneficiaries, including obstetrical services, reside in clinical APCs, not New Technology APCs. From CY 2003 claims data we were able to use 20 of the 21 claims submitted for CPT code 95965, 7 of the 7 claims submitted for CPT code 95966, and 4 of the 6 submitted for CPT code 95967 to calculate median costs of the procedures. For CY 2006 based on CY 2004 hospital claims data, we were able to use 10 of the 10 claims submitted for CPT code 95965 and 3 of the 4 submitted for CPT code 95966, while we had no claims for CPT code 95967.

In contrast to the comments, we are committed to relying increasingly on those data, especially in a case like this where the few hospitals that offer this technology have been billing these procedures for at least four years and the technology is no longer new. However, we also are sensitive to the potential access effects of relying on a low volume of claims to establish payment rates, as well as to the APC Panel's recommendation regarding these procedures as noted by the commenters. Therefore, for CY 2006 we considered charge and cost information provided to us during the comment period in addition to our claims data. A commenter provided total charge information billed to multiple payers, including Medicare, for MEG services from one hospital which showed charges of about $10,500. Also included in the information we received during the comment period were cost estimates for the procedures from various sources, and the estimates of costs varied considerably. For example, we were provided with estimates of hospital costs per case for CPT code 95965 that ranged from $8,321 to $4,054. We believe that some of that variation may be due to differences in the number of cases used in amortization estimates, as the costs of the equipment used in MEG procedures are significant. However, the fact that volume varies from one provider to another does not mean that we will base our payments on the high cost per case that results from allocating costs over only a few cases. In the case of MEG, we are especially sensitive to this given the very low level of Medicare beneficiary participation in the technology because of the clinical circumstances in which MEG services are typically provided. The OPPS payment rates for services need to make appropriate payments for the services provided to Medicare beneficiaries, recognizing that, as a budget neutral payment system, the OPPS does not pay the full hospital costs of services. We expect that our payment rates generally will reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings.

We agree with the APC Panel and the commenters that there are no currently existing clinical APCs containing other services where MEG services could be appropriately assigned, based on clinical and resource homogeneity with other OPPS services. We carefully considered our claims data, information provided by commenters, and the APC Panel recommendation that we retain the MEG procedures in New Technology APCs. As a result of this analysis, we determined that using a 50/50 blend of the code-specific median costs from our most recent CY 2004 hospital claims data and the CY 2005 code-specific payment amounts as the basis for assignment of the procedures for CY 2006 would be one way to recognize both the current payment rates for the procedures, which were originally based on the theoretical costs to hospitals of providing MEG services, and the median costs based upon our hospital claims data regarding actual MEG services provided to Medicare beneficiaries by hospitals. Accordingly, for CY 2006, because we are not fully confident in our claims data for MEG procedures and there are no clinical APCs containing other services that share clinical and hospital resource characteristics with MEG procedures, we believe that it is most appropriate to place MEG services in New Technology APCs for CY 2006 to accommodate these adjusted costs. We agree with the commenters that these APCs should be ''S'' status so no multiple procedure reduction will apply, as we are determining an adjusted cost for each specific MEG service. For CPT codes 95965 and 95966, we averaged the services' median costs from CY 2004 claims data with their CY 2005 payment rates to determine adjusted costs for the procedures and, therefore, their appropriate New Technology APC assignments. There were no CY 2004 claims for CPT code 95967, and thus, no median cost to use for such an adjustment. For that procedure, we based the New Technology APC assignment on the historical relationship (66 percent in CY 2005) between the New Technology APC payment for that procedure and the New Technology APC payment for CPT code 95966, the code to which CPT code 95967 is an add-on. We used 66 percent of our CY 2006 payment rate for CPT code 95966 to determine the adjusted cost of CPT code 95967 and establish the New Technology payment amount for CPT code 95967 for CY 2006. The table below provides the CY 2006 payment rates and the resulting APC assignments for MEG services.

As suggested by the APC Panel, we will continue to study the APC assignments for these procedures over the coming year and invite members of the public to submit any information they believe will be helpful to us. We have given these procedures special consideration through this adjustment methodology for CY 2006 to help assure that Medicare beneficiaries have appropriate access to MEG services. With an additional year of data and improved consistency of billing by hospitals providing MEG services, we are hopeful that the claims-based median costs of these services in future years will more consistently and appropriately reflect hospitals' costs of providing MEG procedures.

TABLE 10.—CY 2006 APC ASSIGNMENTS FOR MEG SERVICES

CPT	CY 2006 median cost	CY 2005 payment	Adjusted cost	CY 2006 payment amount/APC
95965	$644.71	$5,250	$2,947.35	$2,750/1523
95966	1,013.34	1,450	1,231.67	1,250/1514
95967	N/A	950	818.97	850/1510

g. Positron Emission Tomography (PET) Scans

(1) Nonmyocardial PET Scans

Positron emission tomography (PET) serves an important role in the clinical care of many Medicare beneficiaries. As stated in the November 15, 2004 final rule with comment period (69 FR 65716), we believe there are sufficient claims data to assign nonmyocardial PET scans to a single clinical APC. However, to minimize any potential impact that a payment reduction resulting from this move might have had on beneficiary access to this technology, we set the CY 2005 OPPS payment for nonmyocardial PET scans based on a 50/50 blend of their CY 2005 median cost and the payment rate of the CY 2004 New Technology APC to which they were assigned. Therefore, nonmyocardial PET scans were assigned to New Technology APC 1513 (New Technology—Level XIV ($1,000–$1,200) for a blended payment rate of $1,150 in CY 2005.

At the February 2005 APC Panel meeting, the Panel agreed with a presenter's assertion that the resource costs associated with nonmyocardial PET scans are similar to the costs associated with myocardial PET scans, and recommended that myocardial PET scans be placed in the same New Technology APC 1513 in which the nonmyocardial PET scans currently reside. Furthermore, presenters at the February 2005 APC Panel meeting expressed concern that movement of nonmyocardial PET scans from their New Technology APC to lower paying clinical APC 0285 could impede beneficiary access to this technology, similar to concerns articulated by commenters in previous years.

As a result of a recent Medicare national coverage determination (Publication 100–3, Medicare Claims Processing Manual section 220.6), effective January 28, 2005, we discontinued the PET G-codes listed in Table 10, and activated the CPT codes listed below in Table 11 for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization. These lists of codes along with claims processing instructions, are provided in Change Request 3756, Transmittal 514, Publication 100–04, Medicare Claims Processing Manual.

Table 11.--HCPCS Codes for PET Services Not Valid for Medicare for Dates of Service on or after January 28, 2005

HCPCS Code	HCPCS Code	HCPCS Code	HCPCS Code
G0030	G0042	G0215	G0228
G0031	G0043	G0216	G0229
G0032	G0044	G0217	G0230
G0033	G0045	G0218	G0231
G0034	G0046	G0220	G0232
G0035	G0047	G0221	G0233
G0036	G0125	G0222	G0234
G0037	G0210	G0223	G0253
G0038	G0211	G0224	G0254
G0039	G0212	G0225	G0296
G0040	G0213	G0226	G0336
G0041	G0214	G0227	

TABLE 12.—CPT CODES FOR COVERED PET SCAN INDICATIONS EFFECTIVE FOR DATES OF SERVICE ON OR AFTER JANUARY 28, 2005

CPT code	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation.
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress.
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress.
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation.
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck).
78812	Tumor imaging, positron emission tomography (PET); skull base to mid thigh.
78813	Tumor imaging, positron emission tomography (PET); whole body.
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck).
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh.
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body.

In the CY 2006 OPPS proposed rule, we proposed to maintain CPT codes 78608, 78609, 78811, 78812, and 78813 for nonmyocardial PET scans in New Technology APC 1513 (New Technology—Level XIII, $1,100–$1,200) at a payment rate of $1,150, the same APC placement as their predecessor G-codes, to ensure continuing beneficiary

access to this technology. We also proposed to maintain CPT codes 78814, 78815, and 78816, which describe concurrent PET/CT scans for anatomical localization, in New Technology APC 1514 (New Technology—Level XIV, $1,200–$1,300) at a payment rate of $1,250, based on input claiming that the costs associated with PET/CT technology are higher than the costs of PET technology alone.

Comment: Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged that we replace the G-codes for PET procedures with the established CPT codes for PET scans, while commenters to the July 25, 2005 proposed rule (70 FR 42674) applauded our transition to the CPT codes for PET scans. These commenters stated that movement to the established CPT codes for PET scans would greatly reduce the burden on hospitals of tracking and billing the G codes which are not recognized by other payors, and would allow for more uniform hospital billing of these scans. Furthermore, while a few commenters urged that we increase the payment for PET scans, the majority of commenters supported our proposal to maintain nonmyocardial PET scans in New Technology APC 1513 (paying $1,150), consistent with the payment level under their predecessor G-codes. Commenters stated that hospital claims data do not accurately reflect the costs of providing these services, and beneficiary access to this technology would be threatened if hospital claims data alone were used to set the CY 2006 payment rates.

Response: We agree with commenters that movement from the G-codes to the established CPT codes for PET scans allows for more uniform billing of these scans. Furthermore, we concur, in general, with commenters' recommendations that the payment levels under the established CPT codes for PET scans be consistent with the payment levels under their predecessor G-codes. Therefore, we are maintaining newly established CPT codes 78608, 78811, 78812, and 78813 for nonmyocardial PET scans in New Technology APC 1513 (New Technology—Level XIII, $1,100–$1,200) at a payment rate of $1,150. In addition, for myocardial PET scans we are assigning CPT codes 78459 and 78491 to newly established APC 0306 (Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation) and CPT code 78492 to newly established APC 0307 (Myocardial Positron Emission Tomography (PET) imaging, multiple studies), where the APC medians have been calculated based on data from their predecessor G-codes, as discussed in more detail below. However, we are changing the status indicator for CPT code 78609 (Brain imaging, PET; perfusion evaluation) from ''S'' (separately paid under the OPPS) to ''E'' (not paid under the OPPS) retroactive to January 28, 2005, as historically there has been and currently there remains no coverage for this service under the Medicare program.

Comment: Numerous comments applauded our recognition of the newly established CPT codes for concurrent PET/CT scans and acknowledgement of the clinical usefulness of concurrent PET/CT scans for attenuation correction and anatomical localization in the management of patients with cancer. However, several commenters expressed concern that the proposed assignment of PET/CT scans (CPT codes 78814, 78815, and 78816) to New Technology APC 1514 (paying $1,250) may not adequately cover the costs of providing PET/CT services. These commenters explained that hospitals incur more capital and maintenance costs with PET/CT than with conventional PET. For instance, a large trade association commented that a new PET/CT scanner costs approximately $1.8 million, compared to $1.2 million for a conventional PET scanner. Another commenter quoted annual maintenance costs of approximately $240,000 for a new PET/CT scanner, compared to $120,000 for a conventional PET scanner. These commenters asserted that the proposed payment rate for PET/CT scans does not recognize the additional diagnostic benefits provided by concurrent PET/CT scans over traditional diagnostic PET and CT scans. These commenters further explained that the CT scan performed during a PET/CT is not limited to one part of the body but includes the entire area imaged by the PET scan and, therefore, is more efficient than performing one PET scan plus several separate CT scans for different regions of the body. Several commenters recommended that we assign the newly established CPT codes for PET/CT scans (CPT codes 77814, 78815, and 78816) to New Technology APC 1519 (paying $1,750) based on external data and an economic analysis submitted by one of the commenters, which reported the costs of providing a PET/CT scan at approximately $1,717. In contrast, a leading mobile provider of PET/CT scans reported an average cost of $1,485 for providing a PET/CT scan, which included FDG, mileage to sites, technologists, supplies, equipment maintenance, and scheduling.

Response: While we acknowledge that concurrent PET/CT scans for attenuation correction and anatomical localization in the management of patients with cancer may be clinically useful, we have received no convincing data that support the assignment of PET/CT scans (CPT codes 78814, 78815, and 78816) to an APC paying higher than $1,250. The external data and economic analysis submitted by one of the commenters failed to meet the criterion for consideration of external data that we proposed in our August 12, 2003 proposed rule (68 FR 47987) and finalized in our November 7, 2003 final rule (68 FR 63424). The external data and analysis was not provided with the level of detail that would have allowed us to verify the claims data nor to have adjusted the claims data should we have determined an adjustment was necessary. Furthermore, one commenter reported an average cost of $1,485 for providing a PET/CT scan, which included FDG, among other related costs. Considering that FDG will be paid separately at charges adjusted to cost for CY 2006 (estimated typically to be about $250), the payment rate of $1,250 for PET/CT scans (not including FDG) adequately covers the cost of $1,485 that this commenter reported for providing PET/CT scans (including FDG). While we acknowledge that PET/CT scanners may be more costly to purchase and maintain than dedicated PET scanners, a PET/CT scanner is versatile and may also be used to perform individual CT scans, thereby potentially expanding its use if PET/CT scan demand is limited. Therefore, for CY 2006, we are maintaining CPT codes 78814, 78815, and 78816, which describe concurrent PET/CT scans for attenuation correction and anatomical localization, in New Technology APC 1514 (New Technology—Level XIV, $1,200–$1,300) at a payment rate of $1,250.

Comment: One commenter expressed concern that the proposed payment rate of $1,250 for a PET/CT scan may not cover the costs of a diagnostic CT when performed in conjunction with a PET/CT scan. The commenter stated that although many of the technical resources for acquiring diagnostic CT data when performed as a single acquisition with a PET/CT scan are the same as for the CT for attenuation correction and anatomical localization, the initial capital costs are greater for a PET/CT scanner capable of performing a diagnostic CT. In addition, there are added costs for acquiring the diagnostic CT data such as for the contrast agent and appropriate personnel. This commenter expressed interest in a continued dialogue with CMS on the issue of appropriate payment for the

technical costs of performing a diagnostic CT acquired simultaneously with a PET/CT scan.

Response: We appreciate the commenter's concerns regarding appropriate billing and OPPS payment for a PET scan with CT for attenuation correction and anatomical localization and a diagnostic CT scan performed as a single acquisition. We will consider this issue should we issue more specific hospital billing guidance regarding various combinations of medically reasonable and necessary PET and CT scans.

(2) Myocardial PET Scans

Comment: Two commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged CMS to delete HCPCS code G0230 (PET imaging, metabolic assessment for myocardial viability following inconclusive SPECT study) and recognize CPT code 78459 (myocardial imaging, positron emission tomography, metabolic evaluation) by changing its status indicator from ''B'' to ''S.''

Response: As a result of a recent Medicare national coverage determination Publication 100–3, Medicare Claims Processing Manual section 220.6), effective January 28, 2005, we discontinued HCPCS code G0230 and activated CPT code 78459, changing its status indicator from ''B'' to ''S.'' For CY 2006, we are maintaining CPT code 78459 as the active code for billing ''myocardial imaging, positron emission tomography, metabolic evaluation.''

Comment: Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) and the CY 2006 OPPS proposed rule (70 FR 42674) stated that the payment rate for APC 0285 does not accurately reflect the costs associated with performing multiple studies of PET myocardial perfusion imaging. They noted that, as configured, APC 0285 violated the two times rule for CY 2005 and was proposed as an exception to the two times rule for CY 2006. These commenters suggested that CMS split myocardial PET scans into two APCs to distinguish the resource consumption differences between single-study and multiple-study PET imaging.

Response: We agree with commenters that the significant cost differences between single study and multiple studies myocardial PET imaging services reflected in our historical hospital claims data for the G-code myocardial PET scan services support the splitting of APC 0285 into two myocardial PET scan APCs for more accurate rate-setting for these services for CY 2006. Furthermore, the splitting of APC 0285 resolves the two times violation that occurred in the CY 2006 proposed rule configuration of APC 0285. Therefore, we are assigning single-study myocardial PET imaging procedures and metabolic evaluation of myocardial PET imaging to APC 0306 (Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation) with a median cost of $800, based on the CY 2004 hospital claims data for the predecessor G-codes that have been replaced with CPT codes 78459 and 78491. In addition, we are assigning multiple-study myocardial PET imaging procedures to APC 0307 (Myocardial Positron Emission Tomography (PET) imaging, multiple studies) with a median cost of $2,482, based on the CY 2004 hospital claims data for the predecessor G-codes that have been replaced with CPT code 78492.

Comment: One commenter explained that myocardial PET perfusion studies may be performed with or without gating similar to myocardial SPECT procedures. However, for myocardial PET perfusion studies, there are no additional codes to describe gating; therefore, the provider receives the same payment regardless of having performed a gated study versus a non-gated study. The commenter requested that the payment rate for myocardial PET perfusion studies be adjusted to assure proper payment for gated studies.

Response: While we recognize that the CPT codes describing myocardial PET scans make no distinction between gated and non-gated studies, we received numerous comments urging that we discontinue the G-codes for PET scans and recognize these CPT codes for PET scans. Furthermore, the splitting of the myocardial PET scans into two APCs to distinguish single-study imaging from multiple-study imaging, as discussed in detail above, may improve payment for certain gated studies that involve multiple studies and address the commenter's concern for adequate payment for gated studies.

h. Proton Beam Treatment

In the CY 2005 OPPS proposed rule (69 FR 50467), we proposed to reassign CPT codes 77523 (Proton treatment delivery, intermediate) and 77525 (Proton treatment delivery, complex) from New Technology APC 1511 (New Technology, Level XI, $900–$1,000) to clinical APC 0419 (Proton Beam Therapy, Level II). In response to this proposal, we received numerous comments urging that we maintain CPT codes 77523 and 77525 in New Technology APC 1511 at a payment rate of $950 for CY 2005, arguing that the proposed payment rate of $678 for CY 2005 would halt diffusion of this technology and negatively impact patient access to this cancer treatment. Commenters explained that the low volume of claims submitted by only two facilities provided volatile and insufficient data for movement into the proposed clinical APC 0419. They further explained that the extraordinary capital expense of between $70 and $125 million and high operating costs of a proton beam facility necessitate adequate payment for this service to protect the financial viability of this emerging technology.

In the November 15, 2004 final rule with comment period (69 FR 65719 through 65720), we considered the concerns expressed by numerous commenters that patient access to proton beam therapy might be impeded by a significant reduction in OPPS payment. Therefore, we set the CY 2005 payment rate for CPT codes 77523 and 77525 by calculating a 50/50 blend of the median cost for intermediate and complex proton beam therapies of $690 derived from CY 2003 claims and the CY 2004 New Technology payment rate of $950. We used the result of this calculation ($820) to assign intermediate and complex proton beam therapies (CPT codes 77523 and 77525) to New Technology APC 1510 (New Technology—Level X ($800–$900) for a blended payment rate of $850 for CY 2005.

Our examination of the CY 2004 claims data has revealed a second year of a stable, albeit modest, number of claims on which to set the CY 2006 payment rates for CPT codes 77523 and 77525. However, unlike the median of $690 for the proposed CY 2005 Level II proton beam radiation therapy clinical APC containing CPT codes 77523 and 77525 derived from the CY 2003 claims data, the median for a comparable Level II proton beam radiation therapy clinical APC was $934 derived from partial CY 2004 claims data at the time of development of the CY 2006 proposed rule. This more recent median appears to more accurately reflect the significant capital expense and high operating costs of a proton beam therapy facility, and supports patient access to proton beam therapy. Therefore, we proposed to move CPT codes 77523 and 77525 from New Technology APC 1510 to clinical APC 0667 (Level II Proton Beam Radiation Therapy) based on a median cost of $934 for CY 2006.

Comment: Numerous commenters applauded our proposal to reassign CPT codes 77523 (Proton treatment delivery, intermediate) and 77525 (Proton

treatment delivery, complex) from New Technology APC 1510 (New Technology—Level X ($800–$900) to clinical APC 0667 (Level II Proton Beam Radiation Therapy), setting payment on the median cost of $1,133 derived from the CY 2004 claims, an increase from the median cost of $934 in the proposed rule. Commenters also supported our proposal to maintain CPT codes 77520 (Proton treatment delivery; simple, without compensation) and 77522 (Proton treatment delivery; simple, with compensation) in APC 0664 (Level I Proton Beam Radiation Therapy), setting the payment on the median cost of $947 derived from the full year CY 2004 claims. Commenters stated that these proposed payments more accurately reflect the significant capital expense and operating costs of a proton beam therapy center. Commenters also were pleased with our proposal to maintain separate APCs for distinguishing simple from intermediate and complex proton beam therapies, stating that the distinction is necessary to differentiate between the resource demands of the different treatment levels. Commenters urged CMS to continue protecting beneficiary access to this technology, especially during this early stage of clinical adoption to ensure economic viability of both existing facilities and those in various stages of construction and development.

Response: We agree with commenters that the CY 2004 median cost data for proton beam therapy services more accurately reflect the significant capital expense and high operating costs of a proton beam therapy facility. Furthermore, our reassignment of CPT codes 77523 and 77525 from New Technology APC 1510 to clinical APC 0667 based on the improved median cost data and stable frequency is consistent with our policy of transitioning New Technology services into a clinically appropriate APC with payment based on median cost data once the data for these services become sufficiently stable to protect patient access to such services. Therefore, we are finalizing our proposal to reassign intermediate and complex proton beam therapy services (CPT codes 77523 and 77525) from New Technology APC 1510 to clinical APC 0667, and to maintain simple proton beam therapy services (CPT codes 77520 and 77522) in APC 0664 for CY 2006.

i. Smoking Cessation Counseling

Comment: Two commenters expressed concern about our proposal to move smoking cessation HCPCS codes G0375 (Smoking and tobacco-use cessation counseling visit; 3–10 minutes) and G0376 (Smoking and tobacco-use cessation counseling visit; greater than 10 minutes) from their current New Technology APC 1501 (Level I, $0–$50) with a payment rate of $25, to New Technology APC 1491 (Level IA, $0–$10) with a payment rate of $5. Both commenters contended that the current payment rate of $25 is not sufficient to cover resources associated with this type of visit. Both commenters expressed the conviction that, once claims data reflecting the costs of the service become available, it would become clear that a payment rate closer to $52 is warranted. One commenter urged us to maintain these codes in their current New Technology APC until provider claims data become available. The other commenter took the position that placement in a New Technology APC is not appropriate, as the services could reasonably be placed in an existing clinical APC. Specifically, this commenter recommended that HCPCS codes G0375 and G0376 be assigned immediately to APC 0600 (Low Level Clinic Visits), which the commenter considers appropriate in terms of resource costs and clinical characteristics. Finally, both commenters pointed out that there was an inconsistency in our tables in the proposed rule with regard to the APC assignments of codes G0375 and G0376. Specifically, Table 10 in the proposed rule (70 FR 42706) showed HCPCS code G0375 assigned to New Technology APC 1491 (with a payment rate of $5), while HCPCS code G0376 was assigned to New Technology APC 1492 (with a payment rate of $15). However, Addendum B of the proposed rule (70 FR 42936) showed both HCPCS codes G0375 and G0376 assigned to New Technology APC 1491 (with a payment rate of $5).

Response: We thank the commenters for bringing to our attention a typographical error that appeared in Table 10 of the proposed rule (70 FR 42706). This error did not come to our attention in time for correction. Our intent, as indicated in Addendum B, was to assign both HCPCS codes G0375 and G0376 to APC 1491 (with a payment rate of $5). We regret the error. We do not agree with the commenter who suggested that it is appropriate at this time to remove HCPCS codes G0375 and G0376 from assignment to a New Technology APC and to assign them to clinical APC 0600 (Low Level Clinic Visits). One purpose of assignment to a New Technology APC is to provide an opportunity to collect claims data from our system, in order to allow for the ultimate placement of a code in the most appropriate clinical APC in terms of hospital resource requirements. At this time, we lack any data that would justify placing these codes in the clinical APC recommended by the commenter or in any other clinical APC. We believe that these smoking cessation services, because they are so specifically defined with respect to coding and coverage, may not require similar hospital resources as those required of other services assigned to APC 0600. As two specific G-codes were developed for these new smoking cessation services, the specific services likely bear little clinical resemblance to many of the evaluation and management services assigned to APC 0600, whose median cost currently reflects CY 2004 claims from hospitals. We also cannot agree with the commenter recommending placement of these codes in one or more higher-paying New Technology APCs. Our proposal to reassign these codes from their current New Technology APC 1501 (with a payment rate of $25) to New Technology APC 1491 (with a payment rate of $5) was based on our assessment that the hospital facility resources required for this service are likely to be very limited. At the time of activation of these new G-codes in CY 2005, New Technology APC 1501 was the New Technology APC applicable to new OPPS services with expected hospital costs of between $0 and $50. As we proposed to refine the New Technology cost bands for CY 2006 and are finalizing that proposal in this final rule, we believe that for CY 2006 assignment of the smoking cessation G-codes to New Technology APC 1491 now more appropriately reflects the hospital resources required for these services. Therefore, for CY 2006, we are finalizing that proposal in this final rule. However, for CY 2007 rate-setting, we will reassess the APC placement of these codes in light of the available partial year CY 2005 hospital claims data.

j. Stereoscopic Kv X-ray

Comment: A number of commenters addressed our creation of a new code for stereoscopic kilovolt x-ray imaging, HCPCS code C9722 (Stereoscopic kilovolt x-ray imaging with infrared tracking for localization of target volume), and assignment of the service to a New Technology APC. Commenters stated that the ''definition,'' which appears to refer to the code descriptor, combines two technologies into one HCPCS code. A commenter claimed that this descriptor excludes other superior technologies to acquire kilovolt (kV) x-ray images for localization of target volume that do not rely on infrared

tracking. Commenters asserted that the key feature of the service is the use of kV x-ray imaging for localization of target volume, while the infrared tracking feature is used for patient monitoring only to ensure immobilization, not for positioning and localization. A commenter stated that many kV x-ray systems do not use infrared tracking. The commenters, including a number of cancer centers, recommended modifying the descriptor of HCPCS code C9722 to ''Stereoscopic kV x-ray imaging with or without infrared tracking for localization of target volume,'' claiming that this would allow hospitals equal reimbursement for providing the service regardless of the vendor from whom they bought the kV x-ray equipment. One commenter stated that the kV x-ray is part of Image Guided Radiation Therapy (IGRT), a new generation of conformal radiation therapy techniques, and that it was working with the CPT Editorial Panel to submit CPT applications for stereoscopic x-ray guidance, as well as other IGRT technologies. A commenter stated that there is a new CPT code for stereoscopic x-ray guidance effective January 1, 2006, and recommended that we crosswalk HCPCS code C9722 to the new CPT code.

Response: The AMA's CPT Editorial Panel created new CPT code 77421, ''Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy'', which will be effective January 1, 2006. We will replace HCPCS code C9722 with CPT code 77421 for CY 2006, mapping the new code to the same New Technology APC as for CY 2005—APC 1502. As with the instructions embedded in the descriptor for HCPCS code C9722, CPT code 77421 should not be reported with the five G-codes for stereotactic radiosurgery treatment to be billed under the OPPS in CY 2006. As CPT code 77421 makes no reference to infrared tracking, the commenters' concerns are addressed by the use of this CPT code and its descriptor.

k. Stereotactic Radiosurgery (SRS)

In a correction to the November 7, 2003 final rule with comment period, issued on December 31, 2003 (68 FR 75442), we considered a commenter's request to combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and HCPCS code G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code in order to capture the costs of this treatment in single procedure claims because the majority of patients receive the planning and delivery of this treatment on the same day. We responded to the commenter's request by explaining that several other commenters stated that HCPCS code G0242 was being misused to code for the planning phase of linear accelerator-based stereotactic radiosurgery planning. Because the claims data for HCPCS code G0242 represented costs for linear accelerator-based stereotactic radiosurgery planning (due to misuse of the code), in addition to Cobalt 60-based stereotactic radiosurgery planning, we were uncertain of how to combine these data with HCPCS code G0243 to determine an accurate payment rate for a combined code for planning and delivery of Cobalt 60-based stereotactic radiosurgery.

In consideration of the misuse of HCPCS code G0242 and the potential for causing greater confusion by combining HCPCS codes G0242 and G0243 into a single procedure code, for CY 2004 we created a planning code for linear accelerator-based stereotactic radiosurgery (HCPCS code G0338) to distinguish this service from Cobalt 60-based stereotactic radiosurgery planning. We maintained both HCPCS codes G0242 and G0243 for the planning and delivery of Cobalt 60-based stereotactic radiosurgery, consistent with the use of the two G-codes for planning (HCPCS code G0338) and delivery (HCPCS codes G0173, G0251, G0339, G0340, as applicable) of each type of linear accelerator-based stereotactic radiosurgery (SRS). We indicated that we intended to maintain these new codes in their current New Technology APCs until we had sufficient hospital claims data reflecting the costs of the services to consider moving them to clinical APCs.

During the February 2005 APC Panel meeting, the APC Panel discussed the clinical and resource cost similarities between planning for Cobalt 60-based and linear accelerator-based SRS. The APC Panel also discussed the use of CPT codes instead of specific G-codes to describe the services involved in SRS planning, noting the clinical similarities in radiation treatment planning regardless of the mode of treatment delivery. Acknowledging the possible need for CMS to separately track planning for SRS, the APC Panel eventually recommended that we create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. However, a hospital association and other presenters at the APC Panel meeting urged that we discontinue the use of G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. Lastly, one presenter urged that we combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code to reflect that the majority of patients receive the planning and delivery of this treatment on the same day as a single fully integrated service.

The APC Panel recommended that we make no changes to the coding or APC placement of SRS delivery codes G0173, G0243, G0251, G0339, and G0340 for CY 2006. We first established the above full group of delivery codes in CY 2004, so we have only one year of hospital claims data reflecting costs of all of the services. In addition, presenters to the APC Panel described current ongoing deliberations amongst interested professional societies around the descriptions and coding for SRS. The APC Panel and presenters suggested that we wait for the outcome of these deliberations prior to making any significant changes to SRS delivery coding or payment rates.

In an effort to balance the recommendations of the APC Panel with the recommendations of presenters at the APC Panel meeting, in accordance with the APC Panel recommendations, we proposed to make no changes to the APC placement of the following SRS treatment delivery codes for CY 2006: HCPCS codes G0173, G0243, G0251, G0339, and G0340.

In the CY 2006 proposed rule, we acknowledged concerns expressed by some presenters urging that we discontinue the use of the G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. In addition, we indicated that we had no need to separately track SRS planning services, which share clinical and resource homogeneity with other radiation treatment planning services described by current CPT codes.

When HCPCS code G0242 was established for SRS planning, several radiology planning services were considered in determining its APC placement. In the November 30, 2001 final rule, in which we described our determination of the total cost for SRS planning based on our claims experience, we added together the median costs of the following CPT codes

that we found to be regularly billed with SRS delivery (CPT code 61793 in the available hospital data): 77295, 77300, 77370, and 77315. In the CY 2006 proposed rule, our examination of the costs from the CY 2004 claims data available to us at that time for the above-mentioned CPT codes closely approximated the CY 2004 median costs reported for HCPCS codes G0242 and G0338. The APC median costs for the above-mentioned CPT codes based on the CY 2004 claims data utilized for the proposed rule totaled $1,297, while the median cost for HCPCS code G0242 was $1,366 and the median cost for HCPCS code G0338 was $1,100 based on the partial year CY 2004 claims data. In addition, three of the above-mentioned CPT codes were included on the proposed bypass list for CY 2006, so we did not anticipate that the billing of these codes on the same day as an SRS treatment service would cause significant problems with multiple bills for SRS services. Therefore, we proposed to discontinue HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPS, and to instruct hospitals to bill charges for SRS planning using all of the available CPT codes that most accurately reflect the services provided.

We acknowledged one APC Panel presenter's concern that the coding structure of Cobalt 60-based SRS, using either the current SRS planning G-code or the appropriate CPT codes for planning services as we proposed for CY 2006, might not necessarily reflect the same day, integrated Cobalt 60-based SRS service furnished to the majority of patients receiving Cobalt 60-based SRS. Thus, we specifically requested public comment on the clinical, administrative, or other concerns that could arise if we were to bundle Cobalt 60-based SRS planning services, currently reported using HCPCS code G0242 and proposed for CY 2006 to be billed using the appropriate CPT codes for planning services, into the Cobalt 60-based SRS treatment service, currently reported under the OPPS using HCPCS code G0243. Under such a scenario, the SRS treatment service described by HCPCS code G0243 would be placed in a higher paying New Technology APC to reflect payment for the costs of the SRS planning and delivery as an integrated service. Hospitals would be prohibited from billing other radiation planning services along with the Cobalt 60-based SRS treatment delivery code. In contrast to Cobalt 60-based SRS coding, we did not consider bundling the planning for linear accelerator-based SRS with the treatment delivery services, given the various timeframes for planning that may occur with linear accelerator-based SRS.

As discussed in detail above, the APC Panel recommended that CMS create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. Furthermore, the Panel recommended that we make no changes to the coding or APC placement of SRS treatment delivery HCPCS codes G0173, G0243, G0251, G0339, and G0340 for CY 2006.

For reasons discussed below, we are discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPS for CY 2006, and instructing hospitals to bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided. In addition, while we are reassigning HCPCS code G0243 to clinical APC 0127 for CY 2006, we are making no changes to the APC placement of SRS treatment delivery HCPCS codes G0173, G0251, G0339, and G0340.

We received a number of public comments on these SRS issues.

Comment: We received numerous comments supporting our proposal to discontinue HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0338 (Linear accelerator-based SRS planning) for the reporting of charges for SRS planning, and to instruct hospitals to bill charges for SRS planning using available CPT codes that most accurately reflect the services provided. These commenters agreed that available CPT codes more accurately describe the services involved in SRS planning and are less administratively burdensome for providers because other payors recognize them. Some commenters urged that we retain separate codes for reporting the planning and treatment delivery of Cobalt 60-based SRS, whether through the use of existing G-codes (HCPCS codes G0242 and G0243) or through available CPT codes. Several of these commenters explained that although the planning and treatment delivery of Cobalt 60-based SRS most often occur on the same date of service, there are instances in which the planning and treatment are not delivered on the same date of service due to an unanticipated problem that arises during the planning that precludes the treatment delivery. In such instances where only planning for the Cobalt 60-based SRS is performed, commenters stated that CMS would need to clarify how providers should bill these services if separate codes are not maintained for the planning and treatment delivery of Cobalt 60-based SRS. Commenters expressed concern that combining the planning code (HCPCS code G0242) and treatment delivery code (HCPCS code G0243) for Cobalt 60-based SRS into a single combination code would necessitate the use of a modifier when they are not performed on the same date of service and would complicate the billing of these services and increase the administrative burden on hospitals. One commenter suggested that, if we decide to maintain HCPCS code G0242 for Cobalt 60-based SRS planning rather than transition to the CPT codes, we consider placing the planning code (HCPCS code G0242) on the bypass list as an alternative solution to generating more single bills for future rate-setting, rather than combining the planning and treatment delivery codes for Cobalt 60-based SRS into a single combination code.

In contrast, a few commenters urged that we continue to recognize HCPCS codes G0242 and G0338 for the reporting of SRS planning rather than transition to the available CPT codes that describe these services. These commenters predicted that another year of stability would allow CMS to collect more reliable data for use in setting the CY 2008 payment rates for SRS planning services.

Many commenters urged that we refrain from treating various forms of SRS (i.e., Cobalt 60-based and linear accelerator-based) differently by ''bundling'' planning into the treatment delivery for Cobalt 60-based SRS by creating a single combination code, while ''unbundling'' planning and treatment delivery for linear accelerator-based SRS by paying separately for these services. These commenters asserted that the planning and treatment delivery of SRS, regardless of the form of delivery, are clinically distinct services that should be reported separately to distinguish their distinct resource requirements. One commenter refuted claims that the administration of the planning and treatment delivery of SRS on the same date of service is unique to Cobalt 60-based SRS, arguing that the planning and treatment delivery of LINAC-based SRS likewise are typically performed on the same day, and that a mere time proximity of the two services does not necessitate a single combination code for either form of SRS. Several commenters cautioned against establishing different coding schemes for various SRS services that would likely cause confusion for coders, inaccurate coding, and unreliable data for future rate setting.

Numerous other commenters urged CMS to combine the planning code (HCPCS code G0242) and treatment delivery code (HCPCS code G0243) for Cobalt 60-based SRS into a single surgical code, preferably CPT code 61793 (stereotactic radiosurgery, particle beam, gamma ray, or linear accelerator, one or more sessions), which would replace all of the SRS G codes regardless of the mode of delivery. These commenters stated that the planning and treatment delivery of Cobalt 60-based SRS are always performed on the same day and that a single combination code would be less confusing for coders, provide more accurate claims data, and result in a more appropriate payment for Cobalt 60-based SRS. While some of these commenters urged that we assign this single combination code to a higher paying New Technology APC consistent with its CY 2004 median cost data until more accurate cost data are available for determining an appropriate clinical APC, other commenters strongly opposed the designation of Cobalt 60-based SRS as a new technology service, noting that Cobalt 60-based SRS became a standard of care for treating cancer patients over two decades ago and a new technology label is no longer appropriate. Commenters stated that CMS' designation of Cobalt 60-based SRS as a new technology service has led other insurers to consider the treatment to be experimental, which frequently delays, and sometimes prevents, access to treatment for critically ill patients. These commenters urged that we assign this new combination code reflecting planning and delivery of Cobalt 60-based SRS to a surgical APC and set the payment based on the median cost calculated from the CY 2004 hospital claims data. Some of these commenters recommended that this single combination code describe all forms of SRS, while other commenters emphasized the importance of maintaining separate combination codes for Cobalt 60-based SRS and LINAC-based SRS to distinguish the significant clinical and resource cost differences associated with these services.

One commenter urged that if CMS replaces the G-codes for SRS planning with available CPT codes describing these services, we should not assign HCPCS code G0243 (Cobalt 60-based SRS treatment delivery) to a New Technology APC paying higher than its CY 2005 payment rate of $5,250. This commenter supported our proposal to make no changes to the APC placement of SRS treatment delivery codes that describe a complete course of treatment in one session, stating that the proposed payment of $5,250 for all single session SRS treatment services for CY 2006 is appropriate based on the hospital resources involved in furnishing these services.

Response: We thank the many commenters for their insightful thoughts and recommendations for the reporting of hospital charges for SRS services under the OPPS for CY 2006. In recognition of the heightened level of diligence that the current coding scheme for SRS services requires of hospital coders to ensure that charges for these services are reported under the appropriate G-code, we carefully considered several options for simplifying the coding scheme for SRS services while maintaining a certain level of data specificity to reflect the differential clinical considerations and hospital resource utilization that are necessary to inform future rate setting.

First, we considered several recommendations by commenters to bundle the planning for Cobalt 60-based SRS into the treatment delivery (HCPCS code G0243) for Cobalt 60-based SRS by either establishing a single combination G-code describing both the planning and delivery of Cobalt 60-based SRS or by instructing providers to report CPT code 61793 for such services. However, we agree with the majority of commenters who expressed strong opposition to a single combination G-code or CPT code to report the planning and treatment delivery of Cobalt 60-based SRS, noting the following concerns: (1) The administrative burden on providers of maintaining duplicative codes for SRS planning to accommodate various payors (that is, G-codes for Medicare and CPT codes for non-Medicare payors); (2) the added complexity of attaching a modifier to the code for instances when planning and delivery are not provided on the same date of service because treatment does not proceed due to an unanticipated problem; (3) the confusion for coders and unreliable data that could emanate from inconsistent coding schemes for different forms of SRS (that is, Cobalt 60-based and LINAC-based SRS); and (4) the nonspecificity of the descriptor for CPT code 61793 which describes all forms of SRS treatment delivery and makes no mention of SRS planning services. We also agree with the majority of commenters who stated that the G-codes (G0242 and G0338) for SRS planning are duplicative of existing CPT codes that adequately describe such services and that are much less administratively burdensome on hospitals because they are recognized by non-Medicare payors. Furthermore, our analysis of the CY 2004 claims data revealed that the median costs for HCPCS codes G0242 and G0338 closely approximated the sum of the median costs for the CPT codes (77295, 77300, 77315, 77370) that were most commonly billed under the OPPS for SRS planning prior to the establishment of HCPCS codes G0242 and G0338. In addition, we remind commenters that three of the above-mentioned CPT codes are included on the bypass list for CY 2006, so we do not anticipate that the billing of these codes on the same day as an SRS treatment delivery service will cause significant problems with multiple bills for SRS services, eliminating any need for recognizing a single combination G-code or CPT code which describes both planning and treatment delivery SRS services for the purpose of generating more single bills. Finally, based on additional confirmation from commenters that the similarities in clinical characteristics and resource costs associated with treatment planning for services delivering radiation, regardless of the mode of treatment delivery, dispel the need to separately track planning services for SRS, we are discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPS for CY 2006, and instructing hospitals to bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided.

We also agree with the majority of commenters who strongly urged that we reassign HCPCS code G0243 (Cobalt 60-based treatment delivery) from New Technology APC 1528 to a clinical APC, pointing out that Cobalt 60-based SRS became a standard of care for treating cancer patients over two decades ago and, therefore, a new technology label no longer appropriately describes the service. Furthermore, the median costs from hospital claims for HCPCS code G0243 based on a significant number of single claims each year have been quite stable over the past three years, supporting movement of this service out of a New Technology APC and into a clinical APC based on its median cost data from CY 2004. Therefore, we are reassigning HCPCS code G0243 from New Technology APC 1528 to clinical APC 0127 and setting its payment rate based on a median cost of $7,297 for CY 2006.

Lastly, we agree with commenters who emphasized the significant clinical and resource cost differences associated with the treatment delivery of Cobalt 60-based SRS and LINAC-based SRS, and

that establishment of a single code to describe all forms of SRS treatment delivery would result in a loss of essential data specificity for determining appropriate future payment rates for these services. For instance, based on the CY 2004 claims data, the median costs for the various forms of SRS treatment delivery ranged from $2,502 to $7,296. These significant differences in median cost data emphasize the importance of maintaining different codes that distinguish the various forms of SRS treatment delivery for the purpose of setting the most appropriate payment rates for these services. We believe it would be premature, as well, to move the LINAC-based SRS treatment delivery procedures to clinical APCs for CY 2006 because we have only one year of claims data reflecting their current coding structure, although we have hundreds of single claims for some of the services. We will be examining our claims data carefully for the next OPPS update, because we will then have 2 years of data for these LINAC-based SRS treatment delivery services now assigned to New Technology APCs. Therefore, we are maintaining HCPCS codes G0173 and G0339 in New Technology APC 1528, HCPCS code G0251 in New Technology APC 1513, and HCPCS code G0340 in New Technology APC 1525 for CY 2006. And as mentioned elsewhere in this section, we are reassigning HCPCS code G0243 from New Technology APC 1528 to clinical APC 0127.

Comment: One commenter urged that we create a new CPT code titled ''Surgeon-based Gamma Stereotactic Radiosurgery, complete course, one procedure, per lesion'' to describe Cobalt 60-based SRS planning and treatment delivery and assign this CPT code to a new surgical APC titled ''Surgeon-based Gamma Stereotactic Radiosurgery.'' This commenter recommended that we set the payment rate of this new APC based on the combined median costs from claims data for HCPCS codes G0242 and G0243.

Response: We appreciate the commenter's suggestion; however, CMS does not possess the authority to create CPT codes, which are established and maintained by the American Medical Association. Furthermore, under the OPPS, we do not label APCs according to the type of clinician delivering the service (that is, surgeon versus non-surgeon) because such categorization is irrelevant to establishing payment for hospital services billed under the OPPS. Rather, we provide titles for clinical APCs that describe the actual hospital services assigned to the APCs for which providers should report their hospital costs and charges. In addition, as discussed above, we agree with the majority of commenters who opposed the recognition of a single combination code (that is, CPT code 61793) for the planning and delivery of Cobalt 60-based SRS services, for reasons stated previously, i.e. the administrative burden of maintaining duplicative codes, the added complexity of attaching a modifier to the code for instances when planning and delivery are not provided on the same date of service because treatment does not proceed due to an unanticipated problem, the confusion for coders and unreliable data that could emanate from inconsistent coding schemes for different forms of SRS (that is, Cobalt 60-based and LINAC-based SRS), and the nonspecificity of the descriptor for CPT code 61793 which describes all forms of SRS treatment delivery and makes no mention of SRS planning services. Therefore, as discussed elsewhere in this section, for CY 2006, we are discontinuing HCPCS code G0242 and recognizing existing CPT codes for the reporting of Cobalt 60-based SRS planning, and moving HCPCS code G0243 (Cobalt 60-based SRS treatment delivery) from New Technology APC 1528 to clinical APC 0127 based on a median cost of $7,296.

Comment: Several commenters recommended that we make HCPCS code G0339 (Image guided, robotic, linear accelerator-based (LINAC) SRS treatment delivery, complete session, first session of fractionated treatment) a permanent code and continue to pay this service at the CY 2005 payment rate of $5,250. These commenters also recommended that we eliminate HCPCS code G0340 (Image guided, robotic, linear accelerator-based (LINAC) SRS treatment delivery, fractionated treatment, 2nd–5th sessions) and instruct hospitals to report HCPCS code G0339 for all fractionated treatment sessions, stating that the resource costs are the same for each session regardless of the number of treatment sessions that the patient receives.

Response: We disagree with the commenters' assertions that the resource costs are the same for each session of image-guided, robotic LINAC-based SRS treatment delivery regardless of the number of treatment sessions that the patient receives. Based on CY 2004 claims data, the median cost for HCPCS code G0339 ($4,917) was considerably higher than the median cost for HCPCS code G0340 ($2,502), and does not support the elimination of HCPCS code G0340 or its payment at a rate comparable to the payment rate for HCPCS code G0339. As the SRS treatment delivery G-codes are national Level II HCPCS codes that we utilize for billing SRS treatments in the OPPS, we are uncertain what changes the commenter would like us to make for the codes to be ''permanent.'' Therefore, for CY 2006, we are maintaining HCPCS code G0339 in New Technology APC 1528, and HCPCS code G0340 in New Technology APC 1525.

Comment: One commenter urged CMS to assign HCPCS codes G0251 and G0340, for fractionated non-robotic and image-guided robotic LINAC-based SRS respectively, to the same APC, contending that these procedures involve similar resources and should be paid equally. In contrast, another commenter asserted that image-guided robotic LINAC-based SRS is substantially more resource intensive than non-robotic LINAC-based SRS, and that CMS should maintain HCPCS code G0251 in a separate APC from HCPCS code G0340 to distinguish their levels of resource requirements.

Response: We began recognizing HCPCS code G0251 to describe fractionated sessions of non-robotic LINAC-based SRS treatment delivery in CY 2004, which yielded no single procedure claims data for HCPCS code G0251 to substantiate a similarity or lack of similarity of its resource costs in comparison with HCPCS code G0340 (fractionated, 2nd–5th sessions, image-guided robotic LINAC-based SRS treatment delivery). However, the large divergence in the median cost of $2,802 for the complete session of non-robotic LINAC-based SRS treatment delivery (HCPCS code G0173), in comparison with the median cost of $4,917 for the complete and first fractionated sessions of image-guided robotic LINAC-based SRS treatment delivery (HCPCS code G0339), indicates that fractionated image-guided robotic LINAC-based SRS treatment delivery is likely substantially more resource intensive than fractionated non-robotic LINAC-based SRS treatment delivery. Therefore, for CY 2006, we are maintaining HCPCS code G0251 in New Technology APC 1513 and HCPCS code G0340 in New Technology APC 1525. However, for CY 2007, we will reexamine our APC placement of HCPCS codes G0251 and G0340 based on CY 2005 hospital claims data.

Comment: One commenter to the November 15, 2004 final rule with comment period (69 FR 65682) disagreed with CMS' statement that CPT codes 0082T (Stereotactic body radiation, treatment delivery, one or more treatment areas, per day) and

0083T (Stereotactic body radiation therapy, treatment management, per day) are bundled into the current G-codes for SRS treatment delivery. The commenter stated that stereotactic body radiation treatment delivery and management are new technologies and, thus, are not included in the current G-codes for SRS treatment delivery; however, the commenter provided no cost data nor any explanation as to how stereotactic body radiation treatment differs from the current procedures described by the G-codes for SRS treatment delivery. Instead, the commenter simply requested that CMS designate these new tracking codes for stereotactic body radiation treatment delivery and management as new technology services and assign these codes to a New Technology APC.

Response: We disagree with the commenter's unsubstantiated assertion that the current G-codes for SRS treatment delivery do not already describe or include some services that could also be identified as stereotactic body radiation treatment delivery and management described by CPT codes 0082T and 0083T, respectively. Furthermore, we received no evidence to support the commenter's assertion that these services represent new technologies that could not be represented in our hospital claims data. Therefore, for CY 2006, we are maintaining CPT code 0082T with a status indicator of ''B'' because we consider an alternate code to be available for billing this service under the OPPS. Likewise, for CY 2006, we are maintaining CPT code 0083T with a status indicator of ''N'', indicating that the charges for this service are packaged into the payment for other services paid separately under the OPPS.

D. APC—Specific Policies

We received many comments on our proposed changes to specific groups of services as discussed in the CY 2006 OPPS proposed rule preamble and displayed in Addendum B. We have grouped these comments, and our responses, into five general clinical categories as shown below.

We received one comment that generally addresses our APC assignment methodology.

Comment: One commenter objected to the placement of codes for unlisted services in the lowest APC that is clinically appropriate and to the lack of discussion of this policy in the CY 2006 OPPS proposed rule. The commenter asked that CMS examine claims data and match unlisted services to the diagnosis to determine if there is a more appropriate APC than the lowest level.

Response: We discussed this policy in the CY 2005 OPPS proposed rule which we published on August 16, 2004 (69 FR 50448), and we made our existing policy final in the November 15, 2004 final rule (69 FR 65682). We proposed no changes to this policy in the CY 2006 OPPS proposed rule (which we published on July 25, 2005 (70 FR 42674)) and, therefore, we have not changed the policy. The HCPCS codes for unlisted services should be used only if there is no existing code that can be used alone or with existing modifiers to report the service that was furnished. We believe that their use should be very rare. We do not believe that examination of the diagnoses on claims for unlisted procedures would enable us to properly place the codes into APCs because there are so many different types of services at different levels of resource use that could apply to a single diagnosis. There is a 2-year lag between the year of hospital claims data and the OPPS payment rates that are established based on the data. New procedure-specific HCPCS codes are developed on an annual basis, and there are continuous changes in procedures for many diagnoses as medical practice evolves. Therefore, we have no confidence that the array of unlisted services billed by hospitals, and by implication their median costs, in a given year for patients with certain diagnoses would necessarily have any relationship to unlisted services, and their median costs, billed 2 years later for patients with the same diagnoses. Moreover, placing unlisted services in the lowest level APC encourages use of existing codes where it is possible and also encourages development of new HCPCS codes for services for which codes do not exist.

1. Cardiac and Vascular Procedures

a. Acoustic Heart Sound Recording and Analysis

Comment: One commenter requested that CMS change the status indicator for CPT code 0069T (Acoustic heart sound recording and computer analysis only). The commenter requested that we assign the procedure to APC 0099 with an ''S'' status indicator rather than ''N,'' as is currently assigned to CPT code 0069T. The commenter stated that the test's current status as a packaged procedure results in inequitable payment to the hospital. They stated that the cost of an EKG with the acoustic heart sounds recording is $55 whereas, the cost of an EKG without is $31, and that because we have packaged the procedure, the hospital is underpaid by $24 for each test it performs.

Response: It is our understanding that the acoustic heart sound recording and analysis is intended for a specific, targeted group of patients to enhance the provider's ability to diagnose heart failure. The technology, as described by CPT code 0069T, always is performed in conjunction with an EKG and as such is ideal for packaging. It is the hospitals responsibility to increase their charges to reflect the additional costs for those EKGs that include the acoustic heart sound recording. If the hospital uses the test according to the manufacturer guidelines, the costs will be distributed over the large number of EKGs that are performed in the hospital outpatient department and, over time, the additional costs may be recognized in the OPPS rates as increased median costs for EKGs in general.

Comment: One commenter requested that CPT code 0069T (Acoustic heart sound recording and computer analysis only) become separately payable. The commenter was concerned that CMS interpreted the code to be an add-on code to an EKG procedure. The commenter clarified that CPT code 0069T is often used as a stand-alone procedure, provided without an EKG procedure.

Response: We are accepting the APC Panel's recommendations that CPT code 0069T remain packaged for CY 2006. The Panel reviewed this code and determined it to be an add-on code to an electrocardiography service, as indicated by the American Medical Association's descriptor of this code. In addition, we are concerned that there may be unnecessary utilization of this procedure if it is separately payable because it is an add-on code to EKG services, for which there were almost 6 million claims under the OPPS in CY 2004. Lastly, we continue to believe that this service is a minor procedure that may be performed quickly accompanied by an EKG and likely other separately payable services, and thus is appropriately packaged.

b. Cardiac Electrophysiologic Services (APC 0087)

Comment: Commenters objected to the decline in proposed payment rate for APC 0087 from prior years. They also objected to what they view as a two times violation in APC 0087 and asked that we move electrophysiologic ''mapping'' CPT codes 93609, 93613, and 93631 to APC 0086 because the CPT code median costs for these codes are much higher than the median costs for the other codes in APC 0087. They state that because ''mapping'' CPT codes 93609, 93613, and 93631 are billed with other cardiac electrophysiologic services

already assigned to APC 0086, then these ''mapping'' services should also be assigned to the same clinical APC. They also asked that we use only claims that contain the device codes required for these CPT codes in setting the median cost for the APC into which CMS places these codes.

Response: We disagree that there is a 2 times violation, under our rules, in APC 0087. The law permits an exception to the two times rule for ''low volume items and services.'' We define any service that does not meet our test as a ''significant service'' to be a ''low volume item or service.'' A significant service is a service with a single bill frequency greater than 1,000 (which no services in APC 0087 meet) or a service with a single bill frequency greater than 99 and more than 2 percent of the single bills (which no services in APC 0087 meet). Because APC 0087 does not have any codes which meet the test of being significant, all of the codes in APC 0087 are ''low volume'' under our definition, and there is no two times violation.

Notwithstanding the absence of a 2 times violation under our rules, we acknowledge the commenter's concerns, and we will ask for the APC Panel's views regarding the assignment of these codes to APC 0087 in preparation for the CY 2007 OPPS update. We also recognize that, for many of the procedures assigned to APC 0087, multiple procedure claims are the norm. We will also work with the APC Panel to develop potential strategies which could enable us to use more claims for rate setting for these cardiac electrophysiologic services. We disagree, however, that because the electrophysiology ''mapping'' codes are performed with other cardiac electrophysiology studies, the clinical and resource characteristics of the ''mapping'' procedures necessarily are similar to the base services provided.

See section IV.A. for our discussion of adjustments to median costs for device-dependent APCs for the CY 2006 OPPS. See Table 16 for the adjusted median cost for APC 0087 for the CY 2006 OPPS.

c. Cardioverter-Defibrillator Implantation (APC 0107, 0108)

The median costs for APC 0107 (Implantation of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads and Insertion of Cardioverter-Defibrillator) have been adjusted each year since CY 2003 when pass-through payment expired for cardioverter-defibrillators, because the unadjusted medians have differed significantly from the prior year's payment medians. Moreover, because we use single procedure claims to set the median costs, the median costs for these APCs have always been set on a relatively small number of claims as compared to the total frequency of claims for the services under the OPPS. For example, for the CY 2006 OPPS proposed rule, the unadjusted median cost for APC 0107 was set based on 445 single procedure claims, which is 5.5 percent of the 8,073 claims on which a procedure code in the APC was billed. Similarly, the unadjusted median cost for APC 0108 was set based on 520 single procedure claims, which is 8.7 percent of the 6,003 claims on which a procedure code in the APC was billed. Commenters have frequently told us that using the single procedure median costs for these APCs does not accurately reflect the costs of the procedures because claims from typical clinical circumstances involving multiple procedures, which constitute the majority of claims under these APCs, are not used to establish the medians.

At the February 2005 APC Panel meeting, the APC Panel recommended that CMS package CPT codes 93640 and 93641 (electrophysiologic evaluation at time of initial implantation or replacement of cardioverter-defibrillator leads). The APC Panel recommended that we always package the costs for these codes because the definitions of the codes state that these evaluations are done at the time of lead implantation. Therefore, CPT codes 93640 and 93641 would never be correctly reported without a code in APC 0107 or APC 0108 also being reported. In addition, when a service assigned to APC 0107 or APC 0108 is provided, we would expect that CPT codes 93640 or 93641 for electrophysiologic evaluation and testing would also be performed frequently, and CY 2004 claims data for services in APC 0107 and APC 0108 confirm this. The APC Panel believed that packaging the costs of CPT codes 93640 and 93641 would result in more single bills available for setting the median costs for APC 0107 and APC 0108, and thus would likely yield more appropriate median costs for those APCs. Those medians would then include the costs of the electrophysiologic testing commonly performed at the time of the implantable cardioverter-defibrillator (ICD) insertion.

The APC Panel further recommended that CMS treat CPT code 33241 (Subcutaneous removal of cardioverter-defibrillator) as a bypass code when the code appeared on the same claims with services assigned to APC 0107 or APC 0108. The APC Panel recommended bypassing charges for this code only when it appeared on the same claim with codes in APC 0107 or APC 0108, because when a cardioverter defibrillator (ICD) is removed and replaced in the same operative session, it is appropriate to attribute all of the packaged costs on the claim to the implantation of the device rather than to the removal of the device. The line costs for CPT code 33241 that are removed from the claims in this case would be discarded and would not be used to set the median cost for APC 0105 (the APC in which the code is located).

We modeled the median costs that would be calculated for APCs 0107 and 0108, if we were to make the changes recommended by the APC Panel for these APCs, under four possible scenarios: (1) The cardioverter-defibrillator device is inserted without removal or testing; (2) the device is inserted and tested with no removal; (3) the device is removed and inserted but not tested; and (4) the device is removed, inserted, and tested. For each unique scenario, we then compared the sum of the unadjusted median costs, the sum of the proposed adjusted median costs and the sum of the costs that we modeled using the APC Panel recommendations. These results were shown in the proposed rule in Tables 16 and 17.

We proposed to set the medians for these APCs at 85 percent of their CY 2005 payment medians and based our modeling of the scalar and the impact analysis on that proposal, although we believed that the APC Panel recommendations have significant merit, particularly when we move to complete reliance on claims data in updating the OPPS for CY 2007. Although we proposed to adjust the median costs for these APCs in the same manner as other device-dependent APCs, we stated in the proposed rule that we will consider, based on the public comments, whether it would be appropriate to apply the multiple procedure claims methodology to these APCs for the CY 2006 OPPS. We specifically invited public comments on the APC Panel recommendations regarding packaging and bypassing services frequently performed with procedures assigned to APC 0107 and APC 0108, with the goal of increasing single bills available for rate-setting in order to improve the accuracy of median costs based upon hospital claims.

We received many public comments concerning our proposal.

Comment: Many commenters stated that the payments CMS proposed for APCs 0107 and 0108 are inadequate to cover the acquisition costs of the

devices, much less the full hospital costs of providing the services. They asserted that the proposed payments for APCs 0107 and 0108 are only 84 percent of the cost of the device alone, leaving the hospital with an out of pocket loss for the device and no payment for the service costs. They indicated that if the proposed payment rates are made final, APCs 0107 and 0108 will have incurred reductions of 20.5 percent and 29.4 percent respectively since CY 2002. They urged that CMS use external data for the device portion of the median cost or at a minimum, accept the APC Panel recommendation to set the payment rate for APCs 0107 and 0108 at no less than the CY 2005 OPPS payment rate updated by the full market basket increase. They say that beneficiary access to care will be inhibited by continued inadequate payments for these services.

Response: We have considered the comments and, as proposed, will adjust the medians for the services in APCs 0107 and 0108 under the same policy being applied to other device-dependent APCs. See section IV.A. of this preamble for our discussion of the use of external data, and requests to update the CY 2005 OPPS median costs and payment rates by the market basket for purposes of setting the CY 2006 OPPS payments. Also see section IV. A. of this preamble for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the CY 2006 adjusted median costs for device-dependent APCs, including APCs 0107 and 0108.

Comment: One commenter supported the recommendations of the APC Panel that CMS package CPT codes 93640 and 93641 (electrophysiologic evaluation at time of initial implantation or replacement of cardioverter-defibrillator) and treat CPT code 33241 (subcutaneous removal of cardioverter-defibrillator) as a bypass code when it appears on claims with services assigned to APCs 0107 or 0108. The commenter believed that these changes would result in a more robust set of claims to be used to set the median costs for APCs 0107 and 0108. Other commenters indicate that with or without these changes, the increased volume of claims is unlikely to result in adequate median costs for these procedures.

Response: We believe that it may be appropriate to package CPT codes 93640 and 93641 into the services assigned to APCs 0107 and 0108, and that it may be appropriate to bypass CPT code 33241 only when it appears on the same claim with codes in APCs 0107 or 0108, and we will explore doing this in the future. The APC Data Subcommittee will continue to advise us on efforts to increase the amount of usable claims data for services that very frequently are provided along with other separately payable procedures.

As noted above, consistent with payment for other device-dependent APCs, the CY 2006 OPPS payment for APCs 0107 and 0108 is set based on 90 percent of the CY 2005 OPPS adjusted median cost. See Table 16 for a complete listing of device-dependent APCs and the adjusted median costs on which the payment rates are based.

d. Endovenous Ablation (APC 0092)

Comment: One commenter addressed our final rule (November 15, 2004) regarding the APC assignment of new CPT codes 36475 (Endovenous radiofrequency ablation, first vein) and 36476 (Endovenous radiofrequency ablation, vein add-on). The commenter asserted that the assignment to APC 0092 (Level I Vascular Ligation) was inappropriate and results in payment that is inadequate to cover the costs of the procedure. The commenter recommended creation of two new APCs, Level I and Level II endovenous ablation procedures, and advocated assignment of both CPT codes 36475 and 36476 to the higher of the two levels. The commenter stated that radiofrequency (RF) ablation procedures are quite different from other vein stripping methods and require substantially more operating room time and hospital resources than do vein stripping or endovenous laser procedures.

Further, the commenter stated that our assignment of CPT codes 36475 and 36476 to APC 0092 was inconsistent with the cost data CMS analyzed for making pass-through payments for the ablation catheter (HCPCS code C1888, which expires December 31, 2005). The commenter asserted that we failed to add the costs for the ablation device into the procedure when we made the assignment to APC 0092. The commenter also stated that hospitals and the manufacturer have submitted cost information and charge data to CMS that support assignment of the procedures to an APC with a payment rate of about $2,500.

We received one comment, from the same commenter, on our proposed rule. The commenters stated that the RF ablation procedures are more like those assigned to APC 0086, Ablate Heart Dysrythm Focus, than those in APC 0092 (Level I Vascular Ligation). Similar to its comment on the final rule, the commenter recommended that CMS reassign CPT codes 36475 and 36476 to a new APC with a payment amount of approximately $2,800. The commenter also recommended that we assign new CPT codes 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated) and 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites) to the lower level of the two new endovascular ablation procedure APCs that they requested, with a payment rate of approximately $2,300.

In its proposed rule comments, the commenter provided detailed information about the costs of the endovenous ablation procedures from the practice expense cost inputs for the Medicare Physician Fee Schedule. The commenter based its recommendations for OPPS payment on those data and provided prices for the RF ablation catheter ($680) and the laser fiber kit ($325), as well as for the capital equipment for each procedure type.

Response: Prior to the CY 2005 implementation of CPT codes 36475 and 36476 for radiofrequency ablation and CPT codes 36478 and 36479 for laser ablation, the radiofrequency ablation device used in the endovenous ablation procedure was coded using HCPCS code C1888 (Catheter, ablation, non-cardiac, endovascular) and was separately paid as a pass-through until December 31, 2004 when the pass-through status expired.

We received a significant number of bills for HCPCS code C1888 (1787 units) in CY 2004 and considered the median cost ($636) based on those bills, along with clinical information and historical hospital claims data for other OPPS services in making the APC assignments of the new CPT codes. We assigned all RF and laser endovenous ablation procedures for the first vein and second and subsequent veins to APC 0092, status indicator ''T,'' with other vein procedures and a CY 2005 payment rate of $1,538. However, in response to the comment we reconsidered our decision. While there are no two times rule violations for APCs 0092 and 0091 for CY 2006, the median costs for individual procedures assigned to those APCs significantly overlap. Nevertheless, APC 0091 has a somewhat higher payment rate for CY 2006. Given the costs for the disposables and other resources used in delivery of both laser and RF endovenous ablation services, we determined that assignment to the higher paying of these APCs was a more

accurate placement than APC 0092 as we proposed. Therefore, for CY 2006, CPT codes 36475, 36476, 36478, and 36479 will be assigned to APC 0091. The ''T'' status of the APC should ensure appropriate payment when ablation of more than one vein is performed in an operative session. For CY 2007 we will have hospital claims data for those codes for the first time, and, with the assistance of the APC Panel, we will reconsider the APC assignments for them and the other procedures assigned to APCs 0091 and 0092 because we believe that for procedures assigned to APCs 0091 and 0092 CY 2007 APC reconfiguration may be advisable.

e. External Counterpulsation Therapy (APC 0678)

Comment: One commenter submitted comments about external counterpulsation therapy (EECP, HCPCS code G0166). The commenter requested that we base the CY 2006 payment for this procedure on the OPPS relative weight for the procedure from CY 2005. The commenter was concerned because the OPPS rate for this procedure has decreased every year since CY 2000, and they believed that the lower payments might result in diminished beneficiary access to the therapy. The commenter believed that the low costs in the CMS data may be due to hospitals filing inaccurate claims.

Response: Although the OPPS payment rate for EECP has decreased every year since CY 2000 as noted by the commenter, we are committed to relying on our hospital claims data for this APC. In addition, we note that the total numbers of OPPS claims for this service have increased over the past several years, from 26,836 in CY 2002, to 37,568 in CY 2003, and again to 40,362 in our most recent claims data for CY 2004. We have no reason to believe that Medicare beneficiaries are having trouble accessing this therapy. Hospitals have been billing Medicare for EECP since CY 2000 and so should be filing accurate bills. The procedure is in an APC that has no other procedures that can affect its median, and the median cost for the CY 2006 OPPS is based on more than 38,000 single claims. Therefore, we will finalize our proposed CY 2006 APC assignment and payment rate for APC 0678, based on our standard OPPS methodology.

f. Intracardiac Echocardiography (APC 0670)

Comment: One comment submitted comments about the APC assignment for CPT code 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation). The commenter objected to the procedure's assignment to APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) for several reasons. First among those reasons was that the procedure should not be assigned to the same APC as is CPT code 92978, Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report. The commenter stated that the two procedures are dissimilar clinically and with respect to resource consumption. The differences between the two procedures listed by the commenter were: the intracardiac echocardiography (ICE) procedure can be used to image the entire heart rather than just a coronary vessel as does the intravascular ultrasound (IVUS) procedure; ICE is closely associated with electrophysiology and interventional cardiology procedures; IVUS is an imaging technique used as an adjunct to coronary/peripheral stent deployment; IVUS catheters cost from $500 to $700 whereas ICE catheters cost from $900 to $2,800; and the mean and median costs for the procedures are very different.

Response: The ICE procedure is a CPT code ''add-on,'' and so normally is not reported alone on OPPS bills. For that reason, only 10 of the 541 claims for the procedure were single claims that we could use to calculate its procedure-specific median cost of $1,815. In fact, all four of the procedures assigned to APC 0670 are ''add-on'' codes, and two of the procedures had no single claims for CY 2004 because one of the codes, CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)), was new for CY 2005 and CPT code 93571 (Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel) was packaged under the OPPS in CY 2004 and when unpackaged for CY 2005, no single claims were available. The fourth code in APC 0670, CPT code 92978, the IVUS procedure, had a median cost of $1,505 and 115 single claims and, therefore, had a disproportionate influence on the median cost for the APC.

We do not agree that there are no significant clinical similarities among the procedures assigned to APC 0670. These similarities include their ''add-on'' status and their use of intravascular or intrabronchial catheters or wires with complex capabilities to provide clinical information, such as images or flow data. The hospital resources required for all of these services are highly related to the costs of the technologies used for the procedures. In general, our hospital claims data are quite consistent with assignment of CPT code 93662 to APC 0670 with a median cost of $1,505 for CY 2006, along with the other services previously described. We note that our CY 2004 total claims volume for CPT code 93662 almost doubled between CY 2003 and CY 2004, providing no evidence that Medicare beneficiaries are having trouble accessing this service.

As discussed elsewhere in this preamble, we are working on alternative strategies for determining the costs for procedures that are reported as CPT ''add-on'' codes. When we are better able to identify those costs, we will reevaluate the assignment of the ICE and IVUS procedures. At this time, however, we believe that APC 0670 is the most appropriate assignment for CPT codes 93662 and 92978.

g. Percutaneous Thrombectomy and Thrombolysis (APC 0676)

Comment: One commenter submitted comments regarding the APC assignment for CPT code 92973, Percutaneous transluminal coronary thrombectomy and CPT code 37195 (Thrombolysis, cerebral, by intravenous infusion). The commenter stated that the payment rate for APC 0676 (Thrombolysis and Thrombectomy) was based largely on only one of the procedures assigned to the APC, CPT code 36550 (Declotting by thrombolytic agent of implanted vascular access device or catheter), and that it was inappropriately low for CPT codes 92973 and 37195. The commenter stated that the procedures coded by CPT codes 92973 and 37195 require a mechanical device costing hundreds of dollars or significant quantities of expensive lytic agents, respectively. The comment also suggested that the difficulty that CMS has in obtaining accurate cost data for these procedures is due to the fact that they are rarely reported as single claims, and that next year there will be new codes for percutaneous thrombectomy that will help to remedy that situation.

Response: For CY 2006, we proposed to retain CPT code 92973 in APC 0676 and to remove CPT code 37195 from the inpatient list and assign it to APC 0676 as well. The median cost for each of these procedures was based on one single claim each, out of 149 and 28 total claims respectively. The very low volume of single claims is expected for these two procedures because CPT code

92973 is an ''add-on'' code and would not be expected to be reported alone, and CPT code 37195 was on the inpatient list in CY 2004, and therefore, we do not have many outpatient hospital claims for it.

The commenter's point that the APC 0676 payment rate was based mainly on one of the other procedures assigned to that APC is correct. The procedure coded with CPT code 36550 (Declotting by thrombolytic agent of implanted vascular access device or catheter) had a very high volume of single claims with a procedure-specific median cost of $128 so that its claims disproportionately influenced the APC median cost of $135. There were 5,099 single claims for that procedure and the next highest volume of single claims in APC 0676 was only 439 claims for CPT code 37201 (Transcatheter therapy, infusion for thrombolysis other than coronary).

While we acknowledge the small number of claims for CPT code 92973, we agree with the commenter than its continued assignment to APC 0676 could lead to significant underpayment for this service that utilizes a costly catheter. Therefore, we will reassign CPT code 92973 to APC 0088 (Thrombectomy) with an APC median of $2,171 for CY 2006, where other procedures that are more clinically and resource coherent with CPT code 92973 reside. As this service is an ''add-on'' code to other surgical procedures and is assigned status indicator ''T,'' we expect that its payment rate will be reduced by 50 percent when it is correctly billed with other surgical procedures.

With respect to CPT code 37195, we will finalize its assignment to APC 0676 for CY 2006. We expect that the lytic drugs that will be administered to a patient during this procedure will generally be separately payable under the OPPS, as well as some of the other services that typically will be provided to a patient receiving cerebral thrombolysis by intravenous infusion. While we expect that performance of this procedure in the hospital outpatient setting will remain rare, we believe that APC 0676 should make appropriate payment for CPT code 37195 for CY 2006. As always, we will examine the costs from hospital claims as new data become available to ensure that the OPPS payment is appropriate.

h. Coronary Flow Reserve (APCs 0416 and 0670)

Comment: One commenter requested that CMS make permanent the revised APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) and new APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve), as presented in the November 15, 2004 final rule. In addition, the commenter requested that we reactivate discontinued HCPCS code C3556 which was used previously for three specific brands of sensors, including guidewire-mounted coronary flow reserve sensors. The commenter believed that the requirement to report HCPCS device codes for device-dependent APCs would result in inaccurate cost information for the flow reserve sensors because these devices are currently coded using HCPCS code C1769 which is also used to code all types of guidewires.

Response: We appreciate the comment concerning these new and revised APCs as we published them in the November 15, 2004 final rule. We have made those changes final.

Beginning April 1, 2001, many manufacturer and device-specific HCPCS codes established for device pass-through payment purposes were discontinued in favor of more general codes to describe categories of devices. HCPCS code C3556 was discontinued as of April 1, 2001 as part of that action. The guidewire-mounted coronary flow reserve sensors previously reported with HCPCS code C3556 were cross-walked to HCPCS code C1769, which was established for coding guidewires. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 required us to establish categories, or types, of devices and no longer create codes to describe each device specifically. Further, we do not create new device codes unless one is needed to support accurate payment for devices that meet our criteria for transitional pass-through payment. There is no such need in this case as the guidewire-mounted coronary flow reserve sensor received its full period of device pass-through payments.

We do not believe that use of HCPCS code C1769 will result in inaccurate cost data for coronary flow reserve measurement services. Reporting the device code on claims for device-dependent procedures is meant to ensure that the bills upon which we rely for calculation of the median costs include the device costs integral to the procedures. We base this policy on our belief that if a hospital includes the code for the device on the bill, even though there is no separate payment for the device, the bill is more likely to be an accurate and complete report of hospital charges (and thereby, costs). We expect that hospitals reporting the required guidewire device C-code along with a coronary flow reserve measurement service will provide an appropriate charge for the device used in the procedure.

The new requirement for device coding is one technique that we believe will help us to address the ongoing problem of hospitals inadvertently failing to accurately and fully bill the charges for all hospital resources utilized to perform procedures. By requiring that the device code be on the claim, we are more confident that the device costs have been included in the hospital's bill and that we will capture accurate costs for rate setting for the procedure as a whole.

i. Vascular Access Procedures (APCs 0621, 0622, and 0623)

Many of the codes that currently describe vascular access procedures were new in the CY 2004 version of CPT and were assigned into APC groups by crosswalking the newly created CPT codes to the deleted codes' APC assignments. Although the new codes were implemented in January 2004, because of the delay between a bill being submitted to Medicare and when the bill data are viable for analysis, we did not have cost and utilization data for the new codes available for analysis until this year in preparation for the CY 2006 OPPS.

Since those original APC assignments were made, we have received requests from the public for specific APC assignment changes. We were reluctant to make changes without data to support reassignments and, therefore, made few changes to those original APC assignments.

As an outcome of an analysis of procedure-specific median costs and 2 times rule violations in preparation for the CY 2006 update of the OPPS, for the proposed rule we developed a new APC configuration for vascular access procedure codes and several other related codes. The proposed new assignments were supported by CY 2004 hospital claims data and are based on median cost and clinical considerations.

Thus, for CY 2006 we proposed to reassign many of the CPT codes that are currently in the following APCs:

- APC 0032 (Insertion of Central Venous/Arterial Catheter)
- APC 0109 (Removal of Implanted Devices)
- APC 0115 (Cannula/Access Device Procedures)
- APC 0119 (Implantation of Infusion Pump)
- APC 0124 (Revision of Implanted Infusion Pump)
- APC 0187 (Miscellaneous Placement/Repositioning)

The configuration that we proposed placed all of the procedures currently

assigned to APC 0187 into more clinically appropriate APCs. We also proposed to reassign all of the vascular access procedure codes currently assigned to any of the identified APCs to existing or newly reconfigured clinical APCs to create more clinical and median cost homogeneity. As a result of the proposed reassignments, those clinical APCs were comprised of a different mix of codes than is currently the case for the CY 2005 OPPS. There were no codes assigned to APC 0187 because the only procedures that remained in APC 0187 after reassigning the vascular access procedures as we proposed were CPT code 75940 (X-ray placement of vein filter) and CPT code 76095 (Stereotactic breast biopsy), which we reassigned to more clinically appropriate APCs. We proposed to reassign CPT code 75940 to APC 0297 (Level II Therapeutic Radiologic Procedures) and CPT code 76095 to APC 0264 (Level II Miscellaneous Radiology Procedures).

We proposed to create three new clinical APCs, APC 0621 (Level I Vascular Access Codes), APC 0622 (Level II Vascular Access Codes), and APC 0623 (Level III Vascular Access Codes) and assign procedures to each of these based on median cost and clinical homogeneity. We also proposed to rename APCs 0109 and 0115 as follows: APC 0109 (Removal of Implanted Devices); and APC 0115 (Cannula/Access Device Procedures).

We presented this proposal to the APC Panel at its February 2005 meeting. The APC Panel was supportive of the proposed reassignments and recommended that we make these changes. Therefore, for the stated reasons we proposed the APC modifications for CY 2006 OPPS as summarized in Table 13 of the proposed rule (70 FR 42713).

We received a few comments on our proposal.

Comment: All of the comments were supportive of our reconfiguration of the APCs and encouraged us to make the proposal final.

Response: We appreciate the commenters' support.

Therefore, we are finalizing our proposal without modification for FY 2006.

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Table 13.--Current and Final APC Assignments for Vascular Access Procedures and Related Procedures for CY 2006

CPT Code	Descriptor	CY 2005 APC	CY 2006 APC
APC 0621	**Level I Vascular Access Procedure**		
36555	Insertion non-tunneled cv cath	0187	0621
36556	Insertion non-tunneled cv cath	0187	0621
36568	Insert tunneled cv cath	0187	0621
36569	Insert tunneled cv cath	0187	0621
36575	Repair tunneled cv cath	0187	0621
36576	Repair tunneled cv cath	0187	0621
36580	Replace tunneled cv cath	0187	0621
36584	Replace tunneled cv cath	0187	0621
36589	Remove tunneled cv cath	0109	0621
36590	Remove tunneled cv cath	0187	0621
36596	Mech removal tunneled cv cath	0187	0621
36597	Reposition venous catheter	0187	0621
APC 0622	**Level II Vascular Access Procedures**		
36557	Insert tunneled cv cath	0032	0622
36558	Insert tunneled cv cath	0032	0622
36578	Replace tunneled cv cath	0187	0622
36581	Replace tunneled cv cath	0032	0622
36585	Replace tunneled cv cath	0032	0622
36570	Insert tunneled cv cath	0032	0622
36571	Insert tunneled cv cath	0032	0622
36595	Mech removal tunneled cv cath	0187	0622
36262	Removal intra-arterial inf. Pump	0124	0622
APC 0623	**Level III Vascular Access Procedures**		
36560	Insert tunneled cv cath	0115	0623
36561	Insert tunneled cv cath	0115	0623
36563	Insert tunneled cv cath	0119	0623
36565	Insert tunneled cv cath	0115	0623
36582	Replace tunneled cv cath	0115	0623
36583	Insertion of access device	0119	0623
36640	Insertion catheter, artery	0032	0623
36260	Insertion of infusion pump	0119	0623
36261	Revision of infusion pump	0124	0623
APC 0115	**Cannula/Access Device Procedures**		
36835	Artery to vein shunt	0115	0115
35903	Excision, graft, extremity	0115	0115
36815	Insertion of cannula	0115	0115
36861	Cannula declotting	0115	0115
35761	Exploration of artery/vein	0115	0115
49419	Insert abdominal cath for chemo	0115	0115
36800	Insertion of cannula	0115	0115
37204	Transcatheter occlusion	0115	0115
36810	Insertion of cannula	0115	0115
APC 0109	**Removal of Implanted Devices**		
33284	Remove pt-activated heart recorder	0109	0109
63746	Removal of spinal shunt	0109	0109

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2. Radiology, Radiation Oncology, and Nuclear Medicine

a. Angiography and Venography (APCs 0279, 0280, and 0668)

Comment: One commenter supported our proposal to reassign CPT code 75790 (Angiography, arteriovenous shunt, radiological supervision and interpretation) from APC 0281 (Venography of Extremity) to APC 0279 (Level II Angiography and Venography except Extremity). However, this same commenter objected to our proposal to move CPT codes 75820 (Venography, extremity, unilateral, radiological supervision and interpretation) and 75822 (Venography, extremity, unilateral, radiological supervision and interpretation) from APC 0281 (Venography of Extremity) to APC 0668 (Level I Angiography and Venography except Extremity). The commenter contended that CPT codes 75790, 75820, and 75822 share similar clinical characteristics and resource requirements and, therefore, should be mapped to the same APC 0279. For instance, the commenter stated that all three services require the use of guidewires, catheters, local anesthetic, and contrast. Furthermore, the commenter asserted that CPT code 75822 involves a bilateral procedure which requires much higher resource costs than other services assigned to APC 0668. Lastly, the commenter stated that CPT codes 75790, 75820, and 75822 share similar clinical characteristics with CPT code 75658 (Angiography, brachial, retrograde, radiological supervision and interpretation), which currently resides in APC 0279, differing only with respect to whether a vein is accessed versus an artery in an extremity. The commenter urged that CMS reassign CPT codes 75790, 75820, and 75822 to APC 0279 for CY 2006. In addition, the commenter recommended that CMS modify the title of APC 0668 to exclude language referring to extremities based on the commenter's belief that none of the other CPT codes assigned to APC 0668 relate to extremities.

Response: Based on our analysis of our CY 2004 claims data we disagree with the commenter that services described by CPT codes 75790, 75820, and 75822 require similar hospital resources. CPT code 75790 has a median cost of $548, based on over 18,000 single claims from CY 2004, and is assigned to APC 0279 (Level II Angiography and Venography), which has a median cost of $517. We believe that this APC appropriately reflects the clinical and hospital resource characteristics of CPT code 75790 and provides appropriate payment to hospitals for this service.

In contrast, CPT code 75720 has a median cost of only $258, based on almost 3,500 single claims that represent over half of the total claims for the service. Similarly, CPT code 75722 has a median cost of $349, based on over 2,400 claims that represent more than half of the total claims for the service. Both of these procedures are assigned to APC 0668 which has a median cost of $375. We believe that APC 0668 appropriately reflects the clinical and hospital resource characteristics of both of these procedures. Thus, although these three codes were assigned to the same clinical APC 0281 for CY 2005, when we eliminated that APC and reassigned the three services, we were able to place them in such a way as to provide more accurate payments for each of the services.

We appreciate the commenter's drawing our attention to the phrase ''Except Extremity'' that remained in the APC titles for APCs 0668, 0279, and 0280 after we eliminated the CY 2005 APC for extremity venography services. For CY 2006, we have removed the phrase ''Except Extremity'' from the APC title for APCs 0668, 0279, and 0280, so they are now renamed Levels I, II, and III Angiography and Venography, respectively.

b. Brachytherapy (APCs 0312, 0313, and 0651)

Comment: Commenters objected to the proposed reduction in the payment rates for APCs 0312, 0313 and 0651 for the CY 2006 OPPS. They indicated that the reductions could result in decreased access to care. They recommended that CMS use only claims on which a brachythearpy source appears with the procedure code, which they describe as ''correctly coded'' claims, as the basis for the median cost calculations for these APCs. They indicated that using only claims on which the brachytherapy source code was billed results in median costs that are higher than the median costs calculated using all single procedure claims. At its August 2005 meeting, the APC Panel recommended that we evaluate this proposal. The commenters also asked that CMS expand the adjustment proposed for selected device dependent APCs to APCs 0312, 0313 and 0651. They asked that CMS consider alternative methodologies to utilize single and multiple procedure claims for rate setting purposes so that more claims could be used. They also asked that CMS use external proprietary and confidential data to determine median costs for rate-setting. They said that because brachytherapy sources are required to furnish these services, they should be treated like device dependent APCs with regard to adjustment of medians and required editing for the presence of sources on the claims.

Response: We have not accepted the commenters' recommendations to use external data for the reasons we cite in the discussion of external data in section II. of this preamble. Moreover, we have not accepted the recommendation that we use only claims that contain a brachytherapy source on the claim to calculate the median costs for APCs 0312, 0313, and 0651 because we believe that the presence of a source on the claim is not relevant, since sources are paid separately. While the median costs presented by the commenters based on claims that contain sources resulted in higher median costs, we do not see a valid reason to limit the claims to claims with sources because the presence of the source is not relevant to the median cost of the procedural APC. We have no reason to believe that the claims without sources on the claim do not contain the full charges for the procedural services furnished. We have applied adjustments to the median costs for device dependent APCs for CY 2006 because of the difficulties in ensuring device charges are fully reflected on claims for these services, thus allowing appropriate packaging of the device costs into the APC payments. This rationale does not apply to the APCs for application of brachytherapy sources, so we have not applied the device dependent APC median adjustment policy to APCs 0312, 0313, and 0651 for CY 2006.

We disagree that these services should be treated like device dependent APCs solely because they require brachytherapy sources. The critical distinction is that the APC payment for device dependent APCs includes payment for the packaged devices, while payment for these brachytherapy source application APCs is exclusive of payment for the sources, which are paid on the basis of charges reduced to cost. The editing for the presence of key devices on claims for services assigned device dependent APCs is not ''correct coding'' editing. Instead, the edit is made to maximize the likelihood that the charge for the principle device required to perform the service is included on the claim so that we will capture the cost of the device in setting the median cost for the APC.

Although the brachytherapy procedure comments have largely

focused on the payment for CPT code 77778, the application of the brachytherapy sources, we note that all the related procedures, such as needle or catheter use and placement, must be considered for a full analysis of payment for brachytherapy services. The brachytherapy source application service is but one component of the entire procedure. The hospital also bills for the placement of the needles or catheters, the imaging and planning services, and is paid separately for the sources at charges reduced to costs.

Because of the particularly large drop in median cost from the median based on CY 2003 data compared to the median cost based on CY 2004 claims data for APC 0651, we extensively reviewed the cost of APC 0651, which is most commonly billed for the provision of interstitial prostate brachytherapy and frequently appears on the same claim with CPT code 55859, the code for placement of needles or catheters into the prostate. Contrary to the commenters' belief that ''correctly coded'' claims for CPT code 77778 also contain brachytherapy sources, in most cases of prostate brachytherapy both CPT codes 55859 and 77778 are found on the same claim with a radiologic guidance code (often CPT codes 76000 or 76965) and/or with a radiation planning code (usually CPT code 77290). This results in a correctly coded claim for interstitial brachytherapy designated as a multiple procedure claim. Furthermore, these claims not only contain the two major procedures (CPT codes 55859 and 77778), but they also often contain the three ancillary procedures (CPT codes 76000, 76965 and/or 77290), which are not on the bypass list because they have packaging in excess of $50 or they have packaging on more than 5 percent of single bills.

In our review, we identified 11,341 claims containing both CPT codes 55859 and 77778 on the same date of service. We then looked for claims in this subgroup that contained no separately paid codes other than the three ancillary services (after we applied the bypass list and removed any codes on it). This gave us 7,533 claims containing CPT codes 55859 and 77778 with no other major procedures except for the 3 ancillary services. We believe that claims with CPT codes 55859, 77778 and one or more of these 3 ancillary services represent the most typical combinations of services furnished when brachytherapy sources are applied. We then calculated two combination median costs: a combination package and combination bypass. The first combination median cost was calculated by treating these three codes as if they were grouped into one comprehensive service by adding the costs of these codes to the costs on the claim for CPT codes 55859 and 77778 and all other packaged costs. This ''combination group median'' is $3,187.86. This ''combination group median'' overstates the costs of CPT codes 55859 and 77778 by the extent to which the costs of the three ancillary services and the packaging that is associated with them are reflected in it. We then calculated a second combination median cost in which we treated these three ancillary codes as if they were on the bypass list by removing the line item charges for these codes and associated all packaging on the claim with CPT codes 55859 and 77778. This ''combination bypass median'' is $2,968.64. This ''combination bypass median'' overstates the costs of CPT codes 55859 and 77778 to the extent that the packaged costs associated with the 3 ancillary services are reflected in it.

We then compared the sum of the single bill medians calculated from our OPPS stated methodology for CPT codes 55859 and 77778 to both of these combination medians. The sum of the single bill medians for these codes (without any costs from the three ancillary procedures) is $2,662.62. We then summed the medians for CPT codes 55859, 77778, 76000, and 77290, a typical combination of codes for these services, resulting in a sum of $2,975.50, similar in range to both the ''combination group median'' and the ''combination bypass median.''

Under our analysis, the sum of the single bill medians for insertion of needles or catheters in the prostate and the application of brachytherapy sources is well within the range of the combination medians we calculated based on the multiple procedure claims. Accordingly, we have no reason to believe that the single bill median costs for the services reported by CPT codes 55859 and 77778 do not otherwise appropriately reflect the costs for those services. Therefore, we have used the standard OPPS methodology for clinical brachytherapy services to set the payment rates for the CY 2006 OPPS.

Comment: One commenter stated that date of service stratification results in pseudo single claims for APCs 0312 and 0651 that lack packaging because all packaging on the claim has the same date of service as the other procedure on the claim (i.e. not the procedure code in APC 0312 or 0651). The commenter indicated that the median costs for these ''pseudo no package'' claims is significantly lower than the medians for other single procedure bills for these services and, therefore, should be deleted from the claims used to set the median costs for these APCs.

Response: We have no basis to believe that the charges for the procedure code are not all-inclusive charges for all packaged items and services associated with the procedure when a single charge appears for a procedure code. Again, we encourage hospitals to bill all relevant HCPCS codes that appropriately reflect the services provided.

c. Computed Tomography (APCs 0283 and 0333)

Comment: One commenter supported our proposal to pay separately for low osmolar contrast material (LOCM) and most magnetic resonance contrast agents. However, the commenter expressed concern that the separate payment for these agents will not adequately compensate for the reduced payment which CMS proposed for APCs 0283 (CT with contrast) and 0333 (CT and CTA without contrast followed by contrast). The commenter stated that they did not understand CMS' rationale for proposing to reduce payments for APCs 0283 and 0333 to a level that results in an overall net loss for contrast-enhanced CT studies.

Response: We do not agree with the commenter's assertion that the proposed CY 2006 payment rates for APCs 0283 and 0333 will necessarily reduce overall payments for contrast-enhanced CT studies. First, the proposed CY 2006 payments for APCs 0283 and 0333 decreased by less than 3 percent compared to their CY 2005 payment rates. Second, our proposal to pay separately for LOCM products (HCPCS codes Q9945 through Q9951) as a result of the mean costs per day of their predecessor codes (HCPCS codes A4644 through A4646) exceeding $50, may increase overall payments for some contrast-enhanced CT studies while decreasing overall payments for other contrast-enhanced CT studies, depending on the volume and concentration of the LOCM used. The CY 2006 final payment rates for APCs 0283 and 0333 were calculated from CY 2004 hospital claims data utilizing the standard OPPS methodology based on our comprehensive payment policies for CY 2006, which include unpackaging LOCM.

Therefore, hospital charges for LOCM in association with single claims for services assigned to APCs 0283 and 0333 were not packaged into the median cost calculations for these APCs. As a result, we would expect the APC payment rates for APCs 0283 and 0333 to decline slightly for CY 2006. For CY 2006, we are applying our standard

OPPS rate setting methodology using CY 2004 hospital claims data to set the payment rates for APCs 0283 and 0333, and are paying separately for LOCM based on the payment methodology described in section V.B.3.a.(3) of this preamble.

d. Computed Tomographic Angiography (APC 0333)

In Addendum B of the CY 2006 proposed rule (70 FR 42776), we proposed to maintain a number of imaging procedures discussed below in their CY 2005 APCs.

Comment: Several comments expressed concern that the CY 2006 proposed payment rate for Computerized Tomographic Angiography (CTA) procedures (APC 0662) continues to be lower than the proposed payment rate for conventional CT procedures. These commenters recommended that CMS set the payment rate for CTA procedures at a level equal to the payment for a CT scan (APC 0333) plus a three-dimensional image reconstruction (APC 0282) by either increasing the payment for APC 0662 or reassigning CTA procedures to an existing APC whose payment rate more closely reflects the resource costs of performing CTA procedures.

Response: As we stated in the November 15, 2004 final rule with comment period (69 FR 65722), accurate cost information about the cost of image reconstruction for CTA specifically, and for CT alone as utilized with CTA, would be required in order to implement the commenter's suggestion that we make the payment rate for CTA (APC 0662) equal to the sum of the rates for CT alone (APC 333) plus image reconstruction (APC 282). Such cost information is not available. The CY 2004 image reconstruction CPT code 76375 (coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) is not limited to image reconstruction performed for CTA and may be used in a number of other procedures. Based on the available CPT codes for CTA, we would not expect any current utilization of CPT code 76375 to be for CTA post-image processing, unless there was no appropriate CTA code to describe the body region imaged, which we believe would rarely be the case. In addition, we would not expect our current cost data for CTA alone to necessarily reflect the resources utilized for the CT portion of CTA.

Commenters provided no evidence suggesting that Medicare beneficiaries have experienced difficulty accessing these services in the hospital outpatient setting. To the contrary, our number of claims for CTA procedures increased steadily between CY 2002 and CY 2003 and nearly doubled from CY 2003 to CY 2004. Furthermore, we used over 50 percent (99,000 single claims out of nearly 180,000 total claims) of the CY 2004 claims for CTA procedures to calculate the CY 2006 payment rate for these services.

We now have several years of robust claims data for CTA procedures and have no reason to doubt this data. Based on the full year of CY 2004 data, the median costs for the APCs 0333 (CT) and 0662 (CTA) are about equal, and have decreased minimally from their median costs based on CY 2003 claims data. Because hospitals set their own charges for services, which we then convert to costs, we still see no reason why adding the costs for CT alone plus the costs for image reconstruction would necessarily provide a better estimate of costs for CTA than our analysis of our specific CTA claims. Furthermore, no other existing clinical APC appears to contain services that share more clinical and resource cost homogeneity with CTA procedures than APC 0662, whose median cost reflects solely the claims data from 8 CTA procedures. For this reason, we are not reassigning CTA procedures to any other clinical APC(s) for CY 2006. Instead, for CY 2006, we are applying our standard OPPS rate-setting methodology for calculating the payment rate for CTA procedures residing in APC 0662. Once again, we encourage all hospitals to take all actions necessary to ensure that they are billing accurately and including in their charges all resources utilized to deliver CTA services.

e. Computed Tomographic Guidance (APC 0332)

Comment: One commenter objected to the proposed payment rate of $194 for CPT code 76362 (Computed tomography guidance for, and monitoring of, visceral tissue ablation), which was proposed to be assigned to APC 0332 (Computerized Axial Tomography and Computerized Angiography without Contrast) for CY 2006. The commenter said that, although CMS included only 9 single claims in the calculation of the $371 median cost for CPT code 76362 in the proposed rule, they identified 202 single bills with a median cost of $580 for CPT code 76362. The commenter indicated that it found that CPT code 76362 was not being treated as a major procedure in CMS' median cost calculations, and it could not determine if CMS packaged the cost for CPT code 76362 into the payment for the other separately payable procedure on the claim. The commenter indicated that it simulated removing the exception (although they did not specify what they did) and by doing so found 202 single bills with a median cost of $580 for the code. The commenter asked that we place CPT code 76362 in New Technology APC 1507 (Level VII $500–$600) so that payment would be set at $550. The commenter also requested that CMS add CPT code 76362 to the bypass list in future years.

Response: We do not agree that CPT code 76362 would be appropriately assigned to New Technology APC 1507 because CT is not a new technology. The use of CT guidance for and monitoring of visceral tissue ablation is a more recent application of this well-established technology. We acknowledge that we have few single bills upon which to base our calculation of the median cost of this service, but this is consistent with our expectations based on the nature of the service. We believe that all correctly coded claims would also include a CPT code for the specific ablation service that was monitored using CT and billed along with CPT code 76362.

We believe that the primary costs directly attributable to CTP code 76362, as opposed to the accompanying ablation procedure, are the hospital resources required for the lengthy operation of the necessary CT scanner. In examining the clinical characteristics of the use of CT for visceral tissue ablation, we believe that the CT use time for the procedure, although variable depending on the specific ablation procedure provided, would typically be longer than the CT use time for most noncontrast CTs assigned to APC 0332.

Because the commenter indicated their comfort with CPT code 76362 being added to the bypass list, we analyzed the line item charges for all units of service of CPT code 76362 billed by hospitals in CY 2004. The median charge per unit based on over 1,000 units was $1,165. Application of a hospital average CCR of 0.28 for the diagnostic radiology cost center to the median charge of $1,165 for CPT code 76362 yielded a procedure-specific line item cost of approximately $325 for this service. This is quite consistent with our final single claim median cost of $363 based on 9 single claims.

Therefore, we are reassigning CPT code 76362 to APC 0333 (Computerized Axial Tomography and Computerized Angiography Without Contrast Followed by Contrast) with an APC median cost of $303 for CY 2006, where

CT procedures that include both noncontrast and contrast studies in one examination session reside. We believe that, although the ablation monitoring service is not necessarily provided both without and with contrast, the longer time of use of the CT scanner for CPT code 76362 is more consistent with the scanner use time for services assigned to APC 0333. In addition, the median cost of APC 0333 is similar to the median cost of CPT code 76362 based on single claims and to the other cost estimate based on our analysis of all billed units of the code.

With respect to the commenter's data findings, CPT code 76362 is considered to be a minor procedure (notwithstanding the status indicator of ''S''), because it so frequently occurs on the same claim as other separately paid procedures and is ancillary to them. As such, when a minor procedure is on the same claim as a major procedure, the claim is considered to be a single major procedure claim and the costs of the minor procedure are not used to set the median for the minor procedure, nor are they packaged into the payment for the major procedure. The only single claims that are used in the calculation of the median cost for the minor procedure code and, therefore, for the APC to which the code is assigned are single minor procedure claims which are derived from circumstances in which the minor procedure appears alone on a claim or when it appears as one of several multiple minor procedures on a claim and can be split off because the services have different dates of service.

We considered making CPT code 76362 a major procedure and adding the service to the bypass list. However, the code does not meet the empirical criteria we have established for considering new additions to the bypass list. Of the total claims for CPT code 76362, we had only 9 single procedure claims (less than the 100 required for a code to go onto the bypass list); 6 of the 9 claims (67 percent) contained packaged services (more than the 5 percent limit) that yielded a median of $1,231 (considerably above the $50 median limit). Hence, because the data for CPT code 76362 from CY 2004 do not meet any of the criteria for addition of the code to the bypass list, we will not convert it to a major procedure and add it to the bypass list for CY 2006. However, we will consider for CY 2007 whether we should make an exception to our empirical criteria for additions to the bypass list for services such as CPT code 76362. We will continue to develop a more appropriate median cost for the procedure and it seems plausible that the procedure should have very little associated packaging.

f. Computerized Reconstruction (APC 0417)

Comment: One comment expressed concern about the payment rate for HCPCS code G0288 (Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery). The commenter was concerned because the proposed rule indicated that the rate for HCPCS code G0288 would decrease for CY 2006, continuing a trend of decreases that began in CY 2004. The commenter made several recommendations to CMS that it believed would help to limit the decreased rate for CY 2006 and to prevent continuation of the downward trend for coming years. The first recommendation was for CMS to mandate which revenue code hospitals are to use to report HCPCS code G0288. The commenter recommended use of revenue code 0780, Telemedicine. This was based on their finding that hospitals used 17 different revenue codes to report HCPCS code G0288. The commenter stated that more consistent use of a revenue code would alleviate the effects of providers not billing charges high enough to result in cost findings near the acquisition costs.

Next, the commenter recommended that for CY 2006, CMS use the hospital overall CCRs to calculate the median for HCPCS code G0288. The commenter believed use of the overall CCRs would increase the median for APC 0417 to approximately $415.

Third, the commenter recommended as a fallback measure, in case the first two recommendations could not be implemented, that CMS should use the CY 2005 rate, adjusted upward in accordance with the CY 2006 conversion factor, for APC 0417 in CY 2006.

Finally, the commenter requested that the descriptor for HCPCS code G0288 be revised to read, ''Three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation in accordance with measurements and modeling specifications of the Society for Vascular Surgery.'' They stated that the revised descriptor would ensure that the code would be used more accurately.

Response: Regarding the commenter's last request, that we revise the descriptor for HCPCS code G0288, we do not believe that is necessary. HCPCS code G0288 was revised in CY 2004 to clarify that the service can be provided for both treatment planning prior to surgery and for postsurgical monitoring. Other than this one comment, we have had no indication that there is confusion among providers about when to use the code. In addition, we generally allow hospitals to allocate their charges across revenue codes as they feel is appropriate to their specific institutional settings, and we see no reason to deviate from this policy for the service described by HCPCS code G0288. We do not understand how specifying a revenue code for reporting would necessarily ensure adequate hospital charges for the service.

In response to the commenter's recommendations regarding our hospital cost data, we conducted a detailed examination of our CY 2004 claims data and, like the commenter, found that hospitals used 17 different revenue codes to report HCPCS code G0288. However, we also found that although 8 different cost centers for HCPCS code G0288 were used in our conversion of charges to costs for the service, for 83 percent of the approximately 5,300 single bills utilized for rate setting we converted hospital charges to costs using one cost center, namely Diagnostic Radiology. Therefore, while we acknowledge that utilizing an overall hospital CCR for HCPCS code G0288 yields a higher median cost, $335 for APC 0417 based on our analysis, as opposed to a median cost of $235 utilizing our standard revenue code to cost center crosswalk, we do not believe that it would be appropriate to substitute specific hospital overall CCRs in our calculation of this APC's median. We utilize one hospital-specific departmental CCR for the conversion of charges to costs for most of the single claims, and we have no reason to believe that the CCR in this case is inappropriate. Also, hospitals should bill adequate and complete charges for the service to account for all of the hospital resources required.

Additionally, we see no reason to adjust the payment rate for APC 0417 to the CY 2005 rate adjusted upward in accordance with the CY 2006 conversion factor. We note that despite reductions in payment rates over the last several years, the number of total procedures billed under the OPPS for HCPCS code G0288 has continued to rise from 2,065 in CY 2002, to 4,733 in CY 2003, and most recently to 8,421 in CY 2004. We have no evidence that Medicare beneficiaries are having trouble accessing this service based on our hospital claims information. Therefore, we believe that it is appropriate for us to use our historical hospital cost data as the basis for the CY 2006 payment amount, and we are

finalizing our payment rate for APC 0417 at $235.66 for CY 2006.

g. Diagnostic Computed Tomographic Colonography (APC 0333)

We proposed to reassign CPT 0067T (diagnostic computed tomographic colonography (CTC-Dx)) to APC 0333 (CT and CTA without contrast followed by contrast) for CY 2006.

Comment: One commenter responded to the November 15, 2004 final rule with comment period (69 FR 65682), explaining that CPT code 0067T (diagnostic computed tomographic colonography (CTC-Dx)) was established in CY 2005 to replace the previous coding scheme for CT colonography involving two computed tomography (CT) scans (i.e., abdomen and pelvis) and three-dimensional image reconstruction. Furthermore, the commenter explained that the two CT components of a CTC-Dx may be administered in a variety of ways: (1) CT without contrast, (2) CT with contrast, or (3) CT without contrast followed by a CT scan with contrast. The commenter stated that CMS' assignment of CPT code 0067T to APC 0332 (CT and CTA without contrast) for CY 2005 failed to recognize the cost differential between a CT scan and the variety of ways in which a CTC-Dx scan is administered, along with the costs associated with the three-dimensional image reconstruction. The commenter urged CMS to reconsider the APC placement of CPT code 0067T, taking into account its advantages as a less invasive and less costly alternative to a colonoscopy.

Response: Due to the recent establishment of CPT code 0067T in CY 2005, we will have no hospital claims data for determining its resource requirements until CY 2007. For CY 2005, we assigned CPT code 0067T to APC 0332 (CT and CTA without contrast) because we considered the clinical characteristics of CTC-Dx to be relatively similar to other services assigned to APC 0332. We thank the commenter for bringing to our attention the variety of ways in which a CTC-Dx can be administered, notably a CT scan without contrast followed by a CT scan with contrast. In light of this additional information, for CY 2006 we proposed to reassign CPT 0067T to APC 0333 (CT and CTA without contrast followed by contrast), where similar services reside involving a CT scan without contrast followed by a CT scan with contrast. We are finalizing our proposal to reassign CPT 0067T to APC 0333 for CY 2006. However, in preparation for CY 2007 rate setting, we will reexamine the APC placement of CPT code 0067T based on available CY 2005 hospital claims data.

h. Intensity Modulated Radiation Therapy (IMRT) (APCs 0310 and 0412)

In Addendum B of the CY 2006 proposed rule, we proposed to maintain CPT code 77301 (Radiotherapy dose plan, intensity modulated radiation therapy (IMRT)) in APC 0310 (Level III Therapeutic Radiation Treatment Preparation) based on the CY 2004 hospital claims data submitted for CPT code 77301. In addition, we proposed to maintain CPT codes 0073T (Compensator-based IMRT treatment delivery) and 77418 (Multileaf collimator-based intensity modulated treatment delivery) in APC 0412 (IMRT treatment delivery) for CY 2006.

We received several public comments related to IMRT issues.

Comment: One commenter expressed concern that the proposed payment rate for CPT code 77301 does not reflect the actual physics planning time and resources for this procedure. The commenter recommended that we take into consideration the costs associated with IMRT planning for a typical head and neck case, including the time spent by the dosimetrists, physicists, and physicians, when setting the payment for CPT code 77301.

Response: The proposed procedure-specific median cost of $827 for CPT code 77301 was calculated using 16,417 single procedure claims out of 16,885 total claims (97 percent of the total claims). We proposed to maintain CPT code 77301 in APC 0310 (Level III Therapeutic Radiation Treatment Preparation) grouped with only one other service, CPT code 77295 (Set radiation therapy field), whose proposed median procedure-specific cost of $844 had the effect of increasing the proposed payment for CPT code 77301 due to its significantly higher single frequency of claims used to set the payment for APC 0310. We have no reason to believe that the single procedure claims for CPT code 77301 that represent IMRT planning for head and neck treatment reflect more accurate costs and charges than those claims for CPT 77301 that represent IMRT planning for other body areas. Thus, we would have no justification for discarding such a subset of claims that appear to be accurately reported under CPT code 77301, but merely require less resource utilization for certain covered clinical indications. Rather, the high percentage of single procedure claims for this service, which remains at 97 percent for the final rule data, along with its relatively stable median cost for several years, confirms our belief that the CY 2006 median cost for CPT code 77301 accurately reflects hospitals' costs for the service. We believe these data represent, on average, the resources consumed by hospitals for the provision of IMRT planning services. We note that the OPPS does not provide payment for physicians' professional services that may be required for procedures. Therefore, for CY 2006, we are maintaining CPT code 77301 in APC 0310 with an APC median cost of $825, higher than the final code-specific median cost of CPT code 77301 of $786.

Comment: In response to the November 15, 2004 final rule with comment period (69 FR 65682) and the CY 2006 OPPS proposed rule (70 FR 42674), several commenters applauded our decision to establish a national payment rate for category III CPT code 0073T for compensator-based IMRT treatment delivery. These commenters stated that our decision to pay for compensator-based IMRT treatment delivery will encourage patient access and diffusion of this cost-effective technology. Furthermore, these commenters agreed with our rationale to assign CPT codes 0073T (Compensator-based IMRT treatment delivery) and 77418 (Multileaf collimator-based IMRT treatment delivery) to the same APC 0412 (IMRT treatment delivery) for rate setting purposes, noting that the IMRT treatment delivery costs are virtually identical for both modalities. In contrast, one commenter to the November 15, 2004 final rule with comment period (69 FR 65682) was opposed to the assignment of CPT code 0073T to APC 0412. This commenter explained that CPT code 0073T was created specifically to distinguish compensator-based IMRT treatment delivery from multileaf collimator-based IMRT treatment delivery, described by CPT code 77418. The commenter believed that the assignment of CPT codes 0073T and 77418 to the same APC 0412 precludes CMS from collecting distinct claims data for each code, and urged CMS to assign CPT code 0073T to a New Technology APC and reserve APC 0412 for CPT code 77418.

Response: Our decision to place CPT codes 0073T and 77418 in the same APC 0412 supports the clinical homogeneity of APC 0412. Because we had no CY 2003 claims data for the newly established Category III CPT code 0073T, we concluded that its resource costs were likely reflected to some degree in the costs and charges reported for CPT code 77418, considering that this was the only CPT code available to providers for the billing of compensator-based IMRT treatment delivery prior to January 1, 2005. Contrary to a belief held by one of the commenters, the assignment of CPT codes 0073T and

74418 to the same APC 0412 for payment purposes does not preclude CMS from collecting distinct claims data for these two codes. Once the CY 2005 claims data for CPT code 0073T become available for setting the CY 2007 payment rate, we will reexamine the APC placement of CPT code 0073T. In the meantime, for CY 2006 we will maintain CPT codes 0073T and 77418 in the same APC 0412.

Comment: One commenter explained that, effective January 1, 2005, the descriptor for CPT code 77418 (Multileaf collimator-based intensity modulated treatment delivery) was changed to explicitly exclude compensator-based IMRT treatment delivery and a new Category III code 0073T was created to describe compensator-based IMRT delivery. This commenter requested that we either update the December 19, 2003 Medicare Program Transmittal 32 (CR 3007) or issue a new Medicare Program Transmittal to include compensator-based IMRT treatment delivery code 0073T. The commenter provided CMS with recommended language to clarify the billing of compensator-based IMRT treatment delivery under the OPPS for CY 2006.

Response: We appreciate the commenter bringing to our attention the need to update our billing guidance to reflect the newly established Category III CPT code 0073T for the billing of compensator-based IMRT treatment delivery. We thank the commenter for providing CMS with recommended language and will consider such language as we revise our guidance on the billing of compensator-based IMRT treatment delivery under the OPPS for CY 2006.

i. Kidney Imaging (APC 0267)

Comment: One commenter expressed concern that CMS's proposed reassignment of CPT code 78700 (Kidney imaging, static) from APC 0404 (Level I Renal and Genitourinary Studies) to APC 0267 (Level III Diagnostic Ultrasound) disrupts the clinical homogeneity of the two APCs. The commenter stated that the resource requirements and clinical characteristics of kidney imaging have not changed in the past year and urged CMS to maintain CPT code 78700 in APC 0404 for CY 2006.

Response: We agree with the commenter's observation that the clinical attributes of CPT code 78700 more closely resemble the services assigned to APC 0404 rather than APC 0267. Although our proposal to reassign CPT code 78700 to APC 0267 was based on its median cost data collected for the proposed rule, the more recent median cost data from CY 2004 for CPT code 78700 do not preclude its return to APC 0404. Therefore, in the interest of preserving the clinical homogeneity of APCs 0267 and 0404, we are not adopting our proposed reassignment and will retain CPT code 78700 in APC 0404 for CY 2006.

j. Magnetic Resonance Guided Focused Ultrasound Ablation (APC 0193)

We received one public comment on the CY 2006 OPPS proposed rule concerning the APC assignments for HCPCS codes 0071T and 0072T, along with several related comments on the November 15, 2004 final rule with comment period.

Comment: Several commenters submitted comments on the November 15, 2004 final rule regarding the APC assignments of magnetic resonance guided focused ultrasound (MRgFUS) therapy for uterine fibroids. We proposed to retain magnetic resonance guided focused ultrasound (MRgFUS) procedures in APC 0193 for CY 2006. The commenters believed that the procedure's assignment to APC 0193 (Level V Female Reproductive Procedures) resulted in significant underpayment. They asserted that MRgFUS is a new technology and that CMS should assign the two Category III CPT codes to two separate New Technology APCs, based on external cost data, until adequate claims data are available upon which to base assignments to clinical APCs.

More recently, hospital and manufacturer representatives made a presentation at the August 2005 meeting of the APC Panel and also commented on our July 25, 2005 proposed rule. The Panel recommended that CMS work with stakeholders to assign CPT codes 0071T and 0072T, focused ultrasound ablation of uterine leiomyomata including magnetic resonance guidance, to an appropriate New Technology APC(s).

The procedures are coded with Category III CPT codes 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue). These codes were new CPT codes in CY 2006. The commenters and the presenters at the APC Panel suggested that we assign CPT code 0071T to New Technology APC 1528 (Level XXV) and CPT code 0072T to New Technology APC 1532 (Level XXVI).

Response: In light of the additional information that has been presented to us, we agree that it would be more accurate to assign the two procedures to separate APCs to account for the higher level of resources required to ablate the larger growths. However, we do not agree that it is most appropriate to assign MRgFUS procedures to New Technology APCs 1528 and 1532. Although FDA approval of one specific ablation technology was relatively recent, MRgFUS therapy bears a significant relationship to technologies already in widespread use in hospitals, in particular MRI and ultrasound services. The use of focused ultrasound for thermal tissue ablation has been in development for decades, and the recent application of MRI to focused ultrasound therapy provides monitoring capabilities that may make the therapy more clinically useful. We believe that MRgFUS therapy is a new and integrated application of existing technologies (MRI and ultrasound) and, therefore, is not necessarily most accurately assigned to a New Technology APC. We believe that the technology used in this service fits as well into existing clinical APCs for female reproductive services, as do many other modalities that are currently assigned to those clinical groups. In addition, MRgFUS procedures are most often performed on younger women and are only seldom performed on Medicare beneficiaries. We believe that placing them in clinical APCs with other female reproductive procedures will enable us both to set accurate payment amounts and to maintain appropriate clinical homogeneity of the APCs.

Cost data for MRgFUS procedures provided to us for two hospitals showed high, but disparate costs. The costs per case reported by each of the hospitals were significantly different from one another and were much higher than reports of costs from other publicly available sources. We suspect that much of the variation reflects differences in capital costs and projections of utilization and procedure times, as well as in the types of personnel used to perform the procedures. We understand that the MRI equipment can also be used to perform conventional MRI procedures, and the MRI equipment costs should be allocated accordingly so that amortization of the costs will be shared by those tests. The OPPS payment rates for services need to make appropriate payments for the services to Medicare beneficiaries, recognizing that, as a budget neutral payment system, the OPPS does not pay the full hospital costs of services. We expect that our

payment rates generally will reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings.

We compared the necessary hospital resources for the MRgFUS procedures, including specialized equipment, MRI/procedure room time, personnel, anesthesia and other required resources, to various other procedures for which we have historical hospital claims data. Additionally, we took into consideration projected costs for the MRgFUS procedures submitted to us, and other available information regarding the clinical characteristics and costs of those services. Upon consideration of all of the information available to us, we have determined that a higher level of payment would be more appropriate for the MRgFUS procedures. However, we are rejecting the recommendation of the APC Panel, and we will assign CPT codes 0071T and 0072T to APC 0195 (Level IX Female Reproductive Procedures) and 0202 (Level X Female Reproductive Procedures), respectively for CY 2006. These new APC assignments provide significantly higher payment rates than we proposed for these services in CY 2006. We believe that these placements in APCs 0195 and 0202 will provide appropriate payments for MRgFUS services to provide access for Medicare beneficiaries who need them.

k. Non-Imaging Nuclear Medicine Studies (APC 0389)

In Addendum B of the CY 2006 proposed rule (70 FR 42776), we proposed to maintain CPT codes 78270 (Vitamin B–12 absorption study; without intrinsic factor), 78271 (Vitamin B–12 absorption study; with intrinsic factor), and 78272 (Vitamin B–12 absorption study; with and without intrinsic factor) in APC 0389 (Non-Imaging Nuclear Medicine) for CY 2006.

We received one public comment related to the above-mentioned nuclear medicine procedures.

Comment: One commenter expressed concern that the resource requirements associated with CPT codes 78271 (Vitamin B–12 absorption study; with intrinsic factor), and 78272 (Vitamin B–12 absorption study; with and without intrinsic factor) far exceed the median cost of APC 0389 (Non-imaging Nuclear Medicine) in which they reside. The commenter noted that the exceptionally low single claim counts for these procedures have little or no impact on the overall median cost for APC 0389 due to the thousands of other single claim counts for lower cost CPT codes that reside in APC 0389. To protect beneficiary access to these services, the commenter requested that CMS consider either freezing the payment rate for APC 0389 at its CY 2005 payment rate or buffering the proposed 12 percent decrease from its CY 2005 payment rate. The commenter noted that, in addition to underpayment for the nuclear medicine procedures, the three radiopharmaceuticals that could be used in the tests (C1079—Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin Co-57/58, per 0.5 mCi; C9013—Supply of Co-57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent; and Q3012—Supply of oral radiopharmaceutical diagnostic imaging agent, cyanocobalamin cobalt Co-57, per 0.5 mCi) were proposed to change from status indicator ''K'' in CY 2005 to status indicator ''N'' for CY 2006. The commenter was concerned that the packaging of the necessary radiopharmaceuticals, in addition to the reduced payment rate for the tests, could threaten Medicare beneficiaries' access to these procedures.

Response: While we acknowledge the commenter's concern that the procedure-specific median costs for CPT codes 78271 ($244) and 78272 ($310) appear to far exceed the median cost of APC 0389 ($86) for CY 2006 based on the CY 2004 hospital claims data, we remind the commenter that the exceptionally low single claim counts that they brought to our attention for CPT codes 78271 (9 single claims) and 78272 (5 single claims) significantly increase the volatility of their median costs from year-to-year. Moreover, the higher CY 2005 single claim counts for CPT codes 78271 (209 single claims) and 78272 (133 single claims) based on the CY 2003 hospital claims data yielded lower median costs for CPT codes 78271 ($98) and 78272 ($159). These lower median costs may have been due to separate CY 2005 payments for the required radiopharmaceuticals, in comparison with the median costs from CY 2004 claims developed based on the CY 2006 payment policy of packaging the radiopharmaceuticals.

In reviewing the claims data for all of the CPT codes assigned to APC 0389 for CY 2005, we noted that, in addition to CPT codes 78271 and 78272, several other services had consistently higher procedure-specific median costs than the CY 2006 APC median cost ($86), including CPT code 78003 (Thyroid uptake; stimulation, suppression or discharge); CPT code 78190 (Kinetics, study or platelet survival, with or without differential organ/tissue localization); CPT code 78270 (Vitamin B–12 absorption study; without intrinsic factor); and CPT code 78191 (Platelet survival study) with median costs of $167, $170, $186, and $384, respectively. As these services were all low volume, with fewer than 100 claims each, there was no two times violation in APC 0389, despite the finding that the least expensive procedure assigned to APC 0389 had a median cost of $76. The higher level of hospital resources required for the more costly non-imaging nuclear medicine procedures was notable.

While we will not adjust the CY 2006 median cost of APC 0389 by using its CY 2005 median cost or dampening the decline between CY 2005 and CY 2006 as suggested by the commenter, we acknowledge that the structure of the APC would benefit from reconfiguration. Therefore, we are splitting the services assigned to APC 0389 for CY 2005 into two groupings for CY 2006: APC 0389, Level I Non-Imaging Nuclear Medicine; and newly created APC 0392, Level II Non-Imaging Nuclear Medicine. The assignment of CPT codes to these two APCs is shown in Table 14 below.

TABLE 14.—ASSIGNMENT OF CPT CODES TO APCS 0389 AND 0392 FOR CY 2006

APC 0389	APC 0392
78725, Kidney function study	78003, Thyroid, stimulation, suppression.
78000, Thyroid, single uptake	78190, Platelet survival, kinetics.
78001, Thyroid, multiple uptakes	78191, Platelet survival.
78999U, Nuclear diagnostic exam	78270, Vitamin B–12 absorption exam; without intrinsic factor.
	78271, Vitamin B–12 absorption exam; with intrinsic factor.
	78272, Vitamin B–12 absorption exam; with and without intrinsic factor.

In this reconfiguration, the median cost of APC 0389 for CY 2006 is $85, and the median cost for APC 0392 is $209. We believe that these new APC configurations will result in more accurate payments for non-imaging nuclear medicine studies, by improving clinical and resource homogeneity within the groupings. We note that for the purposes of any studies contemplated by the commenter, different codes will be available for reporting the required radiopharmaceuticals in the CY 2006 OPPS. Specifically HCPCS code C9013 will be deleted, HCPCS code A9546 (Cobalt CO–57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code C1079, and HCPCS code A9559 (Cobalt CO–57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code Q3012. We anticipate that these new permanent HCPCS codes for radiopharmaceuticals will simplify billing and provide more accurate hospital claims data as the basis for potential packaging determinations in future years. With the transition to these new radiopharmaceutical HCPCS codes, we will closely monitor the claims data for APCs 0389 and 0392 in the future, as any changes in the packaging status of required radiopharmaceuticals could affect the median costs of services assigned to them and alter the resource homogeneity of the groupings.

l. Therapeutic Radiation Treatment (APC 0304)

Comment: One commenter objected to our proposal to maintain CPT code 77370 (Radiation physics consult) in APC 0304 (Level I Therapeutic Radiation Treatment Preparation) for CY 2006, noting that the procedure experienced over a 50 percent decrease in its payment rate between CYs 2004 and 2005. The commenter explained that this procedure often involves a significant amount of time spent by the physics department in developing the treatment planning, immobilization, and proper beam placement for the patient. The commenter requested that CMS consider the amount of time spent by the physicists and dosimetrists in collaborating with the physician when determining the APC placement of CPT code 77370 for CY 2006.

Response: The CY 2006 median cost of $140 for CPT code 77370 is based on 96 percent of the CY 2004 total claims (41,123 single procedure claims out of 42,753 total claims). Similarly, the CY 2005 median cost of $136 for CPT code 77370 was based on 95 percent of the CY 2003 total claims (40,723 single procedure claims out of 42,985 total claims). The robust claims data reported by hospitals over the past several years support the placement of CPT code 77370 in APC 0304 for CY 2006. Furthermore, the commenter provided no supporting evidence that the proposed payment of $105 for CY 2006 would jeopardize beneficiary access to this service. Therefore, for CY 2006 we are maintaining CPT code 77370 in APC 0304.

m. Urinary Bladder Study (APC 0340)

At the February 2005 APC panel meeting, the APC Panel recommended that we move CPT code 78730 (Urinary bladder residual study) from APC 0340 (Minor Ancillary Procedures) to APC 0404 (Level I Renal and Genitourinary Studies) for CY 2006, suggesting that the CY 2003 data for CPT code 78730 may have been derived from incorrectly coded hospital claims. For reasons discussed in detail below, we are maintaining CPT code 78730 in APC 0340 for CY 2006.

We received a number of public comments related to such imaging procedures.

Comment: One commenter stated that the resource requirements of CPT code 78730 (Urinary bladder residual study) do not resemble other services assigned to APC 0340 (Minor Ancillary Procedures). The commenter explained that the high volume and low median cost data for CPT code 78730 resulted from inappropriate use of this code to report other services unrelated to nuclear medicine. The commenter noted that during the February 2005 APC Panel meeting, the APC Panel recommended that CMS move CPT code 78730 from APC 0340 to APC 0404 (Level I Renal and Genitourinary Studies), suggesting that the CY 2003 data for CPT code 78730 may have been derived from incorrectly coded hospital claims. The commenter urged CMS to recognize the full costs associated with the nuclear medicine aspects of the procedure by reassigning CPT code 78730 to APC 0404 for CY 2006.

Response: In the November 15, 2004 final rule with comment period (69 FR 65705), we noted that CPT code 78730 was originally created and valued for the MPFS as a procedure requiring the services of a nuclear medicine technician, but that the use of the code subsequently had changed to be used primarily by urologists rather than by nuclear medicine physicians. While we reassigned CPT code 78730 to APC 0340 for CY 2005 based on robust CY 2003 claims data, we solicited other physician specialties to submit resource data for us to review in the context of our hospital claims data so that we could reexamine the appropriate APC placement of CPT code 78730 for CY 2006. While we acknowledge the commenter's repeated concern that the median cost for CPT code 78730 may reflect miscoded claims, the commenter again provided no supporting evidence of what they believe to be the true resource costs associated with CPT code 78730. If some of the reported claims data are inaccurate, we have no way to determine which claims are more or less accurate than others. Rather, a relatively stable number of single procedure claims has generated a consistent median cost for CPT code 78730 over the past four years (that is, ranging from $39 based on the CY 2001 claims data to $53 based on the CY 2004 claims data) and supports our assignment of CPT code 78730 to APC 0340 with an APC median cost of $36, as opposed to APC 0404 with an APC median cost of $217. Therefore, we are maintaining CPT code 78730 in APC 0340 for CY 2006. However, in preparation for the CY 2007 OPPS update, we will reexamine the APC placement of CPT code 78730 by reviewing any resource data submitted by commenters in the context of our CY 2005 hospital claims data. Commenters may wish to identify approaches to distinguishing correctly coded claims so that we could develop a procedure-specific median cost based on correctly coded hospital claims data. As the commenter believes the vast majority of claims for CPT code 78730 were miscoded over many years, they may wish to explore a change in the code with the AMA's CPT Editorial Panel or request their dissemination of guidance on use of the code, to clarify the code's intended use and assist providers in correctly billing for services provided.

3. Gastrointestinal and Genitourinary Procedures

a. Cystourethroscopy With Lithotripsy (APC 0163)

Comment: A few commenters requested that CMS assign CPT code 52353 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy) to the new APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures). The commenters stated that this procedure has been grouped into the same APC (0163, Level IV Cystourethroscopy and other Genitourinary Procedures) with many of the procedures that we reassigned into APC 0429 and that CPT code 52353 should also be assigned to that APC. They stated that the procedure described by CPT code 52353

is used for the same indications as are those in APC 0429, and that much of the same capital equipment is used to perform CPT code 52353 and those in APC 0429.

The commenters asserted that although the median cost in CMS's hospital claims data for CPT code 52353 is lower than those for procedures in APC 0429, its median cost is the highest in APC 0163 and its costs are actually higher than reflected in the claims data since hospitals are failing to report all of the costs associated with the flexible ureteroscope required for the procedure.

Based on their analysis of the proposed rule data, the commenters found that assignment of CPT code 52353 to APC 0429 would only result in small decreases in the median costs for both APCs 0163 and 0429. They estimated that the median cost for APC 0163 would drop by approximately $19 and that the median cost for APC 0429 would decrease by approximately $100. They stated that these drops would not represent payment disruptions for the other procedures in the APCs.

Response: The median cost for CPT code 52353, $2,117, is the highest in APC 0163, but the procedure-specific median costs in APC 0163 vary from lowest to highest by very little. The median cost for APC 0163 is $1,997, only $120 lower than the code-specific median cost for CPT code 52353.

The median cost for APC 0429 is $2,502, and the median costs of the individual procedures with more than 50 single claims assigned to that APC (representing a total of 13,200 claims) vary from $2,475 to $2,602, a difference of only $127. We believe that the decrease in the APC 0429 median that would result from assignment of CPT code 52353 (14,570 claims) would unfairly disadvantage the procedures that we proposed to assign there, and that the $100 drop that the commenters referred to as not representing payment disruptions would not be viewed similarly by hospitals billing for the procedures we proposed for assignment to APC 0429. In addition, we have no reason to doubt the accuracy of our median cost for CPT code 52353 based on thousands of CY 2004 single hospital claims, nor do we understand why hospitals would differentially not be including charges for the costs of all required equipment and supplies for this procedure on their hospital claims in comparison with their billing for other procedures. Any small underpayment that would result from the continued assignment of CPT code 52353 to APC 0163 would be less than the potential for overpayment if the code were moved to APC 0429, which contains some procedures that have different clinical characteristics and services with higher median costs.

We will reevaluate the APC assignment for CPT code 52353 for CY 2007 and finalize our proposal, without modification, to retain it in APC 0163 for CY 2006.

b. GI Stenting (APC 0384)

Comment: Commenters, including the APC Panel, asked that we use only claims containing devices to set the APC median cost for APC 0384, or alternatively, freeze the 2006 CY OPPS payment rate at the CY 2005 OPPS payment.

Response: We considered the comments and have decided to apply the same policy to these services that we will apply to other device-dependent APCs. In the case of this APC, the median on which the CY 2006 OPPS payments will be based was calculated using claims that contain the device codes applicable to the services assigned to APC 0384. See the discussion of payment for device dependent APCs in section VI.A for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the median cost on which the CY 2006 payment rate for APC 0384 is based.

Comment: Some commenters, including the APC Panel, recommended that we establish a separate APC for CPT codes 43268 and 43269 for endoscopic retrograde cholangiopancreatography (ERCP) services because they believed that these services use fluoroscopy while the other codes in APC 0384 do not. Other commenters opposed this change because they said that all services in APC 0384 require use of similar supplies, equipment, and fluoroscopic assistance. They indicated that the hospital resources that are required to furnish a specific GI stenting service are determined more by nuances arising from gaining access to the site at which the stent will be placed, sedating the patient, and providing fluoroscopic monitoring, than by the specific location where the stent is being placed.

Response: We did not create a new APC for ECRP-related stent procedures because those procedures are appropriately placed with the other services in APC 0384, both with respect to clinical characteristics and resources used, particularly in view of the clinical rationale provided by the commenters. In addition, the number of single claims available for establishing payment rates for APC 0384 is already relatively small. We are concerned that if we were to move the two ERCP procedures to another APC, there would be very few single claims remaining in APC 0384 to establish that APC's median cost.

c. Insertion of Uterine Tandems and/or Vaginal Ovoids for Clinical Brachytherapy (APC 0192)

Comment: Several commenters disagreed with our proposal to reassign CPT code 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) from APC 0193 (Level V Female Reproductive Procedures) to 0192 (Level IV Female Reproductive Procedures). The commenters were concerned that the reassignment would result in a 66 percent decrease in payment, and that there was no discussion of the reassignment in the proposed rule. They requested that the procedure be retained in its current CY 2005 APC assignment, and that in the future CMS discuss all changes to APC assignments in the preambles of their proposed rules. They asserted that there have been no changes in the technology or provision of these services that would justify a reduction in payment and that the dramatic decrease in payment amount proposed by CMS would have a negative effect on Medicare beneficiaries' access to this important treatment for vaginal and/or uterine cancer.

Response: The procedure described by CPT code 57155 is for the insertion of the ''holders'' for brachytherapy sources when brachytherapy is to be delivered to specific sites. The procedure to load the radioactive elements and the brachytherapy sources themselves are separately payable under the OPPS. CPT code 57155 was first reassigned from APC 0192 to APC 0193 for CY 2004 Hospital claims data from CY 2002, utilized for the CY 2004 OPPS update, yielded a code-specific median cost for CPT code 57155 of about $743, based on 132 single claims. However, CY 2003 data, utilized for the CY 2005 OPPS update, provided a code-specific median for CPT code 57155 of approximately $232 based on 350 single claims, creating a 2 times violation in APC 0193. For CY 2005, our final OPPS payment policy specifically excepted APC 0193 from the two times rule in light of this violation.

While we did not propose to reassign CPT code 57155 for the CY 2005 OPPS, we now have a second year of hospital claims data from CY 2004 that indicate that CPT code 57155 should be assigned to a lower level Female Reproductive Procedures APC. Therefore, in addendum B of the proposed rule, we proposed to reassign CPT code 57155 to APC 0193. The median cost for CPT code 57155 of $353 based on 867 single claims is in the same range as the

medians for other procedures assigned to APC 192 for CY 2006, making it an appropriate placement for CPT code 57155. If CPT code 57155 were to be assigned to APC 0193 which has a median cost of about $870, we would once again have to except APC 0193 from the two times rule for CY 2006. Based on stable claims data for the past 2 years and significant numbers of single bills, we used our standard OPPS methodology and the updated CY 2004 claims data to determine that hospital claims data for CPT code 57155 are accurate and appropriate to use for making the CY 2006 APC assignment for CPT code 57155. Therefore, we will finalize our proposal to assign CPT code 57155 to APC 0192.

d. Laparoscopic Ablation Procedures (APC 0131)

Comment: One commenter requested that CMS reassign CPT code 47370 (Laparoscopy, surgical; ablation of one or more liver tumor(s); radiofrequency) to APC 0132 (Level III Laparoscopy). The procedure is currently assigned to APC 0131, Level II Laparoscopy, and the commenter stated that the costs for the procedure far exceed the payment rate in that APC. The commenter analyzed OPPS claims for CYs 2002, 2003, and 2004 and found that the median cost for that procedure has been more than ''two times greater than the median of the lowest cost item or service'' in APC 0131 during all of those years. Further, they asserted that the procedure's median cost is actually more similar to those of the procedures assigned to APC 0132.

Response: We examined our median cost data for the years referenced in the comment and concur with their findings that the median cost for CPT code 47370 has been notably higher than those for other procedures in APC 0131 for several years. For CY 2006, we have 28 single claims, and the procedure-specific median cost of $5,088 is significantly higher than the median costs for most of the procedures assigned to APC 0131. The median cost for CPT code 47370 also is higher than the median costs for other procedures currently assigned to APC 0132. We believe that for purposes of clinical homogeneity, APC 0132 is the most appropriate APC assignment for the procedure but we will continue to monitor it for future APC assignment changes. For CY 2006, we will assign CPT code 47370 to APC 0132 (Level III Laparoscopy).

Comment: One commenter requested that CMS reassign CPT code 50542 (Laparoscopy, surgical; ablation of renal mass lesion(s)) to APC 0132 (Level III Laparoscopy). The procedure is currently assigned to APC 0131 (Level II Laparoscopy), and the commenter stated that the costs for the procedure far exceed the payment rate in that APC. The commenter analyzed OPPS claims and found that two of the 11 single claims available for the proposed rule did not reflect separate charges for the ablation device and was concerned that with so few claims, these two apparently incorrect claims may have a significant effect on the median cost.

Response: We examined our median cost data for CY 2005 and CY 2006. For CY 2005, there were 11 single claims used for the final rule median and the assignment of the procedure to APC 0131 was appropriate. For CY 2006, we have 16 single claims and the median cost is significantly higher than the median costs for most of the procedures assigned to APC 131. The median cost for CPT code 50542 is $3,940, within the range of median costs for procedures assigned to APC 0132 for CY 2006. We will assign CPT code 50542 to APC 0132 (Level III Laparoscopy) for CY 2006.

e. Plicator Procedure (APC 0422)

Comment: One commenter submitted comments about the APC assignment for new HCPCS code C9724 (EPS gastric cardia plicator) used in the treatment of gastroesophageal reflux disease (GERD). The commenter suggested that the procedure's assignment to APC 0422 (Level II Upper GI Procedures) is inappropriate because it is a new technology and that placement violates the OPPS two times rule. The commenter recommended that we assign the procedure to an APC with a higher payment rate and suggested that we may want to create a level III upper GI procedures APC. They reported that the cost of the Plicator Procedure kit ($1,795), in addition to the endoscopy (approximately $460) is two times more costly than CPT 43228 (Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique), a high volume procedure that is also assigned to APC 0422.

Response: In April 2004, CMS received an application for this procedure to qualify for payment as a New Technology under the OPPS. In April 2005, CMS assigned it to HCPCS code C9724 and placed it in APC 0422 for payment under the OPPS. We have no claims data for the procedure due to its very recent HCPCS code assignment. We assigned it to APC 0422 because there are other endoscopic procedures for the treatment of GERD assigned to that APC and we believed, based on specific information available to us about the plicator service and hospital cost and clinical information regarding other services payable under the OPPS, that APC 0422 was an appropriate assignment for HCPCS code C9724. We continue to believe that is the most appropriate APC placement for the procedure. We will reevaluate that assignment when we have claims data on which to base a reassignment.

We find that there is no basis for the suggestion that assignment of HCPCS code C9724 represents a two times rule violation because there are no data for HCPCS code C9724 to compare to median costs for the other significant procedures assigned to that APC.

We are finalizing our proposal to assign HCPCS code C9724 to APC 0422 for CY 2006.

f. Prostate Cryosurgery (APC 0674)

For CY 2006 OPPS, we proposed to set the payment rate for APC 0674 (Prostate Cryoablation) based on an unadjusted median cost of $5,780. We received many public comments concerning the payment for prostate cryoablation.

Comment: Commenters objected to the proposed payment rate for cryoablation of the prostate (APC 0674) because they believed that the proposed payment was not sufficient to cover the cost of the procedure. The commenters indicated that a hospital incurs costs of greater than $9,000 to furnish the service. Commenters furnished copies of bills, invoices and cancelled checks intended to substantiate their claims that the total costs are in excess of $9,000 because the costs of the probes alone are no less than $4,000. They indicated that the proposed Medicare payment rate, if implemented, would result in a shortfall of over $3,000 per case. Commenters said that hospitals tend to under report and under charge their true costs for cryosurgery procedures, and that there are incentives to resist billing changes that would result in higher charges for the procedures. Commenters said that CMS should recalculate the median cost for APC 0674 by excluding claims that do not have a charge of at least $6,000 under either HCPCS code C2618 or revenue codes 270, 272 or 278 because any charge for cryoablation probes less than $6,000 would be inadequate to result in a reasonable cost for the device. Commenters indicated that, at a minimum, CMS should not set the payment rate for APC 0674 at less than the CY 2005 payment rate plus inflation.

Response: We share the commenters' concern that these services continue to be available to Medicare beneficiaries

and we will pay APC 0674 under the general policy which we apply to device-dependent APCs. Under this general policy, we have set the median cost for APC 0674 using only claims that contain the device code for the cryoablation probes used in this service. See section IV.A. for our discussion of adjustments to median costs for device dependent APCs. See Table 16 for the adjusted median cost for APC 0674 for CY 2006.

Comment: Commenters indicated that the proposed Medicare payment rate would result in reduced or no access for Medicare beneficiaries. One commenter stated that in the past 2 years, a total of 29 hospitals either ceased performing or elected not to start a cryosurgery program due to inadequate Medicare payment. Commenters stated that inadequate payment under the OPPS would result in hospitals providing more expensive care in the inpatient setting under DRG 315 that could be much more costly to Medicare.

Response: Our review of the claims from hospitals used to set the median costs for APC 0674 shows that from CYs 2003 to 2004, the number of claims for APC 0674 grew from 1,516 to 2,328 or by 35 percent in one year. Similarly, the number of hospital providers furnishing the service grew from 222 to 317 or by 30 percent in one year. Neither the growth in the number of claims or the number of hospitals furnishing the service indicates that there is a barrier to access to care. Moreover, while 29 hospitals may have ceased performing the procedure or decided not to begin a cryosurgery program, the growth in hospitals furnishing the service from CYs 2003 to 2004 is substantial. This is particularly meaningful because the device came off of pass-through payment in CY 2004 and the payment for the device was packaged into the payment for the procedure in CY 2004, rather than being paid separately under the pass-through payment methodology. We see no reason to believe that Medicare beneficiaries have problems in accessing this service. Moreover, as commenters indicate in the discussion of calculation of payment weights, hospitals take many factors into consideration in determining whether to offer a service, only one of which is the rate of Medicare payment.

g. Stretta Procedure (APC 0422)

CPT code 43257, effective January 1, 2005, is used for esophagoscopy with delivery of thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia for the treatment of gastresophageal reflux disease. This code describes the Stretta procedure, including use of the Stretta System and all endoscopies associated with the Stretta procedure. Prior to CY 2005, the Stretta procedure was recognized under HCPCS code C9701 in the OPPS. For the CY 2005 OPPS, HCPCS code C9701 was deleted and CPT code 43257 was utilized for the Stretta procedure. In CY 2005, the Stretta procedure was transitioned from a New Technology APC to clinical APC 0422 (Level II Upper GI Procedures) based on several years of hospital cost data. Procedures within APC 0422 were similar to the Stretta procedure in terms of clinical characteristics and resource use.

We received several public comments in response to the CY 2005 methodology for calculating the median cost for APC 0422 set forth in our CY 2005 OPPS final rule with comment period.

Comment: Commenters objected to the APC assignment of the Stretta procedure (HCPCS code C9701 in 2003; CPT code 43257 beginning in 2004) to APC 0422. Commenters indicated that CMS should recalculate the median cost for the procedure by packaging in the costs of all endoscopies (regardless of CPT code) that were performed on the same date as the Stretta procedure and assigning the procedure to a New Technology APC based on the recalculated median cost. They said that absent this change, CMS should clarify that hospitals may bill and will be paid for each endoscopy done at the time of the Stretta procedure. Commenters asked that we make these changes effective January 1, 2005.

Response: We did not make these changes for CY 2005 because we believe that we correctly calculated the median cost for the Stretta procedure by incorporating the cost of a single endoscopy (CPT codes 43234 and 43235) when billed into the reported median cost for Stretta in the calculation of the final rule median cost for the new CPT code 43257 for CY 2005, based on the codes hospitals correctly reported in CY 2004 for the full Stretta service. Moreover, we believe that assignment of the procedure to the APC that contains similar procedures for the treatment of gastroesophageal reflux disease is appropriate. Therefore, we believe that the Stretta procedure is placed in an APC for CY 2005 which is appropriate both with regard to clinical characteristics and resource use. As the code descriptor for CPT code 43257 includes upper gastrointestinal endoscopy, we do not expect that hospitals would separately bill for each endscopy done at the time of the Stretta procedure.

For CY 2006, we proposed to use both CY 2004 single claims for HCPCS code C9701 and multiple procedure claims containing one unit of HCPCS code C9701 and one unit of either CPT code 43234 or CPT code 43235 to calculate the Stretta procedure's contribution to the median for APC 0422. Claims reporting one endoscopy code (CPT code 43234 or CPT code 43235) along with HCPCS code C9701 were included in the proposed median calculation because, in CY 2002, CMS authorized the separate and additional billing of a single endoscopy code with HCPCS code C9701, while CPT code 43257 now includes all endoscopies performed during the procedure.

Using this proposed methodology, we calculated a median cost for CPT code 43257 (HCPCS code C9701 in the CY 2004 claims data) of $1,669. Using these claims in the calculation of the median cost for APC 0422, we calculated a median cost of $1,386. We proposed to use this methodology, applied to the more complete final rule with comment period claims set, to calculate the final CY 2006 OPPS median cost for APC 0422.

We received several public comments on our proposed methodology for calculating the median cost for APC 0422.

Comment: One commenter objected to the proposed payment for CPT code 43257, the Stretta procedure for the CY 2006 OPPS. The commenter indicated that the payment would create economic disincentives to the utilization of the service and might ultimately impose greater costs on Medicare and its beneficiaries. The commenter asked that CMS create a new APC to which we would assign CPT code 43257 and CPT code 0008T, and that we use a different methodology from that proposed to calculate the median cost. The commenter indicated that because CPT codes 43228 and 43830 have higher volumes but lower costs, the inclusion of them in the same APC as CPT code 43257 does not enable payment of CPT code 43257 at a level that is appropriate to pay the costs of the service. Therefore, the commenter requested that we create a new clinical APC to enable higher payment for CPT code 43257. The commenter believed that creating the new APC is analogous to what CMS proposed to do for vascular access devices for the CY 2006 OPPS.

The commenter also asked that CMS undertake special claims manipulation to establish the median cost for the new APC. The commenter's preference was that we add the median cost for CPT code 43235 to the cost of all claims for

HCPCS code C9701 (CPT code 43257 in 2005) which did not also contain at least one unit of an endoscopy code on the claim. These inflated claims costs would then be combined with all claims for HCPCS code C9701 which also contain at least one unit of an endoscopy code and with the claims for CPT code 0008T to set the median cost for the APC they wanted us to create. The commenter offered a less preferred alternative of using only claims that contained both HCPCS code C9701 and CPT codes 43234, 42235 or any other endoscopy code to calculate the median cost, which would not yield as robust a set of claims for median setting.

Response: We have not created a new APC for CPT code 43257 and CPT code 0008T, and we have kept them both in APC 0422 for the CY 2006 OPPS. The services reported by these CPT codes are clinically similar to the other procedures in APC 0422. In addition the resources used to furnish the services are very similar to the other services in APC 0442 based on hospital claims data. We see no reason to create a new APC for CPT codes 43257 and 0008T.

We also have not undertaken the special claims manipulation that the commenter requested. We do not believe that it is valid to add the median cost for an endoscopy to the costs for claims for which an endoscopy is not billed on the same claim. Similarly, we do not believe that it is valid to include all of the charges for endoscopies other than a single unit of CPT code 43234 or 43235 in the calculation of the median cost for the Stretta procedure. As the commenter indicates, endoscopy is a fundamental part of the Stretta service described by CPT code 43257. Therefore, there is every reason to believe that a hospital included all charges pertaining to the service in the charge for C9701 (the predecessor of CPT code 43257).

To set the median cost for APC 0422, we used all single procedure claims for CPT code 43257, and we also used claims with CPT code 43257 which contained one and only one unit of either CPT codes 43234 or 43235 on the same date of service. We packaged the costs of the single unit of the additional endoscopy and used these claims records in the calculation of the median cost for APC 0422.

For CY 2006 OPPS, the payment for APC 0422 is based on the median cost of $1,434 that was derived from this process. The median for CPT code 43257 which we derived from this process is $1,669. CPT codes 43257 and 0008T remain assigned to APC 0422.

h. Urological Stenting Procedures (APCs 0163 and 0164)

Comment: A few commenters requested reassignment of two urology procedures to newly created APC 0429 (Level V Cystourethroscopy). The commenters requested that CPT codes 0084T (Insertion of a temporary prostatic urethral stent) and 52282 (Cystourethroscopy, with insertion of urethral stent) be assigned to the new APC.

CPT 52282 is currently assigned to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) and the commenters stated that it is neither clinically similar to the other procedures in that APC nor is it similar in terms of hospital resources. Those commenters also stated that CPT code 0084T is better suited for assignment to APC 0429 than to APC 0164 (Level I Urinary and Anal Procedures), to which it is currently assigned.

The commenters requested that if we do not reassign CPT codes 52282 and 0084T to APC 0429, that we at least move CPT code 52282 to APC 0385 (Level I Prosthetic Urological Procedures), where it was assigned for CY 2004. They stated that CMS moved it from APC 0385 for CY 2005 because CMS determined that the urethral stent being implanted was not a prosthetic device, a decision with which they strongly disagree. They asserted that the urethral stent, like collagen implants injected into the urethra and other devices, meets the Medicare definition of a prosthetic device and should be assigned to an APC in line with that designation.

Response: Based on careful examination of the claims data and the comments, we continue to find that assignment for these procedures to APCs 0163 and 0164 is appropriate. The median cost for CPT code 52282, $1,955, is considered within the range of median costs for the other procedures assigned to APC 0163. The APC median cost is $1,997, and the narrow procedure-specific range of median costs within the APC is $1,730 to $2,117. In contrast, the median cost for APC 0385, $4,384, is more than twice that of the median cost of CPT code 52282. In addition, the median cost for APC 0429 of $2,501 is significantly higher that the median cost for CPT code 52282.

While APC 0385 (Level I Prosthetic Urological Procedures), as its title suggests, was established as an APC for some urological procedures requiring prosthetics, it is not required that all procedures utilizing urological prosthetics be assigned to an APC with ''prosthetic'' in the title. Instead, urological procedures that do, or do not, utilize prosthetics, like other services paid under the OPPS, are assigned to APCs based on clinical and resource homogeneity with other services in those clinical APCs. CPT code 52282 for cystourethroscopy with insertion of a urethral stent shares common clinical characteristics with other cystourethrscopy services also assigned to APC 0163. Therefore, we continue to believe that APC 0163 is the most appropriate APC assignment for CPT code 52282 for CY 2006.

In addition, we have no claims data for CPT code 0084T because it was a new code for CY 2005. We assigned it to APC 0164 based on available information regarding the specific service, as well as clinical and cost information for other hospital services payable under the OPPS. *CPT Changes: An Insider's View 2005*, describes CPT code 0084T as the prepping of a patient for a typical sterile urethral device insertion procedure, followed by activities to select and deploy the stent in the prostatic urethra, and assessment of the patient's ability to void prior to discharge from the clinic. As stated earlier, we based our assignment for CPT code 0084T on the expected clinical and hospital resource characteristics of the service, rather than on whether or not the procedure required a prosthetic. Procedures utilizing urological prosthetics do not necessarily show the most clinical and resource compatability with other services assigned to APCs with prosthetic urological procedures in their APC titles, as such individual procedures may exhibit a wide range of clinical and cost differences. We assigned CPT code 0084T to a clinical APC that includes other urinary and anal procedures. We do not agree that its assignment to APC 0429, the highest level cytourethroscopy APC that contains complex laser prostate and percutaneous nephrostolithotomy procedures with a median cost of $2,502, is an appropriate placement for CPT code 0084T for CY 2006. We continue to believe that APC 0164 is the most appropriate APC assignment for CPT code 0084T for CY 2006. We will have CY 2005 claims data for CPT code 0084T and will reassess its APC assignment based on those data for the CY 2007 OPPS update.

We are finalizing, without modification, our proposal to retain CPT code 52282 in APC 0163 and CPT code 0084T in APC 0164 for CY 2006.

4. Other Surgical Services

a. Excision-Malignant Lesions (APCs 0019 and 0020)

Comment: One commenter submitted comments regarding CPT codes 11620 (Excision, malignant lesion, excised diameter 0.5 cm or less) and the code 11621 (excised diameter 0.6 to 1.0 cm). The commenter, representing a hospital, stated that there appeared to be an error in the placement of CPT code 11620 in APC 0020 (Level II Excision/Biopsy) and CPT code 11621 in APC 0019 (Level I Excision/Biopsy) because CPT code 11621 is the more invasive procedure of the two, yet it had been placed in an APC with a lower payment rate for CY 2006.

Response: This is not an error. APCs are arranged based on a combination of considerations, including clinical homogeneity and median costs from hospital claims data reflecting hospital resources used. We have several hundred single claims for CY 2003 and CY 2004 for each of the services. Our data for these years consistently show that CPT code 11621 was performed almost twice as often as CPT code 11620, but it also had a consistently lower median cost, reflecting less hospital resources required for the excision of a larger lesion in comparison with a smaller lesion. Based on CY 2004 hospital claims data, CPT code 11621 has a median cost of about $314 based on 659 single claims and is appropriately assigned to APC 0019, with a median cost of about $247. To place CPT code 11621 in APC 0020 (median cost of about $413) would create a significant overpayment. Conversely, CY 2004 claims data reveal a median cost of about $511 for CPT code 11620, based on 347 single claims, and therefore, the code is appropriately placed in APC 0020.

There could be many reasons why the hospital claims data reflect greater resource utilization for the procedure that the commenter believes is ''less invasive,'' such as different supplies or equipment used for smaller excisions or variations in surgical techniques and related procedural times depending on the size of the lesion. We feel confident that our stable median cost data accurately reflect that the hospital resources are greater for the excision procedure described by CPT code 11620, and therefore, will finalize our proposed CY 2006 APC assignments for CPT code 11620 in APC 0020 and for CPT code 11621 in APC 0019.

b. External Fixation (APCs 0046 and 0050)

Comment: One commenter suggested that the current configuration of APC 0046 (Open/Percutaneous Treatment Fracture or Dislocation) significantly underpays procedures that involve external fixation devices. The commenter gave several recommendations on ways to realign the procedures. First, they recommended that CMS distinguish procedures that involve external fixation devices by allowing hospitals to bill either CPT code 20690 (Application of a uniplane, unilateral, external fixation system) or CPT code 20692 (Application of multiplane, unilateral, external fixation system) together with a fracture procedure code, and that these combinations of codes would be placed in a new APC specifically for ''fracture procedures with fixation devices.'' The commenter reasoned that establishing one or two new APCs for these procedures when billed together would eliminate the ongoing two times rule violation, preserve clinical homogeneity, and more appropriately reimburse hospitals. Second, if CMS were to establish two new APCs, one should be for lower extremity fractures and the second should include upper extremity fractures.

Response: CPT codes 20690 and 20692 are currently in APC 0050, and no changes were proposed for the CY 2006 OPPS. There are no 2 times violations in the APC in which they are located, and each of these codes represents 1 percent or less of the total volume in the APC. Therefore, we see no reason to create a new APC for these codes as we believe APC 0050 provides appropriate payment to hospitals when services described by CPT codes 20690 and 20692 are provided and billed in accordance with correct coding guidelines. However, the CPT codes for treatment of a fracture often include ''with'' or ''without fixation'' in the definition of the code. Where fixation is included in the definition of the code, it would be miscoding to also report 20690 or 20692; these codes should be reported if, and only if, fixation is not included in the CPT code for treatment of the fracture. Providers should review the CPT instructions and look to the AMA's guidance on coding if they have questions about when these codes should be reported.

We do acknowledge, however, that we have excepted APC 0046 from the two times rule for several years, as we will again for CY 2006. This is a large APC to which many procedures are assigned, and the median costs of the significant procedures in this APC range from a low of about $1,231 to a high of approximately $3,460. We will ask the APC Panel at its next biannual meeting to consider whether this APC could be reconfigured to improve its clinical and resource homogeneity.

c. Intradiscal Annuloplasty (APC 0203)

Comment: During the August 2005 meeting of the APC Panel, there was one presentation by a provider in support of a higher payment amount for intradiscal annuloplasty procedures. The presenter provided clinical and cost information to the Panel and stated that the procedures' current assignments to APC 0203 (Level IV Nerve Injections) did not describe the clinical features or hospital resources associated with CPT codes 0062T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level) and 0063T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; one or more additional levels). Further, the presenter suggested that a more appropriate APC assignment that would achieve more clinical and hospital resource homogeneity would be either APC 0050 (Level II Musculoskeletal Procedures except Hand and Foot), or APC 0051 (Level III Musculoskeletal Procedures except Hand and Foot). The APC Panel agreed with the presenter and recommended that CMS assign the procedure to either APC 0050 or 0051.

Commenters on our proposed rule also requested that CMS assign CPT codes 0062T and 0063T to an APC that more accurately reflects the level of the procedures' resource use. The commenters also suggested that placement in either APC 0050 or 0051 would be the most appropriate from both clinical and payment aspects. They, like the presenter to the APC Panel, believed that a musculoskeletal APC was a more clinically accurate description of the procedure than its CY 2005 assignment with nerve injections in APC 0203.

Response: CPT codes 0062T and 0063T were new for January 2005. Thus, we had no hospital claims data upon which to base our APC assignment of these procedures, and we were interested in the additional information that was provided to us for our CY 2006 update to the OPPS. Commenters indicated that performance of the procedures requires a single use electrothermal catheter that costs more than $1,000 and operating room time of one hour. In addition, other more costly capital equipment is required in comparison with procedures assigned to

APC 0203. The presenter to the APC Panel stated that the procedure costs range from $4,000 to about $7,000.

We found the information provided in the APC Panel presentation and the public comments to the proposed rule, in addition to the APC Panel's recommendation and historical hospital claims data regarding other services payable under the OPPS, to be convincing in favor of assignment of this procedure to APC 0050, with an APC median cost of $1,423 for CY 2006. We agree that placement in APC 0050 will result in more accurate payment and more APC clinical homogeneity for the procedure. For our CY 2007 update, we will have hospital claims data for the procedure and we will reevaluate the assignment.

d. Kyphoplasty (APC 0051)

Comment: Two commenters on the November 15, 2004 final rule with comment period (69 FR 65681), a device manufacturer and an orthopedic surgeon, commended CMS for creating C-codes (HCPCS codes C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection; and C9719, Kyphoplasty, each additional vertebral body) for this procedure in the hospital outpatient setting. The commenters stated, however, that placement in APC 0051, Level III Musculoskeletal Procedures Except Hand and Foot, (CY 2005 payment rate of $2,043) does not appropriately reflect the hospital resources used in performing these procedures, and that these assignments violate the two times rule because the resources associated with kyphoplasty are more than two times the cost of the resources for procedures in APC 0051. Both commenters recommended that kyphoplasty procedures be placed in APC 0425, Level II Arthroplasty with Prosthesis, at a CY 2005 payment rate of $5,562 in order to better reflect the clinical features and resources needed to perform the procedures. One commenter alternatively suggested creating a new APC solely for kyphoplasty.

Additionally, these two commenters also submitted new comments to the July 25, 2005 proposed rule containing new recommendations pertaining to the same issues. The commenters recommended that CMS either reassign kyphoplasty procedures to APC 0681 (Knee Arthroplasty) with a payment rate of $8,103 or create a new APC for kyphoplasty titled ''Vertebral spinal augmentation and stabilization using balloon inflation'' with a payment rate of $8,750. They also repeated their prior recommendation to place kyphoplasty services in APC 0425; however, one commenter suggested that this should only be a ''stop gap measure'' for one year until CMS can gather claims data. This commenter also recommended that if the CPT codes for kyphoplasty have a status indicator of ''T,'' they should then be placed in the same APC, as the add-on code would be subject to the multiple procedure reduction. The commenters reasoned that movement to a new APC would better reflect the clinical resources used and referenced outside data showing hospital median charges that range from $4,500 to $41,000, with an average charge of approximately $15,700.

A third individual commenter representing a hospital recommended that CMS either increase reimbursement for kyphoplasty, or change its status indicator to ''C'' to be more consistent with InterQual ''Guidelines for Surgery and Procedures in the Inpatient Setting'' and the Ingenix Cross Coder.

Response: For CY 2005, CMS created two C-codes for the kyphoplasty procedure: C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection and HCPCS code C9719 Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body (List separately in addition to code for primary procedure). These procedures were placed in APC 0051 with a ''T'' status indicator because we believed that this APC was appropriate for these procedures in terms of clinical characteristics and resource costs.

Though we do not yet have claims data, we have been told that a bone biopsy is performed more than half the time in addition to the kyphoplasty procedure. For CY 2005, under the OPPS the bone biopsy could be billed separately along with one or more of the kyphoplasty C-codes. The typical deep bone biopsy code used for a vertebral body procedure, CPT code 20225, was assigned to APC 0020 (Level II Excision/Biopsy), which had a ''T'' status indicator and a payment rate of $434 for CY 2005. Both the biopsy and kyphoplasty procedures had a status indicator of ''T''; therefore, when performed together the hospital would receive fifty percent of the payment rate for the bone biopsy ($217). We have been told that hospitals typically also bill one or more fluoroscopy codes for necessary guidance, such as CPT codes 76003 (Fluroscopic guidance for needle placement), or 76005 (Fluroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnosis or therapeutic injection procedures, including neurolytic agent destruction), along with the kyphoplasty procedure, and we note that these fluoroscopic services were packaged for CY 2005. Thus, for CY 2005 payment to a hospital providing a single level kyphoplasty procedure and billing packaged fluoroscopic guidance that was also accompanied by a bone biopsy would be about $2,260.

For CY 2006, several new CPT codes were created to describe the kyphoplasty procedure. These codes are:

- CPT 22523—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
- CPT 22524—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); lumbar
- CPT 22525—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

CPT codes 22523 and 22524 generally correspond to C code C9718, and CPT code 22525 generally corresponds to C code C9719. We will be deleting the two kyphoplasty C-codes for CY 2006, and hospitals will use the appropriate CPT codes to bill for kyphoplasty services. The new CPT codes include a bone biopsy when performed so hospitals will no longer separately bill CPT code 20225 when a bone biopsy accompanies a kyphoplasty procedure.

CPT code 76012 (Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance) for fluoroscopic guidance also has changed in definition for CY 2006 to include specific reference to vertebral augmentation including cavity creation, which is characteristic of the kyphoplasty procedure. For CY 2006, hospitals using fluoroscopic guidance for kyphoplasty would bill CPT code 76012, which has a status indicator S and is assigned to APC 0274 for calendar year CY 2006 with a payment rate of $173.53. Thus, while a hospital providing a kyphoplasty service in CY 2006 will no longer receive separate payment under the OPPS for an accompanying bone biopsy, hospitals

will be able to bill for and receive separate payment for necessary fluoroscopic guidance. Thus, if there were no change for CY 2006 in the assignment of kyphoplasty services to APC 0051, as they were initially placed for CY 2005, payment to a hospital providing a single level kyphoplasty procedure and billing separately payable fluoroscopic guidance that was also accompanied by a bone biopsy would be about $2,352.

Based on modifications in coding associated with the change from C-codes to new CPT codes and additional clinical and hospital resource information, we believe it is appropriate to move the kyphoplasty procedures from APC 0051 to another APC for CY 2006. As we originally developed C-codes for outpatient hospital billing of kyphoplasty services after extensive clinical review, we do not agree with one commenter that kyphoplasty should by placed on the OPPS inpatient list. In addition, as kyphoplasty procedures do not entail implantation of a prosthesis, we do not agree with the commenters that kyphoplasty is comparable to services that require a prosthesis and, therefore, we will not place the new CPT codes in APC 0425 (Level II Arthroplasty with prosthesis). We also will not place the new CPT codes in APC 0681 (Knee arthroplasty) because we do not believe that the services are clinically coherent with knee arthroscopy procedures, and because we do not believe that resources required for kyphoplasty warrant that level of payment. We also will not create a separate APC solely for kyphoplasty procedures because we have no claims data from CY 2004 upon which to base a calculation of median cost for such an APC.

After considering the additional comments submitted, we have decided to place CPT codes 22523, 22524, and 22525 in APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot) for CY 2006, based on clinical and resource compatibility with other procedures assigned to that APC. We agree with the commenters that the initial level procedures and the add-on code for each additional level should be assigned to the same ''T'' status APC. Although we received outside data on hospital charges and costs for this procedure, the data that was presented to us was highly variable in terms of charges and presented cost data for only one hospital. We will examine the median costs from hospital claims data for these services when it becomes available for the CY 2007 OPPS update.

e. Neurostimulator Electrode Implantation (APCs 0040 and 0225)

Comment: Commenters, including the APC Panel, recommended that the services currently assigned to APCs 0040 (percutaneous implantation of neurostimulators electrodes, excluding cranial nerve) and 0225 (implantation of neurostimulators electrodes, cranial nerve) be reorganized into three APCs, based on clinically coherent groupings of percutaneous, laminectomy or incision, and cranial neurostimulator electrode implantation. They indicated that such a realignment would enhance clinical and cost congruence of the procedure groupings. Other commenters objected to the reassignment of CPT code 63655 from APC 0225 to APC 0040.

Response: We agree with the proposal for creation of a new neurostimulator electrode implantation APC and have made the change. CPT codes 63655 (from APC 0225), 64575 (from APC 0040), 64577 (from APC 0225), 64580 (from APC 0225) and 64581 (from APC 0040) have been reassigned to newly created APC 0061 (Laminectomy or incision for implantation of neurostimulators electrodes, excluding cranial nerve).

See section IV. A. for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the adjusted median costs for APCs 0040, 0225 and 0061 for CY 2006.

f. Neurostimulator Generator Implantation (APC 0222)

Comment: Commenters indicated that the proposed payment for neurostimulator generator implantation is inadequate and that CMS should use external data to set the payment rates. They explained that if payment rates were not increased, providers would cease providing the services. They asked that CMS set the median cost at the CY 2005 OPPS payment median inflated by the market basket.

Response: The proposed payment for APC 0222 (Implantation of neurological device) was based on a median cost that was set at 85 percent of the CY 2005 payment median. As with some other device-dependent APCs, the median cost on which the CY 2006 OPPS payment rate will be based will be set at 90 percent of the CY 2005 OPPS payment median. See the discussion of device-dependent APCs in section IV.A of this preamble.

Comment: Commenters objected to the payment for rechargeable neurostimulators under APC 0222 because they said that the payment rate for APC 0222 is inadequate for the payment of nonrechargeable devices, and that hospitals will not permit implantation of the rechargeable neurostimulators for this inadequate payment. They stated that CMS recognized the need for additional payment for rechargeable neurostimulators when it provided a new technology add-on payment under the IPPS for 2006, and that CMS should create a new category for rechargeable neurostimulators and should grant pass-through status for rechargeable neurostimulators for the CY 2006 OPPS.

Response: CMS does not announce decisions regarding pass-through status in regulations. There are many new items and services that fall under existing categories and pass-through status for each is determined on the merits of the specific application. When and if pass-through status for rechargeable neurostimulators is granted, it will be implemented through the OCE with creation of an appropriate category and status indicator assignment. Additions to the items qualifying for pass-through status are announced in quarterly updates of the OPPS claims processing and billing instructions sent to our contractors and posted on the CMS Web site.

g. Thoracentesis/Lavage (APC 0070)

Comment: One commenter said that CPT code 32019 (Insert pleural catheter) should be assigned to APC 0652 (Insertion of intraperitoneal catheters) because the clinical and resource characteristics of APC 0652 are more appropriate to CPT code 32019 than are the characteristics of APC 0070, the code's placement for CY 2005. The commenter indicated that APC 0070 is not an appropriate placement for CPT code 32019 because it is not like CPT code 32020 (tube thoracostomy with or without water seal) to which it is often compared and is assigned to APC 0070. The commenter stated that CPT code 32020 is a short term procedure, typically done at bedside with a single percutaneous incision, and uses a catheter with a simpler and different design. The commenter stated that CPT code 32019 is a long term procedure, typically done in a treatment room, using multiple incisions and subcutaneous tunneling, and a catheter with a more complex design. The commenter did not specifically describe the clinical or resource characteristics of APC 0652 that justify the conclusion that CPT code 32019 is more appropriately placed in APC 0652.

Response: We agree that the procedure reported by CPT code 32019 is likely more resource intensive than CPT code 32020 and other higher

volume codes in APC 0070. Therefore, we are reassigning CPT code 32019 to APC 0427 (level III tube changes and repositioning) for the CY 2006. We do not agree that it is necessarily similar in resource use to the insertion of intraperitoneal catheter or cannula procedures currently assigned to APC 0652. We will examine the claims data for this code and review that decision when there are claims data for the code, which was new for CY 2004 and for which no cost data are available for use in the CY 2006 OPPS.

5. Other Services

a. Allergy Testing (APC 0370)

A number of providers have expressed confusion related to the reporting of units for allergy testing described by CPT codes 95004 through 95078. Most of the CPT codes in the code range are assigned to APC 0370 (Allergy Tests) for the CY 2005 OPPS. Nine of those CPT codes instruct providers to specify the number of tests or use the singular word ''test'' in their descriptors, while five of them do not contain such an instruction or do not contain ''tests'' or ''testing'' in their descriptors. Some providers have stated that the lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, ''per visit'') for the CPT codes that instruct providers to specify the number of tests.

In light of the variable hospital billing that may be inconsistent with the CPT code descriptors, we carefully examined the CY 2004 single and multiple procedure claims data for the allergy test codes that reside in APC 0370 to set the CY 2006 payment rates. Our examination of the CY 2004 claims data revealed that many of the services for which providers billed multiple units of an allergy test reported a consistent charge for each unit. Conversely, some providers that billed only a single unit of an allergy test reported a charge many times greater than the ''per test'' charge reported by providers billing multiple units of an allergy test.

Our analysis of the claims data appeared to validate reports made by a number of providers that the charges reported on many of the single procedure claims represent a ''per visit'' charge, rather than a ''per test'' charge, including claims for the allergy test codes that instruct providers to specify the number of tests. Because the OPPS relies only on these single procedure claims in establishing payment rates, we believed that this inaccurate coding would have resulted in an inflated CY 2006 median cost for services that were in the CY 2005 configuration of APC 0370.

Therefore, we proposed to move the allergy test CPT codes that instruct providers to specify the number of tests or use the singular word ''test'' in their descriptors from APC 0370 to proposed APC 0381 (Single Allergy Tests) for CY 2006. We proposed to calculate a ''per unit'' median cost for proposed APC 0381 using a total of 306 claims containing multiple units or multiple occurrences of a single CPT code. Packaging on the claims was allocated equally to each unit of the CPT code. Using this ''per unit'' methodology, we proposed a median cost for APC 0381 of $11 for CY 2006. Because we believed the single procedure claims for the codes remaining in APC 0370 reflected accurate coding of these services, we proposed to use the standard OPPS methodology to calculate the median for APC 0370. Table 12 as published in the proposed rule (70 FR 42711) listed the proposed assignment of CPT codes to APC 0370 and proposed APC 0381 for CY 2006.

We received one public comment concerning our proposed policy changes for allergy test procedures.

Comment: One commenter supported our proposal to move the allergy test CPT codes into two APC configurations to differentiate between CPT codes that represent ''per visit'' and ''per test'' services.

Response: We agree with the commenter that differentiating single allergy tests (''per test'') from multiple allergy tests (''per visit'') by assigning these services to two different APCs provides hospital coders with better clarity for billing these services and more accurately places these tests with like services sharing similar resource costs. Therefore, for CY 2006, we are finalizing our proposal to assign single allergy tests to newly established APC 0381 and maintaining multiple allergy tests in APC 0370. We expect that the improved clinical and resource homogeneity of these APCs, along with improved hospital coding of these services, will result in more accurate claims data for setting the CY 2008 payment rates for these services. In the meantime, for CY 2006, we are finalizing our proposal to calculate a ''per unit'' median cost for APC 0381 using a total of 340 claims containing multiple units or multiple occurrences of a single CPT code. Using this ''per unit'' methodology, we are setting the payment rate for APC 0381 based on a median cost of $11 for CY 2006. Because we believe the single procedure claims for the codes remaining in APC 0370 reflect accurate coding of these services, we are finalizing our proposal to use the standard OPPS methodology to calculate the median for APC 0370. Table 15 lists the assignment of CPT codes to APCs 0370 and 0381 for CY 2006. We will be providing billing guidance to hospitals in CY 2006 clarifying the billing of allergy testing services under the OPPS that should be reported with charges per test rather than per visit, so that the accuracy of hospital claims data improves and allows us in the future to calculate median costs for both APCs 0370 and 0381 using our standard OPPS process.

TABLE 15.—ASSIGNMENT OF CPT CODES TO APC 0370 AND APC 0381 FOR CY 2006

APC 0370	APC 0381
95056, Photosensitivity tests	95004, Percutaneous allergy skin tests.
95060, Eye allergy tests	95010, Percutaneous allergy titrate test.
95078, Provocative testing	95015, Intradermal allergy titrate-drug/bug.
95180, Rapid desensitization	95024, Intradermal allergy test, drug/bug.
95199U, Unlisted allergy/clinical immunologic service or procedure	95027, Intradermal allergy titrate-airborne.
	95028, Intradermal allergy test-delayed type.
	95044, Allergy patch tests.
	95052, Photo patch test.
	95065, Nose allergy test.

b. Apheresis (APC 0112)

Comment: Several commenters commended our proposal to reassign CPT code 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion) from APC 0111 (Blood product exchange) to APC 0112 (Apheresis, Photopheresis, and Plasmapheresis) for CY 2006. These commenters stated that the resource requirements and the clinical characteristics of CPT code 36515 more closely resemble the services assigned to APC 0112. However, these commenters expressed concern that the proposed 25 percent reduction in payment for APC 0112 (from $2,127 in CY 2005 to $1,590 proposed for CY 2006) will not cover the costs associated with the disposable supplies, specially trained medical staff, and equipment used in conjunction with the services assigned to APC 0112 and described by CPT codes 36515, 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion), and 36522 (Photopheresis, extracorporeal). For example, commenters explained that the cost of the disposable supplies alone for CPT codes 36515 and 36516 nearly equals the proposed payment for APC 0112. One commenter provided practice expense information from the Medicare Physician Fee Schedule to substantiate supply costs of over $1,400 for CPT codes 36515 and 36516 and over $900 for CPT code 36522. Many commenters alleged that over half the hospitals reporting claims for CPT codes 36515 and 36516 in CY 2004 did not fully reflect the costs of the disposables in their charges for the procedure. Some of these commenters stated that hospitals that charge separately for the disposables are likely to charge more accurately for the full procedure than hospitals that bundle the entire costs of the disposable supplies into their charge for the procedure. These commenters urged that CMS set the payment rate for APC 0112 based only on claims where separate charges for supplies have been identified. Other commenters recommended that we exclude the CY 2004 claims data for CPT codes 36515 and 36516 and set the payment rate for APC 0112 based solely on the claims for CPT code 36522, whose proposed CPT code median cost appeared to be accurate to the majority of commenters. In addition, several commenters urged that we reexamine our calculation of the median cost for APC 0112 for errors in the computation, due to their observation that the proposed median cost of APC 0112 was significantly lower than the proposed median cost for CPT code 36522, which comprised 83 percent of the single claims used to set the proposed payment rate for APC 0112.

One commenter noted that CPT code 36516 is utilized for billing LDL-apheresis treatments, and expressed concern that only 40 percent of the CY 2004 claims used to calculate the proposed payment for CPT code 36516 actually reported diagnoses consistent with LDL-apheresis treatments on the claim. This commenter provided a list of hospitals which the commenter believed to be misreporting CPT code 36516, based on the commenter's experience as a distributor and knowledge of the market, and requested that we exclude the claims for CPT codes 36515 and 36516 submitted by these providers when calculating the payment rate for APC 0112. Another commenter provided a detailed analysis of the claims for CPT codes 36515, 36516, and 36522 that we used to calculate the proposed payment rate for APC 0112. Based on this claims analysis, of the 24 providers that billed CPT code 36515, 29 percent reported costs for the entire procedure at or below $170, and 67 percent reported medical supply costs at or below $1,412. The commenter also noted that nearly half of the single claims for CPT code 36515 were not billed with ICD–9 codes that supported the medical necessity of protein A column apheresis, leading the commenter to conclude that such providers were miscoding the services they performed. For instance, the commenter suspected that several hospitals may have incorrectly billed CPT code 36515 when reporting the collection of venous blood by venipuncture (CPT code 36415) based on the charges reported by these hospitals matching a typical charge for venipuncture. Further claims analysis also revealed that, of the 46 providers that billed CPT code 36516, 63 percent reported medical supply costs at or below $1,485. Furthermore, the commenters said that only 44 percent of the single claims for CPT code 36516 were billed with ICD–9 diagnosis codes that supported the medical necessity of LDL-apheresis. The commenter concluded that the underreporting of costs and assignment of inappropriate ICD–9 diagnosis codes to claims reporting CPT codes 36515 and 36516 were strong indicators that many providers failed to include the charges for medical supplies on the claims for CPT codes 36515 and 36516 or miscoded the services they provided.

Several commenters suggested that because the procedures assigned to APC 0112 utilize device systems to modify or selectively remove agents from the blood, these services should be treated in a manner similar to either device dependent APCs or blood and blood products. For instance, commenters recommended that we apply the same methodology to APC 0112 as we proposed to apply to blood and blood products, limiting the decrease in median cost to 10 percent on the basis that the services assigned to APC 0112 could be considered closely related to blood and blood products. Alternatively, these commenters suggested that we should consider treating APC 0112 as a device dependent APC, limiting the decrease in median cost to 15 percent on the basis that the device systems are integral to the procedures assigned to APC 0112 and comprise a significant cost component of these procedures. One of these commenters urged that we add APC 0112 to the list of device dependent APCs, and set the payment floor at 100 percent of the CY 2005 payment rate plus the market basket update for all device dependent APCs.

Response: We appreciate commenters' concerns that we use accurate and complete claims data to develop the median cost to set the payment rate for APC 0112 for CY 2006. In response to requests by several commenters that we reexamine our calculation of the median cost for APC 0112, we closely studied the single claims charge and cost distributions for CPT codes 36515, 36516, and 36522, those single claims we used to set the payment rate for APC 0112. First, we noted that we had 4,828 single bills drawn from a total of 6,071 bills for services in APC 0112, allowing us to use approximately 80 percent of all claims in establishing the median cost for APC 0112. This large percentage of single bills held true for each of the 3 CPT codes assigned to the APC as well. The availability of almost 5,000 single bills for rate setting, a 15 percent increase over the number of single bills available for the CY 2005 OPPS update, increases our confidence in the accuracy of the median cost of APC 0112 calculated for CY 2006.

Next, we confirmed that we made no errors in the calculation of the APC median cost. The apparent inconsistency between the relatively high median cost of CPT code 36522, which provided the majority of single claims for APC 0112, and the relatively lower APC median cost was explained by the observed distribution of costs of single claims for all of the services assigned to APC 0112. Almost half of the costs of single claims for CPT code 36522 are closer to the APC median. The cost of single claims for CPT code

36522 at the 45th percentile is $1,597.45. We applied all of our usual processes, including standard trimming, to the calculation of the APC median cost.

In our analysis of the distributions of costs from claims for all three CPT codes assigned to APC 0112, we observed that CPT code 36515, in particular, had some claims with very low costs of less than $200 up through the 50th percentile of claims costs. While, in the commenters' opinions, claims with even higher costs could not have represented the full costs of the procedures, we were not confident that we had reason to exclude claims with higher costs in calculating the median cost of APC 0112. Therefore, we identified 12 hospital providers submitting claims for CPT code 36515 with the lowest fifteen percent of costs and then recalculated the median cost for APC 0112, excluding all claims for CPT code 36515 reported by these 12 providers. We found essentially no change in the median cost of APC 0112 in this recalculation, as compared with its median cost based on all single claims.

Because commenters suggested that we set the APC median cost using only claims with medical supply revenue code charges, we proceeded to analyze all single claims for APC 0112 for the presence of separate line item charges under revenue codes 270 (Medical/Surgical Supplies) and 272 (Sterile Supplies) that could most likely represent separate charges for the costly disposables that commenters indicated are required for all 3 CPT codes assigned to the APC. The median cost for claims with medical supply revenue code charges is higher, at $2,800, compared with the median cost for claims without medical supply revenue code charges, $1,400. However, we do not believe it is appropriate to subset the claims based on the presence of medical supply revenue code charges for calculating the median APC cost for several reasons. First, we noted that between 80 and 90 percent of the single claims for each CPT code and, consequently, of all single bills used to estimate the median cost for APC 0112 did not have separate charges under one of the two specified revenue codes. This is fully consistent with our past guidance to hospitals that it is appropriate to bundle the costs of all supplies (excluding implantable devices with active device codes) into the line item charges for the procedures with which they were used. For those claims billed with charges in the 270 and 272 medical supply revenue codes, we observed that the specific median cost associated with those revenue codes was only $349. Because this median cost is well below the approximately $900–1,400 cost commenters expected for the disposable supplies, we are not convinced that the bills with separate revenue code charges are truly more reflective of the full costs of the apheresis procedures. Finally, we observed that there were actually higher total costs in the distribution of those claims without separate billing of revenue code charges, up to $12,296 in comparison with a maximum of $10,131 for those claims with separate revenue codes charges. Considering the small percentage of providers reporting separate supply charges for CPT codes 36515, 36516, and 36522 under revenue codes 0270 and 0272, and the low median cost for such revenue code charges, the majority of providers appear more likely to have included their disposable supply charges in their overall charges for the procedures rather than to have reported such charges under a supply revenue code. We have no reason to believe, based on our analysis, that the claims with separate charges for supplies are more correctly coded or more accurately reflective of the costs of services assigned to APC 0112.

In conclusion, we are not making any adjustments to our standard processes for developing APC median costs for CY 2006 for APC 0112. We will not screen claims for the presence of specified diagnoses that the commenters feel are appropriately treated with these procedures and assume that all other claims are miscoded. The three services treat a number of different medical conditions, and while there are some local coverage policies for the procedures, it would be difficult to identify the correct ICD–9 diagnosis coding for those claims reflecting all of the cases of appropriate utilization of these services. We are not calculating the payment rate for APC 0112 based solely on those claims where separate charges for supplies have been identified. Although we recognize that some of the charges reported for CPT codes 36515 and 36516 in particular are unexpectedly low, we disagree with those commenters who asserted that the hospital claims data for CPT codes 36515 and 36516 are flawed to the extent that would justify discarding all such claims and basing the payment rate for APC 0112 solely on claims for CPT code 36522. We will not exclude all claims for two of the three procedures assigned to APC 112 to calculate the APC's median cost, because we believe that the APC median cost should reflect the variable costs of all services assigned to it. Consistent with details provided in the comments, we do not believe that the costs of procedures described by CPT codes 36515, 36516, and 36522 are the same, as the services are each provided using very specific disposable supplies for patients with different clinical conditions. In addition, we do not agree with those commenters who argued that the services described by CPT codes 36515, 36516, and 36522 should be treated in a manner similar to either device dependent APCs or blood and blood products by mitigating their payment reductions. We do not consider a procedure requiring a disposable supply to be a device dependent APC, which utilizes implantable devices. In addition, we do not believe that the data concerns regarding these procedures that treat the blood are similar to the supply and availability challenges associated with maintaining the nation's blood supply. Therefore, for CY 2006, we are applying our standard OPPS rate-setting methodology to all single claims for APC 0112, setting the payment rate for APC 0112 based on a median cost of $1,568.

c. Audiology (APCs 0364, 0365, and 0366)

Comment: One commenter, an association representing audiologists, requested more detailed explanation for several proposed movements of CPT codes among APCs. We proposed for CY 2006 to make the following APC migrations: CPT codes 92533 (audiometry, air & bone) and 92572 (staggered spondaic word test) from APC 0364 to APC 0365; CPT code 92561 (Bekesy audiometry, diagnosis) from APC 0365 to APC 0364; and CPT code 92577 (Stenger test, speech) from APC 0365 to APC 0366. The commenter did not object to the changes.

Response: With respect to proposed APC reassignments of services that are not specifically discussed in the proposed rule, in general we proposed changes to improve the clinical and resource homogeneity of the involved APCs, and, in particular, to address violations of the two times rule resulting from variable median costs.

In this instance, CPT code 92561 was moved from the Level II Audiometry APC to the Level I Audiometry APC because the data from CY 2004 hospital claims showed that the code-specific median cost of $19 for CPT code 92561 was most compatible with the median cost of APC 0364, at $27. To leave the code in APC 0365 would create a significant overpayment, and there was another clinically appropriate APC

available. A similar rationale applied to CPT code 92577, whose code-specific median cost of $108 was more coherent with the median cost of APC 0366 (Level III Audiometry) of $100 than the median cost of the Level II APC at $80. While we excepted APC 0364, the CY 2005 APC assignment for CPT code 92553, from the two times rule for CY 2005, we proposed to move CPT code 92553 to APC 0365 for CY 2006 to eliminate our need to except APC 0364 from the two times rule for CY 2006. When compared with the median costs of other procedures in APC 0365, the median cost of CPT code 92553 of $43 was reasonably consistent with the median costs of other codes assigned to APC 0365 and to the overall APC median cost of $71. Due to this code's significant volume of single claims and stable median costs, we believed that it was appropriate to propose its reassignment based on both clinical and hospital resource considerations. We are finalizing our APC assignments for CPT codes 92561, 92577, and 92553 as proposed for CY 2006.

We proposed to move CPT code 92572 (staggered spondaic word test) from APC 0364 to APC 0365 for CY 2006 because we believed that its resource requirements, as reflected in hospital claims data, were more consistent with other services assigned to APC 0365 than to procedures assigned to APC 0364. CY 2003 hospital claims data for CPT code 92572 revealed a median cost of about $100 based on 19 single claims. CY 2004 claims data, based on 10 single claims, yielded a median cost of about $167. Although the median does not appear to be as stable for this code as the others discussed nor is the volume of claims large, upon review of final CY 2004 hospital claims data in response to this comment and examination of the clinical characteristics of the service, we believe that CPT code 92572 is most appropriately assigned to APC 0366 for CY 2006. Therefore, we will not finalize our proposal to move CPT code 92572 to APC 0365, but will instead reassign the service to APC 0366 for the CY 2006 OPPS.

d. Bone Marrow Harvesting (APC 0111)

Comment: Several commenters stated that the proposed payment of $735 for CPT code 38230 (Bone marrow harvesting for transplantation) does not adequately cover the costs of providing this service. These commenters called our attention to the large difference in the proposed median cost of $1,209 for CPT code 38230 and the proposed median cost of $747 for APC 0111, where CPT code 38230 resides. Commenters also noted the volatility of the CPT code median as a result of the extremely low frequency of 9 claims, noting that the costs of these claims ranged from $140 to $66,770. Commenters strongly urged CMS to reassign CPT code 38230 from APC 0111 (Blood product exchange) to APC 0123 (Bone marrow harvesting and bone marrow/stem cell transplant) to more accurately reflect the high cost of this procedure and to improve the clinical homogeneity of the two APCs, stating that the APC title for APC 0123 is more applicable to CPT code 38230 than the title of APC 0111.

Response: Hospitals have reported a consistently low median costs for CPT code 38230 for the past several years, prompting us to reassign this service to a lower paying APC, from APC 0123 to APC 0111, for CY 2005. However, closer analysis of this code-specific low median cost leads us to suspect that a number of providers are likely billing this code for services that are not described by CPT code 38230, bone marrow harvesting for transplantation. Considering the typical clinical characteristics of the service, we would expect the costs of the necessary hospital resources to more closely approximate the median costs of services assigned to APC 0123 for CY 2006. Therefore, we will return CPT code 38230 to APC 0123 for CY 2006. However, we will reevaluate the appropriateness of this APC assignment during the OPPS update for CY 2007. In the meantime, we advise providers to exercise greater care when reporting CPT code 38230 to ensure that this code is billed correctly only for services described by the CPT code and that all costs associated with providing the bone marrow harvesting procedure are included in charges on the claims for the service.

e. Computer Assisted Navigational Procedures

Comment: Two commenters expressed concern about computer assisted navigation for orthopedic procedures (CPT codes 0054T, 0055T, and 0056T). Both commenters were concerned that CMS had not assigned these procedures to an APC for OPPS payment, but instead had proposed their status indicators as ''B'' while another computer assisted navigational procedure, CPT code 61795 (Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal), had previously been assigned status indicator ''S'' in APC 302 (Level III Radiation Therapy). Both commenters recommended that orthopedic computer assisted navigational procedures should be assigned to APC 0302 with the other computer assisted navigational procedures, or alternatively each procedure (CPT codes 61795, 0054T, 0055T, and 0056T) should be placed in a new clinical APC with a payment rate equaling the payment rate of APC 0302.

Response: We agree with the commenters that these computer assisted navigational procedures share a common technological theme in their clinical use during surgical procedures and may use comparable hospital resources. We, therefore, will place CPT codes 0054T, 0055T, and 0056T in APC 0302 with CPT 61795 for CY 2006. We will also give APC 0302 a new name, ''Computer Assisted Navigational Procedures,'' because the APC contains only these four services and is thus most appropriately described by that title.

f. Hyperbaric Oxygen Therapy (APC 0659)

When hyperbaric oxygen therapy (HBOT) is prescribed for promoting the healing of chronic wounds, it typically is prescribed on average for 90 minutes, which would be billed using multiple units of HBOT to achieve full body hyperbaric oxygen therapy. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). The OPPS recognizes HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for HBOT provided in the hospital outpatient setting.

We explained in the August 16, 2004 proposed rule (69 FR 50495) that our CY 2003 claims data revealed that many providers were improperly reporting charges for 90 to 120 minutes under only one unit rather than three or four units of HBOT. This inaccurate coding resulted in an inflated median cost of $177.96 for HBOT, derived using single service claims and ''pseudo'' single service claims. Because of these single claims coding anomalies, we proposed to calculate a ''per unit'' median cost for APC 0659, using only multiple units or multiple occurrences of HBOT, excluding claims with only one unit of HBOT and excluding packaged costs. To convert HBOT charges to costs, we used the CCR from the respiratory therapy cost center when available; otherwise, we used the hospital's overall CCR. Using this ''per unit'' methodology, we proposed a median cost for APC 0659 of $82.91 for CY 2005.

In the November 15, 2004 final rule with comment period (69 FR 65758), we agreed with commenters that there was sufficient evidence that the CCR for HBOT was not reflected solely in the respiratory therapy cost center; rather, the CCR for HBOT was reflected in a variety of cost centers. Therefore, we calculated a ''per unit'' median cost of $93.26 for HBOT, using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR.

Our examination of the CY 2004 single procedure claims filed for HCPCS code C1300 revealed similar coding anomalies to those encountered in the CY 2003 single procedure claims data. Therefore, for CY 2006 rate-setting, we recalculated a ''per unit'' median cost for HCPCS code C1300 using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR, which is the same methodology we used for setting the CY 2005 payment rate for HBOT. Excluding claims with only one unit of HBOT, we used a total of 41,152 claims to calculate the proposed median for APC 0659 for CY 2006. Applying the methodology described above, we proposed a median cost for APC 0659 of $93.37 for CY 2006.

We received several public comments concerning our proposed APC payment for HBOT.

Comment: Several commenters approved of our decision to rely on each hospital's overall CCR rather than the respiratory therapy CCR in our calculation of HBOT median costs. However, the commenters noted that most hospitals providing HBOT services report the costs and charges associated with providing this service on a separate line of their cost report. These commenters further encouraged us to use the CCR specific to HBOT for hospitals that report HBOT separately. They also asked CMS to encourage hospitals not reporting costs and charges for HBOT separately, to do so in the future.

Response: Unfortunately, the Healthcare Cost Report Information System (HCRIS), the electronic database of the Hospital Cost Report (CMS–2552–96) that we use to estimate costs from charges, rolls up costs and charges on each hospital's cost report into a standard list of cost centers. Because HBOT is not included on the standard list of cost centers, CMS does not have readily available information about the specific costs and charges that each institution garners in providing HBOT services. Until last year, we had hypothesized that most hospitals providing HBOT services reported the costs and charges for those services as a separate line item in their respiratory therapy cost center. Commenters convinced us that hospitals did not report their HBOT costs and charges in a uniform location on their cost report. In the final rule for CY 2005, we used the overall CCR for each hospital rather than the respiratory therapy CCR to calculate the median cost for HBOT (APC 0659). While we could encourage hospitals to report their costs and charges for HBOT separately, at this time extra effort by hospitals would not allow us to improve the accuracy of our HBOT median cost calculation because we lose line-item specificity when the data is entered into HCRIS.

Comment: One commenter commissioned a study to analyze our rate-setting methodology and conducted an independent survey of hospitals that provide HBOT services. Surveys conducted in CYs 2004 and 2005 asked all hospitals providing HBOT services to identify the standard cost center associated with the line on their cost report where the hospital reports costs and charges for HBOT: 206 hospitals, or 44 percent of all hospitals providing HBOT services, responded to one of the surveys. The commenter believes that the survey results are generalizable to all hospitals providing HBOT services because the demographics of those hospitals not responding to the surveys are comparable to those responding to the surveys. For each of the responding hospitals, the survey results provided the standard cost center on each hospital cost report. The study calculated an HBOT CCR for each hospital based on the costs and charges in the associated standard cost center, not just the costs and charges for HBOT. On the basis of these results, the study then generalized an HBOT CCR to the 56 percent of hospitals not responding to the surveys. Specifically, the study simulated HBOT CCRs for each of the non-responding hospitals by applying a methodology that generalized to the non-responding hospitals HBOT-specific findings from similar hospitals. The study results led the commenter to conclude that the proposed median cost of $93.37 was too low, and that a more accurate estimate of median cost per unit is $118.94. On the basis of this analysis the commenter requested that CMS use the median cost of $118.94 to set the payment rate for APC 0659. The commenter noted that APC 0659, where the HCPCS code for HBOT (C1300) is assigned, is unusual as it is one of only a few APCs that contain only one HCPCS code. They concluded that as no averaging of the costs of services occurs, any changes in the median cost for C1300 in APC 0659 have a particularly great impact on the APC median, as compared to changes in the median cost for a procedure assigned to an APC to which multiple services are assigned.

Response: We receive many submissions of external data from commenters supporting their requests for higher median cost estimates for specific procedures. In many cases, submitted data have not met the minimum standards required for setting payment rates. We have previously provided preferred characteristics of external data to be submitted in comments regarding devices (68 FR 47987). While we have not specifically provided criteria for non-device external data, the subset of our published characteristics that could be applicable to a service such as HBOT include the public availability of the data, its representativeness of a diverse group of hospitals both by location and type, and its identification of its data sources. As part of the CY 2005 study, hospitals gave their consent for their identification and cost report information to be made public, an essential characteristic of data submitted as part of a public comment. The submitted HBOT CY 2005 survey data represent a varied group of 120 hospitals, both by location and type of hospital, as well as 31 percent of the population of total hospitals providing HBOT services according to CY 2004 hospital claims. Inclusion of HBOT survey data from the CY 2004 survey increases the response rate to 44 percent. The survey results provide us with the specific standard cost center in which costs and charges for HBOT are located for the responding hospitals, allowing us to relate the HBOT charge data to cost-to-charge information provided in hospital cost reports for these hospitals. We are appreciative of this study in that it provides us with some useful information as we examine our payment for HBOT services.

These survey results based on this modest response may, therefore, be representative of the 464 hospitals that submitted HBOT claims to the OPPS in CY 2004. However, only a small minority of OPPS hospitals actually provides HBOT services, and there is such significant regional variation in the frequency of billing of hospital outpatient HBOT services that it is unlikely to be fully explained by the different health characteristics of regional populations. We understand that HBOT may also be provided in freestanding centers, and the business decisions around its location may depend upon the local healthcare infrastructure. Therefore, while the

responding hospitals may be similar to the non-responding hospitals with respect to hospital category and geographic location, we are not confident that these characteristics alone signify that the minority of responding hospitals is truly reflective of the relatively small number of OPPS providers billing for HBOT. In addition, we are not certain that comparability of hospitals with respect to their category and geographic location is related to individual hospital decisions about where to include HBOT costs and charges on their Medicare cost reports. Therefore, we are not convinced that it would be appropriate to generalize these HBOT cost center findings to non-responding hospitals to calculate an adjusted payment rate for HBOT.

In addition to our concern about generalizability based on the methodology discussed above, we have several additional reservations about employing the approach recommended by the commenter without the benefit of additional comment from other parties. First, employing this approach may establish an important precedent, which may well be cited by other commenters concerned with the median costs of other services. The OPPS is a prospective payment system that relies upon the coherent grouping of services that share clinical as well as resource utilization characteristics and the packaging of many ancillary services to determine payments. We are concerned that differentially employing methods that depend on additional external collection of information from hospitals may have unintended and potentially negative consequences in a payment system based on averages and relative values. It stands to reason that, as in the case of HBOT, commenters will only submit special surveys and proposals to refine rate-setting when they have at least a strong reason to believe that such customized methods will increase the rates for the specific services in which they are interested. In a budget-neutral payment system based on relative weights, this poses the risk that using this specific external information for select services will actually distort the process of establishing the relative weights in favor of some services but to the disadvantage of other services where such information is not available or not as potentially influential based on the APC assignments of those services. In a relative system such as the OPPS, it may be more important to employ a consistent set of data than to adopt specially ''enhanced'' data and methods for some services, but not for all services generally. Indeed, a consistent data set may be more likely to yield accurate relative values than a mixed data set consisting of both values calculated from hospital claims data and values determined by enhanced methods.

Lastly, our capacity to review, evaluate, and adapt special approaches to increase payment levels for individual services in the OPPS is necessarily limited. Based on all of our concerns previously discussed, it is consequently important that we obtain some idea of the extent of other possible requests for use of special methods and non-claims based data to increase payment levels for particular services or groups of services before setting such a precedent for one specific OPPS service, where there appear to be no pressing access concerns based on our OPPS payment rates to date. Our hospital claims data reveal steadily increasing frequencies of HBOT claims, from 101,843 services in CY 2002, to 188,604 services in CY 2003, and once again to 242,558 services in CY 2004. This more than doubling of HBOT services in hospital outpatient departments over a 2-year time period indicates that Medicare beneficiaries are unlikely to be experiencing difficulty in accessing medically necessary HBOT services in the context of the OPPS payment rates for HBOT.

Before we engage in further rulemaking, we therefore specifically invite input on other situations where special approaches may be appropriate and where high quality external data might be made available. We are interested in the possible merits of these other approaches and in potential criteria that we might use to assess when a special methodology should be employed. We believe these comments can help us to develop options for consideration for the CY 2007 OPPS update. In the meantime, we intend to continue our efforts to improve the precision of the OPPS relative weights by increasing our use of multiple procedure claims and refining our cost estimation process.

While we solicit additional public comment on this subject matter, for CY 2006 rate-setting we are finalizing our proposal to recalculate a ''per unit'' median cost for HCPCS code C1300 using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR, which is the same methodology we used for setting the CY 2005 payment rate for HBOT. Excluding claims with only one unit of HBOT, we used a total of 47,101 claims to calculate the final median cost for APC 0659 for CY 2006. Applying the methodology described above, we are setting the final payment rate for APC 0659 based on a median cost of $90.09 for CY 2006.

Comment: One commenter pointed out that they had difficulty replicating CMS's median cost estimate, in part because the public dataset that we make available included cost data calculated with the respiratory therapy CCR, that the calculation of the ''overall CCR'' was not sufficiently defined in regulations to be replicated, and that using the cost centers marked with a ''Y'' on the ''Revenue Code to Cost Center Crosswalk Description'' did not yield an overall CCR comparable to the one that we used.

Response: We acknowledge the commenter's concern regarding the accessibility and quality of data available to replicate CMS's median cost calculations. While we believe that we have fulfilled our public obligation to provide access to data to support public comments, users of the data can sometimes identify improvements. We agree that the overall CCR calculation should be more transparent. We have provided additional information about this calculation both in the final rule under our discussion of APC median calculations and on our Web site. We also agree that we should have placed the hospital specific overall CCR to estimate costs for HBOT on our public use file. We will remedy this for the CY 2007 rulemaking process.

g. Ophthalmology Examinations (APC 0601)

Comment: One commenter, representing eye physicians and surgeons, agreed with our decision to exempt the APC 0235 (Level I Posterior Segment Eye Procedures) from the 2 times rule for CY 2006. The commenter also agreed with our proposal to move several other ophthalmology procedures into higher paying APC groups (CPT codes 65265, 65285, 66220, 67025, 67027, 67036, 67038, 67039, and 67121). See 70 FR 42704, July 25, 2005 for a table including the proposed changes.

However, this commenter disagreed with the proposal to move CPT codes 92004 (eye exam, new patient) and 92014 (eye exam, established patient) from APC 0602 (High Level Clinic Visits) to APC 0601 (Mid Level Clinic Visits). The commenter urged CMS to reconsider this decision and keep these codes in APC 0602.

Response: At its February 2005 meeting, the APC Panel recommended that CMS restructure APCs 0601 and 0602 to eliminate violations of the two times rule. At the time of the proposed rule for CY 2006, the available median cost data for these two codes showed

that the hospital resources for both codes were more homogenous with other services assigned to the mid level clinic visit APC 0601, as compared to services assigned to the high level clinic visit APC 0602. Keeping these codes in APC 0602 for CY 2006 would have resulted in significant overpayments for both codes based on historical hospital claims data.

We now have additional claims data, reflecting more complete median costs for both codes from CY 2004 claims. Upon review of CPT code 92004, its median cost of $82 based on almost 21,000 single claims is more consistent with the median costs of other services assigned to APC 0602 ($88), and assigning this code to APC 0602 for CY 2006 would not cause a two times rule violation. We, therefore we will not finalize our CY 2006 proposal to move CPT code 92004 to APC 0601, but instead we will reassign CPT code 92004 back to APC 0602 for CY 2006. However, the median cost of CPT code 92014 ($67) based on nearly 100,000 single claims remains more consistent with the median cost of APC 0601 ($60). Based on OPPS hospital claims data, hospitals are consistently reporting higher costs for comprehensive eye exams for new patients in comparison with comprehensive eye exams for established patients. These differences in costs likely result from the additional hospital resources required to provide eye exams to new patients, in keeping with current clinical practice. To return CPT code 92014 to APC 0602 for CY 2006 would significantly overpay comprehensive eye examinations for established patients. We therefore finalize our CY 2006 proposal to assign CPT code 92014 to APC 0601.

h. Pathology Services

Comment: One commenter supported the proposed status indicator of B for HCPCS codes D0472–D0999 because the commenter indicated that providers should bill the appropriate CPT code in place of these codes. The commenter urged CMS to require its contractors to deny claims for HCPCS codes D0472–D0999.

Response: We agree that these HCPCS codes duplicate existing CPT codes and therefore have designated them as not payable or recognized under OPPS. As a practical matter, this change in status indicator has little or no impact on providers because of this entire code series, in all of CY 2004, only 3 units of HCPCS code D0999 were billed by hospitals under OPPS. This CY 2006 final rule with comment period applies to payments under the OPPS and a comment that we should deny claims for these codes submitted by all other providers in all other settings is outside the scope of this final rule.

Comment: One commenter objected to payment of CPT code 86586 under the OPPS and asked that we place it on the clinical laboratory fee schedule for CY 2006 because currently, the only source of payment is under the OPPS and therefore independent laboratories cannot be paid for it.

Response: We agree with this comment and we will pay for this code under the clinical lab fee schedule in CY 2006. This code will therefore not be paid under the OPPS in 2006.

Comment: One commenter objected to payment being made under the OPPS for CPT codes 80500–80502 and 88187–88189, which are for physician interpretation and report services. The commenter asked that we change their status indicators to ''M'' so that the codes would not be billable to a fiscal intermediary nor payable under the OPPS. The commenter believed that these services should only be paid to physicians on claims submitted by carriers.

Response: These services currently have status indicator ''X'' and are separately paid under OPPS. We believe that payment to hospitals is appropriate because of the resources hospitals furnish for the physician to be able to perform these services in a hospital (that is, space, computer, office supplies, medical records system).

i. Photodynamic Therapy of the Skin (APC 0013)

Comment: One commenter supported the proposed move of CPT code 96567 (Photodynamic Therapy of the Skin) from APC 0013, with a proposed payment rate of $66, to APC 0016 with a proposed payment rate of $153. The commenter also expressed appreciation that the drug used with this procedure (HCPCS code J7308) is paid separately and not bundled into the payment for the procedure. The commenter asked that CMS continue to monitor the median costs reported by hospitals so that Medicare beneficiaries may continue to have access to this procedure and the drug associated with the procedure.

Response: We appreciate the thoughtful comments submitted by this pharmaceutical manufacturer. We will finalize the placement of CPT code 96567 in APC 0016 as proposed. As always, we will continue to monitor claims data submitted by hospitals to ensure appropriate payment for all procedures.

j. Wound Care

As stated in the July 25, 2005 proposed rule (70 FR 42692), based upon a recommendation from the APC Panel we referred CPT code 97602 (non-selective wound care) for MPFS evaluation of its bundled status in relation to services provided under the OPPS. In the proposed rule for CY 2006, we assigned CPT code 97602 a status indicator of ''A,'' meaning that while it was not payable under the OPPS, it was payable under a fee schedule other than the OPPS, specifically the MPFS. We explained that, under the MPFS, the nonselective wound care services described by CPT code 97602 are ''bundled'' into the selective wound care debridement codes (CPT codes 97597 and 97598). Furthermore, under the MPFS, a separate payment is never made for ''bundled'' services and, because of this designation, the provider does not receive separate payment for furnishing non-selective wound care services described by CPT code 97602.

We received several public comments concerning our proposed treatment of CPT code 97602 under the OPPS.

Comment: Several commenters objected to our proposal to maintain a status indicator of ''A'' for CPT code 97602, which does not allow for separate payment under the OPPS. These commenters contended that CMS' recognition of this code only under the MPFS as a bundled service is equivalent to CMS asking hospitals to furnish but not charge for this service. They asserted that our decision not to pay for this service under the OPPS is based on a misclassification of this code as an ''always therapy'' service. They further explained that registered nurses, as opposed to physical therapists, routinely perform non-selective wound care services in the hospital outpatient setting. These commenters urged CMS to acknowledge non-selective wound care as meeting the definition of covered outpatient therapeutic services under the OPPS. Two commenters requested that we assign the newly proposed status indicator ''Q'' to CPT code 97602 so that separate payment can be made under the OPPS when this is the only payable service provided under the OPPS. These two commenters also suggested that we pay this service at the same payment rate as services assigned to APC 0600 (Low Level Clinic Visits).

Another commenter strongly recommended that CMS also review our status indicator assignment of ''A'' to CPT codes 97605 (Negative pressure wound therapy; total wound(s) surface area less than or equal to 50 sq. cm.) and 97606 (Negative pressure wound

therapy; total wound(s) surface area greater than 50 sq. cm.), in addition to CPT code 97602 as mentioned by other commenters and discussed above. The commenter urged that we pay separately for these services under the OPPS, emphasizing that these codes represent comprehensive wound care management and are typically not performed with any other service. Furthermore, the commenter objected to our designation of CPT codes 97602, 97605, and 97606 as ''always therapy'' services, contending that these services are often performed by registered nurses and should be classified as ''sometimes therapy'' services and assigned a status indicator of ''S'' which pays separately under the OPPS. Finally, this commenter recommended that we assign CPT codes 97602, 97605, and 97606 to New Technology APC 1502 (Level II $50–$100) with a payment rate of $75 for CY 2006 until we can collect hospital claims data to aid us in assigning these services to a clinical APC based on hospital median costs.

Response: We thank the commenters for their views on the classification and payment status of wound care services under the OPPS. Pursuant to a congressional mandate (Balanced Budget Act of 1997, Pub. L. 105–33) to pay for all therapy services under one prospective payment system, as provided under section 1834(k)(5) of the Act, we created a therapy code list to identify and track outpatient therapy services paid under the MPFS. We provide this list of therapy codes along with their respective designation in the Medicare Claims Processing Manual Pub. 100–04, section 20. We define an ''always therapy'' service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a ''sometimes therapy'' service as a service that may be performed by a non-therapist outside of a certified therapy plan of care. As recommended by the commenters, we have carefully reviewed our designation of CPT codes 97602, 97605, and 97606 as ''always therapy'' codes and our assignment of payment status indicator ''A'' to these codes under the OPPS. In light of the comments, we have also reexamined our classification of CPT codes 97597 (selective wound care; total wound(s) surface area less than or equal to 20 sq. cm.) and 97598 (selective wound care; total wound(s) surface area greater than 20 sq. cm.) as ''sometimes therapy'' codes with respect to payment under the OPPS. The past implications of designating CPT codes 97602, 97605, and 97606 as ''always therapy'' services, in addition to assigning these codes a status indicator of ''A'' under the OPPS indicating they were to be paid off the MPFS, were that hospitals may have been unable to bill and be paid for these services when they were provided as non-therapy in the hospital outpatient setting. When some of these OPPS services were packaged under the MPFS, hospitals received no separate payment, and when other services were paid off the MPFS, the services were required to meet the criteria for therapy services. However, this requirement for payment to hospitals only as therapy services was inconsistent with Medicare's designation of CPT codes 97597 and 97598 as ''sometimes therapy'' services, that could be appropriately provided either as therapy services or as non-therapy services. Therefore, for CY 2006, we are reclassifying CPT codes 97602, 97605, and 97606 as ''sometimes therapy'' services that may be appropriately provided either as therapy or non-therapy services, as well as maintaining our designation of CPT codes 97597 and 97598 as ''sometimes therapy'' services.

In order to pay hospitals accurately when delivering these ''sometimes therapy'' services independent of a therapy plan of care, we are establishing payment rates for CPT codes 97597, 97598, 97602, 97605, and 97606 under the OPPS when performed as non-therapy services in the hospital outpatient setting. To further clarify, hospitals will receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by non-therapists independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under an approved therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) and/or report their charges under a therapy revenue code (that is, 420, 430, or 440) to receive payment under the MPFS. The OCE logic will either assign these services to the appropriate APC for payment under the OPPS if the services are non-therapy, or will direct contractors to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy.

Under the OPPS, we considered several options for determining the APC placement of CPT codes 97597, 97598, 97602, 97605, and 97606. As two commenters suggested, we considered placing these codes in APC 0600 (Low Level Clinic Visits); however, we concluded that these services do not share similar enough characteristics in terms of clinical homogeneity and resource requirements to other services assigned to APC 0600. In particular, specialized supplies are likely necessary for the procedures, unlike many of the supplies used in services assigned to APC 0600. Likewise, we also considered one commenter's recommendation to assign CPT codes 97597, 97598, 97602, 97605, and 97606 to New Technology APC 1502 with a payment rate of $75. However, because we do not consider wound care services to be appropriately described by a new technology designation under the OPPS, nor do we expect the resource intensity of these services to approach $75, we are not assigning these services to New Technology APC 1502. Instead, we sought to place these codes in clinical APCs with like services sharing similar resource requirements. Therefore, for CY 2006, we are assigning CPT code 97602 to APC 0340 (Minor Ancillary Procedures) because we consider the resource requirements of this service to be similar to the hospital resources necessary for many of the other minor hospital procedures assigned to this APC. While it may be that our CY 2004 hospital claims data may not reflect all claims for services that could have been described by CPT code 97602 because some hospitals may have been billing for an evaluation and management service if nonselective wound care was the only procedure provided on a day, we note that based on almost 75,000 single claims the median cost of $42 for CPT code 97602 is very consistent with the CY 2006 median cost of $36 for APC 0340. In addition, we are assigning CPT codes 97597 and 97605 to APC 0012 (Level I Debridement and Destruction), and CPT codes 97598 and 97606 to APC 0013 (Level II Debridement and Destruction) because we consider these services to closely resemble both the clinical characteristics and resource requirements of the other debridement services assigned to these APCs. We have listed these five codes in Addendum B with status indicator ''X'' for CPT code 97602 and status indicator ''T'' for CPT codes 97597, 97598, 97605, and 97606, along with their individual APC assignments to indicate their payment rates in common hospital outpatient circumstances where the services are provided as non-therapy. If a claim indicates, as described above, that the services are provided as therapy, the claim for such services will be paid under the MPFS.

When hospitals provide wound care services, they should bill the most appropriate CPT codes to describe those services. Hospitals should not bill for an evaluation and management service along with the wound care service unless a significant, separately identifiable evaluation and management service, correctly identified with modifier −25 on the claim, was also provided to the patient during the same encounter. Lastly, under the OPPS we consider payment for nonselective wound care to always be included in payment for selective wound care or negative pressure wound therapy if both services are provided at the same anatomic site in one encounter. Therefore, hospitals should not bill for both services when nonselective wound care is provided with selective wound care or negative pressure wound therapy at the same anatomic site in a single encounter. Hospitals would appropriately use the −59 modifier to indicate nonselective and selective wound care or negative pressure wound therapy services provided in a single encounter at different anatomic sites.

IV. Payment Changes for Devices

A. Device-Dependent APCs

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass-through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median costs for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three-pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians. Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS we deleted the device codes (''C'' codes) from the HCPCS file in the belief that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50–50 blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure and also implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

1. Public Comments and Our Responses on the November 15, 2004 OPPS Final Rule With Comment Period

We solicited public comments concerning the methodology set forth in our CY 2005 OPPS final rule with comment period (November 15, 2004, 69 FR 65681). A summary of the comments we received and our responses follow:

Comment: One commenter asked that CMS implement device edits other than those included in Table 19 of the November 15, 2004 final rule with comment period in April 2005. The commenter asked that CMS add the following APCs to the list of device-dependent APCs and implement device editing for them using the specific device codes provided by the commenter: APC 0088 (Thrombectomy), APC 0141 (Level I Upper GI Procedures), APC 0151 (Endoscopic Retrograde Cholangio-Pancreatography), APC 0154 (Hernia/Hydrocele Procedures), APC 0187 (Miscellaneous Placement/Repositioning), APC 0315 (Level II Implantation of Neurostimulator), APC 0415 (Level II Endoscopy Lower Airway), APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve), and APC 0676 (Level II Thrombolysis and Thrombectomy).

Response: We implemented the device edits for device-dependent APCs in two phases for CY 2005. Those identified in Table 19 of the November 15, 2004 final rule with comment period (69 FR 65763) were implemented effective for services furnished April 1, 2005, and later. The remaining edits for device-dependent APCs were implemented effective for services furnished October 1, 2005, and later. We implemented the edits in two phases so that we could ensure that any systems issues that might arise with implementation of the first set of edits would be resolved before we implemented the remainder of the edits. We limited the edits we implemented to those for services included in the list of device-dependent APCs that we posted on the CMS Web site for public review to minimize the possibility of unintended claims processing problems. At this time, we have not expanded the scope of device-dependent APCs or the scope of the edits because of concerns raised by hospitals regarding the administrative burden that edits impose on hospitals. We will evaluate the impact of the edits on hospitals and on our claims data before we consider expanding the scope of the edits to other services such as those suggested by the commenter.

Comment: One commenter recommended that device codes C1750 (Cath, hemodialysis, long-term) and C1752 (Cath, hemodialysis, short-term) be allowed when billing for services using CPT codes 36557 (Insert tunneled cv cath), 36558 (Insert tunneled cv cath), and 36581 (Replace tunneled cv cath). The commenter further recommended that CMS allow the use of device code C1898 (Lead, pmkr, other than trans) when billing for services using CPT codes 33211 (Insertion of heart electrode), 33216 (Insert lead pace-defib, one), and 33217 (Insert lead pace-defib, dual).

Response: We agree with the commenter's recommendations and made the changes when the edits were implemented in the two phases for CY 2005 discussed above in response to the preceding comment.

Comment: One commenter recommended that device codes for

brachytherapy needles, catheters, and sources be required when providers bill for the following CPT codes for brachytherapy application: 77761, 77762, 77763, 77776, 77777, 77778, 77781, 77782, 77783, and 77784. Numerous other commenters strongly opposed device editing for brachytherapy procedures due to the burden that it would impose on them.

Response: We did not require these edits for CY 2005. The needles and catheters that are placed for the application of brachytherapy sources are not placed when the procedures cited are performed but are generally placed in procedures that are coded separately. In the case of application of seeds for prostate brachytherapy (CPT code 77778), the needles or catheters are placed when CPT code 55859 (Percut/needle insert, pros) is performed and not as part of CPT code 77778. Moreover, for CY 2005, sources of brachytherapy are billed and paid separately on the basis of charges reduced to cost and, therefore, are irrelevant to the calculation of a median cost for the application of the brachytherapy sources because, unlike other devices, the cost of brachytherapy sources is not packaged into the payment for the service in which the sources are required.

2. CY 2006 Proposal, APC Panel Recommendations, and Responses to Public Comments Received

In the CY 2006 OPPS proposed rule, we proposed to base the OPPS device-dependent APC medians on CY 2004 claims, the most current data available. In CY 2004, the use of device codes was optional. Thus, for the CY 2006 OPPS proposed rule, we proposed to calculate median costs for these APCs using all single bills without regard to whether there was a device code reported on the claim. We calculated median costs for this set of APCs using the standard median calculation methodology. This methodology uses single procedure claims to set the median costs for the APC. We then compared these unadjusted median costs to the adjusted median costs that we used to set the payment rates for the CY 2005 OPPS. We found that 21 APCs experienced increases in median cost compared to the CY 2005 OPPS adjusted median costs, 1 APC median was unchanged, 16 APCs experienced decreases in median costs, and 8 APCs were proposed to be reconfigured in such a way that no valid comparison was possible. Table 15 published in the CY 2005 OPPS proposed rule showed the comparison of these median costs (70 FR 42714).

As we stated previously, in CY 2004, CMS reissued HCPCS codes for devices and asked hospitals to voluntarily code devices utilized to provide services. As part of our development of the medians for this final rule with comment period, we examined CY 2004 claims that contained device codes that met our device edits, as posted on the OPPS Web site at *http://www.cms.hhs.gov/providers/hopps/default.asp*. We found that, in many cases, the number of claims that passed the device edits was quite small. To use these claims to set medians for the CY 2006 OPPS would mean that the medians for some of these APCs would be set based on very small numbers of claims, reflecting the fact that, in CY 2004 when device coding was optional under the OPPS, relatively few hospitals chose to code for devices. Therefore, we did not propose to use only claims that passed the device edits to set the median costs for device-dependent APCs for the CY 2006 OPPS.

When we considered whether to base the weights for these APCs on the unadjusted median costs, we found that, for 10 of the 38 APCs for which the APC composition is stable, basing the payment weight on the unadjusted median cost would result in a reduction of more than 15 percent in the median cost for the CY 2006 OPPS compared to the CY 2005 OPPS.

In the CY 2006 proposed rule, we stated that we fully expect to use the unadjusted median costs for device-dependent APCs as the basis of their payment weights for the CY 2007 OPPS because device coding is required for CY 2005 and device editing is being implemented in CY 2005, so that all CY 2005 claims should reflect the costs of devices used to provide services. Nevertheless, we recognized that a payment reduction of more than 15 percent from the CY 2005 OPPS to the CY 2006 OPPS may be problematic for hospitals that provide the services contained in these APCs. Therefore, for the CY 2006 OPPS, we proposed to adjust the median costs for the device-dependent APCs listed in Table 15 of the CY 2006 proposed rule (70 FR 42714) for which comparisons with prior years are valid to the higher of the CY 2006 unadjusted APC median or 85 percent of the adjusted median on which payment was based for the CY 2005 OPPS. We stated that we viewed this as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years.

As stated in the proposed rule (70 FR 42714), we expect that CY 2006 will be the last year in which we would make an across-the-board adjustment to the median costs for these device-dependent APCs based on comparisons to the prior year's payment medians. We believe that mandatory reporting of device codes for services furnished in CY 2005, combined with the editing of claims for the presence of device codes, where such codes are appropriate, would result in claims data that more fully reflect the relative costs of these services and that across-the-board adjustments to median costs for these APCs would no longer be appropriate.

a. APC Panel Recommendations

In the CY 2005 proposed rule, we proposed to treat APCs 0107 and 0108 in the same manner as we proposed to treat other device-dependent APCs. We note that at its August 2005 meeting, the APC Panel recommended that CMS set the payment rates for cardioverter defibrillator APCs (APCs 0107 and 0108) at the CY 2005 payment rates plus the full market basket increase for CY 2006. We did not accept this recommendation because to do so would greatly contradict our stated policy of applying a single standardized methodology wherever possible to establish APC payment amounts that are appropriately relative to one another.

The APC Panel also recommended that CMS add APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) and, in particular, CPT code 37250 (Iv us first vessel add-on) to the list of device-dependent APCs and require device editing for CPT code 37250.

We did not accept this recommendation. Many services that require devices are not included in the set of APCs to which we have given special attention as they came off pass-through status. We package the costs of relatively high cost devices into the median costs for the device-dependent APCs, and the absence of charges for these devices on claims is the reason for special treatment of the APCs in the past. The absence of charges also gives rise to our application of device editing to the services in the device-dependent APCs so that our hospital claims data are more complete for these specific services. At this time, we see no compelling reason to expand this list of device-dependent APCs. This is particularly true given that we expect that, for CY 2007, these APCs will not receive special attention as a class. However, we note that we will make case-by-case decisions regarding the adjustment of median costs where we believe that it is appropriate.

b. Public Comments Received and Our Responses

We received numerous public comments concerning our proposal. Following is a summary of those comments and our responses:

(1) Adjustment of Median Costs

Comment: Some commenters supported the proposed median cost adjustment for device-dependent APCs and supported the use of claims data to set the relative weights for the CY 2006 OPPS. However, many commenters stated that the proposed payments are inadequate to compensate hospitals for the full costs of the devices and procedures for many APCs, including, but not limited to, implantation of cochlear implants, neurostimulators, urologic prosthetics, and cardioverter defibrillators.

Commenters presented a variety of requests for revised median costs or revised payment rates. Many commenters asked that CMS accept and use external data in place of claims data and requested that CMS accept and use confidential and proprietary information that cannot be made public. Other commenters objected to the use of external data to set median costs that are the basis of the rates and to the use of any proprietary or confidential information that cannot be shared with the public. Some commenters asked CMS to substitute specific amounts they identified for the device portion of the median cost, for the full median cost, or for the payment amount for the APCs of interest to them. Commenters urged CMS to restrict the claims used to calculate the median costs for device-dependent APCs to those with specified diagnoses, or to those with specified HCPCS device codes, or with specified revenue code charges only if the charges associated with those codes exceeded amounts they recommended. Some commenters asked that CMS set the CY 2006 median cost at the CY 2005 adjusted median with an inflation adjustment for the full market basket increase for CY 2006. Other commenters asked CMS to adjust the medians to no less than 95 percent of the CY 2005 OPPS adjusted medians for all APCs, as well as for device-dependent APCs. These commenters stated that a transitional step to 85 percent was too great to prevent disruption to care.

Some commenters asked CMS to disregard requests to set the payment rates at 100 percent of the CY 2005 OPPS payment rates plus inflation for neurostimulator and cardioverter defibrillator APCs, which they stated have been given preferential treatment over other device-dependent APCs in past years. These commenters requested that the same adjustment policy apply to all device-dependent APCs. Some commenters asked CMS to use only claims that contained appropriate device codes in the calculations of the median costs because the presence of the device code and a charge for the device are more likely to produce the best possible estimate of relative cost for the service. All commenters who addressed this general issue of device-dependent APCs supported an adjustment of some type to median costs for these high cost APCs.

Response: After considering all of the comments received, we have set the median costs for device-dependent APCs for CY 2006 at the highest of: The median cost of all single bills; the median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than $1; or 90 percent of the payment median that was used to set the CY 2005 payment rates. We set 90 percent of the CY 2005 payment median as a floor in consideration of comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We also incorporated, as part of our methodology, the recommendation to base payment on medians that were calculated using only claims that passed the device edits. We believe that this policy provides a reasonable transition to full use of claims data in CY 2007, while better moderating the amount of decline from the CY 2005 OPPS payment rates. Table 16 of this final rule with comment period contains the CY 2005 payment median, the CY 2006 unadjusted single bill median, the amount represented by 90 percent of the CY 2005 payment median, the CY 2006 median calculated using only claims containing appropriate devices, and the CY 2006 adjusted median on which payment is based. As we discussed, in the CY 2006 proposed rule, we did not adjust the medians for APC 0122 (Level II Tube Changes and Repositioning), APC 0427 (Level III Tube Changes and Repositioning) APC 0166 (Level I Urethral Procedures), APC 0168 (Level II Urethral Procedures), APC 0621 (Level I Vascular Access Procedures), APC 0622 (Level II Vascular Access Procedures), and APC 0623 (Level III Vascular Access Procedures) because of substantial migration of HCPCS codes within these APCs.

We did not inflate the CY 2005 median cost or payment rate by the market basket, or substitute specific amounts derived from external studies or other external sources, as requested by commenters, because doing so would contradict our stated policy of using claims data developed from a single source, and applying a single standardized methodology wherever possible to establish payment amounts that are appropriately relative to one another. The Medicare claims database we use contains all claims for all services paid under the OPPS for all Medicare patients (other than those in Medicare managed care programs). As such, we believe that it is the best and most reliable source for standardized utilization and cost data in the Nation with regard to Medicare outpatient hospital care. Because the OPPS is a relative weight system, we believe it is important that, to the maximum extent possible, the relative weights be calculated using standardized processes and a standardized base of claims data.

(2) Effects of Inconsistent Markup of Charges

Comment: Some commenters objected to the use of claims data because they believed the payments that result are less than the cost of the procedures and the devices due to the high markup of low cost items and services and the low markup of high cost items and services. They indicated that the use of CCRs applied to hospital charges results in median costs that are inadequate for high cost devices because the markup on high cost devices is insufficient to result in the correct costs for the devices after application of CCRs calculated from all services in the applicable departments. Commenters offered a variety of recommendations for dealing with this phenomenon that they identified as ''charge compression.'' They suggested that CMS establish a sample of hospitals from which data would be collected for use in place of claims data or to validate the data derived from claims. They also suggested that CMS establish a new cost center solely for high cost devices and calculate an appropriate CCR for this new specialized cost center. Some of the commenters recommended that CMS conduct a study of the data of volunteer hospitals to determine an appropriate CCR for high cost devices that would be applied to all hospitals. They noted that CMS could adjust claims-based medians by substituting proprietary confidential cost data for the device portion of the median costs. They suggested that CMS could also calculate a charge decompression factor that would estimate the markup function from charges on claims and device acquisition cost data and incorporate these data into setting two CCRs: one for high cost devices and one for low cost

devices, which would be used in place of actual hospital CCRs. Lastly, the commenters also suggested that CMS could create a broad stakeholder panel to address this issue.

Other commenters stated that the use of the hospital's average CCR results in computed costs and relative weights that are more or less than specific actual costs, but that this averaging is appropriate and desirable in a PPS and should continue. They stated that the alternative is a micromanaged payment system that resembles the system that Congress discarded in favor of a bundled PPS. The commenters urged CMS to remain committed to the principles of a PPS and the use of averaging, rather than seeking to pay the actual cost for one element of costs at the expense of all other items and services, which they stated would occur as a result of the application of budget neutrality adjustments required by law. They reiterated that many factors go into the decision of what services to furnish in a hospital, and that the payment for a specific service is only one of the applicable factors.

Response: We agree that the use of the hospital's average CCR results in computed costs and relative weights that may be more or less than specific actual costs and that this averaging is appropriate and desirable in a PPS and should continue. One of the principal purposes of determining median costs for weight setting in a budget neutral payment system is to determine the appropriate relativity in resource use among services, so that the fixed amount of money can be fairly and equitably distributed among hospitals based on case-mix. We note that, in general, the median costs derived from this process may not represent the actual acquisition costs of the services being furnished, nor will they ever represent acquisition costs. They are estimated relative costs that are converted to relative weights, scaled for budget neutrality, and then multiplied by a conversion factor to result in payments that, as we have previously discussed, were designed in such a manner that they are not expected to pay the full costs of the services.

(3) Effects of Multiple Procedure Reduction

Comment: Some commenters stated that all device-dependent APCs should be assigned a status indicator of ''S'' (significant service, separately payable) because none of the procedures assigned to these APCs should ever be reduced when performed with another procedure. Commenters stated that much of the cost of these procedures is a function of the cost of the device, and that the device cost remains unchanged whether the procedure in which it is required is performed with other surgical procedures or not. Commenters specifically objected to the movement of CPT code 33225 (L ventric pacing lead add-on) from New Technology APC 1525 in CY 2005 where it has a status indicator of ''S'' to APC 0418 (Insertion of Left Ventricular Pacing Elect) for CY 2006, in which it was proposed to have status indicator ''T,'' because the payment for the procedure, when performed in addition to another procedure, would be reduced by 50 percent although most of the cost of the procedure is in the device, the cost of which remains fixed. Commenters also specifically objected to the assignment of status indicator ''T'' to APCs 0223 and 0227 because it results in a reduction in payment when services to place a catheter and implant an infusion pump are provided in the same session.

Response: We decide on a service-by-service basis whether the assignment of a status indicator ''S'' or ''T'' is appropriate. In the case of most device-dependent APCs, the service in question is never reduced because it is always the procedure with the highest payment rate (for example, cochlear implants and insertion of a cardioverter defibrillator (ICD)), and the assignment of a status indicator ''T'' is necessary so that the lower cost services are reduced in payment to reflect the efficiencies that occur when they are done at the same time as the highest paid procedure.

In the case of CPT code 33225 for insertion of a left ventricular pacing electrode at time of insertion of an ICD, we believe that payment at 50 percent of the payment rate for APC 0418 is appropriate for this add-on procedure based on the information furnished to us by manufacturers, hospitals, and physicians who are familiar with the service. This procedure is always done as an adjunct to insertion of a cardioverter defibrillator and a significant portion of the cost of the procedure is in the extension of operating room time and not in the cost of the device, drugs, or supplies needed to furnish the service. While CPT code 33225 is an add-on code, we discuss our ongoing exploration of possible solutions to the data challenges in developing appropriate payment rates for add-on codes in the data section (section II.A.) of this final rule with comment period. Also assigned to APC 0418 is the stand-alone procedure for insertion of the left ventricular lead, and we believe the add-on lead insertion is appropriately reduced by 50 percent in comparison with the payment rate for the stand-alone insertion procedure. Therefore, we believe that payment at 50 percent of the amount for APC 0418 to which we proposed to assign CPT code 33225 is appropriate and, as proposed, we have moved CPT code 33225 to APC 0418 with a status indicator of ''T.''

When a spinal infusion pump is implanted along with an intrathecal or epidural catheter, CPT codes billed likely include those assigned to APCs 0227 and 0223, respectively. The higher paying APC 0227 for implantation of the infusion pump would receive full payment, while the catheter insertion APC 0223 would receive 50 percent of the APC payment because both APCs are assigned ''T'' status indicators. We believe this reduction is appropriate, as there are some efficiencies when both services are performed in a single session. In addition, we note that the CPT code for the catheter implantation includes the possibility of repositioning in its descriptor, so it is possible that this procedure may not require a new device every time it is performed. Therefore, we believe that the procedures assigned to APCs 0223 and 0227 are appropriately assigned ''T'' status indicators.

(4) Impact of Proposed Rates on Access to Care

Comment: Some commenters stated that under the proposed payments, Medicare beneficiaries may not get the device-related services they need because Medicare payments would be inadequate to compensate hospitals for their costs, and that hospitals would not furnish the services to Medicare beneficiaries for the rates that Medicare proposed to pay in CY 2006. They stated that hospitals will either cease providing certain services, or they will decide not to furnish them due to low Medicare payment rates.

Response: We share the commenters' concern that beneficiaries have access to all of the care they need, regardless of the type of service. As other commenters have stated, hospitals decide upon the range of services to offer based on a variety of factors, of which Medicare outpatient hospital payment is only one. We believe that the best way to ensure access to care for Medicare beneficiaries is to establish the OPPS using as many claims as possible from all hospitals so that the relative weights on which the payments are based result in the most fair and equitable distribution possible of Medicare's funding for outpatient hospital services.

We note that our regulations at 42 CFR 489.53(a)(2) state that a hospital

risks termination of its Medicare provider agreement if it treats Medicare beneficiaries differently from other similar patients in the hospital.

(5) Addition of Other APCs as Device-Dependent APCs

Comment: Some commenters asked that CMS expand the list of APCs for which medians will be adjusted to include all APCs that require the use of a device. Specifically, they requested that we apply any median adjustment for device-dependent APCs also to APC 0112 (Apheresis, Photopheresis, and Plasmapheresis), APC 0312 (Radioelement Applications), APC 0313 (Brachytherapy), and APC 0651 (Complex Interstitial Radiation Source Application). They asked that CMS set the median for all such APCs that use a device at the CY 2005 OPPS adjusted median after inflating by the full market basket increase for CY 2006. Commenters asked that CMS add APC 0416 Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) and, in particular, CPT code 37250 (Iv us first vessel add-on) to the list of device-dependent APCs and require device editing for CPT code 37250. They stated that this service requires a device, that its APC should be treated like all other device-dependent APCs, and that claims for the service should be returned if they are submitted without the HCPCS code for the device so that the full cost of the device will be included on every claim.

Response: As previously stated in response to the APC Panel's recommendation on a similar issue, many services that require devices are not included in the set of APCs to which we have given special attention as they came off pass-through status. We package the costs of relatively high cost devices into the median costs for the device-dependent APCs, and the absence of charges for these devices on claims is the reason for special treatment of the APCs in the past. The absence of charges also leads to our application of device editing to the services in the device-dependent APCs so that our hospital claims data are more complete for these specific services. At this time, we see no compelling reason to expand this list of device-dependent APCs. This is particularly true given that we expect that, for CY 2007, these APCs will not receive special attention as a class. However, we note that we will make case-by-case decisions regarding the application of edits where appropriate.

(6) Instructions on Reporting Device Charges

Comment: Some commenters asked that CMS educate providers on how to report charges for devices and technologies that do not have HCPCS codes, and that CMS issue explicit instructions regarding consistent use of revenue codes for reporting charges for devices and technologies to ensure that such charges are fully reported on claims.

Response: CMS' instructions regarding the need to report device codes and charges are included in the Internet Only Manual, Claims Processing Manual 100–4, Chapter 4 (CMS Web site: *http://www.cms.hhs.gov/manuals/*). Section 61.1 of that manual provides instructions on the requirement to report the device code and directs providers to the CMS Web site for the most current list of HCPCS codes for devices and for the most recent set of procedure code to device edits. In addition, section 20.5.1 specifies revenue centers that should be used when devices are reported. As always, when devices do not have appropriate HCPCS codes for reporting, hospitals should be sure to include all charges associated with their use on claims for services with which the devices were used.

(7) Application of Wage Index to Device-Dependent APCs Containing Devices

Comment: Some commenters objected to the application of the wage index to an APC into which devices were packaged. They indicated that applying the wage index will continue to further undervalue new technology services. They asked that CMS revise its policy and apply the wage index only to the service portion of the procedure for APCs for which the device cost is more than 80 percent of the total APC payment.

Response: Whether the application of the wage index to 60 percent of the APC payment will raise or reduce the payment for the service depends on the wage index value of the area in which the hospital is located. However, while we do not believe that the application of the wage index underpays new technology items or services, we acknowledge the commenter's request, and we will consider it as we develop our policies for future updates of the OPPS.

(8) Recalls of High Cost Devices

Comment: Some commenters are concerned that claims for items subject to a recall not be used for claims setting as there is no charge for the device on the claim, and the use of the claim could skew the median cost. These commenters also asked that CMS provide explicit guidance on how to report devices for which the provider incurred no cost due to replacement by the manufacturer under a recall of the device.

Response: The recalls of a significant number of cardioverter defibrillators and pacemakers to which the commenters referred occurred very late in CY 2004 and in CY 2005. Therefore, we believe that they have no effect on the CY 2004 claims used to set the rates for the CY 2006 OPPS. We are aware of the potential impact on data used for ratesetting for the CY 2007 OPPS and are already considering a strategy for ensuring that the CY 2005 claims data we will use for the CY 2007 OPPS will be appropriately reflective of the costs of the devices. We note that one way of doing this is to not use claims that contain device charges of $1.01 or less in the calculation of the median costs for these APCs. In the July 2005 OPPS instruction, Change Request 3915, dated June 30, 2005, we issued interim instructions regarding how hospitals should report device codes and charges when the device was furnished without cost by the manufacturer under a recall. Specifically, we advised hospitals to report the HCPCS code for the device and a token charge of $1.01 or less on the line with the device code. Accordingly, we will use the device code and charge combination to find these claims in the CY 2005 data.

For the future, beginning January 1, 2006, hospitals should report modifier ''FB'' on the claim with the device code (where there is one to report) or with the procedure code (where there is no appropriate device code) to indicate that a device used in the procedure was furnished without cost to the provider and, therefore, is not being charged to Medicare or the beneficiary. The device edits will recognize the modifier and will not return the claim to the provider as incomplete because the device code is not on the claim. CMS will issue instructions regarding use of the modifier in the January 2006 OPPS change request issuance.

(9) Separate Payment for High Cost Devices

Comment: Some commenters asked that we pay separately for high cost devices and recommended that CMS define ''high cost'' devices as those with a cost greater than 50 percent of the APC payment rate. They indicated that even with device editing, they do not believe

that hospitals will be diligent about reporting all of their services or setting charges that reflect the costs of the devices. They believed that separate payments for high cost devices is the only way to achieve valid cost data for devices and related services.

Response: In general, we believe that packaging the costs of items needed to furnish services into the payments for the services and the assignment of multiple services to a single APC create incentives for efficiency and for the selection of the least costly device that meets the patient's needs. Therefore, for the CY 2006 OPPS, we will continue to package payment for all devices without pass-through status, and which are not brachytherapy sources, into the payments for the procedures that utilize them. However, we recognize that there may be valid reasons to consider whether it would be appropriate to pay separately for some high cost devices, and we will consider whether there are circumstances in which this may be appropriate in the future.

After carefully reviewing all comments received concerning our proposed median cost adjustment for device-dependent APCs for CY 2006, we have set the medians for device-dependent APCs at the highest of: the median cost of all single bills; the median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than $1; or 90 percent of the payment median that was used to set the CY 2005 payment rates. Table 16 below shows the adjusted median costs for the listed device-dependent APCs for which comparisons with prior years are valid to the highest of the CY 2006 unadjusted APC median, 90 percent of the adjusted median on which payment was based for the CY 2005 OPPS, or the median calculated using only claims that meet the device code edits implemented in CY 2005.

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Table 16.--Median Cost Adjustments for Device-Dependent APCs for CY 2006

APC	Description	SI	Adjusted Final 2005 OPPS Median	Unadjusted CY 2006 OPPS final rule median	Change from CY 2005 adjust to CY 2006 final unadjust	90% of CY 2005 payment median	CY 2006 OPPS final rule median w "C" code claims only and device cost >$1	CY 2006 final rule total frequency (CY 2004 claims)	Adjusted final CY 2006 median
0039	Implantation of Neurostimulator	S	$12,878.01	$9,836.02	-24%	$11,590.21	$10,296.79	1,983	$11,590.21
0040	Level I Implantation of Neurostimulator Electrodes (lost codes to APC 61 after NPRM)	S	NA	$3,021.79	NA	NA	$2,991.69	10,671	$3,021.79
0061	Level II Implantation of Neurostimulator Electrodes (created after NPRM by taking codes from APCs 40 and 225)	S	NA	$5,552.67	NA	NA	$4,025.40	2,370	$5,552.67
0080	Diagnostic Cardiac Catheterization	T	$2,123.65	$2,160.24	2%		$2,149.34	423,665	$2,160.24
0081	Non-Coronary Angioplasty or Atherectomy	T	$1,918.04	$1,947.72	2%		$2,512.59	143,106	$2,512.59
0082	Coronary Atherectomy	T	$6,035.25	$4,531.43	-25%	$5,431.72	$4,899.36	373	$5,431.72
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	$3,241.85	$2,887.41	-11%	$2,917.66	$3,285.85	6,072	$3,285.85
0085	Level II Electrophysiologic Evaluation	T	$2,034.82	$2,030.08	0%		$2,033.39	22,479	$2,033.39
0086	Ablate Heart Dysrhythm Focus	T	$2,637.96	$2,499.71	-5%		$2,404.64	10,139	$2,499.71
0087	Cardiac Electrophysiologic Recording/Mapping	T	$2,180.19	$814.47	-63%	$1,962.17	$1,830.20	14,377	$1,962.17
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	$6,416.90	$6,307.74	-2%		$6,957.99	4,808	$6,957.99
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	$5,301.99	$5,362.17	1%		$4,904.18	6,848	$5,362.17
0104	Transcatheter Placement of Intracoronary Stents	T	$4,750.06	$4,510.86	-5%		$4,802.39	8,870	$4,802.39
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	$3,229.10	$1,834.34	-43%	$2,906.19	$3,325.21	4,301	$3,325.21
0107	Insertion of Cardioverter-Defibrillator	T	$18,460.10	$14,062.73	-24%	$16,614.09	$15,772.87	9,001	$16,614.09

APC	Description	SI	Adjusted Final 2005 OPPS Median	Unadjusted CY 2006 OPPS final rule median	Change from CY 2005 adjust to CY 2006 final unadjust	90% of CY 2005 payment median	CY 2006 OPPS final rule median w "C" code claims only and device cost >$1	CY 2006 final rule total frequency (CY 2004 claims)	Adjusted final CY 2006 median
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	$24,788.26	$18,699.78	-25%	$22,309.44	$21,487.56	6,965	$22,309.44
0115	Canula/device access procedures	T	$1,502.71	$1,872.60	25%		$2,198.37	11,055	$2,198.37
0202	Level X Female Reproductive Proc	T	$2,322.83	$2,396.88	3%		$2,451.09	16,353	$2,451.09
0222	Implantation of Neurological Device	T	$12,714.60	$9,739.50	-23%	$11,443.14	$10,001.56	6,208	$11,443.14
225	Level III Neurostimulator Electrodes (lost codes to APC 61 after NPRM)		NA	$13,794.14	NA	NA	$14,912.04	1,021	$14,912.04
0227	Implantation of Drug Infusion Device	T	$8,806.84	$8,131.78	-8%		$9,216.76	3,050	$9,216.76
0229	Transcatherter Placement of Intravascular Shunts	T	$3,638.52	$3,660.15	1%		$3,943.56	51,409	$3,943.56
0259	Level VI ENT Procedures	T	$26,006.74	$21,236.83	-18%	$23,406.07	$21,646.15	1,078	$23,406.07
0315	Level II Implantation of Neurostimulator	T	$20,633.70	$12,425.59	-40%	$18,570.33	$15,190.25	388	$18,570.33
0384	GI Procedures with Stents	T	$1,585.92	$1,262.06	-20%	$1,427.33	$1,598.84	22,357	$1,598.84
0385	Level I Prosthetic Urological Procedures	S	$4,080.56	$4,384.16	7%		$3,980.70	833	$4,384.16
0386	Level II Prosthetic Urological Procedures	S	$6,674.53	$7,148.86	7%		$7,545.49	4,982	$7,545.49
0418	Left ventricular lead	T	$4,363.37	$6,398.41	47%		$10,067.34	5,306	$10,067.34
0425	Level II Arthroplasty with prosthesis	T	$5,715.97	$6,017.66	5%		$6,226.13	959	$6,226.13
0648	Breast Reconstruction with Prosthesis	T	$2,957.76	$2,917.03	-1%		$3,182.21	1,489	$3,182.21
0652	Insertion of Intraperitoneal Catheters	T	$1,626.29	$1,704.49	5%		$1,745.63	5,491	$1,745.63
0653	Vascular Reconstruction/Fistula Repair with Device	T	$1,644.53	$1,805.31	10%		$2,196.11	31,835	$2,196.11
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	$6,170.83	$5,908.47	-4%		$6,659.66	22,236	$6,659.66
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	$7,913.85	$7,970.77	1%		$8,134.94	15,112	$8,134.94
0656	Transcatheter Placement of Intracoronary Drug Eluting Stents	T	$6,156.14	$6,428.89	4%		$6,370.83	22,347	$6,428.89
0670	Intravenous and Intracardiac Ultrasound	S	$1,779.08	$1,505.28	-15%	$1,601.17	$1,709.36	5,126	$1,709.36
0674	Prostate Cryoablation	T	$6,569.33	$5,950.05	-9%		$6,620.83	2,328	$6,620.83
0680	Insertion of Patient Activated Event Recorders	S	$3,744.69	$3,765.01	1%		$4,452.85	2,395	$4,452.85
0681	Knee Arthroplasty	T	$5,374.98	$7,993.50	49%		$8,052.87	728	$8,052.87

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B. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, 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. In our November 15, 2004 final rule with comment period (69 FR 65773), we specified three device categories currently in effect that would cease to be eligible for pass-through payment effective January 1, 2006.

The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, we paid for pass-through devices under the OPPS on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002 and 2 categories expired after CY 2003. All of the categories listed in Table 17, along with their expected expiration dates, were created since we published the criteria and process for creating additional device categories for pass-through payment on November 2, 2001 (66 FR 55850 through 55857). We based the expiration dates for the category codes listed in Table 17 on the date on which a category was first eligible for pass-through payment.

There are three categories for devices that would have been eligible for pass-through payments for at least 2 years as of December 31, 2005. In the November 15, 2004 final rule with comment period, we finalized the December 31, 2005 expiration dates for these three categories—C1814 (Retinal tamponade device, silicone oil), C1818 (Integrated keratoprosthesis), and C1819 (Tissue localization excision device). Each category includes devices for which pass-through payment was first made under the OPPS in CY 2003 or 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). For CY 2003, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in CY 2001. Brachytherapy sources for other than prostate brachytherapy, which are now separately paid in accordance with section 621(b)(2) of Pub. L. 108–173, are an exception to this established policy. For CY 2005, we continued to apply this policy, the same as we did in CYs 2003 and 2004, to categories of devices that expired on December 31, 2004.

2. Proposed and Final Policy for CY 2006

For CY 2006, we proposed to implement the final decision we made in the November 15, 2004 final rule with comment period that finalizes the expiration date for pass-through status for device categories C1814, C1818, and C1819. Therefore, as of January 1, 2006, we will discontinue pass-through payment for C1814, C1818, and C1819. In accordance with our established policy, we proposed to package the costs of the devices assigned to these three categories into the costs of the procedures with which the devices were billed in CY 2004, the year of hospital claims data used for the CY 2006 OPPS update.

We received two public comments concerning the expiration of pass-through payment for these three device categories.

Comment: One commenter recommended that CMS extend the pass-through payment for device category C1819 until December 31, 2006, rather than ending pass-through payment on December 31, 2005. The commenter expressed concern that our median cost data for the procedure codes utilizing a tissue localization excision device do not include the costs attributed to device category C1819, and that the volume of C1819 claims is not sufficient to affect the median costs for CPT codes 19125 (Excision, breast lesion) and 19160 (Removal of breast tissue).

Response: We finalized the pass-through payment for device category code C1819 in the CY 2005 final rule with comment period and responded to a similar comment in that same rule (69 FR 65773). In this CY 2006 final rule with comment period, we are merely implementing that decision effective for services furnished on or after January 1, 2006. Moreover, we believe that the device costs represented by device category code C1819 are found in our median cost data, as we have CY 2004 hospital claims billed with C1819 that have been used to establish CY 2006 payment rates. As the device median cost was only approximately $67 and the median cost of APC 0028 (Level I Breast Surgery), where the accompanying procedure CPT codes 19125 and 19160 mentioned in the comment reside, is over $1,100, we anticipate that the packaging of this device will not limit appropriate access. We note that as usage of this device grows, the device costs may become more prominent contributors to the median costs of procedures utilizing the device, as long as hospitals report the device code and its associated charges on their claims.

Comment: One commenter expressed concern regarding the appropriate packaging of expiring device categories from pass-through payment for ophthalmologic devices after December 31, 2005. The commenter recommended that device category code C1814 be packaged with HCPCS codes 67036 (Removal of inner eye fluid), 67040 (Laser treatment of retina), 67108 (Repair detached retina), and 67112 (Rerepair detached retina), all of which the commenter claimed are paid under APC 0672. The commenter recommended that device category code C1818 be packaged with HCPCS code 65770 (Revise cornea with implant), which is proposed to be paid through APC 0244 (Cornea Transplant).

Response: Our policy is to package the expired device categories' costs with the costs relating to the procedure codes with which they were billed in our claims data. We will apply this policy to device category codes C1814 and C1818 as well. To the extent that the HCPCS codes reported in our claims data for the services associated with device codes C1814 and C1818 are the same as those HCPCS service codes noted in the comment, the median cost data for those HCPCS codes will include the costs associated with codes C1814 and C1818.

As indicated in the November 15, 2004 final rule with comment period, device categories C1814, C1818 and C1819 will expire from pass-through payment on December 31, 2005. We remind the public that these C-codes are still active for the billing and reporting of devices and their charges along with the HCPCS codes for the procedures with which they are used. When billing for procedures utilizing devices that have active device codes, hospitals are required to report the codes for the devices on their claims for the procedures.

TABLE 17.—LIST OF CURRENT PASS-THROUGH DEVICE CATEGORIES BY EXPIRATION DATE

HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
C1818	Integrated keratoprosthesis	7/1/03	12/31/05
C1819	Tissue localization excision device	1/1/04	12/31/05

C. Other Policy Issues Relating to Pass-Through Device Categories

1. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups

a. Background

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the CY 2002 OPPS quarterly update (April 1, 2002), we deducted from the pass-through payments for the identified devices an amount that reflected the portion of the APC payment amount that we determined was associated with the cost of the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 interim final rule with comment period, we published the applicable offset amounts for CY 2003 (67 FR 66801).

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. That is, for CY 2002 OPPS updating, we used CY 2000 claims data and for CY 2003 OPPS updating, we used CY 2001 claims data. For CY 2002, we used median cost claims data based on specific revenue centers used for device related costs because C-code cost data were not available until CY 2003. For CY 2003, 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 the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

The offset list that we have published each year is a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount is applied only when a new device category is billed with a HCPCS procedure code that is assigned to an APC appearing on the offset list. The list of potential offsets for CY 2005 is currently published on the CMS Web site: *http://www.cms.hhs.gov*, as ''Device-Related Portions of Ambulatory Payment Classification Costs for 2005.''

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described earlier. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for the CY 2004 OPPS update. For the CY 2005 update to the OPPS, our data consisted of CY 2003 claims that did not contain device codes and, therefore, for CY 2005 we utilized the device percentages as developed for CY 2004. In the CY 2004 OPPS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the device categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset to $0 for CY 2004. We continued this policy of setting offsets to $0 for the device categories that continued to receive pass-through payment in CY 2005.

For the CY 2006 OPPS update, CY 2004 hospital claims are available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis. We have reviewed our CY 2004 data, examining hospital claims for services that included device C-codes and utilizing the methodology for calculating device offsets noted above. The numbers of claims for services in many of the APCs for which we calculated device percentages using CY 2004 data were quite small. Many of these APCs already had relatively few single claims available for median calculations compared with the total bill frequencies because of our inability to use many multiple bills in establishing median costs for all APCs, and subsetting the single claims to only those including C-codes often reduced those single bills by 80 percent or more. Our claims demonstrate that relatively few hospitals specifically coded for devices utilized in CY 2004. Thus, we are not confident that CY 2004 claims reporting C-codes represent the typical costs of all hospitals providing the services. Therefore, we did not propose to use CY 2004 claims with device coding to propose CY 2006 device offset amounts. In addition, we did not propose to use the CY 2005 methodology, for which we utilized the device percentages as developed for CY 2004. Two years have passed since we developed the device offsets for CY 2004, and the device offsets originally calculated from CY 2002 hospitals' claims data may not appropriately reflect the contributions of device costs to procedural costs in the current outpatient hospital environment. In addition, a number of the APCs on the CY 2004 and CY 2005 device offset percentage lists are either no longer in existence or have been so significantly reconfigured that the past device offsets likely do not apply.

b. Proposed and Final Policy for CY 2006

For CY 2006, we proposed to continue to review each new device category on a case-by-case basis as we have done in CY 2004 and CY 2005, to determine whether device costs associated with

the new category are packaged into the existing APC structure. If we do not determine for any new device category the device costs associated with the new category are packaged into existing APCs, we proposed to continue our current policy of setting the offset for the new category to $0 for CY 2006. There are currently no established categories that would continue for pass-through payment in CY 2006. However, we may establish new categories in any quarter. If we create a new device category and determine that our data contain a sufficient number of claims with identifiable costs associated with the devices in any APC, we would adjust the APC payment if the offset is greater than $0. If we determine that a device offset greater than $0 is appropriate for any new category that we create, we proposed to announce the offset amounts in the program transmittal that announces the new category.

For CY 2006, we proposed to use available partial year or full year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device C-codes and their costs when hospitals bill for services which utilize devices described by the existing C-codes. In addition, during CY 2005 we are implementing device edits for many services that require devices and for which appropriate device C-codes exist. Therefore, we expect that the number of claims, including device codes and their respective costs, will be much more robust and representative for CY 2005 than for CY 2004. We also note that offsets would not be used for any existing categories at this time. If a new device category is created for payment, for CY 2006 we proposed to examine the available CY 2005 claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we proposed to utilize the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percentage for those APCs with which the new category would be reported.

We proposed not to publish a list of APCs with device percentages as a transitional policy for CY 2006 because of the previously discussed limitations of the CY 2004 OPPS data with respect to device costs associated with procedures. We expect to reexamine our previous methodology for calculating the device percentages and offset amounts for the CY 2007 OPPS update, which will be based on CY 2005 hospital claims data where device C-code reporting is required.

We did not receive any public comments in response to our proposals.

Accordingly, we are finalizing our proposed policy for CY 2006 for calculating device percentages and applying offsets.

2. Criteria for Establishing New Pass-Through Device Categories

a. Surgical Insertion and Implantation Criterion

One of our criteria, as set forth in § 419.66(b)(3) of the regulations, for establishing a new category of devices for pass-through payment is that the item be surgically inserted or implanted. The criterion that a device be surgically inserted or implanted is one of our original criteria adopted when we implemented the BBRA requirement that we establish pass-through payment for devices. This criterion helps us define whether an item is a device, as distinguished from other items, such as materials and supplies. We further clarified our definition of the surgical insertion and implantation criterion in the November 13, 2000 final rule (65 FR 67805). In that rule, we stated that we consider a device to be surgically inserted or implanted if it is introduced into the human body through a surgically created incision. We also stated that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically inserted or implanted.

In our November 15, 2004 final rule with comment period, we responded to comments received on our CY 2005 OPPS proposed rule, which requested that we revisit our surgical insertion and implantation criterion for establishing a new device category. The commenters specifically requested that CMS eliminate the current requirement that items that are included in new pass-through device categories must be surgically inserted or implanted through a surgically created incision. The commenters expressed concern that the current requirement may prevent access to innovative and less invasive technologies, particularly in the areas of gynecologic, urologic, colorectal, and gastrointestinal procedures. These commenters asked that CMS change the surgical insertion or implantation criterion to allow pass-through payment for potential new device categories that include items introduced into the human body through a natural orifice, as well as through a surgically created incision. Several of the commenters recommended that CMS allow the creation of a new pass-through category for items implanted or inserted through a natural orifice, as long as the other existing criteria are met.

In responding to the commenters, we stated in the November 15, 2004 final rule with comment period (69 FR 65774) that we were also interested in hearing the views of other parties and receiving additional information on these issues. While we appreciate and welcome additional comments on these issues from the medical device makers, we were also interested in hearing the views of Medicare beneficiaries, of the hospitals that are paid under the OPPS, and of physicians and other practitioners who attend to patients in the hospital outpatient setting. For that reason, we solicited additional comments on this topic within the 60-day comment period for the November 15, 2004 final rule with comment period (69 FR 65774 through 65775). In framing their comments, we asked that commenters consider the following questions specific to devices introduced into the body through natural orifices:

1. Whether orifices include those that are either naturally or surgically created, as in the case of ostomies. If you believe this includes only natural orifices, why do you distinguish between natural and surgically created orifices?

2. How would you define ''new,'' with respect to time and to predecessor technology? What additional criteria or characteristics do you believe distinguish ''new'' devices that are surgically introduced through an existing orifice from older technology that also is inserted through an orifice?

3. What characteristics do you consider to distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies such as sutures, clips or customized surgical kits that are used incident to a service or procedure?

4. Are there differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope?

(1) Public Comments Received on the November 15, 2004 Final Rule With Comment Period and Our Responses

Below is a summary of the public comments we received on the four stated surgical insertion and implantation device criterion questions and our responses to them.

Comment: Most commenters generally framed their responses to the four

questions listed above. Commenters were generally in favor of modifying our surgical insertion and implantation criterion so that devices that are placed into patients without the need for a surgical incision would not be ineligible for pass-through payment, claiming that devices that are inserted through a natural orifice offer important benefits to Medicare beneficiaries, such as avoidance of more costly and more invasive surgery. One commenter stated that procedures that could be performed with minimal morbidity and on an outpatient basis are the trend for surgery and should be encouraged. Another commenter believed that our criterion of surgical insertion or implantation through a surgically created incision was ineffective as a clear and comprehensive description of surgical procedures, including endoscopic and laparoscopic procedures.

Regarding the first specific question we posed, whether devices introduced into the body through natural orifices includes orifices that are either naturally or surgically created, commenters generally stated CMS should include devices as potentially eligible for pass-through categories whether they are introduced through orifices that are either naturally or surgically created, as in the case of ostomies, if the devices meet other cost and clinical criteria, in order to encourage the development of new technologies.

Regarding the second question restated above, which asked how the public would define ''new'' with respect to time and to predecessor technology, some commenters stated that they believed the current clinical and cost criteria are sufficient and that no additional criteria or characteristics are needed. Several commenters indicated that the timeframe for what CMS considers ''new'' could be clarified so that if the device in question was not FDA approved or not used for the services in the OPD during the year of the hospital claims that provided the basis for the most recent OPPS update, it should be considered ''new.'' Some commenters elaborated by example. They stated that if CMS changes the surgical insertion or implantation requirement to include devices inserted through natural orifices in CY 2005, devices approved by the FDA and in use in the OPD in CY 2003 or previously would not be eligible, while devices approved by FDA in CY 2004 or later and used in the OPD settings would be eligible for pass-through consideration. Another commenter stated that the definition of ''new'' device should include those devices that require only an FDA investigational device exemption (IDE) clearance. The commenter further stated that these devices should be granted ''new'' status at the time of FDA release as an IDE. The commenter stated that if FDA required a premarket approval (PMA) for the device, a determination of newness should be made on a case-by-case basis.

Regarding the question of what characteristics distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies that are used incident to a service or procedure, some commenters generally believed that the current clinical and cost criteria are sufficient to distinguish devices that might be eligible from materials and supplies. Other commenters stated that the device must be an integral part of the procedure or that it should include the characteristic of having a diagnostic or therapeutic purpose, without which the procedure could not be performed. Thus, according to these commenters, the device must function for a specific procedure, while supplies may be used for many procedures. One commenter pointed out that many devices are now implanted through the use of naturally occurring orifices or without significant incisions. This commenter indicated that the requirement of a ''traditional incision'' no longer serves the purpose of distinguishing between devices that are and are not implanted, or between devices and supplies and instruments. The commenter stated that retaining the requirement of a traditional incision could create incentives to use more invasive technology, if that is the technology that is eligible for pass-through payments and less invasive technology is not. The commenter suggested excluding tools and disposable supplies by excluding any item that is used primarily for the purpose of cutting or delivering an implantable device. However, the commenter recommended not reducing payment when delivery systems are packaged with the device. The commenter further recommended that the term ''incision'' be clearly defined to include all procedures involving the cutting, breaking, or puncturing of tissue or skin, regardless of how small that cut is, provided that the device is attached to or inserted into the body via this cut, puncture, or break. Another commenter stated that there are items included in a surgical kit that have significant cost and are single use, for example, guidewires, implying that it is sometimes difficult to determine what a supply is.

Regarding our question about whether there are differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope, commenters believed that the definitions of supplies and eligible devices are independent of the use of a scope during a procedure, and stated there were no distinguishing features of supplies or equipment. One commenter reiterated that the current clinical and cost criteria are sufficient to distinguish eligible devices (that is, those with ''a specific therapeutic use'') from materials and supplies. Commenters believed that the use of a scope should not be a factor in the distinction between devices and supplies.

One commenter urged us to consider the points that the surgical incision requirement is not mandated by statute and that CMS' criterion to limit devices to only those that are surgically inserted or implanted may have been based upon concern that less restrictive criteria would cause spending on pass-though items to exceed the pool of money set to fund the pass-though payments. The commenter indicated that this concern would no longer be valid, given the relatively few items currently paid on a pass-through basis.

Response: As we stated in the November 15, 2004 final rule, we share the view that it is important to ensure access for Medicare beneficiaries to new technologies that offer substantial clinical improvement in the treatment of their medical conditions. We also recognize that since the beginning of the OPPS, there have been beneficial advances in technologies and services for many conditions, which have both markedly altered the courses of medical care and ultimately improved the health outcomes of many beneficiaries.

We carefully considered the comments and proposed to maintain our current criterion that a device must be surgically inserted or implanted, but also proposed to modify the way we currently interpret this criterion under § 419.66(b)(3) of the regulations. We proposed to consider eligible those items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice (such as through an ostomy), as well as those that are inserted or implanted through a surgically created incision. We noted that we would maintain all of our other criteria in § 419.66 of the regulations, as elaborated in our various rules, such as the November 1, 2002 final rule (67 FR 66781 through 66787).

Specifically, we noted that we would maintain the clarification made at the time we clarified the surgically inserted or implanted criterion in our August 3, 2000 interim final rule with comment period, namely, that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically implanted or inserted (65 FR 67805).

With this proposed revision of our definition of devices that are surgically inserted or implanted, we reminded the public that device category eligibility for transitional pass-through payment continues to depend on meeting our substantial clinical improvement criterion, where we compare the clinical outcomes of treatment options using the device to currently available treatments, including treatments using devices in existing or previously existing pass-through device categories. We expect that requested new pass-through device categories that successfully demonstrate substantial clinical improvement for Medicare beneficiaries would describe new devices, where the additional device costs would not be reflected in the hospital claims data providing the costs of treatments available during the time period used for the most recent OPPS update.

(2) Public Comments Received on the CY 2006 OPPS Proposed Rule and Our Responses

We received many comments concerning our proposals to modify the surgical insertion or implantation criterion for new pass-through device categories.

Comment: Commenters supported our proposal to modify the way we currently interpret our criterion that a device must be surgically inserted or implanted under § 419.66(b)(3) of the regulations, but suggested that CMS consider eligible those items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice (such as through an ostomy), as well as items that are surgically inserted or implanted through a surgically created incision. A few commenters suggested that CMS modify the regulatory language to codify this change, by explicitly stating in § 419.66(b)(3) that the device is implanted or inserted through a natural or surgically created orifice or through a surgically created incision. These commenters made this request in the context of stating that the proposed interpretation resolves the current need to make a traditional surgical incision to insert or implant a device through an orifice for that device to be considered eligible for a pass-through device category.

Response: We appreciate the support for our proposal to modify our interpretation of the surgical insertion or implantation criterion for pass-through payment eligibility for devices. Our current criterion is that a device must be surgically inserted or implanted, while our interpretation of this criterion up to this point has been to consider eligible only those devices that are inserted or implanted through a surgically created incision, as clarified in our August 3, 2000 interim final rule. As stated above, other clarifications in that interim final rule remain. We do not believe that it is either essential or advisable to revise the regulations. Therefore, we are not changing the current language of § 419.66(b)(3), as some commenters have suggested. However, we are adopting as final our interpretation that surgical insertion or implantation criteria include devices that are surgically inserted or implanted via a natural or surgically created orifice, as well as those devices that are inserted or implanted via a surgically created incision. We will maintain all of the other criteria in § 419.66 of the regulations, as elaborated in our various rules, such as the November 1, 2002 final rule (67 FR 66781 through 66787) and our August 3, 2000 interim final rule with comment period, namely, that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically implanted or inserted (65 FR 67805).

b. Existing Device Category Criterion

One of our criteria, as set forth in § 419.66(c)(1) of the regulations, to establish a new device category for pass-through payment is that the devices that would populate the category not be described by any existing or previously existing category. Commenters to our various proposed rules, as well as applicants for new device categories, have expressed concern that some of our existing and previously existing device category descriptors are overly broad, and that the category descriptors as they are currently written may preclude some new technologies from qualifying for establishment of a new device category for pass-through payment. These parties have recommended that CMS consider modifying the descriptors for existing device categories, especially when a device would otherwise meet all the other criteria for establishing a new device category to qualify for pass-through payment.

We agree that implementation of the requirement that a new device category not be described by an existing or previously existing category merits review. Beginning with CY 2006, 3 years will have elapsed since the vast majority of the 97 initial device categories we established on April 1, 2001, will have expired: 95 categories expired after December 31, 2002, and 2 categories expired after December 31, 2003. Several additional years will have passed since those categories were first populated in CY 2000 or CY 2001. Thus, while some of the initial device category descriptors sufficed at the time they were first created, further clarification as to the types of devices that they are meant to describe is indicated. Therefore, we proposed to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. This may entail the need to clarify or refine the short or long descriptors of the previous category. We will evaluate each situation on a case-by-case basis. We proposed that any such clarification will be made prospectively from the date the new category would be made effective.

We also proposed to revise § 419.66(c)(1) of the regulations, accordingly, to reflect, as one of the criteria for establishing a device category, our determination that a device is not appropriately described by any of the existing categories or by any category previously in effect. In order to determine if a ''new'' device is appropriately described by an existing or previously existing category of devices, we proposed to apply two tests based upon our evaluation of information provided to us in the device category application. First, we will expect an applicant for a new device category to show that its device is not similar to devices (including related predicate devices) whose costs are reflected in the OPPS claims data in the most recent OPPS update. Second, we will require an applicant for a new device category to demonstrate that utilization of its device provides a substantial clinical improvement for Medicare beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories. We will consider a new device that meets both of these tests not to be appropriately described by one of the existing or previously existing pass-through device categories.

We received a large number of public comments concerning our proposal to create an additional category for devices

that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device.

Comment: Commenters generally supported our proposal to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device, and which may entail the need to clarify or refine the short or long descriptors of the previous category. The commenters believed that CMS has sufficient documentation on devices in expired categories to differentiate those devices from new devices, as well as the authority to clarify the definitions of previously existing categories. The commenters gave examples of devices that they believe are not appropriately described by existing categories and whose descriptors are overly broad. Commenters also supported the application of the two tests that we proposed to apply in order to determine if the devices in device category applications are described by an existing or previously existing category. One commenter expressed that it would be useful for CMS to provide additional details on how we intend to evaluate whether a new technology is similar to existing technologies. Another commenter expressed concern that we have not developed standards of proof of substantial clinical improvement, which is one of the proposed tests, and encouraged CMS to develop further explanation of the substantial clinical improvement test.

Response: We appreciate the commenters' support for our proposed modification to our policy that a device may not be described by an existing or previously existing device category. Regarding the recommendations made for clarifying whether a nominated new device is similar to an existing technology, as new device applications consist of unique technologies, evaluation of what constitutes a similar technology or substantial clinical improvement is done on an individual application basis. We refer the commenters to our discussion of the substantial clinical improvement criterion that is found in our November 1, 2002 final rule (67 FR 66782–66783), which provides a list of criteria and examples of clinical outcomes that are used to determine if a request for a new category of devices meets our substantial clinical improvement criterion.

Comment: A few commenters recommended that CMS consider pending pass-through applications in light of this modification to the existing category criterion, and that CMS make modifications to existing or previously existing categories effective January 1, 2006, where all device category criteria are met.

Response: It is our intention to evaluate pending pass-through device category applications against any changes to criteria as a result of this final rule with comment period. If any pending applications are then eligible for establishment of a new device category for pass-through payment, we will endeavor to add those for payment effective January 1, 2006. Any payment instructions would be announced in the program transmittal implementing our CY 2006 OPPS update.

Comment: In commenting on our proposal to modify the existing device category criterion for pass-through payment for devices, a number of commenters noted that rechargeable implantable pulse generator (IPG) neurostimulators should be provided with pass-through payment status, and that a new category is needed specifically for rechargeable neurostimulators. The commenters claimed that rechargeable neurostimulators have allowed a significant advance to the field of neuromodulation for the treatment of chronic intractable pain. The commenters stated there is a high degree of patient compliance with rechargeable neurostimulators, and these devices will reduce the cost of spinal cord stimulation over time by reducing the number of surgical battery replacements. A large number of commenters stated that the new class of rechargeable IPG neurostimulators meets our proposed new tests to determine if a device is described by an existing or previously existing category. The commenters requested that CMS clarify the previously existing category to state that it described nonrechargeable neurostimulators. The commenters recommended that CMS apply any revised criterion to pending applications.

Response: We note that two pass-through applications now under consideration are for devices currently described by a previously existing pass-through category. These applications are for implantable rechargeable neurostimulators. Neurostimulators are covered by a previously existing OPPS device category for pass-through payment, C1767, Generator, neurostimulator (implantable). This same type of rechargeable device was considered for the IPPS new technology add-on payment, and passed all that payment system's criteria, including demonstrating substantial clinical improvement. Therefore, with the adoption of our proposal to clarify an existing or previously existing device category if an existing or previously existing device category does not appropriately describe a new device and the device would otherwise be eligible for a new pass-through device category, we will consider the rechargeable neurostimulator applications for pass-through payment beginning January 2006, in which case we would also consider the need to clarify or refine the description of category C1767. Any coding and payment information will be announced in the program transmittal implementing the OPPS for CY 2006. We also note that we have included an estimate for a rechargeable neurostimulator category in our pass-through spending estimate in section VI.B of this rule, should there be creation of a new device category for pass-through payment for such devices.

We are finalizing this proposal without change. We will create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. This may entail the need to clarify or refine the short or long descriptors of the previous category. We will evaluate each situation on a case-by-case basis and apply the two tests described above. Any such clarification to a category descriptor will be made prospectively from the date the new category would be made effective. We are also finalizing our proposed revision of our regulations at § 419.66(c)(1) to reflect this change.

V. Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents

and brachytherapy used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of BIPA (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' drugs, devices, and biological agents that were not being paid for as a hospital OPD 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 drug, device, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B to this final rule with comment period, pass-through drugs and biological agents are identified by status indicator ''G.''

The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on our CMS Web site: *www.cms.hhs.gov*. If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes to the Office of Management and Budget (OMB) for approval, as required under the Paperwork Reduction Act (PRA). Notification of new drugs and biologicals application processes is generally posted on the OPPS Web site at: *http://www.cms.hhs.gov/providers/hopps*.

2. Expiration in CY 2005 of Pass-Through Status for Drugs and Biologicals

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 and no longer than 3 years. The drugs whose pass-through status will expire on December 31, 2005, meet that criterion. In the CY 2006 OPPS proposed rule, in Table 19 (70 FR 42722) we listed the 10 drugs and biologicals for which we proposed that pass-through status would expire on December 31, 2005.

We received one public comment concerning the proposed expiration of pass-through status for those drugs and biologicals on December 31, 2005.

Comment: One commenter noted that the proposed rule did not make clear whether drugs coming off pass-through status will be reassigned to J-codes or will continue to be listed under their C-codes for payment purposes and requested clarification in the final rule.

Response: In order to reduce redundancy and simplify coding for drugs, biologicals, and radiopharmaceuticals under the OPPS, we are deleting the temporary C-codes for items that also have permanent HCPCS codes and are paying for those items under the permanent HCPCS codes if it is appropriate to do so. Among the items whose pass-through status will expire on December 31, 2005, are HCPCS codes C9123, C9203, C9205, C9211, and C9212, which will be deleted effective December 31, 2005. For services furnished on or after January 1, 2006, hospitals should use HCPCS code J7344 to bill for Transcyte, HCPCS code Q9955 to bill for Perflexane lipid micro, HCPCS code J9263 to bill for Oxaliplatin, and HCPCS code J0215 to bill for Alefacept. Later in the preamble, we list all of the C-codes in Table 25 that will be deleted on December 31, 2005 and replaced with other existing or new HCPCS codes in CY 2006.

For this final rule with comment period, in Table 18 below, we are specifying the drugs and biologicals for which pass-through status will expire on December 31, 2005. This listing is the same as that published in the proposed rule.

TABLE 18.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2005

HCPCS	APC	Short descriptor
C9123	9123	Transcyte, per 247 sq cm.
C9203	9203	Perflexane lipid micro.
C9205	9205	Oxaliplatin.
C9211	9211	Inj, alefacept, IV.
C9212	9212	Inj, alefacept, IM.
J0180	9208	Agalsidase beta injection.
J1931	9209	Laronidase injection.
J2469	9210	Palonosetron HCl.
J3486	9204	Ziprasidone mesylate.
J9041	9207	Bortezomib injection.

3. Drugs and Biologicals With Pass-Through Status in CY 2006

In the CY 2005 OPPS proposed rule (70 FR 42722 and 42723), we proposed to continue pass-through status in CY 2006 for 14 drugs and biologicals. These items, which were listed in Table 20 of the CY 2006 OPPS proposed rule (70 FR 42723), were given pass-through status as of April 1, 2005. The APCs and HCPCS codes for drugs and biologicals that we proposed to continue with pass-through status in CY 2006 are assigned status indicator ''G'' in Addenda A and B of this final rule with comment period.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. We note that this section of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. The competitive acquisition program had not been implemented at the time of issuance of the CY 2006 proposed rule. Therefore, we did not have payment rates for certain drugs and biologicals that would be covered under this program at that time. Section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. This payment methodology is set forth in § 419.64 of the regulations. Similar to the payment policy established for pass-through drugs and biologicals in CY 2005, we proposed to pay under the OPPS for drugs and biologicals with pass-through status in CY 2006 consistent with the provisions of section 1842(o) of the Act, as amended by

section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting.

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act, and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological.

In the CY 2006 OPPS proposed rule, (70 FR 42722 and 42731) we proposed to continue to make separate payment in CY 2006 for new drugs and biologicals with a HCPCS code consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108 173, at a rate that is equivalent to the payment they would receive in a physician office setting, whether or not we have received a pass-through application for the item. Accordingly, in CY 2006 the pass-through payment amount would equal zero for those new drugs and biologicals that we determine have pass-through status. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, from the portion of the otherwise applicable fee schedule amount or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act as amended by section 621 of Pub. L. 108–173, the resulting difference is equal to zero.

We proposed to use payment rates based on the ASP data from the fourth quarter of 2004 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of the proposed rule because these were the most recent numbers available to us during the development of the proposed rule. These payment rates were also the basis for drug payments in the physician office setting effective April 1, 2005. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we stated in our proposed rule (70 FR 42722 and 42723) that we planned to make any appropriate adjustments to the amounts shown in Addenda A and B of the proposed rule when we publish our final rule and also on a quarterly basis on our Web site during CY 2006 if later quarter ASP submissions indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary.

In Table 20 of the proposed rule, we listed the drugs and biologicals for which we proposed that pass-through status continue in CY 2006. We assigned pass-through status to these drugs and biologicals as of April 1, 2005. Since publication of the CY 2006 OPPS proposed rule, we have approved three additional drugs and biologicals for pass-through payment beginning on or after July 1, 2005. These products are Abraxane, which has been assigned HCPCS code C9127 (Injection, Paclitaxel Protein Bound Particles, per 1 mg); Macugen, which has been assigned HCPCS code C9128 (Injection, Pegaptanib Sodium, per 0.3 mg); and Clolar, which has been assigned HCPCS code C9129 (Injection, Clofarabine, per 1 mg). (See Change Request 3915, Transmittal 599 issued on June 30, 2005.) In addition, two more products have been approved for pass-through status beginning on or after October 1, 2005. They are Retisert, which has been assigned HCPCS code C9225 (Injection, fluocinolone acetonide intravitreal implant, per 0.59 mg) and Prialt, which has been assigned HCPCS code C9226 (Injection, ziconotide for intrathecal infusion, per 5 mcg). (See Change Request 4035, Transmittal 691 issued on September 30, 2005). For CY 2006, the C-codes C9127, C9128, C9129, and C9226 have been deleted and replaced with permanent HCPCS codes J9264, J2503, J9027, and J2278, respectively. These new eligible pass-through items are listed in Table 19 below. We also have included in Addenda A and B to this final rule with comment period the CY 2006 APC payment rates for all pass-through drugs and biologicals.

We received several public comments on the proposed listing and payment rates for drugs and biologicals with pass-through status continuing in CY 2006.

Comment: A few commenters indicated that our proposal to apply the same payment methodology to pass-through drugs and to drugs that are classified as a ''specified covered outpatient drug'' may not appropriately recognize and pay hospitals for the additional costs that are often associated with new technologies that are given pass-through status. One commenter indicated that the proposal negated the intent of the pass-through payment, which was meant to compensate hospitals for costs not covered by existing APC payments. Commenters urged CMS to consider maintaining a differential in payment systems between innovative and older drugs in order to ensure adequate access to newer therapies within the hospital outpatient setting. One commenter suggested that CMS consider making the pass-through payment methodology consistent with the methodology applied to new drugs in the physician office setting (that is, wholesale acquisition cost or the applicable payment methodology in effect on November 1, 2003) to distinguish and provide sufficient payment for the class of pass-through drugs in future years.

Response: Section 1833(t)(6)(D)(i) of the Act sets the additional payment amount for pass-through eligible drugs or biologicals as the difference between the amount determined under section 1842(o) of the Act and the APC payment rate determined by the Secretary associated with the drug or biological. As we explained earlier, section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the ASP methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. Our proposal to pay for drugs and biologicals with pass-through status in CY 2006 using the ASP methodology at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting is consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173. Specifically, in CY 2006, we will be paying for drugs and biologicals with pass-through status under the OPPS based on the ASP methodology and using ASP data specific to the drug or biological itself. We note that there may be certain drugs and biologicals with pass-through status that are payable under different HCPCS codes in the physician offices and outpatient departments, and for such cases, payment for the drug or biological under the OPPS will be based on the ASP data for the item described by the code that is used under the OPPS. We agree that pass-through payments are designed to recognize differences between the payment rates under the OPPS and the payment rates for certain drugs and biologicals in the physician office setting. Statutory changes in the payment methodology for pass-through drugs and biologicals mean that such cost differentials no longer exist.

We have used payment rates based on the ASP data from the second quarter of CY 2005 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of this final rule with comment period because these were the most recent numbers available to us during the development of this rule. These payment rates are also the basis

for drug payments in the physician office setting effective October 1, 2005. However, the payment rates for pass-through drugs and biologicals that will be effective in the OPPS on January 1, 2006 will be based on ASP data from the third quarter of CY 2005, which will also be the basis for drug payments in physician offices as of January 1, 2006. To be consistent with the ASP-based payments that will be made when these pass-through drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments in CY 2006 to the payment rates for these items if later quarter ASP submissions indicate that adjustments to the payment rates are necessary.

As noted earlier, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. The competitive acquisition program still has not been implemented with issuance of this final rule with comment period. We expect implementation by July 1, 2006. For this final rule with comment period, we do not have payment rates for certain drugs and biologicals that would be covered under this program at that time. However, when the competitive acquisition program is implemented in CY 2006, the OPPS payment rates for pass-through drugs and biologicals that will also be covered under the program will be based on the competitive acquisition program methodology in CY 2006.

We refer readers to section V.B.3.a. of this preamble for a discussion of payment policies for specified covered outpatient drugs.

Comment: The manufacturer of natalizumab (HCPCS code Q4079) supported continued pass-through status for this product, but was concerned that continuation of the 1-mg unit descriptor will create confusion among providers and inject the potential of erroneously denied or underpaid claims. The commenter indicated that a 300 mg dose of the product is always uniformly infused and urged CMS to amend the coding descriptor to reflect its clinical use.

Response: We recognize the commenter's concern. However, the National HCPCS Panel coordinates decisions regarding the descriptors of permanent HCPCS codes. Therefore, we will not respond to this comment as it is outside the scope of this rule.

Table 19 below lists the drugs and biologicals that will have pass-through status in CY 2006. Addenda A and B of this final rule with comment period list the final CY 2006 rates for these pass-through drugs and biologicals, which are based on ASP data reported by manufacturers from the second quarter of CY 2005. These items are assigned to status indicator ''G.''

Comment: A commenter recommended that CMS finalize the proposal to continue payment for HCPCS codes C9221 and C9222 as pass-through biologics in CY 2006 and requested that CMS confirm that the proposed payment rate of $1,234.36 for HCPCS code C9221 reflected ASP+6 percent.

Response: We agree with the commenters that HCPCS codes C9221 and C9222 should be paid as pass-through items in CY 2006; therefore, these items are listed in Table 19 along with other drugs and biologicals that will also have pass-through status under the OPPS in CY 2006 and are also assigned to status indicator ''G'' in Addendum B of this final rule with comment period.

Comment: A commenter indicated that the HCPCS code C9127 (paclitaxel protein-bound particles for injectable suspension, per 1 mg) was granted pass-through status effective July 1, 2005; however, the CY 2006 proposed rule listed this code with a status indicator ''K'' rather than status indicator ''G.'' The commenter requested that this code be assigned to status indicator ''G'' in the final rule indicating its pass-through status.

Response: In the proposed rule, we listed only the drugs and biologicals that received pass-through status as of April 1, 2005. As indicated earlier, there are additional drugs and biologicals that have been approved for pass-through status since the publication of the proposed rule, and HCPCS code C9127 is one of the drugs that received pass-through status effective July 1, 2005. We note that HCPCS code C9127 has been deleted effective December 31, 2005 and replaced with HCPCS code J9264 in CY 2006. Consequently, in this final rule we have assigned HCPCS code J9264 to status indicator ''G'' in Addendum B in this final rule with comment period.

Comment: Another commenter indicated that it was pleased with CMS' proposal to continue pass-through status in CY 2006 for the drug Orthovisc, which is reported under HCPCS code C9220; however, it was also concerned that once the period of eligibility for pass-through payments expired, there will not be a code corresponding to HCPCS code C9220 that will be available for use. The commenter expressed concern about the CMS HCPCS Workgroup's preliminary recommendation to deny a unique code for Orthovisc and to include Orthovisc with other viscosupplements described by HCPCS code J7317. The commenter stated its belief that a new code is necessary and appropriate for Orthovisc under the established HCPCS process, and such a decision would recognize the unique characteristics of Orthovisc, distinguish it from other viscosupplements, allow for appropriate payment, and facilitate patient access. The commenter indicated that it resubmitted its J-code application under the new HCPCS process on December 24, 2004 and requested that CMS recognize Orthovisc as a unique product and grant it a unique HCPCS code.

Response: Effective January 1, 2006, the National HCPCS Panel has created HCPCS code J7318 (Hyaluron/derive intra-art inj) to describe all of the sodium hyaluronate products, including Orthovisc. Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are outside the scope of this rule. However, we note that in CY 2006 because HCPCS code C9220 will continue to have pass-through status under the OPPS both HCPCS code C9220 and HCPCS code J7318 will be payable under the OPPS, and their payment rates will be established using the ASP data for all of the products described by these codes. Therefore, we encourage providers to continue billing for Orthovisc, which has pass-through status, using HCPCS code C9920 in order to receive appropriate payment for furnishing this drug in the hospital outpatient setting.

Comment: A few commenters requested the CMS clarify in the final rule how payment for infusion drugs administered through an item of DME, such as drugs administered through an implantable or external infusion pump, will be paid under the OPPS in CY 2006. One commenter was especially concerned about the payment rate for HCPCS code C9226 (Brand name: Prialt), which is administered through an intrathecal pump. The commenters noted CMS' statement that CY 2006 payment for drugs and biologicals under the OPPS will follow that of the physician office setting; however, CMS did not specifically state that this particular group of drugs, which are not paid under the ASP methodology, will continue to be paid at 95 percent of AWP in CY 2006. Commenters requested that CMS clarify that infusion

drugs administered through an item of DME and furnished in the hospital outpatient setting, like Prialt, will be paid at 95 percent of AWP pursuant to section 1842(o)(1)(D) of the Act. One commenter also requested that CMS clarify that Prialt is not an orphan drug.

Response: HCPCS code C9226 was approved for pass-through status effective October 1, 2005. As a pass-through drug under the OPPS, payment for Prialt was established using the ASP methodology. (See Change Request 4035, Transmittal 691 issued on September 30, 2005). As with other new drugs without ASP data, payment for Prialt was set at WAC+6% ($32.24 per 5 mcg) effective October 1, 2005. We note that Prialt is not considered a single-indication orphan drug under OPPS. As the commenters noted, section 1842(o)(1)(D) of the Act states that drugs infused through DME are paid at 95 percent of AWP until such time as they are incorporated into the DME competitive bidding program. However, section 1842(o)(1) of the Act (which governs section 1842(o)(1)(D)) specifically states that this payment methodology only applies when a ''drug or biological is not paid on a cost or prospective payment basis.'' Payment for drugs under the OPPS is established on the basis of prospective rates. The provision that requires payment for DME infusion drugs at 95 percent of AWP is therefore not applicable to Prialt or any other DME infusion drugs furnished in the hospital outpatient setting. Therefore, in CY 2006 we will continue to pay for Prialt and other non-pass-through DME infusion drugs using the ASP methodology instead of paying at 95 percent of AWP. We note that HCPCS code C9226 has been deleted effective December 31, 2005 and replaced with J2278 in CY 2006. Consequently, in this final rule, we have assigned HCPCS code J2278 to status indicator ''G'' in Addendum B in this final rule with comment period.

TABLE 19.—LIST OF DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2006

HCPCS Code	APC	Short descriptor
C9220	9220	Sodium hyaluronate.
C9221	9221	Graftjacket Reg Matrix.
C9222	9222	Graftjacket SftTis.
C9225	9225	Fluocinolone acetonide.
J0128	9216	Abarelix injection.
J0878	9124	Daptomycin injection.
J2278	1694	Ziconotide injection.
J2357	9300	Omalizumab injection.
J2503	1697	Pegaptanib sodium injection.
J2783	0738	Rasburicase.
J2794	9125	Risperidone, long acting.
J7518	9219	Mycophenolic acid.
J8501	0868	Oral aprepitant.
J9027	1710	Clofarabine injection.
J9035	9214	Bevacizumab injection.
J9055	9215	Cetuximab injection.
J9264	1712	Paclitaxel injection.
J9305	9213	Pemetrexed injection.
Q4079	9126	Injection, Natalizumab, 1 mg.

B. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the CY 2005 OPPS, we currently pay for drugs, biologicals including blood and blood products, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs). We explained in the April 7, 2000 final rule (65 FR 18450) that 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 packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

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, biologicals, 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.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. For CY 2005, we finalized our policy to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than $50 into the procedures with which they are billed. For CY 2005, we also adopted an exception policy to our packaging rule for one particular class of drugs, the oral and injectable 5HT3 forms of anti-emetic treatments (69 FR 65779 through 65780).

2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

In accordance with section 1833(t)(16)(B) of the Act, for CY 2006, the threshold for establishing separate

APCs for drugs and biologicals is required to be set at $50 per administration. Therefore, in the CY 2006 proposed rule we proposed to continue our existing policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than $50 into the procedures with which they are billed. We also proposed to continue our policy of exempting seven oral and injectable 5HT3 anti-emetic products from our packaging rule (Table 21 of the CY 2006 OPPS proposed rule, 70 FR 42723), thereby making separate payment for all of the 5HT3 anti-emetic products. As stated in our CY 2005 final rule with comment period (69 FR 65779 through 65780), chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We want to continue to ensure that our payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 20.—ANTI-EMETICS TO EXEMPT FROM $50 PACKAGING REQUIREMENT

HCPCS Code	Short description
J1260	Dolasetron mesylate.
J1626	Granisetron HCl injection.
J2405	Ondansetron HCl injection.
J2469	Palonosetron HCl.
Q0166	Granisetron HCl 1 mg oral.
Q0179	Ondansetron HCl 8 mg oral.
Q0180	Dolasetron mesylate oral.

For the CY 2006 proposed payment rates, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2004 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2004 to December 31, 2004. In CY 2004, multisource drugs and radiopharmaceuticals had two HCPCS codes that distinguished the innovator multisource (brand) drug or radiopharmaceutical from the noninnovator multisource (generic) drug or radiopharmaceutical. We aggregated claims for both the brand and generic HCPCS codes in our packaging analysis of these multisource products. Items such as single indication orphan drugs, certain vaccines, and blood and blood products were excluded from these calculations and our treatment of these items is discussed separately in sections V.F., V.E., and X.B., respectively, of this preamble.

In order to calculate the per day cost for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2006, we proposed several changes in the methodology that was described in detail in the CY 2004 OPPS proposed rule (68 FR 47996 through 47997) and finalized in the CY 2004 final rule with comment period (68 FR 63444 through 63447). For CY 2006, to calculate the per day cost of the drugs, biologicals, and radiopharmaceuticals, our proposed methodology was the following:

Step 1. After application of the CCRs, we aggregated all line-items for a single date of service on a single claim for each product. This resulted in creation of 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.

Step 2. We then created a separate record for each drug or radiopharmaceutical by date of service, regardless of the number of lines on which the drug or radiopharmaceutical was billed on 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 two line-items with a cost of $10 and 5 units for each line-item. In this case, the computer program would create two records for this drug, and each record would have a total cost of $20 and 10 units of the product.

Step 3. We trimmed records with unit counts per day greater or less than 3 standard deviations from the geometric mean. (This is a new step in the methodology that we proposed for CY 2006.)

Step 4. For each remaining record for a drug or radiopharmaceutical, we calculated the cost per unit of the drug. If the HCPCS descriptor for ''drug X'' 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), the computer program divided the total cost for the record by 10 to give a per unit cost. We then weighted this unit cost by the total number of units in the record. We did this by generating a number of line-items equivalent to the number of units in that particular claim. Thus, a claim with 100 units of ''drug X'' 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.

Step 5. We trimmed the unit records with cost per unit greater or less than 3 standard deviations from the geometric mean.

Step 6. We aggregated the remaining unit records to determine the mean cost per unit of the drug or radiopharmaceutical.

Step 7. Using only the records that remained after records with unit counts per day greater or less than 3 standard deviations from the geometric mean were trimmed (step 3), we determined the total number of units billed for each item and the total number of unique per-day records for each item. We divided the count of the total number of units by the total number of unique per-day records for each item to calculate an average number of units per day.

Step 8. Instead of using median cost as done in previous years, we used the payment rate for each drug and biological effective April 1, 2005 for the physician office setting, which was calculated using the ASP methodology, and multiplied the payment rate by the average number of units per day for each drug or biological to arrive at its per day cost. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2004 hospital claims data to determine their per day cost. Our reasoning for using these cost data is discussed in section V.B.3.a. of this preamble.

Step 9. We packaged the items with per day cost based on the ASP methodology or mean cost less than $50 and made items with per day cost greater than $50 separately payable.

In the past, many commenters had alleged that hospitals do not accurately bill the number of units for drugs and radiopharmaceuticals consistent with expected appropriate clinical use. We have consistently decided not to determine whether a hospital claim reports a clinically appropriate unit dose of a drug for rate-setting purposes. Variations among patients with respect to appropriate doses, the variety of indications with different dosing regimens for some agents, and the possibility of off-label uses make it difficult to know when units are incorrectly reported. However, we believed that trimming the units would improve the accuracy of estimates by removing those records with the most extreme units, without requiring us to speculate about clinically appropriate dosing. Therefore, we believed that trimming the records with unit counts greater or less than 3 standard deviations from the geometric mean would eliminate claims from our analysis that might not appropriately

represent the actual number of units of a drug or radiopharmaceutical furnished by a hospital to a patient during a specific clinical encounter. Because it reduced extreme variation, trimming on greater or less than 3 standard deviations from the geometric mean made this trim more conservative and removed fewer records. This change in methodology gave us even greater confidence in the cost estimates we use for our packaging decisions.

We specifically requested comments on the changes that we proposed in our methodology for packaging drugs and radiopharmaceuticals. In response, we received numerous public comments on the proposed methodology.

Comment: Many commenters supported CMS' continued use of the $50 per day cost threshold to determine whether a drug, biological, or radiopharmaceutical will be packaged or paid separately. One commenter indicated that this system allows hospital outpatient departments to have an efficient option for packaging and for collecting payments for less costly drugs. Numerous commenters also supported CMS' proposal to exempt the 5HT3 anti-emetic products from the current $50 packaging threshold and pay for all of them separately, noting that the policy will help to ensure that Medicare beneficiaries have access to the particular anti-emetic that is most effective for them as determined by the beneficiary and his or her physician. One commenter, to the contrary, indicated that the current threshold for separate payment of radiopharmaceuticals is too high and distorts the resource homogeneity of the nuclear medicine APCs and recommended that CMS make separate payments for all radiopharmaceuticals.

Response: We appreciate the commenters' support of our proposals for CY 2006 to establish a packaging threshold for drugs, biologicals, and radiopharmaceuticals at $50 per day and to pay separately for the seven 5HT3 anti-emetic products. Section 1833(t)(16)(B) of the Act requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CY 2006. Therefore, we cannot change the threshold amount for radiopharmaceuticals, to which the policy also applies, as one of the commenters has suggested.

In determining the packaging status of drugs, biologicals, and radiopharmaceuticals for CY 2006, we calculated the per day costs of these items using the general methodology described above. However, as it is our policy to use updated data for the final rule, to determine the final per day costs of these items we used the payment rate for each drug and biological effective October 1, 2005 for the physician office setting, which was calculated using the ASP methodology, along with updated hospital claims data from CY 2004. The payment rate was multiplied by the average number of units per day for each drug or biological, which were recalculated using all of the CY 2004 hospital claims data used for this final rule with comment period, to arrive at each product's per day cost. For items that did not have an ASP-based payment rate, we used their mean unit cost, which we also recalculated using all of the CY 2004 hospital claims data used for this final rule with comment period to determine their per day cost.

We note that there are two drugs for which we proposed to pay separately in our proposed rule that now have per day costs less than $50 based on the updated cost and claims data. In these cases, we are applying our equitable adjustment authority to the packaging threshold according to the policy that we finalized in the CY 2005 final rule for drugs and biologicals with similar circumstances (69 FR 65780). Therefore, for CY 2006, we are applying the following policy to these drugs and biologicals:

- Drugs and biologicals that were paid separately in CY 2005, were proposed for separate payment in CY 2006, and have per day costs less than $50 based on updated ASPs and hospital claims data used for this CY 2006 final rule with comment period will continue to receive separate payment in CY 2006.
- Those drugs and biologicals that were packaged in CY 2005, were proposed for separate payment in CY 2006, and have per day costs less than $50 based on updated ASPs and hospital claims data used for this CY 2006 final rule with comment period will remain packaged in CY 2006.

Table 21 lists the two drugs and biologicals to which this policy will apply, along with their CYs 2005 and 2006 payment status indicators.

TABLE 21.—DRUGS AND BIOLOGICALS WITH PER DAY COSTS LESS THAN $50 USING FINAL RULE DATA, BUT WERE PROPOSED FOR SEPARATE PAYMENT

HCPCS	Description	CY 2005 status indicator	CY 2006 status indicator
J0580	Penicillin g benzathine inj	N	N
J3350	Urea injection	K	K

We also note that there were several drugs, biologicals, and radiopharmaceuticals that we proposed to package in the proposed rule and that now have per day costs greater than $50 using updated ASPs and all of the hospital claims data from CY 2004 used for this final rule with comment period. In accordance with our established policy for such cases, for CY 2006 we will pay for these drugs, biologicals, and radiopharmaceuticals separately. Table 22 lists the drugs and biologicals that were proposed as packaged items, but will be paid separately in CY 2006.

TABLE 22.—DRUGS AND BIOLOGICALS WITH PER DAY COSTS ABOVE $50 FOR WHICH SEPARATE PAYMENT WILL BE MADE IN CY 2006

HCPCS [1]	Description
90665	Lyme disease vaccine, im.
90717	Yellow fever vaccine, sc.
A9504	Technetium tc 99m apcitide.
J0350	Injection anistreplase 30 u.
J0470	Dimecaprol injection.
J2700	Oxacillin sodium injection.
J2910	Aurothioglucose injection.
J3470	Hyaluronidase injection.
J7197	Antithrombin iii injection.

Comment: One commenter supported the addition of ''step 3'' to the calculation of the per day cost methodology used to determine the packaging status of drugs, biologicals, and radiopharmaceuticals and stated that the addition of the new step will improve the accuracy of the per day cost calculation by enabling CMS to trim out very high units of service associated with very low costs that may inappropriately lower the overall median cost.

Response: We appreciate the commenter's support of the change in our methodology to determine the per

day costs of drugs, biologicals, and radiopharmaceuticals and are finalizing this change for CY 2006, along with the other proposed changes for determining per day costs of these items.

Comment: We received comments on the packaging status of one drug and several radiopharmaceuticals where the commenters indicated that the items were incorrectly packaged and should be paid separately in CY 2006. Specific items mentioned in the comments were HCPCS codes J1245, A9513, C1079, C9013, and Q3012. One commenter asserted that confusing HCPCS descriptors contributed to the submission of inaccurate claims data to CMS. This commenter also noted that the inconsistent market availability of some of these products resulted in small numbers of claims and variable cost data, which CMS used to determine the per day costs of these items. The commenters indicated that there are other products that are used for the same indication as some of these products, and also that there are clinical situations where physician would prefer to utilize one particular product over another. Therefore, commenters did not want payment rules to affect access to particular products that may be most clinically effective for patients.

Response: We understand the commenters' concerns about the packaging of these items. Based on the methodology we used to calculate per day costs of these items, as described earlier in the preamble, we determined that the per-day costs of these products were below $50. Therefore, these items were packaged. When we recalculated the per day costs of these items using updated CY 2004 claims data and ASP-based payment rates based on data from the second quarter of CY 2005 for the final rule, we observed that the per day costs of these items remained below $50. For radiopharmaceuticals, we recalculate their mean per day costs using updated CY 2004 claims data.

As described earlier, we applied an additional unit trimming step in the methodology to determine per day costs of items in CY 2006. We stated our belief that trimming the units would improve the accuracy of the per day cost estimates by removing those records with the most extreme units, without requiring us to speculate about clinically appropriate dosing. Therefore, we believe that the new trimming step eliminates claims from our analysis that might not appropriately represent the actual number of units of a drug or radiopharmaceutical furnished by a hospital to a patient during a specific clinical encounter. We indicated that this change in methodology gave us even greater confidence in the cost estimates we use for our packaging decisions. Also, section 621(a)(2) of Pub. L. 108–173 requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CY 2006. Therefore, we cannot change the packaging threshold amount from $50, which would be required of us if we were to pay for these items separately. For these reasons, we believe that it is appropriate for us to package these items in CY 2006 under OPPS. We expect that the modest per day costs of these packaged items will allow hospitals to make the most clinically appropriate choices of products in their care of patients, as hospitals will also bill a variety of separately payable services for the care provided.

Comment: One commenter indicated that it is operationally impossible to establish a separate process for charging anti-emetic drugs when they are used only in conjunction with chemotherapy since the majority of their surgical outpatients receive these drugs. The commenter inquired as to whether CMS could develop an edit to only pay for the anti-emetic drug when it is connected to a cancer diagnosis.

Response: We note that separate payments for these 5HT3 injectable and oral anti-emetic drugs will be made as long as these drugs are covered by Medicare, regardless of the clinical indications for the drugs' use. The policy described above for the 5HT3 anti-emetic drugs applies only to the packaging status of these items, not to their coverage status. Hospitals should continue billing for these injectable and oral anti-emetic drugs in accordance with existing coverage rules.

Section 1833(t)(16)(B) of the Act that requires the threshold for establishing separate APCs for drugs and biologicals to be set at $50 per administration will expire at the end of CY 2006. Therefore, we will be evaluating other packaging thresholds for these products for the CY 2007 OPPS update. We specifically requested comments on the use of alternative thresholds for packaging drugs and radiopharmaceuticals in CY 2007.

We received a number of public comments in response to this request.

Comment: Commenters made various suggestions for establishing the packaging threshold for CY 2007. Several commenters encouraged CMS to set the packaging threshold no higher than $50 in CY 2007 and beyond. Other commenters suggested that CMS provide separate payment for all infused and injectable drugs, regardless of their per day costs, and only continue to package oral drugs in CY 2007. Other commenters echoed this general suggestion, but further suggested that the oral anti-emetic drugs be paid separately along with the infused and injectable drugs. One commenter stated that CMS should continue to pay separately for all drugs and biologicals that were separately paid in the past, including all therapies that had received pass-through status. Another commenter suggested that, to the extent CMS may elect to raise the packaging threshold in CY 2007 and beyond, the threshold be linked to an appropriate price indexing mechanism. In establishing the appropriate price indexing measure, the commenter urged CMS to give substantial consideration to the impact resulting from capturing more high-cost drugs in packaged payment groups, including the effect such a policy may have on beneficiary access to needed treatments, with particular focus on avoiding unintended disadvantages for newer innovator products. Other commenters suggested that CMS determine appropriate payment levels that will be sufficient to ensure patient access in its consideration of the use of alternative thresholds for packaging drugs in CY 2007, and that CMS utilize ASP data from CY 2005 to determine the appropriate parameters for a packaging threshold in CY 2007. On the other hand, MedPAC indicated that it has long been concerned about the incentives created by the unpackaging of drugs that exists in the OPPS. For example, MedPAC stated that, under the OPPS, providers have an incentive to use a higher-cost drug that is paid separately in place of a lower-cost drug that is packaged. If hospitals act on this incentive, it could raise beneficiaries' overall cost sharing, Part B premiums, and program spending. MedPAC added that setting payment rates for small packages is likely to be less accurate than setting rates for larger packages. It pointed out that, with greater packaging, variations in charging practices are more likely to balance out, leading to payment rates that, on average, are more reflective of costs.

Response: We appreciate receiving these suggestions for establishing an appropriate packaging threshold for CY 2007 and will take the recommendations into consideration as we work on our packaging proposal for the CY 2007 OPPS.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs

(1) Background

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires special classification of certain separately paid radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of ''specified covered outpatient drugs.'' These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(F) of the Act defines the categories of drugs based on section 1861(t)(1) and sections 1927(k)(7)(A)(ii), (k)(7)(A)(iii), and (k)(7)(A)(iv) of the Act. The categories of drugs are ''sole source drugs (includes a biological product or a single source drug),'' ''innovator multiple source drugs,'' and ''noninnovator multiple source drugs.'' The definitions of these specified categories for drugs, biologicals, and radiopharmaceuticals were discussed in the January 6, 2004 OPPS interim final rule with comment period (69 FR 822), along with our use of the Medicaid average manufacturer price database to determine the appropriate classification of these products. Because of the many comments received on the January 6, 2004 interim final rule with comment period, the classification of many of the drugs, biologicals, and radiopharmaceuticals changed from that initially published. We announced these changes to the public on February 27, 2004, through Transmittal 112, Change Request 3144. We also implemented additional classification changes through Transmittal 132 (Change Request 3154, released March 30, 2004) and Transmittal 194 (Change Request 3322, released June 4, 2004).

Section 1833(t)(14)(A) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, also provides that payment for these specified covered outpatient drugs for CYs 2004 and 2005 is to be based on its ''reference average wholesale price (AWP).'' Section 1833(t)(14)(A)(ii) of the Act, as added by section 621(a) of Pub. L. 108–173 requires that in CY 2005—

- A sole source drug must be paid no less than 83 percent and no more than 95 percent of the reference AWP.
- An innovator multiple source drug must be paid no more than 68 percent of the reference AWP.
- A noninnovator multiple source drug must be paid no more than 46 percent of the reference AWP.

Section 1833(t)(14)(G) of the Act defines ''reference AWP'' as the AWP determined under section 1842(o) the Act as of May 1, 2003. We interpreted this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003.

For CY 2005, we finalized our policy to determine the payment rates for specified covered outpatient drugs under the provisions of Pub. L. 108–173 by comparing the payment amounts calculated under the median cost methodology as done for procedural APCs to the AWP percentages specified in section 1833(t)(14)(A)(ii) of the Act.

(2) Changes for CY 2006 Related to Pub. L. 108–173

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108 173, requires that payment for specified covered outpatient drugs in CY 2006 be equal to the average acquisition cost for the drug for that year as determined by the Secretary subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary.

(3) Data Sources Available for Setting CY 2006 Payment Rates

Section 1833(t)(14)(D) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, outlines the provisions of the hospital outpatient drug acquisition cost survey mandated for the GAO. This provision directs the GAO to collect data on hospital acquisition costs of specified covered outpatient drugs and to provide information based on these data that can be taken into consideration for setting CY 2006 payment rates for these products under the OPPS. Accordingly, the GAO conducted a survey of 1,400 acute care, Medicare-certified hospitals and requested hospitals to provide purchase prices for specified covered outpatient drugs purchased between July 1, 2003 and June 30, 2004. The survey yielded a response rate of 83 percent; 1,157 hospitals provided usable information. To ensure that its methodology for data collection and analysis was sound, the GAO consulted an advisory panel of experts in pharmaceutical economics, pharmacy, medicine, survey sampling and Medicare payment.

The GAO reported the average and median purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004. These items represented 86 percent of Medicare spending for specified covered outpatient drugs during the first 9 months of CY 2004. The initial GAO data did not include any radiopharmaceuticals. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations. The GAO survey data were available in time for consideration in the CY 2006 OPPS proposed rule.

At the time of issuance of the CY 2006 OPPS proposed rule, another available source of drug pricing information was the ASP data from the fourth quarter of CY 2004, which were used to set payment rates for drugs and biologicals in the physician office setting effective April 1, 2005. We had ASP-based prices for approximately 475 drugs and biologicals (including contrast agents) payable under the OPPS. However, we did not then have (and we still do not have) any ASP data on radiopharmaceuticals. Payments for most of the drugs and biologicals paid in the physician office setting were based on ASP+6 percent. Payments for items with no reported ASP were based on wholesale acquisition cost (WAC).

Lastly, the third source of cost data that we had at the time of issuance of the proposed rule for drugs, biologicals, and radiopharmaceuticals was the mean and median costs derived from the CY 2004 hospital claims data. In our data analysis for the proposed rule, we

compared the payment rates for drugs and biologicals using data from all three sources described above. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for specified covered outpatient drugs in CY 2006 be equal to the ''average'' acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined using the GAO acquisition cost survey and the hospital claims data, instead of using median costs.

For the proposed rule, we estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results which we presented in the proposed rule are shown in Table 23 below.

TABLE 23.—COMPARISON OF RELATIVE PRICING FOR OPPS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES

Type of pricing data	Time period of pricing data	ASP equivalent (55 GAO drugs only)	ASP equivalent (all separately billable drugs)
GAO mean purchase price	12 months ending June 2004	ASP+3%	N/A
ASP+6%	4th quarter of 2004	ASP+6%	ASP+6%
Mean cost from claims data	1st 9 months of 2004	ASP+8%	ASP+8%

Prior to any adjustments for the differing time periods of the pricing data, the results indicated that using the GAO mean purchase prices as the basis for paying the 55 drugs and biologicals would be equivalent to paying for those drugs and biologicals, on average, at ASP+3 percent. In addition, using mean unit cost from hospital claims data to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+8 percent.

In determining the payment rates for drugs and biologicals in CY 2006, we did not propose to use the GAO mean purchase prices for the 55 drugs and biologicals because the GAO data reflect hospital acquisition costs from a less recent period of time. The survey was conducted from July 1, 2003 to June 30, 2004; thus, the purchase prices are generally reflective of the time that is the midpoint of this period, which is January 1, 2004. The hospital purchase price data also do not fully account for rebates from manufacturers or payments from group purchasing organizations made to hospitals. We also noted that it would be difficult to update the GAO mean purchase prices during CY 2006 and in future years.

We also did not propose, in general, to use mean costs from CY 2004 hospital claims data to set payment rates for drugs and biologicals in CY 2006. In previous OPPS rules, we stated that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median costs of drug administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of acquiring the item (66 FR 59896 and 67 FR 66769). However, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their handling costs as well as their acquisition costs. Therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as well as their pharmacy overhead costs. For CY 2006, the statute specifies that payments for specified covered outpatient drugs are required to be equal to the ''average'' acquisition cost for the drug. Payments based on mean costs would represent the products' acquisition costs plus overhead costs, instead of acquisition costs only. Therefore, at the time of issuance of the proposed rule, we determined that it would be appropriate for us to use a source of cost information other than the CY 2004 hospital claims data to set the payment rates for most drugs and biologicals in CY 2006.

Based on these considerations, we proposed to pay ASP+6 percent as the acquisition payment for separately payable drugs and biologicals in CY 2006. Given the data as described above, we determined at the time of issuance of the proposed rule that this was our best estimate of average acquisition costs for CY 2006. We noted in the proposed rule (70 FR 42726) that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data, on average, were equivalent to ASP+3 percent. However, as noted earlier, we determined that this comparison was problematic for two reasons. First, there were differences in the time periods for the two sources of data. The GAO data were from the 12 months ending June 2004, and the ASP data were from the fourth quarter of CY 2004. It could be argued that prices increased in the intervening time period. However, we determined that there was no source of reliable information on specific price changes for this time period for the drugs studied by the GAO. In the future, we will have better information on price trends for Medicare Part B drugs as more quarters of pricing information are reported under the ASP system.

We also noted that the comparison between the GAO data and the ASP data was problematic as the ASP data included rebates and other price concessions and the GAO data did not. Inclusion of these rebates and price concessions in the GAO data would decrease the GAO prices relative to the ASP prices, suggesting that ASP+6 percent may be an overestimate of hospitals' average acquisition costs. Unfortunately, we did not have a source of information on the magnitude of the rebates and price concessions for the specific drugs in the GAO data at that time.

Therefore, we determined in the proposed rule that it was difficult to adjust the GAO prices for inflation, rebates, and price concessions to make the comparison with ASP more precise. We indicated that we would continue to examine new data to improve our future estimates of acquisition costs. In future years, our proposed pricing would be modified as appropriate to reflect the most recent data and analyses available. We also noted that, in addition to the importance of making accurate

estimates of acquisition costs for drug pricing, there were important implications for prices of other services due to the required budget neutrality of the OPPS. For example, drugs and biological prices set at ASP+3 percent instead of ASP+6 percent would have made available approximately an additional $60 million for other items and services under the OPPS.

In the proposed rule, we also noted that ASP data are unavailable for some drugs and biologicals. For the few drugs and biologicals, other than radiopharmaceuticals as discussed later, where ASP data were unavailable, we proposed to use the mean costs from the CY 2004 hospital claims data to determine their packaging status for rate-setting. Until we received ASP data for these items, we proposed that payment would be based on their mean cost.

Our proposal used payment rates based on ASP data from the fourth quarter of CY 2004 because these were the most recent numbers available to us during the development of the proposed rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we stated in our proposed rule (70 FR 42726) that we planned to make any appropriate adjustments to the amounts shown in Addenda A and B to the proposed rule for these items based on more recent ASP data from the second quarter of CY 2005, which is the basis for setting payment rates for drugs and biologicals in the physician office setting effective October 1, 2005, prior to our publication of the CY 2006 OPPS final rule, and also on a quarterly basis on our Web site during CY 2006. We noted that we would determine the packaging status of each drug or biological only once during the year during the update process. However, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis.

We also noted that we intend for the quarterly updates of the ASP-based payment rates for separately payable drugs and biologicals to function as future surveys of hospital acquisition cost data, as section 1833(t)(14)(D)(ii) of the Act instructs us to conduct periodic subsequent surveys to determine hospital acquisition cost for each specified covered outpatient drug.

We specifically requested comments on our proposal to pay for drugs and biologicals (including contrast agents) under the OPPS using the ASP-based methodology that is also used to set the payment rates for drugs and biologicals furnished in physician offices and the adequacy of the payment rates to account for hospital acquisition costs of the drugs and biologicals.

During the August 2005 meeting of the APC Panel, the Panel recommended that CMS evaluate all the separately payable drug to be paid at ASP+6 percent under the OPPS and pay particular attention to those whose payments would drop or rise precipitously. We appreciate the Panel's support of our payment proposal and discuss the final CY 2006 policies for drugs and biologicals below.

We received many public comments in response to our proposal to pay for drugs and biologicals under the OPPS using the ASP methodology.

Comment: Many commenters, including national organizations representing leading pharmaceutical and biotechnology companies, hospital associations, and hospitals, supported CMS' proposal to pay for most separately payable drugs and biologicals at ASP+6 percent. These commenters stated that paying for drugs and biologicals at this rate appeared to be both a reasonable and the best available estimate of average hospital acquisition cost. One commenter stated that ASPs reported by manufacturers are as close to real-time costs as any data source CMS uses for rate-setting. Some of the commenters indicated that this policy offered hospitals the assurance that the payment rates will reflect market conditions as those rates will be updated on a quarterly basis. Other supporters of this proposal noted that the policy had the additional benefit of providing consistent payment rates under the OPPS and under Part B in the physician office setting, thus helping to avoid financial incentives for selection of sites of service. One commenter indicated that the proposed policy also offered simplicity to the OPPS, both for CMS and providers, by treating almost all separately paid drugs uniformly and noted that paying for pass-through drugs the same way as other separately payable drugs without pass-through status created appropriate incentives to provide the most effective therapies, regardless of their costs and payment amounts.

A comment from MedPAC acknowledged the problems presented by the GAO purchase price information and recognized the use of ASP data as a viable alternative. However, MedPAC indicated that a limitation of ASP data is that CMS derives ASPs from manufacturers' sales to all distribution channels, including wholesalers, group purchasing organizations, hospitals, and other providers such as physicians. Therefore, the ASPs do not specifically reflect hospital acquisition costs. Furthermore, MedPAC indicated that reporting may not be consistent across manufacturers, and CMS may need to verify the accuracy of ASP data through confidential audits. Although MedPAC stated that it supports CMS' proposed use of ASPs, it remained concerned about the proposal to pay for most specified covered outpatient drugs at a rate of ASP+8 percent, specifically ASP+6 percent for the drug and an additional 2 percent for handling costs. MedPAC noted that CMS' analysis of hospitals' mean purchase prices for drugs studied in the GAO survey indicated that the hospitals' mean purchase prices were equivalent to ASP+3 percent. Given that average ASP values have declined in recent quarters and that the GAO's data did not fully reflect rebates, MedPAC stated that the proposed payment rates for drugs alone may be too high.

Several commenters, however, remained concerned that this proposal will result in significant reductions in payments below acquisition costs for certain types of drugs and biologicals, such as IVIG and drugs and biologicals used to treat rare disorders, and was inadequate to protect beneficiary access to these therapies. One commenter indicated that payments increased to ASP+8 percent also resulted in compensation below acquisition costs for certain products. Many of these commenters urged CMS to monitor patient access problems and take prompt steps to adjust payment rates where necessary to address such problems. Several commenters requested that CMS implement the APC Panel's recommendation to monitor for ''precipitous'' drops in payment rates during the transition to ASP-based payments and apply a dampening policy to the payment rates for certain drugs and biologicals. Several dampening options were suggested, such as limiting payment decreases to 15 percent from CY 2005, paying at the higher of ASP+8 percent or 90 percent of drugs' CY 2005 payment rates, and freezing payment at the CY 2005 levels. One commenter recommended that no change be made to the payment rates for drugs and biologicals from CY 2005 to CY 2006. Another commenter urged CMS to gather data on the adequacy of ASP payment over the next year and report to Congress if the agency finds that ASP is not an appropriate payment formula.

A comment from a large cancer care provider raised several issues concerning the use of ASPs. The commenter noted that the prices and discounts included in the calculation of

ASP often are not passed along to providers. The commenter added that small hospitals without purchasing power are likely to purchase drugs above ASP rates. In addition, the commenter noted that because manufacturers typically raise prices two to three times per year, the two-quarter lag in the calculation of ASP may cause hospitals to suffer losses each time they administer drugs. Another commenter questioned whether ASP could be calculated regionally instead of nationally. One commenter noted that CMS did not make clear in the proposed rule what data will be used to establish payment rates for separately payable drugs and biologicals as of January 1, 2006. The commenter indicated that ASP data for the third quarter of CY 2005 will be available on October 30, 2005 and requested that these data be used to set payment rates for the first quarter of CY 2006.

Response: We appreciate the commenters' support of our proposal to pay for separately payable drugs and biologicals at ASP+6 percent. For this final rule with comment period, we again evaluated the three data sources that we have available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the proposed rule, these data sources are the GAO reported average and median purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004; ASP data; and mean and median costs derived from hospital claims data used for this final rule with comment period. For this final rule with comment period, we are able to use updated ASP data from the second quarter of CY 2005, which are used to set payment rates for drugs and biologicals in the physician office setting effective October 1, 2005. We are also able to use updated claims data, reflecting all of the hospital claims data from CY 2004 and updated CCRs.

In our data analysis for this final rule with comment period, we again compared the payment rates for drugs and biologicals using data from all three sources described above. As described in the proposed rule, we limited our analysis to the mean costs of drugs and biologicals determined using the GAO acquisition cost survey and the hospital claims data, instead of using median costs. We estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results based on updated ASP and claims data are presented in Table 24 below.

TABLE 24.—COMPARISON OF RELATIVE PRICING FOR OPPS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES

Type of pricing data	Time period of pricing data	ASP equivalent (55 GAO drugs only)	ASP equivalent (all separately billable drugs)
GAO mean purchase price	12 months ending June 2004	ASP+4%	N/A
ASP+6%	2nd quarter of 2005	ASP+6%	ASP+6%
Mean cost from claims data	12 months of 2004	ASP+6%	ASP+6%

Prior to any adjustments for the differing time periods of the pricing data, the results indicated that using the GAO mean purchase prices as the basis for paying the 55 drugs and biologicals would be equivalent to paying for those drugs and biologicals, on average, at ASP+4 percent. In addition, using mean unit cost from hospital claims to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. We note that these levels are slightly different from the estimates we determined for the proposed rule, where the GAO data were equivalent to ASP+3 percent and mean costs derived from the CY 2004 claims data were equivalent to ASP+8 percent, on average. (See Table 22 of the CY 2006 OPPS proposed rule, 70 FR 42725).

We understand the concerns raised by commenters about the reductions in payment rates for certain drugs and biologicals with the transition from an AWP-based methodology to an ASP-based methodology. However, our intent is to pay for drugs and biologicals based on their hospital acquisition costs, and we believe that market-based ASP data, which are reported by the manufacturers, better represent these costs than dampened payment rates. We also note that commenters did not present actual evidence demonstrating that access problems currently exist for some of these products. They presented anecdotal reports and results based on surveys that we can not validate. Therefore, we believe that it is still appropriate for us to base payment for these items on the ASP data.

As noted earlier and in the proposed rule, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. Therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as well as their related pharmacy overhead costs. Our calculations indicated that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on the ASP+6 percent, on average. This result also seems to confirm MedPAC's comment that paying for the acquisition cost of drugs alone at ASP+6 percent may be too high. Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, our current data therefore indicate that payment for drugs and biologicals and pharmacy overhead at a combined ASP+6 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products.

Therefore, in this final rule with comment period for CY 2006, we are adopting a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+6 percent. In other words, payment at ASP+6 percent will serve as a proxy to make

appropriate payment for both the acquisition cost and overhead cost of each of these products. We discuss in additional detail our responses regarding payments for pharmacy overhead costs later in the preamble.

As noted in the proposed rule, ASP data are unavailable for some drugs and biologicals. For these few drugs and biologicals, we used the mean costs from the CY 2004 hospital claims data to determine their packaging status for rate-setting. Until we receive ASP data for these items, payment will be based on their mean cost calculated from CY 2004 hospital claims data. The payment rates for separately payable drugs and biologicals shown in Addenda A and B to this final rule with comment period represent payments for their acquisition costs in addition to their overhead costs.

For this final rule with comment period, we are using payment rates based on ASP data from the second quarter of CY 2005 because these are the most recent numbers available for the development of this final rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available and post the payment rate changes on our Web site during each quarter of CY 2006. Effective January 1, 2006, we will base payment rates for separately payable drugs and biologicals on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. We discussed in the proposed rule that we would determine the packaging status of each drug or biological only once during the year during the update process; however, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis. Specifically, for CY 2006, the packaging status of each drug or biological has been established using the ASP data from the second quarter of CY 2005 and the appropriate packaging status indicator can be found for these items in Addendum B of this final rule with comment period. During CY 2006, we will only update quarterly the payment rates for the separately payable drugs and biologicals whose payments are based on the ASP methodology.

Comment: One commenter requested that CMS standardize the HCPCS code descriptions in Addendum B, so that the drug names appear first (and can be sorted alphabetically), rather than using ''injection'' as the first word. The commenter also sought clarification on the dosage sizes of several HCPCS codes and identified HCPCS codes for drugs that the commenters believed are obsolete.

Response: We note that the HCPCS code descriptions in Addendum B of our final rule with comment period are based on the short descriptors assigned to the HCPCS codes by the National HCPCS Panel. The National HCPCS Panel also determines the units associated with the HCPCS codes. We suggest that the commenter pursue its concerns related to the HCPCS codes through the process set up by the National HCPCS Panel.

Comment: One commenter indicated that there are currently five sodium hyaluronate products approved for use in the United Stated that differ in terms of molecular weights, proposed biological effects, active ingredient doses per treatment, number of treatments per course, and labeling for repeated treatment courses. Because of the existing coding mechanism for these products, the commenter noted that the proposed payment rates associated with the HCPCS codes may create financial incentives for hospitals to stock and use certain products instead of choosing products based on clinical judgment and appropriate treatment for patients. The commenter expressed the belief that the dosing differences among these agents warrant the creation of specific codes for each single source product and has submitted recommendations to CMS for specific coding and nomenclature for adoption in CY 2006.

Response: We recognize the commenter's concerns about payment for these sodium hyaluronate products under the OPPS. As noted earlier, the National HCPCS Panel has created HCPCS code J7318 (Hyaluron/derive intra-art inj) to describe all of the sodium hyaluronate products effective January 1, 2006. The payment rate for HCPCS code J7318 in CY 2006 will be established using the ASP data for all of the products described by this code. HCPCS code J7318 will be used in the OPPS during CY 2006 to report the administration of all products described by that code that do no have another OPPS-specific code available due to their pass-through status.

Comment: We received many comments on the significant proposed reduction in payment rates from CY 2005 to CY 2006 for several wound care products. The products of concern are Apligraf, Dermagraft, and Orcel, which are reported by HCPCS codes C1305, C9201, and C9200 respectively under the OPPS in CY 2005. Commenters indicated that the proposed CY 2006 payment rates for the acquisition and overhead costs of all three of these products were incorrectly based on the CY 2004 claims data, instead of ASP+8 percent as proposed for other separately payable drugs and biologicals, and they were very concerned that decreased payments will significantly underpay hospitals and jeopardize patient access to these therapies. One of the commenters stated that CMS based payment for Apligraf on mean costs derived from the CY 2004 claims data because there had been no ASP payment rate specific to HCPCS code C1305 and noted that the ASP rate for Apligraf is reported by CMS in the physician office setting under HCPCS code J7340. Other commenters raised similar concerns for Dermagraft whose ASP rate is reported in the physician office setting under HCPCS code J7342, instead of HCPCS code C9201. With respect to Orcel, one commenter stated that this product was not commercially available during CY 2004 and, as a result, neither ASP data nor hospital outpatient claims data should have existed for the product. The commenter recommended that, in the absence of either claims or ASP data, CMS should follow its payment policy for drugs and biologicals that do not have ASP data and establish the payment rate for Orcel using WAC. If WAC was not available, then CMS should set payment for Orcel at 95 percent of the May 1, 2003 AWP.

Response: We recognize the commenters' concerns about the proposed reduction in payment rates for these wound care products in CY 2006. The commenters were correct in stating that we based the payment rates for these items on their mean costs derived from the CY 2004 claims data in the proposed rule because we believed that we did not have any ASP data for these C-codes. We appreciate the commenters indicating to us that HCPCS codes C1305 and C9201 are billed using HCPCS codes J7340 and J7342, respectively, in the physician office, and the ASP data submitted for these products were associated with their permanent J-codes.

For this final rule with comment period, we reviewed the NDCs for which ASP data from the second quarter of CY 2005 were reported under HCPCS codes J7340 and J7342, and verified that these NDCs included Apligraf and Dermagraft products, respectively. Therefore, for CY 2006, we will be deleting the HCPCS code C1305 for Apligraf and HCPCS code C9201 for Dermagraft and paying for these

products using the ASPs calculated for HCPCS codes J7340 and J7342, respectively. As one of the commenters noted, ASP data are not available currently for HCPCS code C9200, which describes Orcel. Based on our review of the descriptor for HCPCS code J7340, we determined that this code appropriately describes Orcel; therefore, we will be deleting HCPCS code C9200 and paying for this product using HCPCS code J7340. Even though the calculation of the ASP-based payment rate for HCPCS code J7340 does not currently account for the ASP of Orcel, we believe that it is still appropriate for us to pay for Orcel using HCPCS code J7340 since this code appropriately describes this product. Also, once Orcel becomes available in the market and we receive ASP data for this product, the ASP-based payment rate for HCPCS code J7340 will properly reflect the market price for Orcel. We believe that this coding policy will lessen confusion for providers, enhance coding consistency between the OPPS and physician offices, and result in appropriate payment rates for these three wound care products in CY 2006.

In addition to reviewing whether permanent HCPCS codes duplicate the three temporary C-codes describing wound care products in the CY 2005 OPPS, we also reviewed whether there are permanent HCPCS codes that currently exist or will be created in CY 2006 that describe the other C-codes for drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS in CY 2005 to determine if we could streamline coding for other items as well. Based on our review, we found that there are several C-codes for drugs, biologicals, and radiopharmaceuticals that are payable under OPPS in CY 2005 that will be replaced with new permanent HCPCS codes in CY 2006. We also found that there are some C-codes that are also described by other permanent HCPCS codes that existed in CY 2005. In cases where it is appropriate to do so, we are deleting these C-codes and replacing them with new CY 2006 HCPCS codes or existing HCPCS codes that appropriately describe products currently coded in the OPPS by the C-codes. As discussed later in the preamble, we are also deleting the C-codes that were created to represent the innovator multiple source (brand) drugs and instructing hospitals to use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug in CY 2006. Table 25 lists the C-codes that we are deleting effective December 31, 2005 and the permanent HCPCS codes that will be replacing them in CY 2006. For services furnished on or after January 1, 2006, hospitals should use replacements codes to bill for the products whose C-codes will be deleted on December 31, 2005.

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Table 25.--List of C-codes That Will Be deleted on December 31, 2005 and Their CY 2006 Replacement Codes

CY 2005 HCPCS Code	CY 2005 HCPCS Description	CY 2006 Replacement HCPCS Code(s)	CY 2006 HCPCS Description
C1079	CO 57/58 per 0.5 uCi	A9546	Co57/58
C1080	I-131 tositumomab, dx	A9544	I131 tositumomab, dx
C1081	I-131 tositumomab, tx	A9545	I131 tositumomab, rx
C1082	In-111 ibritumomab tiuxetan	A9542	In111 ibritumomab, dx
C1083	Yttrium 90 ibritumomab tiuxe	A9543	Y90 ibritumomab, rx
C1091	IN111 oxyquinoline,per0.5mCi	A9547	In111 oxyquinoline
C1092	IN 111 pentetate per 0.5 mCi	A9548	In111 pentetate
C1093	TC99M fanolesomab	A9566	Tc99m fanolesomab
C1122	Tc 99M ARCITUMOMAB PER VIAL	A9549	Tc99m arcitumomab
C1200	TC 99M Sodium Glucoheptonat	A9550	Tc99m gluceptate
C1201	TC 99M SUCCIMER, PER Vial	A9551	Tc99m succimer
C1305	Apligraf	J7340	Metabolic active D/E tissue
C1775	FDG, per dose (4-40 mCi/ml)	A9552	F18 fdg
C9000	Na chromateCr51, per 0.25mCi	A9553	Cr51 chromate
C9007	Baclofen Intrathecal kit-1am	J0476	Baclofen intrathecal trial
C9008	Baclofen Refill Kit-500mcg	J0475	Baclofen 10 MG injection
C9009	Baclofen Refill Kit-2000mcg	J0475	Baclofen 10 MG injection
C9013	Co 57 cobaltous chloride	A9559	Co57 cyano
C9102	51 Na Chromate, 50mCi	A9553	Cr51 chromate
C9103	Na Iothalamate I-125, 10 uCi	A9554	I125 iothalamate, dx
C9105	Hep B imm glob, per 1 ml	90371	Hep b ig, im
C9112	Perflutren lipid micro,	Q9957	Inj perflutren lip

CY 2005 HCPCS Code	CY 2005 HCPCS Description	CY 2006 Replacement HCPCS Code(s)	CY 2006 HCPCS Description
	2ml		micros,ml
C9123	Transcyte, per 247 sq cm	J7344	Nonmetabolic active tissue
C9127	Paclitaxel protein pr	J9264	Paclitaxel injection
C9128	Inj pegaptanib sodium	J2503	Pegaptanib sodium injection
C9129	Inj clofarabine	J9027	Clofarabine injection
C9200	Orcel, per 36 cm2	J7340	Metabolic active D/E tissue
C9201	Dermagraft, per 37.5 sq cm	J7342	Metabolically active tissue
C9202	Octafluoropropane	Q9956	Inj octafluoropropane mic,ml
C9203	Perflexane lipid micro	Q9955	Inj perflexane lip micros,ml
C9205	Oxaliplatin	J9263	Oxaliplatin
C9206	Integra, per cm2	J7343	Nonmetabolic act d/e tissue
C9211	Inj, alefacept, IV	J0215	Alefacept
C9212	Inj, alefacept, IM	J0215	Alefacept
C9218	Injection, azacitidine	J9025	Azacitidine injection
C9223	Inj adenosine, tx dx	J0150	Injection adenosine 6 MG
C9223	Inj adenosine, tx dx	J0152	Adenosine injection
C9226	Ziconotide intrathecal inf	J2278	Ziconotide injection
C9400	Thallous chloride, brand	A9505	TL201 thallium
C9401	Strontium-89 chloride,brand	A9600	Sr89 strontium
C9402	Th I131 so iodide cap, brand	A9517	Th I131 so iodide cap millic
C9403	Dx I131 so iodide cap, brand	A9528	Iodine I-131 iodide cap, dx
C9404	Dx I131 so iodide sol, brand	A9529	I131 iodide sol, dx
C9405	Th I131 so iodide sol, brand	A9530	I131 iodide sol, rx
C9410	Dexrazoxane HCl inj, brand	J1190	Dexrazoxane HCl injection
C9411	Pamidronate disodium, brand	J2430	Pamidronate disodium /30 MG

CY 2005 HCPCS Code	CY 2005 HCPCS Description	CY 2006 Replacement HCPCS Code(s)	CY 2006 HCPCS Description
C9413	Na hyaluronate bran	J7317	Sodium hyaluronate injection
C9414	Etoposide oral, brand	J8560	Etoposide oral 50 MG
C9415	Doxorubic hcl chemo, brand	J9000	Doxorubic hcl 10 MG vl chemo
C9417	Bleomycin sulfate inj, brand	J9040	Bleomycin sulfate injection
C9418	Cisplatin inj, brand	J9060	Cisplatin 10 MG injection
C9419	Inj cladribine, brand	J9065	Inj cladribine per 1 MG
C9420	Cyclophosphamide inj, brand	J9070	Cyclophosphamide 100 MG inj
C9421	Cyclophosphamide lyo, brand	J9093	Cyclophosphamide lyophilized
C9422	Cytarabine hcl inj, brand	J9100	Cytarabine hcl 100 MG inj
C9423	Dacarbazine inj, brand	J9130	Dacarbazine 100 mg inj
C9424	Daunorubicin, brand	J9150	Daunorubicin
C9425	Etoposide inj, brand	J9181	Etoposide 10 MG inj
C9426	Floxuridine inj, brand	J9200	Floxuridine injection
C9427	Ifosfomide inj, brand	J9208	Ifosfomide injection
C9428	Mesna injection, brand	J9209	Mesna injection
C9429	Idarubicin hcl inj, brand	J9211	Idarubicin hcl injection
C9430	Leuprolide acetate bran	J9218	Leuprolide acetate injeciton
C9431	Paclitaxel inj, brand	J9265	Paclitaxel injection
C9432	Mitomycin inj, brand	J9280	Mitomycin 5 MG inj
C9433	Thiotepa inj, brand	J9340	Thiotepa injection
C9435	Gonadorelin hydroch, brand	J1620	Gonadorelin hydroch/ 100 mcg
C9436	Azathioprine parenteral,brnd	J7501	Azathioprine parenteral
C9437	Carmus bischl nitro inj	J9050	Carmus bischl nitro inj
C9438	Cyclosporine oral, brand	J7502	Cyclosporine oral 100 mg
C9439	Diethylstilbestrol injection	J9165	Diethylstilbestrol injection
C9440	Vinorelbine tar,brand	J9390	Vinorelbine tartrate/10 mg

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Comment: One commenter noted that CMS should confirm that payment for echocardiography contrast agents will be based on ASP+6 percent plus an appropriate amount to reflect handling (no less than two percent) so that payment for these items is consistent with all other separately payable drugs under OPPS. A few commenters indicated that CMS should implement the new HCPCS codes for echocardiography contrast agents, which will be effective January 1, 2006, to facilitate uniform billing for all echocardiography contrast agents across all sites of service.

Response: In CY 2005, echocardiography contrast agents are

described by three C-codes, which are HCPCS code C9112 (Perflutren lipid micro, 2ml), HCPCS code C9202 (Octafluoropropane), and HCPCS code C9203 (Perflexane lipid micro). In the proposed rule, we proposed to deleted these C-codes and pay for the products using Q-codes in CY 2006. As noted in the previous response to comments, these three C-codes will be deleted as of December 31, 2005 and replaced with HCPCS codes Q9957, Q9956, and Q9955, respectively. Hospitals should use the new Q-codes in CY 2006 when billing for these echocardiography contrast agents. We also note we will be paying for the acquisition and overhead costs of these separately payable echocardiography contrast agents at a combined rate of ASP+6 percent in CY 2006.

Comment: We received many comments that expressed concerns about the proposed reductions in OPPS payment rates for intravenous immunoglobulin (IVIG) products. Commenters requested that CMS make special consideration in its payment for IVIG due to the current access problems facing patients that rely on this lifesaving therapy. Commenters indicated that payment at ASP+6 percent has not been adequate to permit the continued purchase and administration of IVIG in physician offices, infusion suites, and home care settings, resulting in a shift of care to hospitals. Consequently, hospitals have been overburdened by the increase in demand for IVIG, which has not been easily accessible. The commenters indicated that CMS' goal in setting payment rates for IVIG should be to ensure that patients have access to all brands of IVIG in all sites of care. Commenters requested that CMS use any and all authority and flexibility to address the existing payment problems that will arise if the proposed OPPS payment rates for IVIG are implemented and recommended several actions. In order of priority, commenters' recommendations were to: (1) Provide a proxy add-on payment rate for IVIG when determining the CY 2006 payment levels; (2) in the absence of a proxy add-on, apply the 15-percent dampening provision proposed for device-dependent APCs to determine the CY 2006 payment rates for IVIG; (3) establish unique HCPCS codes for each brand of IVIG and set their payment rates on the ASP data specific to each product; (4) classify IVIG as a biologic response modifier and pay its administration through a high complexity intravenous infusion APC; and (5) exclude prompt pay discounts when calculating the ASPs for the IVIG HCPCS codes and equalize the lag time between the ASP reporting by manufacturers and CMS' posting of the ASP-based payment rates for the OPPS and Part B physician office payment rates. One commenter urged CMS to revert to the original J-codes for IVIG (J1563 and J1564) and maintain the CY 2005 payment rates. Other commenters suggested that, at minimum, CMS should continue payment for IVIG at the CY 2005 payment rates of 83 percent of AWP for 2 years, during which time CMS, consulting with Congress, manufacturers, distributors, providers, and patient groups, should conduct a study to determine the best payment methodology for IVIG with the goal of ensuring access to IVIG and continuity of care in all practice settings.

Response: As discussed earlier, we believe that ASP data are reflective of present hospital acquisition costs for separately payable drugs and biologicals under the OPPS. We believe this to be true for IVIG as well. We therefore cannot agree that it is appropriate to make adjustments to the payment rates for IVIG based on past prices, as we have more current ASP data available that reflect current market pricing for all of the brands of IVIG.

With respect to establishing brand-specific HCPCS codes for the different IVIG products, we note that the procedures for HCPCS coding specifically reject brand-specific coding, and we do not see a compelling reason to override that standard. For further discussion of HCPCS coding, see *http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp.* Finally, we note that in CY 2006 the OPPS and physician offices will both be paid based on the most recently available quarter's ASP data, with implementation of payment rate changes in both systems on the same date. As noted earlier, effective January 1, 2006 we will base payment rates for all separately payable drugs and biologicals under the OPPS on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. After considering these factors, we are finalizing our proposal to pay for IVIG under the OPPS at ASP+6 percent for CY 2006, the same payment rate as in the physician office setting.

We will, however, continue to work with the IVIG community, manufacturers, Congress, and other entities to seek better understanding of the supply and market issues influencing the current IVIG environment. We have discussed the accuracy of the ASP data with the manufacturers and have been assured by these manufacturers that their ASPs have been developed in accordance with applicable guidance and that the resulting price reflects the current IVIG market. At the same time, the IVIG manufacturers' association, the Plasma Protein Therapeutics Association, reports that the overall supply of IVIG is adequate and has improved in the past several months. However, based on the comments received and our ongoing work with manufacturers, patient groups, and other stakeholders, we continue to be concerned about CY 2005 reports of patients experiencing difficulties in accessing timely IVIG treatments and reports of providers experiencing difficulties in obtaining adequate amounts of IVIG products on a consistent basis to meet their patients' needs in the current marketplace. Most brands of IVIG have been put on allocation by manufacturers, and some manufacturers have reported allocating products to a smaller number of distributors and reducing the size of inventories. In addition, there have been reports of diversion of products to the secondary market and secondary distributors raising prices markedly. The Secretary's Advisory Committee on Blood Safety and Availability has recommended immediate steps be taken to ensure access to IVIG so that patients' needs are being met. However, the complexity of the IVIG marketplace makes it unclear what particular systematic approaches would be most effective in addressing the many individual circumstances that have been shared with us while not exacerbating what appears to be a temporary disruption in the marketplace.

IVIG is a complicated biological product that is purified from human plasma obtained from human plasma donors. Its purification is a complex process that occurs along a very long timeline, and only a small number of manufacturers provide commercially available products. Historically, numerous factors, including decreased manufacturing capacity, increased usage, more sophisticated processing steps, and low demand for byproducts from IVIG fractionation have affected the supply of IVIG. For CY 2006, there are two HCPCS codes that describe all IVIG products, based on their lyophilized versus liquid preparation.

The recent patterns of utilization of IVIG also are unusual in comparison with most other drugs and biologicals. Different IVIG products are FDA-approved in a number of therapeutic areas for various specific conditions, which include: Anti-infective therapy (bone marrow transplant); immune

globulin replacement therapy (primary immune deficiencies and chronic lymphocytic leukemia); anti-inflammatory therapy (Kawasaki disease); and immunomodulation therapy (idiopathic thrombocytopenic purpura). IVIG therapy, which has been available for about 25 years, was initially reserved for the treatment of these FDA-approved indications. More recently, IVIG has been increasingly used off-label so that off-label uses now significantly exceed on-label uses. Many of these off-label uses are for autoimmune, neurological, or systemic inflammatory conditions. Some off-label uses of IVIG are supported by a robust evidence base, while for other medical conditions the evidence has not demonstrated that IVIG infusions are of significant therapeutic benefit. In addition, despite the growing uses of IVIG there are definite risks associated with IVIG treatment, including both early inflammatory reactions and more rare but serious renal and thromboembolic complications, as well as the inherent risk associated with receipt of any biological product even with the ongoing improvements in the safety of these types of products.

Medicare currently has one national coverage determination in place since CY 2002 regarding IVIG infusions to treat autoimmune blistering diseases, and there are numerous local coverage policies that describe Medicare coverage for specific off-label indications. In the context of these national and local coverage policies, IVIG use in hospital outpatient departments has climbed steeply over the most recent years for which data are available, from about 40,000 infusion days in CY 2002, to 60,000 days in CY 2003, and again to over 70,000 days in CY 2004. The infusion of IVIG in physician offices increased from about 2.3 million grams in CY 2003 to 4.0 million grams in CY 2004. In the face of growing demand for IVIG in the absence of significant changes in the prevalence of medical conditions for which there is high quality evidence regarding the effectiveness of IVIG therapy, we are concerned that all patients with medical need for IVIG continue to have access to this expensive and valuable therapy. Over the upcoming year, we will be using our historical claims databases to study the epidemiology of IVIG treatment of Medicare beneficiaries in outpatient settings. We expect that the health system as a whole should encourage an accountable and scientifically grounded use of IVIG, and we welcome discussions with industry, providers, and other interested entities around efforts to ensure that IVIG is responsibly utilized for evidence-based clinical indications so that optimal benefit is obtained.

Based on the potential access concerns, the growing demand for IVIG, and the unique features of IVIG detailed above, as well as our move to an ASP payment methodology for IVIG in the OPPS for CY 2006, as we seek to gain improved understanding of the contemporary, volatile IVIG marketplace we will employ a two-pronged approach during CY 2006 to help ensure the availability of IVIG to physicians and hospital outpatient departments who care for Medicare beneficiaries and will be paid ASP+6 percent for the IVIG products.

First, in addition to ongoing monitoring and outreach activities within the Department of Health and Human Services, the Office of the Inspector General (OIG) is studying the availability and pricing of IVIG as part of its monitoring of market prices pursuant to section 1847A(d)(2)(A). We expect the OIG's work to provide a significant contribution to the analysis of the current situation with respect to the specific activities of manufacturers and distributors that may be contributing to possible access problems for IVIG as we move to the ASP payment methodology in both physician office and hospital outpatient settings. We hope to understand those particular market behaviors that may have led to such public alarm about the availability of IVIG and the adequacy of our payment rate of ASP+6 percent, concerns that have been particularly strong and persistent for IVIG in comparison with other drugs paid under the same ASP methodology.

Second, we will provide additional payment in CY 2006. Presently the IVIG marketplace is a dynamic one, where a significant portion of IVIG products previously available in CY 2005 are being discontinued and other products are expected to enter the market over the next year. In light of this temporary market instability, we understand that manufacturers have continued allocation procedures aimed at stabilizing the supply of IVIG. Even so, we understand that providers may face purchasing whichever brand of IVIG is available, even if it is not a brand the patient is known to tolerate. Many patients treated with IVIG receive regular infusions on a predictable schedule. To meet this need, hospital staff must conduct significant preadministration services prior to IVIG infusions to monitor and manage their inventory, locate available IVIG products, reschedule infusions according to product availability and patients' needs, and implement physicians' determinations regarding whether the available formulations are appropriate for patients and whether specific dosing adjustments are required. Product-specific factors must be evaluated in light of patients' clinical indications for the IVIG infusions, their underlying medical conditions, and their past reactions to various IVIG products, and hospital staff must locate appropriate doses of IVIG products in light of these considerations. If the appropriate IVIG product formulations were more widely and reliably available, we do not believe that routine IVIG infusions would require these extensive preadministration-related services prior to each infusion.

To continue to ensure appropriate patient access to IVIG in CY 2006 during this short-term period of market instability for IVIG, beginning for dates of service on or after January 1, 2006 through December 31, 2006, we will temporarily allow a separate payment to hospitals to reflect the additional resources that are associated with locating and acquiring adequate IVIG products and preparing for an outpatient hospital infusion of IVIG in the current environment. We expect that making separate payment for these additional necessary services will help insure that hospitals are able continue to provide IVIG infusions to their patients who depend upon them. We will also provide an additional payment to physician offices for these special services, to ensure that patients continue to have access to IVIG infusions in the most medically appropriate settings, without undesirable shifts in sites of service for their care.

Because the extra hospital resources currently associated with the preadministration-related services for intravenous infusion of immunoglobulin are not accounted for in the CY 2004 hospital claims data used to establish payments rates for the CY 2006 drug administration HCPCS codes that will be billed for IVIG infusions, we are creating a temporary G-code to describe these additional preadministration services related to the intravenous infusion of immunoglobulin. We have established the following G-code for hospital outpatient billing for CY 2006:

- G0332; Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter (This service is to be billed in conjunction with administration of immunoglobulin.)

Hospitals may bill this service once per day in association with a patient encounter for administration of IVIG, in addition to billing for the appropriate drug administration service(s) and for appropriate units of the HCPCS code that describes the IVIG product infused. In addition, hospitals may also bill for any significant and separately identifiable evaluation and management (E/M) service they perform at a level 2 through 5 in association with the infusion encounter, appending modifier –25 to the E/M service. We have established the payment level for this service in outpatient hospital departments by crosswalking it to the payment level established for the physician office for CY 2006. We believe that the hospital resources required for HCPCS code G0332 should be very similar to the practice expense for this service in the physician office, and, because no physician work is included in the physician office payment for the new service, the HCPCS code G0332 payment rates in physician office and hospital outpatient settings should be generally comparable. HCPCS code G0332 is a new service with no claims history under the OPPS and we cannot identify an appropriate clinical APC for its assignment based on considerations of clinical and resource homogeneity. Therefore, we are assigning HCPCS code G0332 to New Technology APC 1502 (status indicator ''S'') with a payment rate of $75 for CY 2006, based on a direct crosswalk to the New Technology APC that corresponds with the physician office CY 2006 payment of approximately $69.

We believe that this temporary separate payment provided through HCPCS code G0332 in CY 2006 for the physician office and hospital outpatient resources associated with additional IVIG preadministration-related services due to the present significant fluctuations in the IVIG marketplace will ensure that Medicare beneficiaries depending on IVIG experience no adverse health consequences from the market instability for IVIG products. In the meantime, we will continue to evaluate the market factors affecting the pricing and availability of IVIG products in the context of our ASP+6 percent payment methodology and our separate payment for HCPCS code G0332 in CY 2006. We expect that in CY 2006 with continued collection of updated ASP data for IVIG; improved understanding of the IVIG marketplace; more focused attention on the medical necessity of the utilization of IVIG; ongoing collaboration between CMS, the IVIG community, manufacturers, providers, and other interested entities; and this temporary separate payment for hospital and physician office resources required for the intensive preadministration services related to IVIG infusion, the IVIG marketplace will stabilize over the upcoming year. Substantial preadministration-related services for IVIG infusions should no longer be required of physician offices and hospital outpatient departments that provide IVIG infusions to patients who need them. Therefore, this additional payment for G0332 is effective for CY 2006 only. Thus, we will be closely monitoring this issue once again in the context of our rulemaking for CY 2007.

Comment: One commenter requested that CMS provide separate payment for all magnetic resonance imaging contrast agents, including imaging agents covered by HCPCS code Q9953.

Response: In CY 2006, the HCPCS codes that will be used to describe magnetic resonance imaging contrast agents are HCPCS codes Q9952 (Inj Gad-base MR contrast, ml), Q9953 (Inj Fe-based MR contrast, ml) and Q9954 (Oral MR contrast, 100 ml). In the proposed rule, we proposed to pay separately for HCPCS code Q9952 and HCPCS code Q9954; however, we proposed to package HCPCS code Q9953 because we were not able to estimate its per administration cost. For CY 2006, we will be paying separately for HCPCS code Q9952 and HCPCS code Q9954, as proposed. Additionally, we will provide separate payment for HCPCS code Q9953 since we have now determined its per day cost to be higher than $50 in this final rule with comment period.

Comment: One commenter indicated that WinRho SDF Liquid is a new intravenous gamma globulin product that recently received marketing clearance from the FDA, and that this product was created to replace the first generation therapy, WinRho SDF. The commenter noted that WinRho SDF Liquid does not require reconstitution, whereas WinRho SDF is a lyophilized product that requires reconstitution and is described by HCPCS code J2792. According to the commenter, if WinRho SDF Liquid is also assigned to HCPCS code J2792, then the OPPS payment in CY 2006 is likely to be below the acquisition cost of this new product. Therefore, the commenter requested that CMS establish separate codes to distinguish between the liquid and lyophilized forms of Rho D Immune Globulin.

Response: We recognize the commenter's concern about payment for this new intravenous gamma globulin product under the OPPS. The National HCPCS Panel coordinates decisions regarding the creation of permanent HCPCS codes; therefore, comments related to the HCPCS code creation process are outside the scope of this rule.

Comment: One commenter was concerned that where the ASP information does not exist, CMS will use the CY 2004 hospital claims data, and with drug cost increases averaging 5 to 10 percent over the past two years, the payments would not be enough to cover the costs of providing these drugs.

Response: We understand the commenter's concern. However, as we stated in the proposed rule, until ASP data are available for certain drugs and biologicals, their payment rates will be based on their mean costs derived from the CY 2004 claims data. We note that with respect to items for which we currently do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent. Therefore, we encourage the manufacturers of these drugs and biologicals to report their ASPs to CMS.

We received several public comments on the November 15, 2004 final rule with comment period concerning issues related to payment for drugs and biologicals in CY 2005. For those issues that have not already been addressed in other sections of this preamble, below is a summary of those comments and our responses.

Comment: One commenter stated that CMS incorrectly calculated a payment rate of $6.60 per cm2 for the product Integra described by HCPCS code C9206 (Collagen-Glycosaminoglycan Bilayer Matrix, per cm2) and that the payment rate was inappropriate in the OPPS setting. The commenter noted that Integra is provided in four sizes that are appropriate for different clinical needs and settings, and the payment rate set by CMS represented a single payment rate based on the cost of the largest package size used in the inpatient setting. The commenter recommended that either three additional and separate payment HCPCS codes be established for the different sizes, with payment rates established according to their different WACs, or that the payment rate for Integra be based on the costs of the smallest packaging sizes, which are the ones used in the hospital outpatient department. In addition, the commenter recommended that the unit descriptor for HCPCS code C9206 be changed to 25 cm2 so that it is consistent with the descriptors of the CPT codes used with this product and also so that it is convenient and easy to apply for

hospital personnel inputting codes on claim forms.

Response: Effective January 1, 2005, HCPCS code C9206 (Collagen-Glycosaminoglycan Bilayer Matrix, per cm2) was created to describe Integra. To accommodate the different package sizes that currently exist or may enter the market in the future, our policy is to create a HCPCS code descriptor based on the lowest possible dosage or size of the product; therefore, we assigned a unit of cm2 to HCPCS code C9206. The payment rate of $6.60 per cm2 for this biological was calculated using the standard methodology used to determine the payment rates for drugs and biologicals in the physician office setting, where for drugs and biologicals without an ASP, our methodology prescribes the use of the lesser of the median WAC for all sources of the generic forms of the product or the brand name product with the lowest WAC. Therefore, because Integra is a brand name product with four different package sizes and prices, we set the payment rate for HCPCS code C9206 at $6.60, which was the lowest WAC per cm2. This payment rate was in effect during the first quarter of CY 2005. We note that the payment rates for C9206 for the second quarter of CY 2005 and following quarters were based on 106 percent of its ASP, based on the ASP methodology for drugs furnished in the physician office setting on or after January 1, 2005. We note that for CY 2006, HCPCS code C9206 has been deleted and replaced with the permanent HCPCS code J7343.

Comment: One commenter requested that CMS revise the first quarter CY 2005 ASP rate for HCPCS code J0180 (Injection, agalsidase beta, 1 mg) from $121.12 to $121.14 because it believes that CMS made an error in the weighting of the different ASP figures provided to CMS for the two National Drug Codes for this product.

Response: The methodology used to establish the ASP-based payment rates for drugs and biologicals is discussed in the CY 2006 Medicare Physician Fee Schedule final rule. Therefore, we will not respond to this comment since it is outside the scope of this rule.

Comment: One commenter expressed concern about the creation of the new HCPCS code J3396 (Injection, verteporfin, 0.1 mg) in CY 2005 for verteporfin and the deletion of HCPCS code J3395 (Injection, verteporfin, 15 mg). The commenter stated that the new code will create confusion among providers and urged CMS to reinstate HCPCS code J3395 for use with verteporfin injections and/or to clarify and implement measures to ensure that the change to HCPCS code J3396 will not impact providers' ability to accurately bill for their use of this medication.

Response: Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are outside the scope of this rule.

In CY 2005, we applied an equitable adjustment to determine the payment rate for darbepoetin alfa (HCPCS code Q0137) pursuant to section 1833(t)(2)(E) of the Act. However, for CY 2006, we proposed to establish the payment rate for this biological using the ASP methodology. The ASP data represent market prices for this biological; therefore, we believe it is appropriate to use the ASP methodology to establish payment rates for darbepoetin alfa because this method will permit market forces to determine the appropriate payment for this biological. We specifically requested comments on the proposed payment policy for this biological.

We received several public comments on our proposal.

Comment: A number of commenters expressed concern about our proposal to establish payment for both epoetin alfa (marketed under the trade name of Procrit®) and darbepoetin alfa (marketed under the trade name of Aranesp®) using the ASP methodology. Several commenters urged CMS to implement this proposal so that a market-oriented, ASP-based payment system can function as the Pub.L. 108–173 intended without any arbitrary government interference. In addition, one of the commenters indicated that this policy would promote appropriate patient and physician choice in making health care decisions. One of the commenters supported the proposal to establish a payment rate for darbepoetin alfa using the ASP methodology and to discontinue application of an equitable adjustment to its payment rate. This commenter also stated that CMS accurately noted in the CY 2006 proposed rule that ''the ASP data represent market prices for this biological,'' and that using the ASP methodology to establish the CY 2006 OPPS payment rate for darbepoetin alfa ''will permit market forces to determine the appropriate payment for this biological.'' Therefore, the commenter reasoned that an equitable adjustment is not needed in CY 2006 since payments for all separately payable drugs and biologicals will be based on market prices. The commenter also provided clinical and economic data to further support CMS' proposal not to apply an equitable adjustment to the payment rate for darbepoetin alfa in CY 2006. For example, the commenter noted that new clinical data demonstrate that darbepoetin alfa and epoetin alfa achieve comparable clinical outcomes at comparably priced doses. By applying the proposed payment rates for doses of the two drugs based on current clinical guidelines and validated randomized controlled trials, the commenter concluded that overall Medicare and beneficiary spending would decrease for similar clinical outcomes with the use of darbepoetin alfa rather than epoetin alfa. In addition, the commenter highlighted that applying an equitable adjustment to the payment rate for darbepoetin alfa in CY 2006 would, in fact, increase Medicare and beneficiary spending on darbepoetin alfa. This commenter also recommended that if CMS plans to utilize its equitable adjustment authority again, then the conversion ratio should be increased to 400:1 to reflect the results of a new clinical study that proves the clinical comparability of darbepoetin alfa and epoetin alfa at such a dosing ratio.

One commenter on this topic also provided detailed results of clinical studies that the commenter believes provide a strong rationale for continuing the equitable payment adjustment for darbepoetin alfa and demonstrate that the appropriate conversion ratio for making this adjustment is less than or equal to 260:1. The commenter stated that Medicare and beneficiary spending for these two drugs under the proposed payment policy for CY 2006 will be higher in order to achieve comparable therapeutic effects unless CMS maintains the equitable adjustment policy and re-establishes a conversion ratio that is less than or equal to 260:1.

Response: We appreciate the many thoughtful and detailed comments on our proposed CY 2006 payment rates for darbepoetin alfa and epoetin alfa. Based on our ASP market price data from the second quarter of CY 2005 for these two drugs, we observed that the payment rates for epoetin alfa and darbepoetin alfa would decrease by similar levels in CY 2006 from their current CY 2005 payment rates. Payment for epoetin alfa would decrease by 17 percent and payment for darbepoetin alfa would decrease by 18 percent. In CY 2006, if we continued the CY 2005 equitable adjustment policy of determining the payment rate for darbepoetin alfa using a conversion ratio of 330 Units of epoetin alfa to 1 microgram of darbepoetin alfa (330:1), then the payment rate for darbepoetin alfa would decrease by 17 percent, the same rate of

change as that for epoetin alfa. Following the payment methodology described earlier for separately payable drugs and biologicals where payment for their acquisition and overhead costs would be equal to ASP+6 percent in CY 2006, the payment rate for epoetin alfa would be $9.22 per 1000 Units and the payment rate for darbepoetin alfa would be $3.01 per microgram. However, if we applied the CY 2005 conversion ratio of 330:1, the payment rate for darbepoetin alfa would be $3.04 per microgram.

In determining our payment policy for darbepoetin alfa in CY 2006, we reviewed the results of the many recent clinical studies that were provided in the comments. We independently assessed the methodological rigor of the study designs and the generalizability of the results of the various studies. This assessment included the appropriateness and comparability of the sizes and characteristics of the subject groups, the duration of the trials, the administered doses of the investigational agents, the drop out rates in the treatment arms, and the consideration of other possible causes of study bias. With the limitations of the studies supporting either an increase or a decrease in the conversion factor, the quality and quantity of the currently available published evidence do not provide sufficient, clear evidence to support a change in the appropriate conversion factor at this time. Methodological shortcomings included insufficient sample sizes, excessive dropout rates, inadequate study duration, and failure to adequately account for confounding effects. Some studies have yet to be published as full, peer-reviewed journal articles; abstracts do not provide sufficient detail for our review. Overall, the results of these clinical studies were not consistent or conclusive in defining a single, different conversion ratio for dosing between these two products, particularly with respect to the timing of specific doses of the two drugs required to achieve several different meaningful clinical outcomes. The results of contemporary clinical studies demonstrated that a wide range of conversion ratios could be considered, and these ratios varied by a factor of two or more depending on the specific study design, the measured clinical outcomes, and the treated patient populations. As we have noted above, the payment rate for darbepoetin alfa at ASP+6 percent ($3.01 per microgram) is slightly lower than but consistent with the payment rate for darbepoetin alfa using the 330:1 conversion ratio ($3.04 per microgram) that we established in CY 2005. This conversion ratio is also well within the range of the conversion ratios that may be supported by the available clinical data. We therefore do not believe that there is sufficient clinical evidence to indicate that we should specifically employ our equitable adjustment authority to adjust the payment rate for darbepoetin alfa in CY 2006. By finalizing this payment policy specifically for the CY 2006 OPPS, based on our latest payment rate analysis and independent review of the recent clinical literature, it is not our intention to preclude the use of a conversion ratio to establish the OPPS payment rates for epoetin alfa and darbepoetin alfa in the future. Rather, as long as the market price for darbepoetin alfa is consistent with a payment rate derived using a clinically appropriate conversion ratio, invoking our equitable adjustment authority would not lead to a different result. However, we retain our authority to apply an equitable adjustment in the future to determine the payment rate for darbepoetin alfa pursuant to section 1833(t)(2)(E) of the Act. We will once again assess the need to exercise this authority when we next update the payment rates under the OPPS based on the latest available clinical evidence on the appropriate conversion ratio and based on the actual pricing experience at that time.

Effective April 1, 2005, several HCPCS codes were created to describe various concentrations of low osmolar contrast material (LOCM). These new codes are HCPCS codes Q9945 through Q9951. However, in Transmittal 514 (April 2005 Update of the OPPS), we instructed hospitals to continue reporting LOCM in CY 2005 using the existing HCPCS codes A4644, A4645, and A4646 and made Q9945 through Q9951 not payable under the OPPS. For CY 2006, we proposed to activate the new Q-codes for hospitals and discontinue the use of HCPCS codes A4644 through A4646 for billing LOCM products. We have CY 2004 hospital claims data for HCPCS codes A4644 through A4646, which show that the mean costs per day for these products are greater than $50. Because we did not have CY 2004 hospital claims data for HCPCS codes Q9945 through Q9951, we crosswalked the cost data for the HCPCS A-codes to the new Q-codes. There is no predecessor code that crosswalks to HCPCS code Q9951 for LOCM with a concentration of 400 or greater mg/ml of iodine. Therefore, we proposed that our general payment policy of paying separately for new codes while hospital data are being collected would apply to HCPCS code Q9951. As our historical hospital mean per day costs for the three A-codes exceeded the packaging threshold and our payment policy for new codes without predecessors applied to one of the new codes, we proposed to pay for the HCPCS codes Q9945 through Q9951 separately in CY 2006 at payment rates calculated using the ASP methodology. We noted that because the new Q-codes describing LOCM were more descriptively discriminating and had different units than the previous A-codes for LOCM, as well as widely varying ASPs, we expected that the packaging status of these Q-codes might change in future years when we have specific OPPS claims data for these new codes. We specifically invited comments on our proposed policy to pay separately for LOCM described by HCPCS codes Q9945 through Q9951 in CY 2006.

We received several public comments in response to our request.

Comment: Several commenters supported CMS' proposal to pay separately for LOCM using HCPCS codes Q9945 through Q9951, indicating that this policy will help to protect beneficiary access to the most appropriate therapies. The commenters believed that this change would promote consistency across sites of services. A comment from a manufacturer of contrast agents expressed concern about the use of the new Q-codes for LOCM and the corresponding ASP payment methodology to determine their payment rates. The commenter noted that the proposed payment rates for the contrast media codes increase as the iodine or active material concentration decreases and believed that the coding tiers adopted by CMS do not appropriately categorize the various media products. The commenter was also concerned that such a payment scheme might be a perverse incentive for hospitals to use a lower concentration LOCM in diagnostic imaging procedures in order to qualify for higher payment rates or motivate clinically unnecessary and potentially dangerous switches in contrast media selections. The commenter recommended that CMS review whether an alternative payment mechanism would be more appropriate for LOCM and proposed a revised version of the Q-code classifications for LOCM.

Response: We appreciate the commenters' support of our proposal to implement new HCPCS codes for LOCM in CY 2006 and pay for them separately. In the final rule, the payment rates for these codes are based on their market prices from the second quarter of CY 2005, and we believe that the ASP-based

rates appropriately reflect the acquisition and pharmacy overhead costs of these products under each of the HCPCS codes. Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. We suggest that commenters who have concerns about the new Q-codes for LOCM should pursue appropriate changes through the process set up by the National HCPCS Panel to establish HCPCS codes.

(4) CY 2006 Proposed and Final Payment Policy for Radiopharmaceutical Agents

We do not have ASP data for radiopharmaceuticals. Therefore, for CY 2006, we proposed to calculate per day costs of radiopharmaceuticals using mean unit costs from the CY 2004 hospital claims data to determine the items' packaging status similar to the drugs and biologicals with no ASP data. In a separate report, the GAO provided CMS with hospital purchase price information for nine radiopharmaceuticals. As part of the GAO survey described earlier, the GAO surveyed 1,400 acute-care, Medicare-certified hospitals and requested hospitals to provide purchase prices for radiopharmaceuticals from July 1, 2003 to June 30, 2004. The radiopharmaceutical part of the survey yielded a response rate of 61 percent, where 808 hospitals provided usable information. The GAO reported the average and median purchase prices for nine radiopharmaceuticals for the period July 1, 2003, to June 30, 2004. These items represented 9 percent of the Medicare spending for specified covered outpatient drugs during the first 9 months of CY 2004. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations.

When we examined differences between the CY 2005 payment rates for these nine radiopharmaceutical and their GAO mean purchase prices, we found that the GAO purchase prices were substantially lower for several of these agents. We also found similar patterns when we compared the CY 2005 payment rates for radiopharmaceuticals with their CY 2004 median and mean costs from hospital claims data. In the proposed rule, we indicated that our intent was to maintain consistency, whenever possible, between the payment rates for these agents from CY 2005 to CY 2006, because such rapid reductions could adversely affect beneficiary access to services utilizing radiopharmaceuticals.

As we did not have ASPs for radiopharmaceuticals that best represent market prices, we proposed as a temporary 1-year policy for CY 2006 to pay for radiopharmaceuticals that were separately payable in CY 2006 based on the hospital's charge for each radiopharmaceutical agent adjusted to cost. As we noted in the proposed rule, MedPAC has indicated that hospitals currently include the charge for pharmacy overhead costs in their charge for the radiopharmaceutical. Therefore, we also noted in the proposed rule that paying for these items on the basis of charges converted to cost would be the best available proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost until we received ASP and overhead information on these agents. We noted that we expected hospitals' different purchasing and preparation and handling practices for radiopharmaceuticals to be reflected in their charges, which would be converted to costs using hospital-specific CCRs. To better identify the separately payable radiopharmaceuticals to which this policy would apply, we proposed to assign them to status indicator ''H.'' We specifically requested public comment on the proposed payment policy for separately payable radiopharmaceuticals in CY 2006.

We received many comments on this proposal.

Comment: Numerous commenters expressed concern about our proposal to pay for separately payable radiopharmaceuticals at hospitals' charges converted to cost in CY 2006. Most of the commenters generally supported the proposed payment methodology for radiopharmaceuticals in CY 2006. However, several of the commenters noted their belief that this methodology may trigger drastic decreases in the payment rates for certain items based on their review of hospital charge data for these agents. Some of the commenters urged CMS to consider refining the methodology for CY 2006 and offered several options. Several commenters recommended that CMS utilize hospital-specific overall CCRs, rather than departmental CCRs, indicating that overall CCRs were more reflective of hospitals' overall charges and that department-specific CCRs would fail to convert charges for radiopharmaceuticals to ''average'' acquisition costs, resulting in significantly lower payments than the CY 2005 levels. Some of the commenters expressed concern about the effect of cost compression using a CCR method, stating that the proposed methodology will result in underpayment for more expensive radiopharmaceuticals. The commenters noted that because hospitals do not tend to maintain a constant CCR, as radiopharmaceutical costs increase, the differences between actual costs and the CMS derived costs increase exponentially. One commenter suggested that CMS address this issue by establishing a national and unique CCR for radiopharmaceuticals during CY 2006, which could more accurately account for radiopharmaceutical handling and overhead costs, while a few other commenters recommended that CMS facilitate hospital reporting of accurate charges for radiopharmaceuticals by clarifying exactly which cost-to-charge ratio would apply to each hospital to calculate the hospital outpatient payment for radiopharmaceuticals in CY 2006. Another commenter suggested that CMS provide a template that hospitals may use to prepare their claims for radiopharmaceuticals, including handling and other costs, and provide instructions to fiscal intermediaries regarding the implementation of this policy. One of the commenters suggested that CMS recognize the general reasonable concern regarding using the hospital-specific overall cost-to-charge methodology for highly expensive radiopharmaceuticals, and identified 19 radiopharmaceuticals with hospital acquisition costs per patient study greater than $500, for which it recommended that CMS use external data to verify and pay based on invoice acquisition costs plus handling fees, or freeze the CY 2005 payment rates for these radiopharmaceuticals, or both. Other commenters suggested limiting decreases in payment rates for separately payable radiopharmaceuticals from CY 2005 to CY 2006, including (1) establishing a payment floor during CY 2006, based on an appropriate percentage of the CY 2005 payment rate for specific radiopharmaceuticals; (2) ensuring that the resultant payment rate for each product in CY 2006 does not fall below the level identified in the GAO data or, if GAO data were unavailable, that the payment not be less than 95 percent of the CY 2005 payment rate for the product; and (3) ensuring that payments for these products do not fall below 95 percent of their CY 2005 rates. One commenter, to the contrary, indicated that while the concerns of other commenters advocating a payment floor

under the proposed methodology for CY 2006 are understandable, CMS should not implement a floor in addition to implementing a CCR approach for payment. This commenter noted that there were variations in the cost data reported by hospitals in their charge reports, and it was important that hospitals, as well as manufacturers, be encouraged to report accurately to CMS and that setting an artificial payment floor reduces hospitals' incentives to do so. The commenter further stated that because the proposed policy already would provide hospitals with an opportunity to report charges accurately for each claim, there was no need for CMS to provide any additional safeguards to ensure sufficient payment and that hospitals would already have the ability to receive appropriate payment by reporting appropriate charges for these agents in their claims.

Lastly, several of the commenters indicated that CMS incorrectly stated that overhead costs for radiopharmaceuticals are included in the hospital charges for the radiopharmaceuticals. One commenter stated that some hospital costs associated with radiopharmaceutical purchase and use are captured in hospital charges. However, the preparation, distribution, administration, and safe disposal of radiopharmaceuticals, along with labor costs and necessary patient and hospital staff protection costs, are not uniformly and accurately reflected in hospital charges. These commenters urged CMS to provide hospital outpatient departments with clear guidance on the array of costs associated with radiopharmaceutical acquisition and handling that should be appropriately included in their charges for radiopharmaceuticals, so that payments and data in CY 2006 accurately reflect hospital acquisition and pharmacy overhead costs for each radiopharmaceutical. One commenter also noted that an additional payment for overhead and handling of radiopharmaceuticals should be made because these costs are not captured in charges for the radiopharmaceuticals.

Response: We appreciate the commenters' support of our proposed payment policy for separately payable radiopharmaceuticals in CY 2006. As recommended by several commenters, in this final rule with comment period, we are using hospital-specific overall CCRs to derive the costs of these items from the hospitals' reported charges. We acknowledge the commenters' concerns about the use of the CCRs resulting in cost compression. We believe that hospitals have the ability to set charges for items properly so that charges converted to costs can appropriately account fully for their acquisition and overhead costs. The specific payment rates for separately payable radiopharmaceuticals are not being determined on a prospective basis in CY 2006 because hospitals will receive a newly calculated payment for each claim submitted for a separately payable radiopharmaceutical, based on the specific radiopharmaceutical charge on that claim and the applicable overall hospital CCR. Therefore, if necessary we believe that hospitals can appropriately adjust their charges for radiopharmaceuticals so that the calculated costs properly reflect their actual costs. Specifically, it is appropriate for hospitals to set charges for these agents in CY 2006 based on all costs associated with the acquisition, preparation, and handling of these products so that their payments under the OPPS can accurately reflect all of the actual costs associated with providing these products to hospital outpatients. We believe that payment for these items using charges converted to costs will be the best available proxy for the average acquisition costs of the radiopharmaceuticals along with their handling costs and that no additional dampening based on historical payment rates is necessary to pay appropriately for radiopharmaceuticals. Therefore, for CY 2006, we are finalizing the proposed policy to pay for radiopharmaceuticals that are separately payable based on the hospital's charge for each radiopharmaceutical adjusted to cost. We note that we will not be indicating exactly which cost-to-charge ratio will apply to each hospital, as the fiscal intermediaries determine those values. We also note that we have never provided such information in previous years for pass-through devices and brachytherapy sources which are also paid under the same methodology. As indicated in the proposed rule, we are assigning all radiopharmaceuticals that will be separately payable in CY 2006, to which this policy will apply, status indicator ''H'' in Addendum B of this final rule with comment period.

Comment: A commenter indicated that the OPPS Final Rule should reflect the use of HCPCS code A9523, rather than HCPCS code C1083, to describe the imaging agent in the Zevalin therapeutic regimen in the event that the HCPCS Committee modifies the HCPCS descriptor of HCPCS code A9523 to reflect a per dose unit.

Response: We note that HCPCS codes C1083 and A9523 will be deleted on December 31, 2005 and replaced with the new HCPCS code A9543 (Yttrium Y–90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries) for services furnished on or after January 1, 2006.

Comment: One commenter recommended that HCPCS code G3001 (Administration and supply of tositumomab, 450 mg), currently applicable to both doses of the non-radioactive component of therapy and its administration, be amended to apply only to the non-radioactive component of the regimen. The commenter also recommended that hospitals should be allowed to use CPT code 90784 for the administration of the non-radioactive component of BEXXAR and HCPCS code G3001 to reflect the supply of tositumomab, thus allowing hospitals to identify the non-radioactive product accurately in their claims with a familiar product code and receive appropriate payment for the infusion of the product. Consequently, the commenter strongly urged CMS to retain HCPCS code G3001 as a product-only code, so that these facilities can continue to provide treatment to Medicare beneficiaries.

Response: As we had stated in the November 7, 2003 final rule with comment period for CY 2004 (68 FR 63443), unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but it is a supply that is required as part of the Bexxar treatment regimen. We do not make separate payment for supplies used in services provided under the OPPS. Payments for necessary supplies are packaged into payments for the separately payable services provided by the hospital. Administration of unlabeled tositumomab is a complete service that qualifies for separate payment under its own APC. This complete service is currently described by HCPCS code G3001. Therefore, we do not agree with the commenter's recommendation that we assign a separate code to the supply of unlabeled tositumomab. Rather, we will continue to make separate payment for the administration of tositumomab, and payment for the supply of unlabeled tositumomab is packaged into the administration payment.

Comment: One commenter suggested that CMS establish HCPCS descriptors based on ''per dose'' units for radiopharmaceuticals, indicating that such a policy would help facilitate a smoother transition as CMS moves to establish payments for radiopharmaceuticals based on average acquisition costs and pharmacy handling APCs.

Response: For CY 2006, the National HCPCS Panel has changed the

descriptors of many of the radiopharmaceutical product to indicate per dose units. The new CY 2006 HCPCS codes and their descriptors can be found on the HCPCS Web site at *http://www.cms.hhs.gov/medicare/hcpcs/*. The payment status indicators associated with these codes can be found in Addendum B of this final rule with comment period.

Comment: One commenter suggested that CMS require hospitals to report HCPCS codes and charges for all radiopharmaceuticals to facilitate accurate data collection and help ensure that the costs and charges of radiopharmaceuticals (as well as the associated handling costs) are considered in establishing payment rates under the OPPS. Another commenter commended CMS for clarification and education provided to hospitals regarding the importance of coding and reporting charges for radiopharmaceuticals and encouraged CMS to continue to remind hospitals to report charges regardless of N, K, or H status indicators assigned to the radiopharmaceuticals, as these charges have a key role in setting future APC rates and assignment of appropriate status indicators.

Response: We will continue to strongly encourage hospitals to report charges for all drugs, biologicals, and radiopharmaceuticals using the correct HCPCS codes for the items used, including the items that have packaged status in CY 2006. We agree with the commenters, that a robust set of claims for each packaged or separately payable item paid under the OPPS aids in obtaining the most accurate data for future packaging decisions and rate-setting. In the CY 2005 final rule, we noted that, with just a very few exceptions, hospitals appeared to be reporting charges for drugs, biologicals and radiopharmaceuticals using the existing HCPCS codes, even when such items had packaged status (69 FR 65811). Therefore, we do not believe it is necessary to institute a coding requirement for drugs, biologicals, and radiopharmaceuticals in CY 2006 as we are currently doing for device category codes required to be reported when used in procedures.

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician office setting where the fewer numbers (relative to the hospital outpatient setting) of radiopharmaceuticals are priced locally by Medicare contractors. However, the statute does not exempt radiopharmaceutical manufacturers from ASP reporting. We currently do not require reporting for radiopharmaceuticals because we do not pay for any of the radiopharmaceuticals using the ASP methodology. However, for CY 2006, we proposed to begin collecting ASP data on all radiopharmaceuticals for purposes of ASP-based payment of radiopharmaceuticals beginning in CY 2007.

As we had stated in the November 7, 2003 final rule with comment period for CY 2004 (68 FR 42728), in the CY 2006 proposed rule we recognized that there are significant complex issues surrounding the reporting of ASPs for radiopharmaceuticals. Most radiopharmaceuticals must be compounded from a ''cold kit'' containing necessary nonradioactive materials for the final product to which a radioisotope is added. There are critical timing issues, given the short half-lives of many radioisotopes used for diagnostic or therapeutic purposes. Significant variations in practices exist with respect to what entity purchases the constituents and who then compounds the radiopharmaceutical to develop a final product for administration to a patient. For example, manufacturers may sell the components of a radiopharmaceutical to independent radiopharmacies. These radiopharmacies may then sell unit or multi-doses to many hospitals. However, some hospitals also may purchase the components of the radiopharmaceutical and prepare the radiopharmaceutical themselves. In some cases, hospitals may generate the radioisotope on-site, rather than purchasing it. The costs associated with acquiring the radiopharmaceutical in these instances may vary significantly. In addition, there may only be manufacturer pricing for the components. However, the price set by the manufacturer for one component of a radiopharmaceutical may not directly translate into the acquisition cost of the ''complete'' radiopharmaceutical, which may result from the combination of several components. In general, for drugs other than radiopharmaceuticals, the products sold by manufacturers with National Drug Codes (NDCs) correspond directly with the HCPCS codes for the products administered to patients so ASPs may be directly calculated for the HCPCS codes. In the case of radiopharmaceuticals, this 1 to 1 relationship may not hold, potentially making the calculation of ASPs for radiopharmaceuticals more complex.

In addition, some hospitals may generate their own radioisotopes, which they then use for radiopharmaceutical compounding, and they may sell these complete products to other sites. The costs associated with this practice could be difficult to capture through ASP reporting. We invited very specific comments on these and all other relevant issues surrounding implementation of ASP reporting for radiopharmaceuticals.

We received numerous public comments on our proposal to begin collecting ASP data on all radiopharmaceuticals for purposes of ASP-based payment of radiopharmaceuticals beginning in CY 2007.

Comment: Many commenters provided detailed discussions of the policy, including practical and legal challenges related to our proposal to require ASP reporting for radiopharmaceuticals in CY 2006. Some of these commenters indicated that radiopharmaceuticals are formulated, distributed, compounded, and administered in unique distribution channels that preclude the determination of ASP relevant to a radiopharmaceutical HCPCS code by the manufacturer. Most radiopharmaceuticals are typically formed from two or more components. Thus, one manufacturer does not know if a hospital combining individual components to generate the end product, a patient dose, uses exclusively the manufacturer's raw materials, or instead combines raw materials from more than one manufacturer. In this case, the manufacturer has no way to calculate the ASP of the end product patient dose, as the manufacturer only knows the sales prices of its own components. Consequently, radiopharmaceutical manufacturers could not in good faith sign CMS required ASP-reporting certifications as they generally have no knowledge or access to end product unit prices. In addition, the components may be combined to generate a vial of radiopharmaceutical from which multiple patient doses can be drawn. Pricing for a patient unit dose would thus vary, depending on how many patient doses are drawn from a vial. Commenters also noted that a significant proportion of radiopharmaceuticals are sold as components to independent freestanding radiopharmacies or nuclear pharmacies. These radiopharmacies prepare patient unit doses, which are then purchased by hospitals. The manufacturer of the component may not know what the radiopharmacies' prices are for a final unit dose product, and may be precluded from accessing such information. Some of the commenters indicated that if ASP reporting were imposed, it might require reporting from

commercial radiopharmacies, entities that are currently not subject to ASP reporting.

Many commenters also questioned whether CMS has the legal authority to impose ASP reporting on radiopharmaceutical manufacturers and the authority to implement payment for radiopharmaceuticals based on ASP. They noted that Pub. L. 108–173 exempted radiopharmaceuticals from the ASP-based payment methodology in physician offices. One of the commenters stated that when Congress exempted radiopharmaceuticals from the Pub. L. 108–173 provision modifying Part B payments for drugs and biologicals furnished in the physician office setting, it did so because of the unique nature and complexities associated with radiopharmaceuticals rather than the unique nature of the physician office setting. Therefore, it was unlikely that Congress intended for CMS to collect ASP data for radiopharmaceuticals that would be precluded from use in a Part B radiopharmaceutical payment methodology.

Most of the commenters agreed that the variability and complexities associated with radiopharmaceuticals and their preparation make uniform application of the ASP processes to products virtually impossible for CMS. One commenter believed that it may be appropriate to pay hospitals for therapeutic radioimmunotherapies based on the same calculation for ASP as used for physician-administered pharmaceuticals. However, this commenter did not provide an opinion on the applicability of the ASP methodology for diagnostic radiopharmaceuticals. Another commenter suggested that ASP data could be adapted to the unique features of radiopharmaceuticals if CMS considered collecting ASP data from independent radiopharmacies in addition to manufacturers. The commenter noted that if CMS were to use some form of ASPs for outpatient hospital radiopharmaceutical payments, it must—(1) qualify manufacturer reporting; (2) use a weighted average that includes manufacturer and radiopharmacy ASP data; (3) work with stakeholders to determine the appropriate crosswalk between NDCs and HCPCS codes; (4) conduct surveys of the relationships between end-user acquisition costs at the HCPCS level from independent radiopharmacies and hospital radiopharmacies and the manufacturer-reported ASPs; and (5) develop a specific proposal for reporting radiopharmaceutical ASPs appropriately and allow stakeholders to comment on the proposal before it is finalized.

Most commenters urged CMS to recognize the operational and statutory impediments to ASP reporting for radiopharmaceuticals and the inherent difficulties in establishing the OPPS payments for these products based upon any ASP methodology. Rather than attempting to determine ASP for radiopharmaceuticals based on some manipulation of a hypothetical radiopharmaceutical ASP, many commenters urged CMS to consider continuation of the CCR methodology to pay for separately payable radiopharmaceuticals using the overall hospital-specific CCRs with some refinements in CY 2007, as this policy may generate combined hospital average acquisition and overhead costs, consistent with statutory requirements. One commenter suggested that CMS consider all issues surrounding radiopharmaceutical acquisition, dispensing, and dosage before adopting any alternative payment mechanisms. Other commenters urged CMS to continue working with hospitals and manufacturers to ensure that both short-term and long-term payment methodologies for radiopharmaceuticals would sufficiently pay providers for medically necessary diagnostic tests and therapies and generate valid and reliable data to support future payment rates.

Response: We appreciate all of the comments that we received on our proposal to begin ASP reporting for radiopharmaceuticals in CY 2006. We recognize that there are many complex issues surrounding our ability to collect accurate ASP data for these agents in CY 2006. At this time, we agree with the commenters about the difficulties in translating ASP information gathered from manufacturers regarding radiopharmaceutical raw materials into individual patient doses of specific radiopharmaceuticals, as described by particular HCPCS codes. As this transitional step would be essential to any future OPPS radiopharmaceutical payment methodology based on ASP data, we are hesitant at this time to establish required ASP reporting for radiopharmaceuticals, with its accompanying administrative complexities. Therefore, in this final rule with comment period, we are not adopting our proposal to require reporting of ASP data by radiopharmaceutical manufacturers in CY 2006. Instead, we will continue to further explore the issues surrounding ASP reporting and crosswalking ASPs to patient doses of radiopharmaceuticals. In addition, we will take into consideration other radiopharmaceutical payment alternatives to ASP reporting suggested by commenters as we develop our policies for the CY 2007 OPPS. We will continue to seek input and guidance from hospitals, radiopharmaceutical manufacturers, and other interested organizations as we contemplate alternative payment methodologies for radiopharmaceuticals.

Comment: Several commenters requested that for CY 2007 and future years CMS carefully review and analyze radiopharmaceutical costs acquired in CY 2006 and consider continuing the use of the CCR methodology for payment, along with other possible options. Some commenters suggested that CMS consider the impact to the payment system and the burden to hospitals to significantly change payment methods for radiopharmaceuticals from year to year. Other commenters encouraged CMS to work in close consultation in the future with hospitals and manufacturers to help ensure that the costs of radiopharmaceuticals are properly captured in the OPPS rates beyond CY 2006. One commenter stated that data from the GAO survey of hospital acquisition costs could be one basis for acquiring information on which national payment rates could be established. Another commenter recommended that CMS explore the possibility of treating radiotherapies such as Bexxar and Zevalin differently from traditional radiopharmaceuticals in order to preserve patient access to them.

Response: We appreciate receiving these suggestions for establishing an appropriate payment methodology for radiopharmaceuticals beyond CY 2006 and will take all of the recommendations into consideration when we start developing our payment proposal for radiopharmaceuticals for the CY 2007 OPPS. Other payment options for radiopharmaceuticals that we will also consider include basing payments on mean costs derived from hospital claims data or creating charge-based payment rates for these items. Another option would be to develop a hospital payment methodology using the invoice data submitted to carriers when radiopharmaceuticals are administered in physician offices. It is not our intention to maintain the CY 2006 methodology of paying for radiopharmaceuticals on the basis of charges converted to costs permanently. Rather, we will actively seek other sources of information on radiopharmaceutical costs that might provide a basis for payment. We

welcome suggestions about such sources of data and alternative methodologies.

We discuss in section V.B.3.a.(5) of this preamble our CY 2006 proposed payment policies for overhead costs of drugs, biologicals, and radiopharmaceuticals. In section V.D. of this preamble, we discuss the methodology that we proposed to use to determine the CY 2006 payment rates for new drugs, biologicals, and radiopharmaceuticals.

While payments for drugs, biologicals and radiopharmaceuticals are taken into account when calculating budget neutrality, we note that we proposed to pay for the acquisition costs of drugs, biologicals, and radiopharmaceuticals without scaling these payment amounts. We proposed not to scale these payments because we believed that Congress, in section 621 of Pub.L. 103–178, intended for payments for these drugs to be based on average acquisition costs. Scaling these payments would mean that they are no longer based solely on acquisition costs. Therefore, at the time of the proposed rule we believed that it was most consistent with the statute not to scale these payment rates. In section V.B.3.a.(5) of this preamble, we also discuss that we proposed to add 2 percent of the ASP to the payment rates for drugs and biologicals with rates based on the ASP methodology to provide payment to hospitals for pharmacy overhead costs associated with furnishing these products. We proposed to scale these additional payment amounts for pharmacy overhead costs. In the CY 2006 proposed rule, we specifically invited public comments on whether it was appropriate to exempt payment rates for drugs, biologicals, and radiopharmaceuticals from scaling and scale the additional payment amount for pharmacy overhead costs.

We note that further discussion of the budget neutrality implications of the various drug payment proposals that we considered is included in section XIX.C. of this preamble.

We received a few public comments on these scaling issues associated with drugs, biologicals, and radiopharmaceuticals.

Comment: MedPAC expressed concern that CMS proposed to apply budget neutrality adjustments to all APCs, while exempting payment for the acquisition costs of specified covered outpatient drugs from these adjustments. MedPAC's concern was that this policy, by reducing the payment rates for clinical APCs but not drugs, may exacerbate any existing incentives for hospitals to use separately payable products. For example, the financial incentive to use a SCOD instead of a packaged drug would be increased by the proposed method of budget neutrality adjustment, creating higher payments for hospitals that are relatively high users of SCODs and reducing payments for low users. Another commenter supported the use of these rates for budget neutrality estimates and impact analysis.

Response: We understand MedPAC's concern about our proposal to not scale the payment rates for separately payable drugs and biologicals. The statute contains a general requirement (section 1833(t)(9)(B)) that changes to the APC relative weights, APC groups, and other adjustments ''for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease.'' We therefore apply a budget neutrality adjustment, or scalar, to the APC relative weights to satisfy this requirement. Section 1833(t)(14)(A)(iii)(I) requires that, beginning in CY 2006, we pay for a separately payable drug on the basis of ''the average acquisition cost of the drug.'' We believe that the best interpretation of the specific requirement that we pay for such drugs on the basis of average acquisition cost, is that these payments themselves should not be adjusted as part of meeting the statutory budget neutrality requirement. If we were to apply the budget neutrality scalar to these payments, we would no longer be paying the average acquisition cost, but rather an adjusted average acquisition cost, for separately payable drugs. For CY 2006, as described earlier, we will be paying for the acquisition and overhead costs of drugs and biologicals at ASP+6 percent, without scaling for budget neutrality. We believe that these amounts are the best proxies we have for the aggregate average acquisition and pharmacy overhead costs of drugs and biologicals. We continue to believe that not scaling these payments is most consistent with the statutory requirement of paying for the acquisition costs of drugs on the basis of average costs. Because we are no longer identifying a separate payment amount for overhead costs, we will not scale any part of the ASP+6 percent payment for drugs in order to maintain consistency with the statutory requirement to pay on the basis of average acquisition costs. It is also worth noting that the budget neutrality adjustment is not always negative. For CY 2006, for example, the budget neutrality adjustment is 1.012508103. Therefore applying the adjustment to clinical APCs but not to drug payments does not always increase any incentive that otherwise may exist for a hospital to use a SCOD instead of a packaged drug.

(5) MedPAC Report on APC Payment Rate Adjustment for Specified Covered Outpatient Drugs

Section 1833(t)(14)(E) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, required MedPAC to submit a report to the Secretary, not later than July 1, 2005, on adjusting the APC rates for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. This provision also required that the MedPAC report include the following: a description and analysis of the data available for adjusting such overhead expenses; recommendation as to whether a payment adjustment should be made; and the methodology for adjusting payment, if an adjustment is recommended. Section 1833(t)(14)(E)(ii) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, authorized the Secretary to adjust the APC weights for specified covered outpatient drugs to reflect the MedPAC recommendation.

The statute mandates MedPAC to report on whether drug APC payments under the OPPS should be adjusted to account for pharmacy overhead and nuclear medicine handling costs associated with providing specified covered outpatient drugs. In creating its framework for analysis, MedPAC interviewed stakeholders, analyzed cost report data, conducted four individual hospital case studies, and received technical advice on grouping items with similar handling costs from a team of experts in hospital pharmacy, hospital finance, cost accounting, and nuclear medicine.

As we discussed in the CY 2006 OPPS proposed rule (70 FR 42728), MedPAC concluded that the handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are not insignificant, as medications typically administered in outpatient departments generally require greater pharmacy preparation time than do those provided to inpatients. MedPAC found that little information is currently available about the magnitude of these costs. According to the MedPAC analysis, hospitals historically set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflected their respective handling costs, and payments covered both drug acquisition and handling. Moreover, hospitals vary considerably in their likelihood of providing specific services which utilize drugs, biologicals,

or radiopharmaceuticals with different handling costs.

As we also reported in the CY 2006 OPPS proposed rule, MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs, according to the level of resources used to prepare the products (Table 23 of the proposed rule, 70 FR 42729) Characteristics associated with the level of handling resources required included radioactivity, toxicity, mode of administration, and the need for special handling. Groupings ranged from dispensing an oral medication on the low end of relative cost to providing radiopharmaceuticals on the high end. MedPAC collected cost data from four hospitals that were then used to develop relative median costs for all categories but radiopharmaceuticals (Category 7+). The case study facilities were not able to provide sufficient cost information regarding the handling of outpatient radiopharmaceuticals to develop a cost relative for Category 7+. The MedPAC study classified about 230 different drugs, biologicals, and radiopharmaceuticals into the seven categories based on input from their expert panel and each case study facility.

In its report, MedPAC recommended the following:

- Establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals, and radiopharmaceuticals; and
- Define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; instruct hospitals to submit charges for these APCs; and base payment rates for the handling fee APCs on submitted charges reduced to costs.

MedPAC found some differences in the categorizations of drug and radiopharmaceutical products by different experts and across the case study sites. In the majority of cases where groupings disagreed, hospitals used different forms of the products, which were coded with the same HCPCS code. For example, a drug may be purchased as a prepackaged liquid or as a powder requiring reconstitution. Such a drug would vary in the handling resources required for its preparation and would fall into a different drug category depending on its form. In addition, the handling cost groupings may vary depending on the intended method of drug delivery, such as via intravenous push or intravenous infusion. For a number of commonly used drugs, MedPAC provided two categories in their final consensus categorizations, with the categories 2 and 3 reported as the most frequent combination. For example, MedPAC placed HCPCS codes J1260 (Injection, dolasetron mesylate, 10 mg) and J2020 (Injection, linezolid, 200 mg) in consensus categories 2 and 3, acknowledging that the appropriate categorization could vary depending on the clinical preparation and use of the drug. We noted in the proposed rule (70 FR 42729) that we have no information regarding hospitals' frequencies of use of various forms of drugs provided in the outpatient department under the OPPS, as the case studies only included four facilities and the technical advisory committee was similarly small. Thus, in many cases it is impossible to assign a drug exclusively and appropriately to a certain overhead category that would apply to all hospital outpatient uses of the drug because of the different handling resources required to prepare different forms of the drugs.

There are over 100 separately payable drugs, biologicals, and radiopharmaceuticals that are separately payable under the OPPS but for which MedPAC provided no consensus categorizations in its 7 drug groups. In preparation for the CY 2006 proposed rule, we independently examined these products and considered the handling cost categories that could be appropriately assigned to each product as described by an individual HCPCS code. As discussed above, many of the drugs had several forms, which would place them in different handling cost groupings depending on the specific form of the drug prepared by the hospital pharmacy for a patient's treatment. In addition, as we stated in the proposed rule, we believe that hospitals may have difficulty discriminating among the seven categories for some drugs, because the applicability of a given category description to a specific clinical situation could be ambiguous. Indeed, in the MedPAC study, initially only about 80 percent of the case study pharmacists agreed with the expert panel category assignments. However, concurrence increased that percentage to almost 90 percent after discussion and review. Nevertheless, there remained a number of drugs for which differences in categorization by the case study facilities and the expert panel persisted.

In light of our concerns over our ability to appropriately assign drugs to the seven MedPAC drug categories so that the categories accurately described the drugs' attributes in all of the OPPS hospitals and the MedPAC recommendations, for CY 2006 we proposed to establish three distinct HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals, by combining several of the categories identified in the MedPAC report. We proposed to collapse the MedPAC categories 2, 3, and 4 into a single category described by HCPCS code CXXXX, and MedPAC categories 5 and 6 into another category described by HCPCS code CYYYY, while maintaining MedPAC category 1 as described by HCPCS code CWWWW. (Our rationale for not proposing to create an overhead payment category for radiopharmaceuticals is discussed below.) We proposed merging categories in this way generally because we believed that doing so would resolve the categorization dilemmas resulting from the most common scenarios where drugs might fall into more than one grouping and minimized the administrative burden on hospitals to determine which category applied to the handling of a drug in a specific clinical situation. In addition, these broader handling cost groupings would minimize any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods. We proposed only to collapse those categories whose MedPAC relative weights differed by less than a factor of two, consistent with the principle outlined in section 1833(t)(2) of the Act that provides that items and services within an APC group cannot be considered comparable with respect to the use of resources if the median cost of the highest cost item or service within an APC group is more than 2 times greater than the median cost of the lowest cost item or service within that same group.

As discussed in previous final rules and in the CY 2006 OPPS proposed rule, we believed that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median cost of drug administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of acquiring the item (66 FR 59896, 67 FR 66769, and 70 FR 42729 through 42730). As a MedPAC survey of hospital charging practices indicated that hospitals' charges for drugs, biologicals, and radiopharmaceuticals reflect their handling costs as well as their acquisition costs, we believed pharmacy overhead costs would be incorporated into the OPPS payment rates for drugs, biologicals, and radiopharmaceuticals if the rates were based on hospital claims

data. However, in light of our proposal to establish three distinct C-codes for drug handling categories, we also proposed to instruct hospitals to charge the appropriate pharmacy overhead C-code for overhead costs associated with each administration of each separately payable drug and biological based on the code description that best reflected the service the hospital provided to prepare the product for administration to a patient. We would collect hospital charges for these C-codes for 2 years, and consider basing payment for the corresponding drug handling APCs on the charges reduced to costs in CY 2008, similar to the payment methodology for other procedural APCs. Median hospital costs for the drug handling APCs should reflect the CY 2006 practice patterns across all OPPS hospitals of handling drugs whose preparation was described by each of the C-codes, reflecting the differential utilization of various forms of drugs and alternative methods of preparation and delivery through hospitals' billing and charges for the C-codes. Table 24 of the proposed rule (70 FR 42730) listed the drug handling categories, C-codes, and APCs we proposed for CY 2006.

We proposed these three categories because we believed that they were sufficiently distinct and reflective of the resources necessary for drug handling to permit appropriate hospital billing and to capture the varying overhead costs of the drugs and biologicals separately payable under the OPPS. We did not propose to adopt the median cost relatives reported for MedPAC's six categories (excluding radiopharmaceuticals). This was because it was very difficult to accurately crosswalk the cost relatives for the six categories to the three categories we proposed. In addition, we were not confident that the cost relatives that were based on cost data from four hospitals appropriately reflected the median relative resource costs of all hospitals that would bill these drug handling services under the OPPS. Instead, we believed it was most appropriate to collect hospital charges for the drug handling services based on attributes of the products that affected the hospital resources required for their handling, and to consider making future payments under the OPPS using the proposed C-codes based on the medians of charges converted to costs for the drug handling APC associated with each administration of a separately payable drug or biological.

For CY 2006, pursuant to section 1833(t)(14)(E)(ii) of the Act, we proposed an adjustment to cover the costs hospitals incur for handling separately payable drugs and biologicals. As we did not have separate hospital charge data on pharmacy overhead, we proposed for CY 2006 to pay for drug and biological overhead costs based on 2 percent of the ASP. As described earlier, we estimated aggregate expenditure for all separately payable OPPS drugs and biologicals (excluding radiopharmaceuticals) using mean costs from the claims data and then determined the equivalent average ASP-based rates. Our calculations at the time of the proposed rule indicated that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on ASP+8 percent. As noted previously, because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals as indicated by the MedPAC study described above, we believed on the basis of the data available at the time of our development of the proposed rule that payments for drugs and biologicals and overhead at a combined ASP+8 percent would serve as a proxy for representing both the acquisition and overhead cost of each of these products. Moreover, as we proposed to pay for all separately payable drugs and biologicals using the ASP methodology, where payment rates for most of these items were set at ASP+6 percent, we believed that an additional 2 percent of the ASP would provide adequate additional payment for the overhead costs of these products and be consistent with historical hospital costs for drug acquisition and handling. Even though we did not propose to scale the payment rates for drugs and biologicals based on the ASP methodology, we proposed to scale the additional payment amount of 2 percent of the ASP for pharmacy overhead costs. Therefore, for CY 2006, we proposed to pay an additional 2 percent of the ASP scaled for budget neutrality for overhead costs associated with separately payable drugs and biologicals, along with paying ASP+6 percent for the acquisition costs of the drugs and biologicals. We specifically requested public comments on this proposed policy for paying for pharmacy overhead costs in CY 2006 and on the proposed policy regarding hospital billing of drug handling charges associated with each administration of each separately payable drug or biological using the proposed C-codes.

During the August 2005 meeting of the APC Panel, the Panel made three recommendations regarding our proposals for determining and paying for overhead costs associated with providing drugs and biologicals. The Panel recommended that CMS: (1) Reconsider carefully the proposal to pay 2 percent of ASP for hospital pharmacy overhead costs to ensure that it is in line with hospital costs and that CMS take into account external data gathered during the comment period; (2) pay for the pharmacy overhead costs of both packaged and separately paid drugs, employing a mechanism that adds only minimal additional administrative burden for hospitals; and (3) delay the implementation of the proposed codes for drug handling cost categories until January 2007 so that further data and alternative solutions for making payments to hospitals for pharmacy overhead costs can be collected, analyzed by CMS, and presented to the Panel at its winter 2006 meeting. The final CY 2006 policies on pharmacy overhead costs are discussed below.

We received many public comments concerning our proposals.

Comment: Commenters were pleased that CMS recognized that additional payments should be provided to hospitals to cover handling costs associated with administering drugs and biologicals in the hospital outpatient setting. However, many commenters were concerned that the proposed payment of 2 percent of the ASP for these costs was not adequate to ensure that hospitals would be able to continue to provide these services. Commenters indicated that these handling costs could be substantial and cited comments in the MedPAC study on pharmacy handling costs attributing 26 to 28 percent of pharmacy department costs to overhead costs. Several commenters noted that MedPAC stated in its report that pharmacy overhead costs are inconsistently reported in hospital charge data. Therefore, these commenters concluded that our analysis of the HCPCS drug charge data derived from CY 2004 provider claims is not likely to reflect pharmacy handling charges accurately and consistently. One commenter stated that an additional payment of 2 percent of ASP for drug handling is not adequate for certain drugs that have very high handling costs due to special equipment or procedures related to the drug's toxicity, or special compounding or preparation requirements. Several other commenters stated that hospitals are facing increased pharmacy handling costs and overhead expenses as a result of at least one, and possibly two, new government requirements that reflect new criteria for compounding sterile products and new procedures to ensure staff and patient safety. According to the commenters, these additional costs were

not reflected in the CY 2004 hospital claims data, and therefore were not accounted for in CMS' estimate of 2 percent of ASP for the pharmacy overhead costs of drugs and biologicals.

Commenters provided various recommendations for CMS to consider in determining appropriate payment levels for drug handling costs in CY 2006. One commenter encouraged CMS to use industry data to set an equitable payment rate for these pharmacy overhead costs instead of the percentage of ASP proposed. Another commenter recommended that CMS increase the payment for pharmacy overhead costs to more closely approximate the findings reported by MedPAC. Several commenters recommended implementing a dampening policy in CY 2006, so that drug payments are no lower than 95 percent of the CY 2005 payment levels. Another dampening policy suggested was that CMS pay for separately payable drugs and biologicals at the higher of ASP+8 percent or 90 percent of the CY 2005 payment rate. One commenter recommended that CMS consider freezing payments in CY 2006 for those drugs whose payments would decline significantly from the CY 2005 rates, particularly those drugs that may have especially complex and costly handling requirements. Some of these commenters indicated that a dampening policy would allow CMS to provide hospitals with a transition mechanism as it moved toward an ASP-based payment methodology, and at the same time provide adequate payment for these items until CMS collected sufficient pharmacy overhead charge data to establish accurate cost-based payment rates for drug handling expenses.

MedPAC expressed concern about the methodology to pay hospitals 2 percent of ASP for each separately payable drug administered because of the proportional nature of this proposal. MedPAC suggested that CMS consider another alternative because the proposed method ties payment for handling costs directly to the acquisition cost of a drug. MedPAC noted that payment for the handling cost of a particular drug could differ sharply from the handling cost hospitals actually incur; for example, a drug with a high acquisition cost does not necessarily also have high handling costs. MedPAC also expressed concern that this method of paying for pharmacy overhead could result in higher drug acquisition costs for hospitals because it gives manufacturers an incentive to increase prices. MedPAC proposed an alternative methodology under which CMS would estimate the total dollars that should be dedicated to paying pharmacy handling costs and determine how much of the total should be allocated to groups of drugs that are similar with respect to their handling costs. MedPAC noted that 2 percent of ASP, as suggested by our analysis of the data on hospitals' acquisition and overhead costs, would be a viable basis for creating such a pool. Under the MedPAC methodology, hospitals would receive the same payment for the handling cost of each specified covered outpatient drug within the same category of handling costs, regardless of the acquisition costs of the specific drugs assigned to the category.

One commenter urged CMS to implement a pharmacy service and handling add-on of at least 8 percent of ASP, in addition to the acquisition cost payment of ASP+6 percent. The commenter used the hospital outpatient claims data to examine the percentage add-on to ASP that would be necessary to maintain aggregate payments in CY 2006 at 95 or 100 percent of the CY 2005 level. The commenter found that, to maintain payments at 95 or 100 percent of the CY 2005 levels for chemotherapy or supportive care drugs, except radiopharmaceuticals, add-on amounts of 7.6 percent of ASP or 13.3 percent of ASP, respectively, would be necessary. The commenter stated that payment at this level would be an appropriate interim measure to limit the potential decreases in drug payments until data are collected to implement a better long-term solution. Many other commenters supported this proposal to pay 8 percent of ASP for overhead costs in addition to paying ASP+6 percent for acquisition costs (for a total payment of ASP plus 14 percent for drug acquisition and overhead costs).

Another commenter recommended that CMS adopt a process similar to what it proposed to support the 2 percent payment for CY 2006 and suggested a variation to the proposed methodology. The commenter indicated that CMS could compute a reasonable estimate of handling costs by use of current claims data by first computing the mean cost of each drug and then deducting the ASP+6 percent amount. The commenter added that, after statistical outliers are excluded, CMS would have a reasonable estimate of the handling costs either by drug HCPCS code or by three categories without hospitals incurring the additional burden of billing a new handling charge. The commenter stated that CMS could then add the estimated handling costs to the drug ASP+6 percent payment to create a single payment for both the acquisition and handling costs. The commenter indicated that this method should also be more accurate than the current proposal of 2 percent of ASP for handling costs that applies equally to all three categories. The commenter expressed concern that the proposed 2 percent of ASP for handling costs is significantly lower than the percentage indicated by both MedPAC and CMS studies. Because the drug handling cost must be paid in a budget neutral manner, the commenter questioned the adoption of an administratively burdensome process which attempted to redistribute OPPS payments for only 2 percent of drug payments. The commenter recommended that CMS withdraw its proposed billing requirement for handling charges and simply adopt the 2 percent of ASP payment method proposed for CY 2006 and future years if CMS believes that its data indicate that drug handling costs are only 2 percent of drug payments. The commenter added that submitting handling charges for the proposed C-codes would be burdensome for such a relatively small payment refinement benefit. Several other commenters believed that, while an imperfect measure, increasing payment for drug handling costs by 2 percent of ASP would be appropriate as a temporary measure.

Some commenters also indicated that CMS should work with hospital and pharmacy stakeholders to develop an approach to establish differential add-on payments for drug handling costs to account for a wide variety of drug handling categories. Lastly, one commenter noted that if CMS implements this policy, it should continue to analyze and refine payment for pharmacy overhead costs in the future to ensure that 2 percent of the ASP adjustment provides adequate payment for these services.

Response: We understand the commenters' concerns about basing the additional payment amount for overhead costs of drugs and biologicals on 2 percent of an item's ASP. We agree with MedPAC and other commenters on the proposed rule that hospital charges for drugs and biologicals are generally reflective of both their acquisition and overhead costs. MedPAC did indicate in its comments that 2 percent would be a viable basis for creating the drug overhead pool. Therefore, we are not convinced by those commenters who contended that drug overhead costs are much higher than 2 percent of ASP (for example, 25 to 30 percent of total drug costs). As described earlier, using updated CY 2004 claims data and ASP information from the second quarter of CY 2005, we determined that using

mean unit costs to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. Consequently, we believe that it is appropriate for us to base payment for average acquisition and overhead costs for separately payable drugs and biologicals on ASP+6 percent for CY 2006 because both acquisition and overhead costs are reflected in the charges submitted by hospitals for these items. We have no reason to believe that, in the aggregate, a payment rate of ASP+6 percent would be insufficient to provide combined appropriate payment for both the hospital acquisition and overhead costs related to providing drugs and biologicals to hospital outpatients.

In the light of this decision to proceed with an integrated payment of ASP+6 percent for the acquisition and overhead costs of drugs, we also are not adopting MedPAC's recommendation to create and appropriately distribute a drug overhead payment pool in this final rule with comment period. We understand MedPAC's concern that a flat percentage add-on payment for overhead costs might underpay these costs for some drugs and overpay for others. However, on the basis of our claims data, we believe that the payment rate that we are adopting will provide adequate payment for both acquisition and overhead costs in the aggregate. We also note the difficulties in determining the relative values of the separate drug handling cost categories in order to allocate spending from MedPAC's overhead drug pool. However, we will continue to study and consider this alternative as we develop our future policies on payment for drug costs in general and overhead costs in particular. As we evaluate other options for paying for drug handling costs in the future, we will also consider different methodologies that could be used to develop clinically meaningful and distinct payment levels for the diverse pharmacy overhead resources associated with administration of drugs and biologicals. We welcome comments and information about sources of data that could be useful in further developing a methodology for payment of drug overhead costs for the CY 2007 proposed rule.

Comment: Two commenters were concerned that the proposed additional payment of 2 percent of ASP did not fully cover hospital costs of procuring, storing, and furnishing clotting factors to patients with hemophilia. The commenters noted that the CY 2005 payment for a clotting factor in the physician office setting is based on ASP+6 percent plus an additional furnishing fee to cover the costs of providing the product to Medicare beneficiaries. According to the commenters, this fee was set at $0.14 per unit of clotting factor for CY 2005 and is required to be updated annually. The commenters also noted that an add-on payment is made to hospitals for clotting factors provided to patients in the hospital inpatient setting. They indicated that for hospital inpatient services the current additional payment for a clotting factor equals 95 percent of its AWP; however, for CY 2006, CMS proposed to set the payment rate and the furnishing fee for clotting factors used in the hospital inpatient setting at the same rate as for clotting factors provided in physician offices under Part B. The commenters argued that the hospital outpatient handling costs should not be treated differently than in the physician office because the costs of inventory, specialized refrigeration, assay management, and formulation of clotting factors are similar for all providers of these drugs and do not very between the hospital inpatient and outpatient setting. The commenters were concerned that the proposed 2 percent of ASP did not fully cover the additional costs of furnishing clotting factors to Medicare beneficiaries in the hospital outpatient setting and urged CMS to apply the Part B furnishing fee to the hospital outpatient setting as well. One of the commenters additionally requested that CMS not include clotting factors in the collection of overhead cost data using the proposed C-codes, as CMS has already established a mechanism for calculating and updating the costs associated with providing these drugs under the Medicare Physician Fee Schedule and Inpatient Prospective Payment System, and it sought clarification in the preamble and regulatory text of the final rule on all payment provisions related to clotting factors.

Response: Section 303 of Pub. L. 108–173 established section 1847A of the Act which requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP) and provided for payment of a furnishing fee for blood clotting factors, effective January 1, 2005. In CY 2006, payment for clotting factors furnished in both the physician office setting and inpatient hospital setting will be made at ASP+6 percent plus an additional amount for the furnishing fee. We agree with the commenters' statements about the use of similar resources to furnish clotting factors across all types of service settings and believe that it is appropriate to adopt a methodology for paying for clotting factors under the OPPS that is consistent with the methodology applied in the physician office setting and the inpatient hospital setting. Therefore, in CY 2006, we will be paying for clotting factors at ASP+6 percent in the OPPS and providing payment for the furnishing fee that will also be a part of the payment for clotting factors furnished in physician offices under Medicare Part B. This furnishing fee will be updated each calendar year based on the consumer price index, and we will update the amount appropriately each year under the OPPS. In CY 2005, the furnishing fee is $0.14 per unit, and for CY 2006, it will be updated to $0.146 per unit. Effective January 1, 2006, we will make payment for clotting factors at ASP+6 percent using ASP data from the third quarter of 2005 along with paying for the furnishing fee using the updated amount for CY 2006. The final CY 2006 regulations establishing the ASP methodology and the furnishing fee for blood clotting factors under Medicare Part B can be found in the CY 2006 Medicare Physician Fee Schedule final rule. We believe that this methodology will allow us to provide adequate payment for both the acquisition and overhead costs of clotting factors under the OPPS in CY 2006.

Comment: One commenter requested that CMS clarify how it will pay hospitals for the costs incurred with handling intrathecal drugs, noting that MedPAC did not discuss the handling costs of intrathecal drugs in its report on pharmacy overhead costs. The commenter noted that intrathecal drugs involve significant handling costs; therefore, CMS should ensure that intrathecal drugs are paid a sum sufficient to cover their handling costs.

Response: In CY 2006, payment for intrathecal drugs will be determined using the same ASP methodology as will be used for other separately payable drugs and biologicals, where payment for acquisition and overhead costs will be set at ASP+6 percent.

Comment: We received many comments on our proposal to implement C-codes for drug handling categories in CY 2006. Many of the commenters opposed the proposal, while other commenters supported it.

A national association of hospitals expressed strong opposition to the proposal to require hospitals to report their drug handling charges using C-codes in order for CMS to pay pharmacy overhead costs and recommended that CMS find an alternative method to

identify drug handling costs. The commenter raised several concerns regarding this proposal. For example, the commenter indicated that by proposing to require hospitals to bill a handling charge when the industry practice has been to bill a combined charge to reflect both the drug acquisition cost and handling cost is contrary to a basic, long standing tenet of the Medicare Act in 42 U.S.C. 1395 that CMS interpreted as prohibiting any interference with hospital charge structures. Also, the commenter noted that Medicare providers must have a consistent charge structure in order to prepare the Medicare cost report and to apportion costs within the Medicare cost report. The proposal to require hospitals to begin billing the drug handling charge as a separate line-item charge will present billing and payment concerns for all other payers because drug handling charges would also have to be billed also to private payers and the Medicaid program, or the provider would have to be able to generate consistent charges for proper Medicare apportionment costs. However, since most other payers do not recognize C-codes and may refuse to accept and/or pay for such handling charges, it would raise concern for a provider as to whether it must pursue collection in order to have a consistent charge structure for payment and apportionment. The commenter noted that drug handling costs are not presently billed separately by the vast majority of hospitals, and most of these hospitals do not have sophisticated cost accounting systems that would permit the determination of handling costs for each billable drug. Reporting pharmacy overhead charges with C-codes would result in a tremendous burden to hospitals, requiring the modification of their pharmacy charge masters to reduce each current drug charge to reflect only the drug acquisition cost and to remove the drug handling costs currently included in each drug line item's charge. Hospitals that do not have sophisticated cost accounting systems would have difficulty in determining the applicable amount attributable to the handling costs. The commenter indicated that even if this administratively burdensome process of billing for handling charges is adopted, CMS would still be unable to determine the drug handling costs at the individual drug level because an average pharmacy department CCR would be applied to billed charges to determine drug handling costs, and these CCRs were never intended to determine cost at the specific procedure level, such as drug handling costs for individual drugs. The commenter also expressed concern that CMS' proposal to pay the drug handling costs only for separately payable drugs would create an additional burden for hospitals as they must identify and modify only those drug charge items that qualify for separate payment under the OPPS. Charges for packaged drugs must continue to include the overhead costs as part of the drug's line item charge or the appropriate revenue code charge. Because Medicare beneficiaries frequently require more than one drug in an outpatient encounter, it may be impossible to identity any correlation between the drug HCPCS code reported and the drug handling category HCPCS code reported. Additionally, there would be no incentives for hospitals to perform the charge master maintenance and educate pharmacy staff as neither the presence nor accuracy of the drug handling HCPCS codes will impact the proposed CY 2006 payment of drug handling costs. Another concern raised was that CMS would be able to determine appropriate payment rates for these C-codes in future years using the claims data only if hospitals can reasonably estimate their drug handling costs and if hospitals mark up their drug handling costs in line with their overall pharmacy mark-up. The last concern cited by the commenter was that there may be an issue if hospitals report the new drug handling costs separately without restructuring their existing drug charges to remove the drug handling costs already included in the drug charges.

Other commenters echoed these concerns. One commenter indicated that even though collecting charge data for handling costs may be useful for CMS, the reporting requirement would overwhelm coding and nursing staffs already challenged with the complex task of ensuring that the correct dosage of the drug is billed. Another commenter strongly opposed the use of C-codes to bill for drug handling costs because it would present an operational nightmare because every drug required ''handling.'' The commenter, therefore, requested that CMS not implement this proposal until further assessments of the system implications associated with such a change are completed.

Several commenters raised other coding, billing, and charging issues related to this proposal. For example, commenters questioned whether CMS would expect multiple line-items to be reported per date of service if multiple drugs from the same drug handling family are provided. They also asked whether CMS would require providers to report a single revenue code with the pharmacy handling C-codes, or would the revenue codes need to match the actual drug revenue code. The commenters urged CMS to review the coding and billing requirements necessary to implement such a mechanism correctly.

One commenter strongly opposed the proposal requiring hospitals to establish separate pharmacy overhead charges for separately payable drugs and biologicals and use the three proposed C-codes for charging these overhead costs in CY 2006. This commenter indicated that it would be extremely burdensome and difficult for hospitals to implement the proposal. The commenter also indicated that there are many complex issues and administratively burdensome aspects to adopting this proposal for charging for drug handling using these new C-codes. The commenter pointed out that even assuming that hospitals could provide differential charges, other concerns remain. For example, the commenter indicated that hospitals would have to evaluate the normal mark-up formula for all pharmacy items and deduct the handling costs for only the separately payable drugs under Medicare, while the drug handling charges for packaged drugs would remain incorporated within overall charges for those drugs. The commenter stated that because the C-codes would only be recognized by and acceptable to Medicare, but not to other payers, hospitals would have to modify their billing systems to separate out the drug handling charge from the drug charge for Medicare claims, but bill them as a single line-item for other payers. The commenter believed that there would also be confusion about how the drug handling C-codes would apply when a hospital pharmacy mixes multiple doses of a drug for a patient, and in particular the question of whether the hospital would report a single C-code for handling costs or multiple C-codes in this situation. The commenter also expressed concern that some hospitals may not be able to accommodate the proposed C-codes because drug pricing is generated through a pharmacy charging system often located outside the hospital's normal charging system. For these reasons, the commenter indicated that it is unclear how CMS would expect providers to report drug charges in the inpatient setting versus the outpatient setting because many hospitals use the same charge master for inpatient and outpatient services.

One of the commenters noted that when hospital clinic nurses and pharmacies bill for drugs, they do not view the patient-specific data to

determine if the patient has Medicare coverage and whether the drug is separately payable to make decisions about whether to report additional services. The commenter pointed out that dispensing fees vary significantly in each hospital due to variances in overhead and handling fees incurred. The commenter believed that the proposal requires more research and consideration in order to reduce the administrative burden that would be required of hospital staff and adequately capture all pharmacy overhead and handling costs incurred. This commenter supported establishing payment for pharmacy overhead costs based on the additional 2 percent of ASP added to each APC drug payment, as this method simplifies the payment mechanism.

Many commenters stated that CMS should not implement the proposed drug handling C-codes in CY 2006 and should instead study alternate mechanisms for obtaining drug handling cost data, including using the cost report to compute an average pharmacy handling percentage that may be used in the future along with the ASP+6 percent model for drug acquisition costs. Other commenters recommended that CMS work with stakeholder groups to collect additional data and develop simpler, alternative solutions for ensuring that hospitals are appropriately paid for their pharmacy overhead and drug handling costs. Some commenters stated that such approaches should incorporate the payment for drug handling directly into the payment rate for the drug itself, rather than requiring separate coding systems. One commenter suggested that CMS obtain more accurate information by surveying hospital pharmacy departments and studying data on the departmental costs of hospital pharmacies. Another commenter stated that CMS should collect data and make payments in a manner similar to the way in which data are collected and payments provided through the Quality Measurement Demonstration Project that was implemented in physicians' offices in CY 2005.

Several commenters supported our proposal to implement the C-codes for drug handling categories. They supported the development of the three proposed distinct C-codes for drug handling categories and the collection of hospital claims data over the next 2 years for use in establishing payment rates based on actual costs in CY 2008 and beyond. One of the commenters supported basing payment for these new categories in CY 2008 on a weighted average of the overhead costs for all drugs to which the categories will apply, thus ensuring the most accurate payment level possible while meeting the objective of the proposal to streamline the overhead payment system.

A few commenters did not believe the three drug handling categories proposed were sufficient to cover the wide range of drug handling costs for all of the separately payable drugs used by hospital outpatient departments and stated that the categories proposed by MedPAC would allow greater differentiation of drug handling costs. One commenter explained that more refined categories can and should be developed and urged CMS to reevaluate the use of the MedPAC categories and to release a listing of the drugs assigned to each drug handling category for hospital review. These commenters indicated that limiting the number of categories for which hospitals report their drug handling costs would not provide accurate cost data and were concerned that CMS' descriptions of these categories did not provide sufficient clarity for hospitals to appropriately classify all of their drugs. One commenter noted that intrathecal drugs should be assigned to category three or a new overhead cost category for intrathecal drugs should be created.

MedPAC was pleased that CMS' proposed methodology to pay for overhead and handling costs beginning in CY 2008 reflected its recommendations and noted that the methodology would be similar to that used to set payment rates for procedural APCs. However, MedPAC encouraged CMS to explore whether it would be reasonable to expand the number of handling cost APCs beyond the proposed three categories after the charge data necessary to set rates for the three handling cost APCs are collected.

Several commenters supported the creation of a mechanism for hospitals to begin capturing and reporting pharmacy costs. However, they indicated that it will take hospitals considerable time and effort to develop this approach as most hospitals do not currently report pharmacy costs directly or capture these costs fully. One commenter recommended that CMS tie reporting of the new C-codes for handling fees to actual payment amounts for the services so that hospitals would have an incentive to quickly develop a mechanism to report these codes. Other commenters supported the general C-code methodology, but were concerned that there was insufficient time to properly instruct and educate hospitals on how and when to use these codes. Therefore, to ensure that the new C-codes can be used effectively, these commenters recommended that CMS consult with hospital organizations on this issue, and after reviewing their feedback, consider delaying C-code implementation until January 1, 2007 while continuing to refine the codes and develop instructions for their use. The APC Panel also recommended that CMS delay implementation of this proposal in order to collect more data and study alternatives.

If this policy is implemented for CY 2006, some commenters suggested that CMS provide a grace period of no less than 90 days after the implementation of the CY 2006 OPPS to allow hospitals time to make necessary system changes and to educate pharmacy staff, finance staff, and coders on the required use of the drug handling C-codes. Other commenters noted that a grace period of no less than 6 months would be required after the implementation of the CY 2006 OPPS. One commenter insisted that CMS collect hospital charge data for overhead costs for 2 years to determine if the proposed 2 percent of the ASP add-on rate is adequate and consider new payment rates for these pharmacy overhead services in CY 2008.

Response: We have carefully considered all the comments and the concerns raised by the commenters. In light of the extensive operational issues related to coding, billing, and charging for C-codes for drug handling categories identified by commenters, we believe there is good reason at this time not to proceed with our proposal for CY 2006. Therefore, we are not finalizing our proposal to collect data on pharmacy overhead costs in CY 2006. Rather, we will continue to solicit input from the industry, APC Panel, and hospitals to explore alternative methodologies for capturing meaningful and complete pharmacy overhead costs, for potential use in providing appropriate payments to hospitals for such services in future updates of the OPPS. We note that for CY 2006 we are requiring specific coding for certain devices, as we require the billing of all separately payable drugs and request that hospitals report packaged drugs. We believe that hospitals can easily ascertain the acquisition costs of devices and decide on an appropriate markup that includes device handling, and these device costs (except for devices with pass-through status) are then appropriately packaged into payments for the separately payable procedures that utilize the devices. Similarly, we believe that hospitals are aware of the acquisition costs of drugs and provide an appropriate markup that includes pharmacy overhead. These billed drugs are then either separately paid at ASP+6% for CY 2006 or their

payment is packaged into payments for the separately payable procedures where the drugs are administered. However, as discussed above, hospitals do not keep track of their pharmacy overhead costs nor their device handling costs separately. Rather, these broad overhead and handling costs are typically built into the charges for the drugs or devices themselves, In many ways, the device charge reported on a claim is like the drug charge, in that both currently reflect the acquisition cost of the device or drug and the handling cost of the device or drug (special handling, storage, etc.). Just as we do not require hospitals at this time to further differentiate their device charges into acquisition and handling components, based on our review of comments to the CY 2006 proposed rule we are also not going to require hospitals for CY 2006 to separate the traditionally highly linked drug acquisition and pharmacy overhead charges.

Comment: Several commenters urged CMS to recognize that low-cost drugs and biologicals may have substantial handling costs depending on the type and volume of the drugs administered, and therefore, recommended that CMS apply additional payments to packaged drugs and biologicals, as well as to separately payable therapies. The APC Panel also recommended that CMS pay for the overhead costs of both packaged and separately paid drugs. One of the commenters suggested that the use of the proposed C-codes for drug handling categories also be extended to include packaged drugs. One commenter recommended that CMS make an add-on payment of at least $14.80 per dose of packaged drug administered, and that CMS consider establishing a new G-code for pharmacy handling services associated with packaged drugs for this purpose. The commenter based its recommendation on an analysis of the amount of required pharmacist and pharmacy technician time, plus indirect overhead costs, associated with preparing each dose of a packaged drug. Another commenter indicated that CMS may believe that overhead costs for packaged drugs are reflected in the payments for drug administration APCs; however, the commenter did not believe that the drug administration APC payment rates are sufficient to pay providers for administration services, or the acquisition and handling costs associated with packaged drugs. In addition, one commenter indicated that CMS should ensure that the add-on payment is applied equally to all drugs, including those on pass-through and new to the market.

One commenter strongly opposed the expansion of the drug handling C-code reporting proposal to packaged drugs, citing that this policy would exponentially increase the coding and administrative burden on hospitals due to the large number of drugs that would require special charging practices for Medicare purposes. For example, the commenter noted that hospitals generally do not provide detailed billing for drugs that are not separately paid. The commenter believed that because all drugs do not have their own unique HCPCS codes, creating new codes for all drugs would be a significant burden. The commenter added that, given the large volume of drugs used in hospital outpatient departments, expanding drug handling coding requirements to all of these drugs, regardless of their packaging status, would dramatically increase hospital administrative costs associated with this proposal. Other commenters expressed similar views.

Response: We agree with the commenters who stated that extending specific payment for handling costs to packaged drugs would impose an excessive burden on hospitals. As the commenters noted, this policy would exponentially increase the coding and administrative burden that our proposed use of C-codes would have imposed. In addition, as we have stated previously, overhead costs are built into the charges for drugs, and these charges are already accounted for in setting the weights for the procedural APCs into which some drugs are packaged. Accordingly, we believe that additional payment for overhead costs of packaged drugs would be duplicative and have not made a separate provision for additional payment.

As discussed earlier, we proposed to pay for separately payable radiopharmaceuticals based on their charges on the claims submitted by hospitals converted to costs. MedPAC found that the handling resource costs associated with radiopharmaceuticals were especially difficult to study and estimate because of the varying resource requirements for handling radiopharmaceuticals in a variety of hospital outpatient settings for different clinical uses. These various methods of preparation of radiopharmaceuticals, and the individual radiopharmaceuticals themselves, differ significantly in the costs of their handling, with substantial variation in such factors as site of preparation, personnel time, shielding, transportation, equipment, waste disposal, and regulatory compliance requirements. However, as MedPAC also found that handling costs for drugs, biologicals, and radiopharmaceuticals were built into hospitals' charges for the products themselves, we stated in the proposed rule that we believed that the charges from hospital claims converted to costs were representative of hospital acquisition costs for these agents, as well as their overhead costs. These costs would appropriately reflect each hospital's potentially diverse patterns of acquisition or production of radiopharmaceuticals for use in the outpatient hospital setting and their related handling costs that vary across radiopharmaceutical products and the circumstances of their production and use. Therefore, we did not propose to create separate handling categories for radiopharmaceuticals for CY 2006.

We received many public comments on this radiopharmaceutical proposal.

Comment: Several commenters stated that CMS should not assume that the hospitals have incorporated handling costs in their hospital charges for radiopharmaceuticals. They indicated that there has been some ambiguity about what costs should be included in radiopharmaceutical charges, as opposed to procedure charges, and this matter is complicated by the difference in payment policies for physician offices as compared to the hospital outpatient setting. They also stated that differing payment policies and lack of clear billing instructions in the different settings contribute to uncertainty about where radiopharmaceutical costs are reported by hospitals. Commenters suggested that CMS specifically declare where the costs for radiopharmaceutical handling should reside for all delivery settings and give clear direction to providers. One commenter stated that, due to the variety of radiopharmaceuticals that can be used with the same procedure, it is most accurate to incorporate radiopharmaceutical handling costs in the charge for the radiopharmaceutical rather than in the charge for the nuclear medicine procedure.

Response: We understand the commenters' concerns. We would emphasize that, in light of the policy that we are adopting in this final rule with comment period of paying for radiopharmaceuticals based on hospitals' charges converted to costs, it is appropriate for hospitals to include all the costs associated with acquiring and handling radiopharmaceuticals in their charges for the radiopharmaceuticals.

However, because we proposed to collect ASP information for radiopharmaceuticals in CY 2006, we

requested specific comments on appropriate categories for potentially capturing radiopharmaceutical handling costs. We stated in the proposed rule that we believed that these handling costs may vary depending on many factors. We also indicated that the handling cost categories should exclude any resources associated with specific diagnostic procedures or administration codes for patient services that utilize the radiopharmaceuticals. However, the handling cost categories should include all aspects of radiopharmaceutical handling and preparation, including transportation, storage, compounding, required shielding, inventory management, revision of dosages based on patient conditions, documentation, disposal, and regulatory compliance. The MedPAC study contractor suggested a variety of discriminating factors that may be related to the magnitude of radiopharmaceutical handling costs, including the complexity of the calculations and manipulations involved with compounding, the intended use of the product for diagnostic or therapeutic purposes, the item's status as a radioimmunoconjugate or nonradioimmunoconjugate, short-lived agents produced in-house, and preparation of the radiopharmaceutical in-house versus production in a commercial radiopharmacy. We sought comments on the construction of radiopharmaceutical handling cost categories that would meaningfully reflect differences in the levels of necessary hospital resources and that could easily be understood and applied by hospitals characterizing their preparation of radiopharmaceuticals.

We received numerous public comments concerning radiopharmaceutical handling cost categories.

Comment: We received comments describing various proposals for creating radiopharmaceutical handling cost categories. One commenter recommended the creation of five handling categories for radiopharmaceuticals and assigning them G-codes, instead of C-codes as proposed, for drug handling categories. The commenter recommended this approach because G-codes are available to all insurers and would assist hospitals in more accurate, consistent, and efficient billing for radiopharmaceuticals. Another commenter suggested seven potential radiopharmaceutical handling categories for our consideration. Still another commenter proposed four categories for capturing the costs of radiopharmaceuticals. MedPAC also encouraged CMS to further study how to best construct categories of handling cost APCs for radiopharmaceuticals, which are generally likely to require greater resources for their preparation than drugs and biologicals. One commenter recommended that all radiopharmaceuticals be paid separately. The commenter believed that because of the potential for hospitals to bill one of the radiopharmaceutical handling category codes, this policy would facilitate appropriate data gathering, recognition, and payment of handling costs for all radiopharmaceuticals.

One commenter was pleased that CMS did not intend to create C-codes for radiopharmaceutical handling costs for CY 2006. Other commenters stated that, if CMS implements its proposal to create handling cost categories for drugs and biologicals in CY 2006, it should also create handling cost categories for radiopharmaceuticals in CY 2006. These commenters added, however, if CMS delays implementation of these drug handling categories, it would be appropriate to delay the adoption of handling cost category codes for radiopharmaceuticals.

Several commenters noted that if CMS implemented specific coding for handling and overhead costs of radiopharmaceuticals in CY 2006, it would have to initiate well in advance of January 2006 an educational effort to communicate to providers the need to use the new codes and to adjust radiopharmaceutical charges during CY 2006 to accurately reflect any changes in HCPCS code descriptors, along with identification of the relevant hospital CCR appropriate for calculating radiopharmaceutical payments. Another commenter suggested that CMS advise hospitals to make timely updates in charges to ensure that they fully, accurately, and uniformly report all relevant costs for radiopharmaceuticals.

A few commenters were concerned about the usefulness of creating additional C-codes for hospitals to report radiopharmaceutical handling costs in CY 2006 for use in CY 2007 without providing any payment to hospitals for this additional work, citing that the process will place an undue administrative burden on hospitals. They recommended that CMS work with medical specialty societies and industry to develop appropriate handling cost categories for radiopharmaceuticals and establish a specific payment rate for each category to help deflect the additional costs to hospitals for this added burden and to ensure adequate data collection. In addition, the commenters asked for concurrent direction to hospitals about including the costs of handling in their charges for radiopharmaceuticals. Another commenter recommended that CMS incorporate these added handling costs directly into the final payment rates for radiopharmaceuticals by individual HCPCS codes.

Response: As discussed earlier, we will not be implementing the C-code handling categories for drugs and biologicals in CY 2006 due to the complex operational and policy issues surrounding this proposal. We will continue to study the possibility of creating handling cost categories for radiopharmaceuticals, as well as drugs, in order to develop viable options for making accurate payments for drug and radiopharmaceutical handling costs for consideration in future updates of the OPPS. In the meantime, as discussed earlier, payment for both acquisition and handling costs of radiopharmaceuticals in CY 2006 will be made based on hospital charges for these items converted to costs using each hospital's overall CCR. This methodology will allow us to pay simultaneously for radiopharmaceutical acquisition and handling costs, without creating additional administrative burden for hospitals.

Comment: One commenter noted that CMS should include the costs associated with specially trained personnel to handle and compound radiopharmaceuticals, waste, and spoilage in its list of elements to consider including as part of radiopharmaceutical handling costs. The commenter also suggested that CMS make clear whether the radiopharmaceutical ''transportation'' costs should reside with the acquisition costs or with the handling costs. At present, many radiopharmaceutical invoice acquisition costs could include the ''transportation'' costs, therefore, the commenter cautioned CMS regarding the potential for double counting.

Response: Since in CY 2006 payment for both acquisition and handling costs of radiopharmaceuticals will be made based on hospital charges for these items converted to costs, we encourage hospitals to include in their charges the costs associated with specially trained personnel to handle and compound radiopharmaceuticals, waste, spoilage, and transportation costs as noted by the commenter. Whether hospitals associate these costs with radiopharmaceutical acquisition or handling is not significant, as both types of costs should be fully reflected in the hospitals' charges for radiopharmaceuticals.

b. Final CY 2006 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for new drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

In the CY 2006 OPPS proposed rule, we proposed to use the same methodology that we used in CY 2005. That is, we proposed to pay for these new drugs and biologicals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the ASP methodology described in the CY 2006 Medicare Physician Fee Schedule final rule. As discussed in the CY 2005 final rule with comment period (69 FR 65797), new drugs, biologicals, and radiopharmaceuticals may be expensive, and we were concerned that packaging these new items might jeopardize beneficiary access to them. In addition, we did not want to delay separate payment for these items solely because a pass-through application was not submitted. We noted in the proposed rule that this payment methodology is the same as the methodology that would be used to calculate the OPPS payment amount that pass-through drugs and biologicals would be paid in CY 2006 in accordance with section 1842(o) of the Act, as amended by section 303(b) of Pub. L. 108–173, and section 1847A of the Act. Thus, we proposed to continue to treat new drugs, biologicals, and radiopharmaceuticals with established HCPCS codes the same, irrespective of whether pass-through status has been determined. We also proposed to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

In the proposed rule, we stated that there were several drugs, biologicals, and radiopharmaceuticals that were payable during CY 2004 or where HCPCS codes for products were created effective January 1, 2005, for which we did not have any CY 2004 hospital claims data. In order to determine the packaging status of these items for CY 2006, in the proposed rule we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product, as determined using the ASP methodology, by an estimated average number of units of each product that would be furnished to a patient during one administration. We proposed to package items for which we estimated the per administration cost to be less than $50 and pay separately for items with an estimated per administration cost greater than $50. We indicated that payment for the separately payable items would be based on rates determined using the ASP methodology established in the physician office setting. There were two codes HCPCS codes 90393 (Vaccina ig, im) and Q9953 (Inj Fe-based MR contrast, ml), for which we were not able to determine payment rates based on the ASP methodology. Because we were unable to estimate the per administration cost of these items, we proposed to package them in CY 2006. We specifically requested public comments on our proposed policy for determining the per administration cost of these drugs, biologicals, and radiopharmaceuticals that were payable under the OPPS, but did not have any CY 2004 claims data.

We received several public comments in response to our request.

Comment: One commenter supported the proposal to price drugs that have a HCPCS code but do not have pass-through status at the same rate they would be paid in the physician office setting based on the ASP methodology.

Response: We appreciate the commenter's support. We are finalizing our proposed policy to pay for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which will be established in accordance with the ASP methodology. We are also paying separately for drugs, biologicals, and radiopharmaceuticals whose HCPCS codes will be payable for the first time under the OPPS in CY 2006 but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPPS.

In CY 2006, payment for these new drugs, biologicals, and radiopharmaceuticals will be based on ASP+6 percent. In accordance with the ASP methodology used in the physician office setting, in the absence of ASP data, we will use wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if WAC is also unavailable, then we will calculate payment at 95 percent of the most recent AWP that we have available at the time of the development of this final rule and for the quarterly updates. We note that with respect to items for which we currently do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent.

For this final rule with comment period, we are basing the payment rates for these items on ASP data from the second quarter of CY 2005, which are effective in the physician office setting on October 1, 2005, because these are the most recent values available for the development of this rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available. Changes in the payment rates will be posted on our Web site during each quarter of CY 2006. Accordingly, effective January 1, 2006, we will base payment rates for all separately payable drugs and biologicals on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006.

For CY 2006, we will apply this policy to several drugs, biologicals, and radiopharmaceuticals that are new effective January 1, 2006 and do not have pass-through status or hospital claims data. These items are listed in Table 26 below and will be separately payable under OPPS in CY 2006, and thus, we have assigned them to status indicator ''K''.

TABLE 26.—CY 2006 PAYMENT METHODOLOGY FOR NEW DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT PASS-THROUGH STATUS AND CY 2004 CLAIMS DATA

HCPCS code	Description	APC	CY 2006 SI
90714	Td vaccine no prsrv >/= 7 im	1634	K
A9567	Technetium TC–99m aerosol	1679	H
A9535	Injection, methylene blue	1640	K
J0132	Acetylcysteine injection	1680	K
J0278	Amikacin sulfate injection	1681	K
J2425	Palifermin injection	1696	K
J2805	Sincalide injection	1699	K
J2850	Inj secretin synthetic human	1700	K
J3471	Ovine, up to 999 USP units	1702	K
J3472	Ovine, 1000 USP units	1703	K
J7341	Non-human, metabolic tissue	1707	K
J8540	Oral dexamethasone	1708	K
J9225	Histrelin implant	1711	K
Q9958	HOCM <=149 mg/ml iodine, 1ml	1714	K
Q9960	HOCM 200–249mg/ml iodine, 1ml	1715	K
Q9961	HOCM 250–299mg/ml iodine, 1ml	1734	K
Q9962	HOCM 300–349mg/ml iodine, 1ml	1735	K
Q9963	HOCM 350–399mg/ml iodine, 1ml	1736	K
Q9964	HOCM >= 400 mg/ml iodine, 1ml	1737	K

Comment: One commenter agreed in principle with CMS' proposed methodology for determining the packaging status for drugs for which CMS did not have CY 2004 claims data. However, the commenter expressed concern about the proposal to package HCPCS code Q9953 (Inj Fe-based MR contrast, ml). The commenter noted that ASP data are available for Q9953, and the data demonstrated that the average per administration cost of Q9953 exceeded the $50 packaging threshold. Thus, the commenter believed that HCPCS code Q9953 should be paid separately in CY 2006. The commenter indicated that the most current ASP data submission, which was submitted to CMS on July 29, 2005, showed an ASP for Feridex I.V., the product described by HCPCS code Q9953, of $28.68 per ml. The commenter pointed out that using an average dosing of 3.5 ml per the Feridex I.V. package insert, the average cost per administration would be $100.39 for HCPCS code Q9953, which far exceeds the CY 2006 OPPS $50 packaging threshold. Therefore, the commenter requested that CMS use the ASP data as reported to establish a CY 2006 OPPS payment amount for HCPCS code Q9953.

Response: Consistent with the commenter's statement, we received ASP data from the second quarter of CY 2005 for HCPCS code Q9953 after the proposed rule was issued. For this final rule with comment period, we are using updated ASP data under the methodology we proposed to determine the packaging status for items that did not have any CY 2004 hospital claims data, and our calculation of the per day cost of HCPCS code Q9953 indicated that it is higher than $50 per day. Therefore, we will make separate payment for HCPCS code Q9953 in CY 2006 and set payment at the rate determined using the ASP methodology.

In this final rule with comment period, we are finalizing the proposed policy for determining the per administration cost of drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS, but which do not have any CY 2004 claims data to determine their packaging status in CY 2006. Table 27 below lists all of the drugs and biologicals to which this policy will apply in CY 2006.

We note that in the proposed rule, we indicated that we are packaging HCPCS code 90393 (Vaccina ig, im) as we were unable to determine a payment rate for this item based on the ASP methodology; thus, we were also unable to estimate the per administration cost of this item, For this final rule with comment period, we were still not able to determine an ASP-based payment for this item to estimate its per administration cost. Therefore, we will continue to package this code in this final rule with comment period.

TABLE 27.—DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2004 CLAIMS DATA

HCPCS code	Description	ASP-based payment rate	Est. average number of units per administration	CY 2006 SI
90581	Anthrax vaccine, sc	$126.46	1	K
C1093*	TC99M fanolesomab	1,197.00	1	H
C9206*	Integra, per cm2	10.69	19	K
C9224	Injection, galsulfase	1,522.15	14	K
J0135	Adalimumab injection	293.98	2	K
J0190	Inj biperiden lactate/5 mg	3.14	1	N
J0200	Alatrofloxacin mesylate	16.03	2.5	N
J0288	Ampho b cholesteryl sulfate	12.00	35	K
J0395	Arbutamine HCl injection	160.00	1	K
J1180	Dyphylline injection	8.05	8.4	K
J1457	Gallium nitrate injection	1.25	340	K
J3315	Triptorelin pamoate	372.86	1	K

TABLE 27.—DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2004 CLAIMS DATA—Continued

HCPCS code	Description	ASP-based payment rate	Est. average number of units per administration	CY 2006 SI
J3530	Nasal vaccine inhalation	15.00	1	N
J7350	Injectable human tissue	5.35	33	K
J7674	Methacholine chloride, neb	0.40	8.875	N
J9357	Valrubicin, 200 mg	369.60	4	K
Q2012*	Pegademase bovine, 25 iu	166.07	56	K
Q2018*	Urofollitropin, 75 iu	48.45	2	K

* For CY 2006, C1093, C9206, Q2012, and Q2018 are deleted and replaced with A9566, J7343, J2504, and J3355 respectively.

Comment: One commenter requested that CMS clarify the coding and payment policies for high osmolar contrast medium (HOCM) that will be applicable during CY 2006. The commenter supported the proposal that would allow hospitals to bill and be paid for these agents using the recently assigned HCPCS codes Q9958—Q9964 and revenue code 636. In addition, the commenter requested that HOCM agents be paid using the ASP methodology in CY 2006. The commenter noted that section 3631 of CMS' Intermediary Manual currently states that ''if billing separately, hospitals use revenue code 255 for contrast material other than LOCM. To prevent confusion and the inappropriate denial of claims, the commenter further requested that CMS specify that hospitals should disregard the program manual instruction and use revenue code 636 and the Q-codes when billing for HOCM.

Response: The HCPCS codes Q9958—Q9964 for HOCM were created effective July 1, 2005. We believe that these codes should be paid separately according to the ASP methodology in CY 2006, similar to our policy of paying separately for new items in CY 2006 because these codes had no predecessor codes in the OPPS and the codes themselves will first be recognized under the OPPS in CY 2006. In this final rule with comment period, we were able to determine ASP-based payment rates for all of the HOCM codes, except HCPCS code Q9959. We were unable to identify a product that crosswalked to this code; therefore, we could not calculate an appropriate payment for this code. Therefore, we are packaging HCPCS code Q9959 in this final rule with comment period. We note that if ASP data become available in later quarter submissions for this code, then we will pay for this code separately based on an appropriate payment rate. The ASP-based payment rates for the separately payable HOCM codes that are listed in Addenda A and B of this final rule with comment period are estimates and have not been published before as these codes are not currently separately paid in the physician office setting. In response to one of the commenter's concerns about appropriate billing for HOCM, the hospitals may wish to post their charges for HOCM on the claim with the revenue code that crosswalks to the cost center on the hospital Medicare cost report where the costs for HOCM are reported. We note that we will be closely examining hospital claims data for HOCM codes, as for all drugs, biologicals, and radiopharmaceuticals, to assess whether packaging or separate payment is appropriate for future OPPS updates.

C. Coding and Billing Changes for Specified Covered Outpatient Drugs

1. Background

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 826), we instructed hospitals to bill for sole source drugs using the existing HCPCS codes, which were priced in accordance with the provisions of section 1833(t)(14)(A)(i) of the Act, as added by Pub. L. 108–173. However, at that time, the existing HCPCS codes did not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug. Therefore, effective April 1, 2004, we implemented new HCPCS codes via Program Transmittal 112 (Change Request 3144, February 27, 2004) and Program Transmittal 132 (Change Request 3154, March 30, 2004) that providers were instructed to use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act. We also instructed providers to continue to use the existing HCPCS codes to bill for noninnovator multiple source drugs to receive payment in accordance with section 1833(t)(14)(A)(i)(III) of the Act. These coding policies allowed hospitals to appropriately code for drugs, biologicals, and radiopharmaceuticals based on their classification and to be paid accordingly. We continued this coding practice in CY 2005 with payment made in accordance with section 1833(t)(14)(A)(ii) of the Act.

2. CY 2006 Payment Policy

In the CY 2006 OPPS proposed rule, we proposed to base the payment rates for drugs and biologicals and their pharmacy overhead costs on the ASP methodology that is used to set payment rates for these items in the physician office setting. Under this methodology, a single payment rate for the drug is calculated by considering the prices for both the innovator multiple source (brand) and noninnovator multiple source (generic) forms of the drug. Therefore, under the OPPS, we noted in the proposed rule that we believed that there was no longer a need to differentiate between the brand and generic forms of a drug. Thus, we proposed to discontinue use of the C-codes that were created to represent the innovator multiple source drugs. In CY 2006, hospitals would use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug as they did prior to implementation of section 1833(t)(14)(A) in Pub. L. 108–173. We specifically requested comments on this proposed policy.

We received a few public comments concerning this proposal.

Comment: Several commenters supported the proposal to eliminate the use of the brand name drug C-codes in CY 2006 as there was no longer a need to distinguish between innovator (brand name) and noninnovator (generic) multiple source drugs. The commenters indicated that this policy will reduce the administrative burden of maintaining and reporting separate HCPCS codes for both generic and brand name drugs. However, some commenters pointed out that the availability of these drugs varies in the marketplace, and they asked CMS to clarify how it determines a single ASP payment for both brand and generic

drugs to ensure that the calculated APC payment accurately reflects the combined cost of both brand and generic forms of the drug. One commenter also requested that CMS clarify whether the ASP is based on the volume of brand versus generic drugs purchased by providers during a given quarter.

Response: Section 1847A(b)(3) of the Act specifies that the payment amount for multiple source drugs is the volume-weighted average of the ASPs reported by the manufacturers of the NDCs assigned to the billing HCPCS code. The computation is weighted by the number of units sold during the reporting period. As availability of products changes in the marketplace, changes in purchasing patterns will be reported in the ASP data. For further discussion of the methodology used to determine the ASP-based payment amounts, see the related ''Frequently Asked Question'' at *http://questions.cms.hhs.gov.* This issue is also addressed in the CY 2006 Medicare Physician Fee Schedule final rule.

For CY 2006, we are finalizing our proposal to discontinue use of the C-codes that were created to represent the innovator multiple source drugs, and note that hospitals are to use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug.

D. Payment for New Drugs, Biologicals, and Radiopharmaceuticals Before HCPCS Codes Are Assigned

1. Background

Historically, hospitals have used a HCPCS code for an unlisted or unclassified drug, biological, or radiopharmaceutical or used an appropriate revenue code to bill for drugs, biologicals, and radiopharmaceuticals furnished in the outpatient department that do not have an assigned HCPCS code. The codes for not otherwise classified drugs, biologicals, and radiopharmaceuticals are assigned packaged status under the OPPS. That is, separate payment is not made for the code, but charges for the code would be eligible for an outlier payment and, in future OPPS updates, the charges for the code are packaged with the separately payable service with which the code is reported for the same date of service.

Drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup could qualify for pass-through payment under the OPPS. An application must be submitted to CMS in order for a drug or biological to be assigned pass-through status, a temporary C-code assigned for billing purposes, and an APC payment amount determined. Pass-through applications are reviewed on a flow basis, and payment for drugs and biologicals approved for pass-through status is implemented throughout the year as part of the quarterly updates of the OPPS.

2. CY 2006 Payment Policy

Section 1833(t)(15) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, provides for payment for new drugs and biologicals until HCPCS codes are assigned under the OPPS. Under this provision, we are required to make payment for an outpatient drug or biological that is furnished as part of covered outpatient hospital services but for which a HCPCS code has not yet been assigned in an amount equal to 95 percent of AWP. This provision applies only to payments made under the OPPS on or after January 1, 2004.

As noted in the proposed rule (70 FR 42733), we initially adopted the methodology for determining payment under section 1833(t)(15) of the Act on an interim basis on May 28, 2004, via Transmittal 188, Change Request 3287, and finalized the methodology for CY 2005 in our CY 2005 OPPS final rule with comment period. In that final rule with comment period, we also expanded the methodology to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned (69 FR 65804 through 65807). We instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the NDC for the product along with new HCPCS code C9399 (Unclassified drug or biological). When HCPCS code C9399 appears on a claim, the OCE suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using the Red Book or an equivalent recognized compendium, and processes the claim for payment. This approach enables hospitals to bill and receive payment for a new drug, biological, or radiopharmaceutical concurrent with its approval by the FDA. The hospital does not have to wait for the next OPPS quarterly release or for approval of a product-specific HCPCS code to receive payment for a newly approved drug, biological, or radiopharmaceutical. In addition, the hospital does not have to resubmit claims for adjustment. Hospitals discontinue billing HCPCS code C9399 and the NDC upon implementation of a HCPCS code, status indicator, and appropriate payment amount with the next OPPS quarterly update.

For CY 2006, we proposed to continue the same methodology for paying for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes. We received a few public comments in response to our proposal.

Comment: Several commenters supported CMS' proposal to pay for new drugs prior to the assignment of a HCPCS code at an amount equal to 95 percent of the drug's AWP and reiterated that the AWP should correspond to the payment rate established by the fiscal intermediaries using the Red Book or an equivalent recognized compendium. One commenter noted that this policy allows providers to receive payment for newer drugs in a timely fashion.

Response: We appreciate the commenters' support for the continuation of our policy to pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes at 95 percent of AWP. For CY 2006, we are finalizing our proposed methodology, without modification.

E. Payment for Vaccines

Outpatient hospital departments administer large numbers of immunizations 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 the 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 the OPPS rates as a major concern. They indicated 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 costs 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 the OPPS in CY 2002, have been receiving payment at reasonable cost for these vaccines since CY 2003.

Influenza, pneumococcal, and hepatitis B vaccines and their administration are specifically covered by Medicare under section 1861(s)(10) of the Act. For CY 2006, we proposed

to continue to pay influenza and pneumococcal vaccines at reasonable cost. However, hepatitis B vaccines have been paid under clinical APCs that also included other vaccines. For CY 2006, we proposed to pay for all hepatitis B vaccines at reasonable cost, consistent with the payment methodology for influenza and pneumococcal vaccines. Influenza and pneumococcal vaccines are exempt from coinsurance and deductible payments under sections 1833(a)(3) and 1833(b) of the Act and have been assigned status indicator ''L''. However, hepatitis B vaccines have no similar coinsurance or deductible exemption. Therefore, we proposed to assign these items status indicator ''F''.

Previously under the OPPS, separately payable vaccines other than influenza and pneumococcal were grouped into clinical APCs 0355 (Level I Immunizations) and 0356 (Level II Immunizations) for payment purposes. Payment rates for these APCs were based on the APCs' median costs, calculated from the costs of all of the vaccines grouped within the APCs. For CY 2006, we proposed to pay for each separately payable vaccine under its own APC, consistent with our policy for separately payable drugs other than vaccines, instead of aggregating them into clinical APCs with other vaccines. We believed this policy would allow us to more appropriately establish a payment rate for each separately payable vaccine based on the ASP methodology. Proposed and final policy changes to coding and payments for the administration of these vaccines are discussed in section VIII.C. of this preamble.

During the August 2005 meeting of the APC Panel, the Panel recommended that CMS change the status indicator for CPT code 90660, intranasal influenza vaccine, to ''L,'' and that the code be reimbursed on a reasonable-cost basis. As discussed below, we accepted this recommendation.

We specifically requested comments on our proposed vaccine policies for CY 2006. We received several public comments concerning our proposal.

Comment: All commenters supported CMS' proposal to continue to pay for influenza and pneumococcal pneumonia vaccines based on reasonable cost. One commenter believed that payment based on reasonable cost helps to ensure that hospitals are adequately paid for providing these vaccines.

Response: We appreciate the commenters' continued support of our policy. We are finalizing our proposal to pay for influenza and pneumococcal pneumonia vaccines at reasonable cost for CY 2006 in this final rule with comment period. We did not receive any comments on our proposals to also pay for Hepatitis B vaccines at reasonable cost and pay for each separately payable vaccine under its own APC. For CY 2006, we are also finalizing these two proposals.

Comment: Several commenters noted that CMS assigned CPT code 90660 (Intranasal influenza vaccine) status indicator ''E,'' indicating that Medicare does not cover the item, does not recognize it, or does not provide separate payment for it. The commenters urged CMS to implement the APC Panel's recommendation to pay for CPT code 90660 on a reasonable cost basis and exempt this code from coinsurance and deductible, similar to all other influenza vaccines.

Response: We agree with the commenters that our proposal to pay influenza vaccines at reasonable cost should also apply to CPT code 90660. Therefore, CPT code 90660 will be paid at reasonable cost and assigned to status indicator ''L'' in CY 2006, similar to all other influenza vaccines.

F. Changes in Payment for Single Indication Orphan Drugs

Section 1833 (t)(1)(B)(i) of the Act gives the Secretary the authority to designate the hospital outpatient services to be covered. The Secretary has specified coverage for certain drugs as orphan drugs (section 1833(t)(14)(B)(ii)(III) of the Act, as added by section 621(a)(1) of Pub. L. 108–173). Section 1833 (t)(14)(C) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, gives the Secretary the authority in CYs 2004 and 2005 to specify the amount of payment for an orphan drug that has been designated as such by the Secretary.

In the CY 2006 OPPS proposed rule (70 FR 42733), we indicated that we recognized that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believed that if the costs of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high costs of this special type of drug. Therefore, we proposed to continue paying for them separately.

In the November 1, 2002 final rule (67 FR 66772), we identified 11 single indication 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).

Eleven single indication orphan drugs were identified as having met these criteria and payments for these drugs were made outside of the OPPS on a reasonable cost basis.

In the November 7, 2003 final rule with comment period (68 FR 63452), we discontinued payment for orphan drugs on a reasonable cost basis and made separate payments for each single indication orphan drug under its own APC. Payments for the orphan drugs were made at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer, unless we were presented with verifiable information that showed that our payment rate did not reflect the price that was widely available to the hospital market. For CY 2004, Ceredase (alglucerase) and Cerezyme (imiglucerase) were paid at 94 percent of the AWP because external data submitted by commenters on the August 12, 2003 proposed rule caused us to believe that payment at 88 percent of the AWP would be insufficient to ensure beneficiaries' access to these drugs.

In the December 31, 2003 correction of the November 7, 2003 final rule with comment period (68 FR 75442), we added HCPCS code J9017 (Arsenic trioxide, 1 mg) to our list of single indication orphan drugs. In the November 15, 2004 final rule with comment period (69 FR 65807), we retained the same criteria for identifying single indication orphan drugs and added two HCPCS codes to our list, HCPCS code C9218 (Injection, Azactidine, per 1 mg) and HCPCS code J9010 (Alemtuzumab, 10 mg) (69 FR 65808). As of CY 2005, the following are the 14 orphan drugs that we have identified as meeting our criteria: HCPCS code C9218 (Injection, Azactidine, per 1 mg); HCPCS code J0205 (Injection, Alglucerase, per 10 units); HCPCS code J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg); HCPCS code J9300 (Gemtuzumab ozogamicin, 5mg); HCPCS code J1785 (Injection, Imiglucerase, per unit); HCPCS code J2355 (Injection, Oprelvekin, 5 mg); HCPCS code J3240 (Injection, Thyrotropin alpha, 0.9 mg); HCPCS code J7513 (Daclizumab, parenteral, 25 mg); HCPCS code J9010 (Alemtuzumab, 10 mg); HCPCS code J9015 (Aldesleukin, per single use vial); HCPCS code J9017 (Arsenic trioxide, 1 mg); HCPCS code J9160 (Denileukin

diftitox, 300 mcg); HCPCS code J9216 (Interferon, gamma 1-b, 3 million units); and HCPCS code Q2019 (Injection, Basiliximab, 20 mg).

In the November 15, 2004 final rule with comment period (69 FR 65808), we stated that had we not classified these drugs as single indication orphan drugs for payment under the OPPS, they would have met the definition of single source specified covered outpatient drugs and received lower payments, which could have impeded beneficiary access to these unique drugs dedicated to the treatment of rare diseases. Instead, for CY 2005, under our authority at section 1833(t)(14)(C) of the Act, we set payment for all 14 single indication orphan drugs at the higher of 88 percent of the AWP or the ASP+6 percent. For CY 2005, we also updated on a quarterly basis the payment rates through comparison of the most current ASP and AWP information available to us. Given that CY 2005 was the first year of mandatory ASP reporting by manufacturers, we did not want potential significant fluctuations in the ASPs to affect payments to hospitals furnishing these drugs, which in turn might cause access problems for beneficiaries. Therefore, in the November 15, 2004 final rule, we did not implement the proposed 95 percent AWP cap on payments for single indication orphan drugs, which was described in the August 16, 2004 proposed rule (69 FR 50518), as we intended to monitor the impact of our payment policy and consider the need for a cap in future OPPS updates if appropriate (69 FR 65809).

As indicated in the proposed rule (70 FR 42734), as a part of the GAO study on hospital acquisition costs of specified covered outpatient drugs, the GAO provided the average hospital purchase prices for four orphan drugs: HCPCS code J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg), HCPCS code J1785 (Injection, Imiglucerase, per unit), HCPCS code J9160 (Denileukin difitox, 300 mcg), and HCPCS code J9010 (Alemtuzumab, 10 mg).

For alpha 1-proteinase inhibitor (HCPCS code J0256), the hospitals in the study sample represented only about 14 percent of the estimated total number of hospitals purchasing the drug. The mean hospital purchase price was about 73 percent of the payment rate based on ASP+6 percent rate and about 63 percent of the CY 2005 payment rate updated in April 2005. We noted in the proposed rule (70 FR 42734) that we believed the GAO acquisition data for alpha 1-proteinase inhibitor were likely not representative of hospital acquisition costs for the drug because the number of hospitals providing data was so small compared to the total number of hospitals expected to utilize the drug. Furthermore, we recognized that the GAO data on hospital drug acquisition costs did not reflect the current acquisition costs experienced by hospitals but instead, relied on past cost data from late CY 2003 through early CY 2004. On the other hand, we stated that the ASP data were more current and thus were likely more reflective of hospital acquisition costs for alpha 1-proteinase inhibitor at the time of issuance of the CY 2006 proposed rule.

In contrast to the GAO data for alpha 1-proteinase inhibitor, the GAO data for imiglucerase (HCPCS code J1785) reflected hospital purchase prices from about 69 percent of the hospitals expected to utilize the drug. For this drug, the mean hospital purchase price was about 93 percent of the CY 2005 payment rate for imiglucerase updated in April 2005, which was based on ASP+6 percent rate. Thus, the ASP-based payment rate also appeared to be appropriately reflective of hospital acquisition costs for imiglucerase, and to be consistent with the GAO mean purchase price.

For denileukin difitox (HCPCS code J9160) and alemtuzumab (HCPCS code J9010), the GAO data for these drugs reflected hospital purchase prices from about 77 percent and 66 percent of the hospitals expected to acquire these drugs, respectively. The mean hospital purchase price for denileukin difitox was about 94 percent of the payment rate based on the ASP+6 percent rate and about 79 percent of the CY 2005 payment rate. As for alemtuzumab, the mean hospital purchase price was about 95 percent of the payment rate based on the ASP+6 percent rate and about 89 percent of the CY 2005 payment rate. For both of these drugs, the ASP-based payment rates also appeared to be appropriately reflective of their hospital acquisition costs, based on confirmation by the GAO average purchase price data from over two-thirds of the hospitals expected to acquire the drugs.

During the quarterly updates to payment rates for single indication orphan drugs for CY 2005, we observed significant improvement in the accuracy and consistency of manufacturers' reporting of the ASPs for these orphan drugs. Overall, we found that the ASPs as compared to the AWPs were less likely to experience dramatic fluctuations in prices from quarter to quarter. We indicated in the proposed rule that we expected that as the ASP system continues to mature, manufacturers will further refine their quarterly reporting, leading to even greater stability and accuracy in their reporting of sales prices. As the ASPs reflect the average sales prices to all purchasers, the ASP data also include drug sales to hospitals. Past commenters have indicated to us that some orphan drugs are administered principally in hospitals, and to the extent that this is true their ASPs should predominantly be based upon the sales of drugs used by hospitals. For three of the orphan drugs for which the GAO provided average purchase prices from a large percentage of hospitals expected to acquire the drugs, the GAO data were very consistent with the ASP+6 percent. For the fourth drug, the GAO mean was significantly lower than the ASP+6 percent and the confidence interval around that mean was quite tight, although only a small proportion of hospitals expected to acquire the drug reported their purchase prices. Thus, in the proposed rule, we stated that we believed that proposing to pay for orphan drugs based on an ASP methodology was appropriate for the CY 2006 OPPS and should assure patients' continued access to these orphan drugs in the hospital outpatient department. Therefore, for CY 2006, we proposed to pay for single indication orphan drugs at the ASP+6 percent.

We believed that paying for orphan drugs using the ASP methodology was consistent with our proposed general drug payment policy for other separately payable drugs and biologicals in the CY 2006 and reflected our general view that ASP-based payment rates serve as the best proxy for the average acquisition cost for these items as described in this section V. of the preamble. In addition, we proposed to pay an additional 2 percent of the ASP scaled for budget neutrality to cover the handling costs of these drugs, also consistent with our proposed general pharmacy overhead payment policy for handling costs associated with separately payable drugs and biologicals. We believed that the ASP+6 percent for orphan drugs would provide appropriate payment for hospital acquisition costs for these drugs that are administered by a relatively small number of providers, so that patients would continue to have access to orphan drugs in the hospital outpatient setting. Hospitals would also receive additional payments for costs associated with their storage, handling, and preparation of orphan drugs. We proposed to update the payment rates on a quarterly basis to reflect the most current ASPs available to us, and we also noted that appropriate adjustments to the payment amounts shown in

Addendum A and B of this final rule with comment period would be made if the ASP submissions in a later quarter indicated that adjustments to the payment rates were necessary. (70 FR 42735) These changes to the Addenda would be announced in our program instructions released on a quarterly basis and posted on our Web site at *http://www.cms.hhs.gov.*

We specifically requested comments on our proposed payment policy for single indication orphan drugs in CY 2006. We received several public comments regarding our proposal.

Comment: One commenter indicated that, under the proposed payment policy for orphan drugs, it did not anticipate access problems generally for orphan drugs that will be used in the hospital outpatient setting in CY 2006. However, the commenter also stated that orphan drugs should be given special consideration as a class and recommended that CMS adopt the definition of ''orphan drugs'' used in the Food, Drug, and Cosmetics Act for purposes of identifying drugs and biologicals that are treatments for rare diseases. The commenter further recommended that CMS establish an evaluation process to determine which orphan products may need special status or assistance to assure access. For example, the commenter suggested that CMS accept orphan products designated by the FDA as a valid class for initial consideration; develop prospective criteria to determine which orphan drugs should not be part of this class; work with stakeholders to identify any access problems that may occur or are likely to occur in the near future; and provide patients and pharmaceutical companies an opportunity to present data and receive a written explanation with examples before making a final decision that an orphan drug access problem exists.

Response: As we stated in the CY 2005 final rule with comment period (69 FR 65808), using the statutory authority in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPS, we have established criteria which distinguish single indication orphan drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination to provide special payment for these drugs in previous years neither affected nor deviated from FDA's classification of any drugs as orphan drugs. The special treatment given to this subset of FDA-designated orphan drugs was intended to ensure that beneficiaries had continued access to these life-saving therapies given that these drugs have a relatively low volume of patient use, lack any other nonorphan indication, and are typically very costly. We will consider the recommendation to establish an evaluation process to determine future changes to the OPPS orphan drug list and the payment rates for these drugs.

Based on our analysis of the ASP rates using data from the fourth quarter of CY 2004 and the GAO reported mean purchase prices for four orphan drugs, we stated in the proposed rule (70 FR 42735) that we believed proposing to pay for orphan drugs using the ASP methodology at a payment rate of ASP+6 percent is appropriate for the CY 2006 OPPS and should ensure patients' continued access to these orphan drugs in the hospital outpatient department. Using updated ASP data reported from the second quarter of CY 2005, we found that our current analysis is consistent with the results we found for the proposed rule. As indicated in the proposed rule, we believe that paying for orphan drugs using the ASP methodology is consistent with our CY 2006 final drug payment policy for other separately payable drugs and biologicals and reflects our general view that ASP-based payment rates serve as the best proxy for the average acquisition costs for these items as described earlier in this preamble.

Earlier in the preamble, we indicated that in CY 2006, we are basing payment for the average acquisition and overhead costs for other separately payable drugs and biologicals on ASP+6 percent because, in part, both the acquisition and pharmacy overhead costs are reflected in the charges submitted by hospitals for these items. In this final rule with comment period, we made this determination using updated ASP data, hospital claims data, and CCRs. We believe that the same observation is true for single indication orphan drugs, as we do not have any reason to believe that hospitals would include their acquisition and overhead costs in the charges for other separately payable drugs and biologicals, but would not follow the same charging practice when billing for single-indication orphan drugs. Therefore, we believe that in CY 2006, a combined payment rate of ASP+6 percent will be sufficient and appropriate for both the acquisition and overhead costs related to providing single-indication drugs to hospital outpatients. Accordingly, in this final rule with comment period, we are adopting the policy of paying for orphan drugs separately at ASP+6 percent, which represents a combined payment for the acquisition and overhead costs associated with furnishing these products. We note that this policy will no longer differentiate how we pay for orphan drugs based on the use of the drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology.

For this CY 2006 OPPS final rule with comment period, we are using payment rates for single-indication orphan drugs based on ASP data from the second quarter of CY 2005, which are effective in the physician office setting on October 1, 2005, because these are the most recent numbers available for the development of this rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available. Changes in the APC payment rates for these items will be posted on our Web site during each quarter of CY 2006. Therefore, effective January 1, 2006, we will base payment rates for single-indication orphan drugs on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006.

Comment: One commenter indicated that payment at ASP+6 percent is inadequate for HCPCS code J9160 (Denileukin diftitox, 300 mcg) because the methodology has resulted in access issues for patients in the physician office setting, which influenced the shift of patients from physician offices to hospital outpatient sites. As CMS proposed to use the same methodology to establish payment rates in the hospital outpatient setting, the commenter is concerned that the consequence will be that patients will be left with no access to this biological. The commenter noted that the GAO data that supported the belief that the median purchase price for hospitals was almost exactly the same as the WAC price for this item for CY 2003. Therefore, the commenter recommended that CMS consider a temporary payment rate for one year that is closer to the actual hospital acquisition cost such as WAC or implement some other special methodology to ensure appropriate payment for this product in CY 2006. The commenter also indicated that an additional payment amount of 2 percent of the ASP for handling costs associated with this biological is inadequate and

requested a higher handling rate for a special class of products, like denileukin diftitox, that require special handling.

Response: As we stated in the proposed rule, the GAO data for denileukin difitox reflected hospital purchase prices from about 77 percent of the hospitals expected to acquire these drugs. The mean hospital purchase price from the GAO study for denileukin difitox was about 91 percent of the ASP+6 percent payment rate based on data from the second quarter of CY 2005 and about 79 percent of the CY 2005 payment rate. We continue to believe in this final rule with comment period that the ASP-based payment rate for this drug appears to be appropriately reflective of its hospital acquisition costs, based on confirmation by the GAO average purchase price data from over three-fourths of the hospitals expected to acquire the drug. Moreover, as stated previously, we believe that like for other single-indication orphan drugs and other separately payable drugs and biologicals, a combined payment of ASP+6 percent in CY 2006 for this drug is adequate to cover both its acquisition and pharmacy overhead costs.

We received two public comments on the proposed payment rate for HCPCS code J0256.

Comment: One commenter indicated that HCPCS code J0256 described three alpha 1-augmentation therapies currently available and urged CMS to recognize the critical importance of the access issues surrounding these therapies. Therefore, the commenter recommended that in CY 2006 CMS set the payment rate for HCPCS code J0256 at the higher of the CY 2005 fourth quarter payment rate or the proposed ASP+8 percent rate. The commenter added that setting a floor should provide access to all three therapies, which is critical because there is not a sufficient supply of any of the alpha 1-proteinase inhibitors to supply all patients for whom the therapy has been prescribed. Another commenter recommended that CMS establish brand-specific codes and payment rates for the different products described by HCPCS code J0256; synchronize operationally the lag time between the manufacturers' ASP reporting and CMS' posting of the updated ASP payment rates on its Web site so that such changes are implemented at the same time for drugs paid under the OPPS and those paid under the physician fee schedule; and consider a proxy add-on payment to cover the overhead costs associated with these drugs.

Response: As discussed earlier in this preamble and noted in the proposed rule, we believe the GAO acquisition data for alpha 1-proteinase inhibitor are likely not representative of hospital acquisition costs for the drug because the number of hospitals providing data is so small compared to the total number of hospitals expected to use the drug. Moreover, the GAO data relied on past hospital cost information from late CY 2003 through early CY 2004. As previously stated, the ASP data are more current, and thus are likely more reflective of present hospital acquisition costs for alpha 1-proteinase inhibitor. We continue to believe this to be true, and therefore, based on rationale cited above, in CY 2006, we will pay for all single-indication orphan drugs, including alpha 1-proteinase inhibitor, at a rate of ASP+6 percent for both the acquisition and overhead costs associated with these items. We find no reason to establish a payment floor for alpha 1-proteinase inhibitor that is related to the CY 2005 payment rates, when we have more current ASP data available that reflect current market prices.

With respect to establishing brand-specific HCPCS codes for the different products described by HCPCS code J0256, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel to establish HCPCS codes. Lastly, we note that in CY 2006 there will not be a lag in the implementation of the ASP-based payment rates for the OPPS and the physician fee schedule. As noted earlier, effective January 1, 2006, we will base payment rates for single-indication orphan drugs on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. We note that HCPCS codes C9128 and Q201 have been deleted effective December 31, 2005 and replaced with HCPCS codes J9025 and J0480, respectively, in CY 2006.

VI. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

A. Total Allowed Pass-Through Spending

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2005 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a 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 payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

As stated in the proposed rule, making an estimate of pass-through spending for devices in CY 2006 entails estimating spending for two groups of items (70 FR 42735). The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2004 and CY 2005 and that would continue to be eligible for pass-through payment in CY 2006. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2005 and would retain pass-through status in CY 2006, as well as items that would be newly eligible for pass-through payment beginning in CY 2006.

B. Estimate of Pass-Through Spending for CY 2006

As we proposed, in this final rule with comment period, we are setting the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2006. As we discuss in section IV.C. of this preamble, the three remaining device categories receiving pass-through payment in CY 2005 will expire on December 31, 2005. Therefore, we estimate pass-through spending attributable to the first group of items described above to equal zero.

To estimate CY 2006 pass-through spending for device categories in the second group, that is, items for which we have no direct claims data, as we proposed, in this final rule with comment period, we used the following approach: For additional device categories that are approved for pass-through status after July 1, 2005, but before January 1, 2006, we used price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question because we did not have any CY 2004 claims data upon which to base a spending estimate. We projected these data forward to CY 2006

using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate CY 2006 pass-through spending for this group of device categories. For device categories that become eligible for pass-through status in CY 2006, we used the same methodology. We anticipated that any new categories for January 1, 2006, would be announced after the publication of the proposed rule, but before publication of this final rule with comment period. Therefore, as indicated in the proposed rule (70 FR 42735), the estimate of pass-through spending in this final rule with comment period incorporates any pass-through spending for device categories made effective January 1, 2006, and during subsequent quarters of CY 2006.

We did not announce pass-through status for any new device categories after July 1, 2005. There is one new device category that we may add for pass-through payment as of January 1, 2006. To estimate CY 2006 pass-through spending for items for which we have no direct claims data, we are adhering to the methodology, as specified above, for estimating pass-through spending for the second group of items, with a refinement to the growth factor. That is, we are projecting forward to CY 2006 the OPPS volume of the procedure utilizing devices that could fall into the potential new device category at a higher rate of increase than the total rate of growth in OPPS services as projected by the OACT. The rate of growth of this relatively new procedure in the OPPS claims data from recent years is several times the overall growth rate of all OPPS services.

With respect to CY 2006 pass-through spending for drugs and biologicals, as we noted in the proposed rule (70 FR 42735) and as explained in section V.A.3. of this final rule with comment period, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status will equal zero. Therefore, our estimate of pass-through spending for drugs and biologicals with pass-through status in CY 2006 equals zero.

In the CY 2005 final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. The pass-through amount for new radiopharmaceuticals approved for pass-through status in CY 2005 is the difference between the OPPS payment for the radiopharmaceutical, that is, the payment amount determined for the radiopharmaceutical as a sole source specified covered drug, and the payment amount for the radiopharmaceutical under section 1842(o) of the Act. However, we have no new radiopharmaceuticals that were added for pass-through payment in CY 2005, and we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2006, for which pass-through status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 final rule with comment period. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2006 will be significant enough to materially affect our estimate of total pass-through spending in CY 2006. Therefore, we are not including radiopharmaceuticals in our estimate of pass-through spending for CY 2006.

In accordance with the methodology described above and the methodology for estimating pass-through spending discussed in our proposed rule for CY 2006, we estimate that total pass-through spending for device categories that first become eligible for pass-through status during CY 2006 will equal approximately $45.5 million, which represents 0.17 percent of total OPPS projected payments for CY 2006. This figure includes estimates for the current device categories continuing into CY 2006, which equal zero, in addition to projections for categories that first become eligible during CY 2006.

This estimate of total pass-through spending for CY 2006 is significantly lower than many previous years' estimates (except for the CY 2005 estimate, which was approximately $23.4 million) both because of the method we used, as discussed in section V.A.3. of this preamble, for determining the amount of pass-through payment for drugs and biologicals with pass-through status, and the fact that there are no CY 2005 pass-through device categories that are being carried over to CY 2006.

Because we estimate pass-through spending in CY 2006 will not amount to 2.0 percent of total projected OPPS CY 2006 spending, we will return 1.83 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this preamble.

We received one public comment on our estimated pass-through spending for CY 2006.

Comment: One commenter commended us for returning, via an adjustment to the conversion factor, the portion of the pass-through spending pool that exceeds the estimated amount for pass-through payments in CY 2006. The commenter indicated that this will ensure beneficiary access to basic services.

Response: We appreciate the commenter's support.

Accordingly, we are finalizing our proposed methodology for estimating CY 2006 OPPS pass-through spending for drugs, biologicals, and categories of devices with the modification as discussed above. Our adoption of this proposal as modified will return 1.83 percent of the pass-through pool to adjust the conversion factor.

VII. Brachytherapy Source Payment Changes

A. Background

Section 1833(t)(16)(C) and section 1833(t)(2)(H) of the Act, as added by sections 621(b)(1) and (b)(2) of Pub. L. 108–173, respectively, establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004, through December 31, 2006.

Section 621(b)(3) of Pub. L. 108–173 requires the Government Accountability Office (GAO) to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations. As indicated in the CY 2006 proposed rule, we are awaiting the report and any recommendations on the payment of devices of brachytherapy, which would pertain to brachytherapy payments after December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and (b)(2)(C) of Pub. L. 108–173. In that rule, we stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. Since January 1, 2004, we have used status indicator ''H'' to denote nonpass-through brachytherapy sources paid on a cost basis, a policy that we

finalized in the CY 2005 final rule with comment period (69 FR 65838).

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (High Dose Rate Iridium 192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108–173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108–173 to pay for HCPCS code C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We finalized this payment methodology in our November 15, 2004 final rule with comment period (69 FR 65839).

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices. In accordance with this provision and based on recommendations of the APC Panel in the February 2004 meeting, we established the following two new brachytherapy source codes for CY 2005 (69 FR 65839):

- C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source
- C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source

In addition to adopting the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Palladium-103 on a per source basis, we adopted this policy for other brachytherapy code descriptors, as well. Therefore, beginning January 1, 2005, we included ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment were not already delineated. Table 40 published in the November 15, 2004 final rule with comment period (69 FR 65840) included a complete listing of the HCPCS codes, long descriptors, APC assignments, and status indicators that we used for brachytherapy sources paid under the OPPS in CY 2005 (69 FR 65840 and 65841).

Further, for CY 2005, we added the following code of linear source Palladium-103 to be paid at cost: C2636 Brachytherapy linear source, Palladium-103, per 1 mm. We had indicated in our August 16, 2004 proposed rule that we were aware of a new linear source Palladium-103, which came to our attention in CY 2003 through an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source fell under the provisions of Pub. L. 108–173. Therefore, we made final our proposal to add HCPCS code C2636 as a new brachytherapy source to be paid at cost in CY 2005.

B. Changes Related to Pub. L. 108–173

As stated in the CY 2006 OPPS proposed rule (70 FR 42736), we consistently invite the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources. We request that commenters provide a detailed rationale to support recommended new codes and to send recommendations to us. We endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Prior to the publication of the CY 2006 OPPS proposed rule, we had then recently received only one such request for coding and payment of a new brachytherapy source since we added separate APC payment beginning in CY 2005 for the three brachytherapy sources discussed above. Therefore, we did not propose any coding changes to the sources of brachytherapy for CY 2006 but listed in Table 26 of the CY 2006 proposed rule (70 FR 42737) the separately payable brachytherapy sources that we proposed to continue for CY 2006. In addition, in that same proposed rule, we stated that we would evaluate the one request that we had received for establishment of a new brachytherapy source code prior to publishing this final rule with comment period (70 FR 42736). Our decision regarding that coding request is discussed below.

At the end of May 2005, we received a recommendation for the creation of a new code and descriptor that would be used to pay separately for Ytterbium-169, a new high activity brachytherapy source for use in High Dose Rate (HDR) brachytherapy, in accordance with sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act, as added by sections 621(b)(1) and (b)(2), respectively, of Pub. L. 108–173. We evaluated this new source and agree with the recommendation to establish a new code and descriptor for Ytterbium-169, effective October 1, 2005. The new coding information was first announced in Program Transmittal 662, dated August 26, 2005, for OPPS implementation effective October 1, 2005. The new code and long descriptor are as follow:

- C2637 Brachytherapy source, Ytterbium-169, per source

This code and descriptor are also listed in Table 29 below.

We received one public comment concerning payment for brachytherapy sources.

Comment: One commenter requested CMS to identify a form of radiation therapy as utilizing a source of brachytherapy and provide a separate payment for the source.

Response: We will evaluate this request and, if warranted, establish a code, descriptor, and separate payment for a source of brachytherapy. Evaluation of potential brachytherapy sources is often complex and requires a significant evaluation period. Because this request was received as one of our comments to the proposed rule for CY 2006, we will continue to evaluate it and provide a code and descriptor, if appropriate, through one of our quarterly OPPS updates.

C. Final Policy for CY 2006

Table 28 provides a complete listing of the HCPCS codes, long descriptors, APC assignments, and status indicators that we will use for brachytherapy sources paid separately on a cost basis under the OPPS in CY 2006.

TABLE 28.— SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2006

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source	1718	Brachytx source, Iodine 125	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytherapy source, Palladium 103, per source.	1720	Brachytx source, Palladium 103	H
C2616	Brachytherapy source, Yttrium-90, per source	2616	Brachytx source, Yttrium-90	H
C2632	Brachytherapy solution, Iodine125, per mCi	2632	Brachytx sol, I-125, per mCi	H
C2633	Brachytherapy source, Cesium-131, per source	2633	Brachytx source, Cesium-131	H
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I-125	H
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P-103	H
C2636	Brachytherapy linear source, Palladium-103, per 1MM.	2636	Brachytx linear source, P-103	H
C2637	Brachytherapy source, Ytterbium-169, per source.	2637	Brachytx, Ytterbium-169	H

VIII. Coding and Payment for Drug Administration

A. Background

From the start of the OPPS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department:

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit).

A fourth OPPS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit) was active from the beginning of the OPPS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and the APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services and moved to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPPS payment rates.

In response to comments we received concerning the available opportunities to gather additional drug administration data (and subsequently facilitate development of more accurate payment rates for drug administration services in future years) and to reduce hospital administrative burden, we proposed for the CY 2005 OPPS to change our coding and payment methodologies related to drug administration services.

After examining comments and suggestions, including recommendations of the APC Panel, we adopted a crosswalk for the CY 2005 OPPS that identified all active CY 2005 CPT drug administration codes and the corresponding OPPS Q-codes, which hospitals had previously used to report their charges for drug administration services. Hospitals were instructed to begin billing CPT codes for drug administration services in the hospital outpatient department effective January 1, 2005.

Payment rates for CY 2005 drug administration services were set using CY 2003 claims data. These data reflected per-visit costs associated with the four Q-codes listed above. To allow for the time necessary to collect data at the more specific CPT code level and to continue accurate payments based on available claims data, we used the Q-code crosswalk to map CPT drug administration codes to existing drug administration APCs. While hospitals were instructed to bill all relevant CPT codes that describe the services provided, the OCE collapsed payments for drug administration services attributed to the same APC and paid a single APC amount for those services for each visit, unless a modifier was used to identify drug administration services provided more than once in a separate encounter on the same day.

In 2004, the CPT Editorial Panel approved several new drug administration codes and revised several existing codes for use beginning in CY 2006. Those physicians paid under the Medicare Physician Fee Schedule were given HCPCS G-codes corresponding to these expected CY 2006 CPT codes to bill for drug administration services provided in CY 2005 in the physician office setting.

B. CY 2006 Drug Administration Policy Changes

For CY 2006 OPPS billing purposes, we proposed to continue our policy of using CPT codes to bill for drug administration services provided in the hospital outpatient department, understanding that the CY 2005 CPT codes were likely going to change significantly for CY 2006. We anticipated that the CY 2005 CPT codes would no longer be active in CY 2006. Therefore, we proposed a CY 2006 crosswalk that mapped CY 2005 CPT codes to the CPT drug administration codes approved by the CPT Editorial Panel in CY 2004. Our closest proxy to the expected CY 2006 CPT codes was the set of HCPCS G-codes used in the physician office setting for CY 2005 and we used these G-codes in an extensive crosswalk (Table 27 in the proposed rule) that provided an overview of our proposed billing and payment policies for CY 2006.

The OPPS drug administration payment rates that we proposed for CY

2006 were dependent on CY 2004 data containing per-visit charges for HCPCS codes Q0081, Q0083, and Q0084. While HCPCS code Q0085 was used to inform payment rates for drug administration APCs for CY 2005, there are no data from this code to develop payment rates for drug administration APCs for CY 2006 because this code was not used in CY 2004. We proposed to map the new CY 2006 CPT codes to existing drug administration APC groups (APC 0116, APC 0117, and APC 0120) as we did in CY 2005. Again, we indicated in our proposal that hospitals would be expected to bill all relevant CPT codes for services provided, despite the per-encounter payment hospitals would receive for services billed within the same APC group without the use of a proper modifier to signify services that were provided in a separate visit on the same day.

The APC Panel approved the crosswalk presented in Table 27 of the CY 2006 OPPS proposed rule at both the February 2005 and August 2005 meetings, and further recommended that CMS evaluate hospital claims data to ensure appropriate payments for subsequent hours of infusion.

We received a number of public comments on several aspects of our proposed drug administration policy for CY 2006.

Comment: Numerous commenters generally supported our proposed policy to use CPT codes to report drug administration services in the hospital outpatient setting in CY 2006. They stated that consistent coding across sites of service reduces hospital burden by simplifying the coding process. The majority of these commenters offered support in the context of the overall principle of utilizing CPT codes when applicable in the hospital outpatient setting to bill for services under the OPPS.

Response: We agree with the commenters that consistent coding across sites of service is preferable when codes are applicable across settings. Our transition to CPT codes in CY 2005 was in response to numerous comments requesting that the OPPS recognize CPT drug administration codes to reduce the overall hospital administrative burden of billing one set of codes for Medicare and another set of codes for non-Medicare payers.

Comment: Commenters expressed concern over the complexity and specificity of the CPT codes and the billing guidelines provided by the AMA for the new CY 2006 CPT codes for drug administration. Specifically, the commenters stated that CPT code descriptions that contain ''initial,'' ''sequential,'' or ''concurrent'' either did not apply or would be very difficult to correctly apply in the hospital setting due to the patient's likelihood of receiving numerous drug administration services from multiple hospital departments during the course of a patient's hospital outpatient encounter. The commenters recommended that CMS instruct hospitals to disregard these terms, particularly the word ''initial'' and the related CPT instruction to bill only one initial service when multiple intravenous injections and infusion are provided, when billing for outpatient services as these codes do not sufficiently describe the way hospital services are often provided. The commenters pointed out that because hospital outpatient charging for drug administration services currently occurs at the departmental level on a flow basis as services are provided, if hospitals were required to use the CPT codes in full accordance with the CPT instructions, extensive, disruptive, and burdensome involvement of medical records staff and coders would be required to bill for these very common hospital outpatient services.

Response: While we understand the commenters' concerns regarding the granularity of the CY 2006 CPT codes, we do not agree that the concepts embedded in CPT codes described with the terms ''initial,'' ''sequential,'' or ''concurrent,'' and the accompanying expectations of differential resources required to perform those services, are inapplicable in the hospital setting. Similar to a physician office setting, we believe it is reasonable to expect that different hospital resources would be used for the first (initial) drug administration service provided to a patient in a hospital outpatient setting on a single day. For example, the first intravenous infusion provided to a hospital outpatient would generally require either the start of an intravenous line or the accessing of an indwelling catheter or port. All subsequent intravenous infusions in the hospital on the same day would likely not involve those additional resources associated with the initial infusion. We understand that the concepts associated with drug administration coding using CY 2006 CPT codes are substantially different from the principles of drug administration coding used by the OPPS in the past. However, this conceptual difference alone does not lead us to conclude that the full adoption of the CY 2006 CPT codes and their descriptors in the hospital setting is inappropriate.

While we acknowledge that hospital charging practices might need to change with implementation of the new CY 2006 CPT codes and their descriptors, in the OPPS we originally moved to the use of CPT codes for the billing of drug administration services at the request of hospitals so they could use one standard code set for billing all payers. We would expect that hospitals would nonetheless need to implement some administrative changes for other payers who will be making payments for hospital outpatient drug administration services based on the CY 2006 CPT codes. While we do not doubt the administrative burden on hospitals associated with billing changes, we cannot and do not understand how our instructing hospitals to ignore certain concepts in the code descriptors for the new CY 2006 CPT codes would substantially reduce the administrative changes necessary for hospitals to bill the codes appropriately to other payers, in addition to Medicare.

Comment: Several commenters pointed out that if the proposed crosswalk were implemented as displayed in Table 27 of the proposed rule and no exceptions to CPT billing guidance were provided, our CY 2005 payment policy of providing separate APC payments for chemotherapy services and nonchemotherapy infusions during the same episode of care would no longer apply. The commenters believed that if our proposal is to package all subsequent hours of infusion therapy (chemotherapy and nonchemotherapy), hospitals following CPT billing guidelines would have coded only one initial code, and therefore only received one APC payment. The commenters expressed concern about this situation and stated that they did not believe it was CMS' intent to reduce payment in this scenario.

Response: The commenters are correct in that it was not our intent to change the drug administration payment policies in place in CY 2005. We appreciate the analysis submitted by the commenters who provided us with detailed recommendations to remedy this situation.

Under CY 2006 CPT guidelines, hospitals would be required to bill one, and only one, initial service code for intravenous drug administration services (unless a modifier is used to indicate an additional episode of care on the same date of service). As many commenters noted, hospital billing personnel recently transitioned from a per-visit concept under the CY 2004 Q-codes to a per-treatment concept under CY 2005 CPT codes, and an additional transition in CY 2006 to even more complex concepts does not allow

sufficient time to properly train and educate hospital personnel regarding correct coding for drug administration.

As we considered the above comments, we developed preliminary OCE logic that would have potentially permitted some of the CY 2006 CPT codes for sequential and additional infusion services to be assigned status indicator ''Q,'' consistent with a variable payment status. That is, under some circumstances where the sequential infusion was the same type of infusion (that is, chemotherapy or nonchemotherapy) as the initial infusion, payment for the sequential infusion would be packaged into payment for the initial drug administration service. In contrast, for situations where the sequential infusion was of a different type than the initial infusion, separate OPPS payment for the sequential infusion would be made. Thus, in order to determine the payment status of some drug administration CPT codes (packaged or separately payable), hospitals would have to be meticulous in correctly coding their claims. Therefore, only expected code pairs that had been built into OCE logic were present on claims. Otherwise, claims would have to be returned to hospitals for correction. We grew concerned that hospitals would have an overwhelming burden not only implementing these new CPT codes in hospital software but also providing the necessary training to a variety of staff who provide and bill these high-volume drug administration services. It is our understanding that a system change this complex may have unintended consequences if implemented for January 1, 2006. One of our main concerns is that without sufficient time to train and educate staff, hospitals may experience a great number of returned claims and, therefore, experience a delay in payment for these high-volume services. We believe that the level of understanding required to properly bill for services under the CY 2006 CPT codes will require substantial hospital efforts to minimize unintentional coding errors that could lead to returned claims.

We have developed the advanced OCE logic that identifies separately payable instances of multiple drug administration services provided in the same episode of care but with only one initial CPT code. Claims not passing this extensive logic would not provide sufficient information in order to assign APC payment to the services billed, and would subsequently result in a return of such claims to providers. We are still reviewing the future use of such logic for drug administration services under the OPPS.

Comment: Commenters provided a variety of other solutions that could permit continuation of CY 2005 OPPS drug administration payment policies while using CY 2006 CPT codes. The commenters' suggestions included reverting back to the three Q-codes (used prior to CY 2005), creating HCPCS codes to mimic the CY 2005 CPT codes, or creating a hybrid of CY 2005 and CY 2006 drug administration codes.

Response: We appreciate the many ideas discussed in the comments we received on the proposed rule, and we considered the above mentioned options in addition to many others before making our decision. However, we believe we have discussed the inherent advantages of using CPT codes, and in order to continue in our efforts to use CPT codes whenever possible, we will be adopting 20 of the 33 CY 2006 drug administration CPT codes for billing and payment purposes under the OPPS for CY 2006 (Table 29).

BILLING CODE 4120–01–P

Table 29.--CY 2006 OPPS Drug Administration CPT Codes

Code	Description	Add-On	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	--	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	--	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	--	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	--	S	0116
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti neoplastic	--	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	--	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	--	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	--	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	--	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	--	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	Y	N	-
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	--	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	--	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	--	S	0116
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	--	S	0116
96521	Refilling and maintenance of portable pump	--	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	--	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	--	N	-
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	--	S	0116
96549	Unlisted chemotherapy procedure	--	S	0116

BILLING CODE 4120–01–C

In addition, we will not recognize under the OPPS 13 of the 33 CY 2006 CPT codes, but instead will instruct hospitals to use 6 new HCPCS C-codes for billing and payment purposes under OPPS for CY 2006 (Table 31). The C-codes generally parallel the less complex CY 2005 CPT codes for infusions and intravenous pushes, as those codes will be deleted for the CY 2006 OPPS. We are adopting these 6 newly created C-codes in an effort to minimize the administrative burden hospitals have indicated they will face if the OPPS were to adopt all 33 of the CY 2006 drug administration CPT codes. The CY 2006 CPT drug administration codes that we will not be using in the OPPS for CY 2006 are codes that require determinations of initial, sequential, and concurrent infusions or intravenous pushes. The C-codes will permit straightforward billing of types of infusions and intravenous pushes, for the first hour and then each additional hour of infusion or for each intravenous

push, an approach to coding that commenters indicated was consistent with current patterns of delivery and billing of drug administration services in the hospital outpatient setting. The OCE logic to determine the appropriate CY 2006 APC payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day will operate as it did for CY 2005. As the C-codes are similar to the CY 2005 CPT codes, we expect that their implementation for CY 2006 billing should be clear, as hospitals have 1 year of experience already with the use of very similar codes during CY 2005.

We believe that providing hospitals with additional time to train staff on the correct billing of the CY 2006 drug administration CPT codes, combined with the opportunity for hospital staff to use these codes for non-Medicare payers during CY 2006, should allow a less burdensome transition to the remaining CPT drug administration codes in the future. In addition, because we will have more specific drug administration median cost data for use in the CY 2007 OPPS and beyond with the first availability of CY 2005 cost data for the CPT codes for drug administration services, we anticipate that ensuring more accurate payment with respect to these remaining CPT drug administration codes may be more feasible for future OPPS updates.

TABLE 30.—CY 2006 OPPS DRUG ADMINISTRATION C-CODES

Code	Description	Add-On	SI	APC
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour		S	0120
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950).	Y	N	
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push		X	0359
C8953	Chemotherapy administration, intravenous; push technique		S	0116
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour		S	0117
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954).	Y	N	

Comment: Commenters requested that CMS provide various billing and coding instructions relating to the CY 2006 CPT drug administration codes, and that CMS include more specific definitions of CPT drug administration terminology in the final rule.

Response: We appreciate the commenters' request for clarity on aspects of the proposed CY 2006 drug administration CPT codes. As we have done in the past, we will release instructions separately from this final rule with comment period that include drug administration billing and coding guidance for hospitals for CY 2006. In addition, as is our longstanding practice, we defer questions about CPT code definitions to the AMA CPT Editorial Panel members who are the creators and maintainers of CPT codes.

Comment: Several commenters requested that CMS provide explicit billing and coding instructions regarding the administration of specific drugs and agents.

Response: As stated above, we do not provide billing guidance to hospitals in the final rule. Information for hospitals that discusses billing and coding specifics will be distributed separately via CMS transmittal following the publication of this final rule with comment period. In addition, we expect that all drug administration codes used in the CY 2006 OPPS, including the new C-codes, will conform to CPT guidance regarding under what clinical circumstances they may be appropriately billed, including instructions related to appropriate coding for the administration of certain complex biologics.

Comment: Commenters requested that a section within the AMA CPT Manual be created to identify and provide hospital-specific definitions for CPT codes that are used by the OPPS.

Response: The OPPS does not issue or maintain CPT codes. Comments regarding the AMA CPT Manual or CPT codes should be directed to the AMA.

Comment: Commenters requested that CMS create non-chemotherapy HCPCS codes similar to the CPT codes for initiation of a prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for these services when provided to patients who require extended infusions of non-chemotherapy medications, including drugs for pain. They argued that the CY 2006 CPT codes for drug administration do not include appropriate codes to bill for these services, which require specific and significant hospital resources.

Response: We agree that codes for these services were needed, and we have created HCPCS codes C8956 (Refilling and maintenance of portable or implantable pump or reservoir for drug delivery for therapy/diagnosis, systemic (eg. intravenous, intra-arterial)) and C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) for this purpose (Table 31).

TABLE 31.—NONCHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

Code	Description	Add-On	SI	APC
C8956	Refilling and maintenance of portable or implantable pump or reservoir for drug delivery for therapy/diagnosis, systemic (eg. intravenous, intra-arterial).		T	0125
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump.		S	0120

Comment: One commenter requested that the OPPS use the information present on the claim, specifically the pharmacy revenue code (636), to identify which payment would be best suited for administration of that type of drug.

Response: We support minimizing the administrative burden that hospitals incur when billing for drug administration services in the outpatient department. However, we do not believe that this suggestion would yield more accurate claims data or reduce the administrative burden on hospitals to code for drug administration services. Hospitals are responsible for identifying which drug administration services are provided and establishing appropriate charges for those services, and implementing a system such as that conceived by the commenter that removes the determination from hospitals would be unproductive.

Comment: Commenters noted that CY 2006 drug administration APC payment rates are derived from CY 2004 claims data and expressed concern that these data are outdated and inaccurate.

Response: While we acknowledge the concern presented by commenters, we do not believe that our reliance on the most recent claims data available provides inaccurate payments for drug administration services provided in hospital outpatient departments. It has been the OPPS policy to set payments for drug administration services, as well as almost all other OPPS services, based on the most recent claims year data available, and we are continuing that methodology in CY 2006.

Comment: Several commenters requested that CMS implement a chemotherapy demonstration program similar to the Quality of Care Demonstration program that was instituted in the physician office setting throughout CY 2005.

Response: While we recognize the desire of the commenters to ensure beneficiary access to drug administration services by providing additional payments to hospitals for drug administration-related services, we believe that the drug administration payment methodology we are finalizing in this final rule with comment period provides accurate payments for hospital drug administration services. Further, we do not believe that there is a beneficiary access issue directly attributable to the OPPS payment policies for drug administration services.

Comment: Many commenters requested that the OPPS provide payment for additional hours of infusion, instead of packaging subsequent hours of infusion into the payment for the initial hour of infusion therapy.

Response: As discussed in the proposed rule, CY 2006 OPPS payment rates rely upon CY 2004 claims data that only has information on the three Q-codes mapped to APCs 0116, 0117 and 0120. For CY 2006, while the codes for initial hour of infusion and subsequent hour(s) of infusion were available for hospitals to report in CY 2005, appropriate CY 2005 claims data are not available to use for ratesetting purposes for the CY 2006 OPPS. As the most recent and complete year of data available from CY 2004 reflects per-visit payment rates for drug administration services, we must continue to use both our crosswalk methodology and the OCE claims logic during CY 2006 which allows us to collect more specific drug administration cost data while continuing to make appropriate drug administration payments. Because of the descriptors of the previous drug administration Q-codes upon which CY 2006 drug administration payment rates are based, each payment for a drug administration APC in CY 2006 is necessarily a payment that reflects an ''average'' infusion service in CY 2004, constituting one or more hours. We appreciate hospitals' continued diligence in accurately billing for the additional hours of infusion for chemotherapy and nonchemotherapy treatments that will once again be packaged for CY 2006, as we gather additional hospital claims data to support our move to more specific payments for individual drug administration services in the future.

Comment: One commenter noted that in Addendum B, Payment Status by HCPCS Code and Related Information Calendar Year 2006, HCPCS code G0258 (IV infusion during obs stay) was incorrectly listed as payable with a status indicator of ''X.''

Response: We agree that HCPCS code G0258 was incorrectly listed in Addendum B of the proposed rule as having status indicator ''X'' rather than ''B.'' However, HCPCS code G0258 is deleted for CY 2006; therefore, it will have no payment status in the CY 2006 OPPS.

Comment: One commenter requested that CMS not reassign CPT codes 95144 through 95165 (Antigen therapy services) to the injection APCs as listed in Addendum B of the proposed rule. Instead, the commenter suggested keeping these services within APC 0371 because of their similarity in resource use and for reasons of clinical coherence.

Response: We agree with the commenter that the median cost data available for these codes do not correspond to the expected levels of service based on the CPT code descriptors. For example, in the proposed rule, HCPCS code 95149 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; five single stinging insect venoms) was mapped to APC 0352 (Level I Injections) based on a median cost of $11.43 from 9 single claims, while HCPCS code 95146 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; two single stinging venoms) was mapped to APC 0359 (Level III Injections) based on a median cost of $70.64 from 43 single claims. These unexpected median cost results may have arisen from miscoding or from the inherently high volatility in costs that may occur due to small numbers of claims. While we are unable to retain these codes in APC 0371 as recommended by the commenter due to the restructuring of the injection codes into three levels of injection APCs, we have decided to place CPT codes 95144 through 95165 in APC 0353 (Level II Injections) because we believe that the services provided by these HCPCS codes are similar to other HCPCS codes within this APC and the CY 2006 median cost for APC 0353 most closely matches the CY 2005 median cost these codes experienced in APC 0371.

C. 2006 Vaccine Administration Policy Changes

Hospitals currently use three HCPCS G-codes to indicate the administration of the following vaccines that have specific statutory coverage:

- G0008—Administration of Influenza Virus Vaccine.
- G0009—Administration of Pneumococcal Vaccine.
- G0010—Administration of Hepatitis B Vaccine.

HCPCS codes G0008 and G0009 are exempt from beneficiary coinsurance and deductible applications and, as such, payment has been made outside of the OPPS since CY 2003 based on reasonable cost. We have made payment for HCPCS code G0010 through a clinical APC (that is, APC 0355) that included vaccines along with this vaccine administration code. Additional vaccine administration codes have been packaged or not paid under the OPPS.

As stated in the CY 2006 OPPS proposed rule, we believe that HCPCS codes G0008, G0009 and G0010 are clinically similar and comparable in resource use to one another and to the administration of other immunizations and other therapeutic, prophylactic, or diagnostic injections. To that end, we concluded that the appropriate APC assignment for these vaccine administration services was newly reconfigured APC 0353 (Injection, Level

II). However, because of their statutory exemption regarding beneficiary deductible and coinsurance, for operational reasons we were unable to include HCPCS codes G0008 and G0009 in an APC with codes that did not share this exemption.

Instead of including these codes within the same APC, we proposed to map HCPCS codes G0008 and G0009 to APC 0350 (Administration of flu and PPV vaccines). As dictated by statute, HCPCS codes G0008 and G0009 would continue to be exempt from beneficiary coinsurance and deductible.

We also proposed to change the status indicator for HCPCS code G0010 from ''K'' (Separate APC Payment) to ''B'' (Not paid under OPPS; Alternate code may be available), and to change the status indicators for vaccine administration codes 90471 and 90472 from ''N'' (Packaged) to ''X'' (Separate APC Payment), in agreement with the recommendation of the APC Panel to unpackage these services. Hospitals would code for hepatitis B vaccine administration using codes 90471 or 90472 (as appropriate), and payment would be mapped to reconfigured APC 0353 (Injection, Level II) that would include other injection services that were clinically similar and comparable in resource use.

In order to pay appropriately for services that we believed were clinically similar and comparable in resource use and, barring technical restrictions, would otherwise be assigned to the same APC, we proposed to calculate a combined median cost for all services assigned to APC 0350 and APC 0353 that would then serve as the median cost for both APCs. This combined median would be calculated using charges converted to costs from claims for services in both APCs and would have the effect of making the OPPS payment rates for APC 0350 and APC 0353 identical, although beneficiary copayment and deductible would not be applied to services in APC 0350.

Our vaccine administration proposed policy also included proposed changes to the status indicators for vaccine administration codes 90473 and 90474 from ''E'' (Not paid under OPPS) to ''S'' (Paid under OPPS) and proposed to make payments for these services when they were covered through proposed APC 1491 (New Technology—Level IA ($0–$10)).

Finally, we proposed to change the status indicators for the four remaining vaccine administration codes involving physician counseling (90465, 90466, 90467 and 90468) from ''N'' (Packaged) to ''B'' (Not paid under OPPS; Alternate code may be available). We proposed that hospitals providing immunization services with physician counseling would use the vaccine administration codes 90471, 90472, 90473, and 90474 to report such services, as we did not believe the provision of physician counseling would significantly affect the hospital resources required for administration of immunizations.

During its August 2005 meeting, the APC Panel made a recommendation to CMS to pay for the administration of flu vaccines similarly under the OPPS regardless of their method of administration. We agree that hospitals should always use the most specific HCPCS codes available, whose descriptors are consistent with the method of administration and type of vaccine, to bill for all vaccine administration services but, in particular, to bill for vaccine services that are congressionally exempt from deductible and coinsurance. However, we note that vaccine administration codes other than G0008 for administration of influenza virus vaccine and G0009 for administration of pneumococcal vaccine are not exempted in the OCE from charging beneficiary deductible and coinsurance and should not be used to report these services which are exempt from copayment.

Comment: Similar to the APC Panel recommendation discussed above, commenters requested that CMS provide payment for the administration of intranasal influenza vaccine similar to payments for other methods of administration of the influenza vaccine.

Response: As stated above, vaccine administration codes other than G0008 for administration of influenza virus vaccine are not exempted in the OCE from charging beneficiary deductible and coinsurance and they should not be used to report these services which are exempt from copayment.

Comment: Numerous commenters supported our proposal to pay separately for vaccine administration services.

Response: We appreciate the commenters' support of our proposed policy and are adopting it as final in this rule.

Comment: Several commenters noted a typographical error in the CY 2006 OPPS proposed rule preamble that incorrectly listed two codes to be used for the administration of hepatitis B vaccine as codes 96471 and 96472 instead of codes 90741 and 90742.

Response: We appreciate the commenters' note, and we have corrected the error in this final rule with comment period.

After consideration of the public comments received, in this final rule with comment period, we are finalizing our proposed CY 2006 methodology to pay separately for vaccine administration services as discussed above. Table 32 below specifies the CY 2006 vaccine administration codes, their APC median costs, the status indicator assigned to each code, and the APC payment amount.

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Table 32.--CY 2006 Vaccine Administration Codes and CY 2006 Payment Rates

HCPCS	Description	CY 2005		CY 2006		
		SI	APC	SI	APC	Payment
G0008	Influenza Vaccine Administration	L	Reasonable Cost	X	0350	$23.31
G0009	Pneumococcal Vaccine Administration	L	Reasonable Cost	X	0350	$23.31
G0010	Hepatitis B Vaccine Administration	K	0355	B	---	---
90465	Immunization Admin, under 8 yrs old, with counseling; first injection	N	---	B	---	---
90466	Immunization Admin, under 8 yrs old, with counseling; each additional injection	N	---	B	---	---
90467	Immunization Admin, under 8 yrs old, with counseling; first intranasal or oral	N	---	B	---	---
90468	Immunization Admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	---	B	---	---
90471	Immunization Admin, one vaccine injection	N	---	X	0353	$23.31
90472	Immunization Admin each additional vaccine injection	N	---	X	0353	$23.31
90473	Immunization Admin, one vaccine by intranasal or oral	E	---	S	1491	$5.00
90474	Immunization Admin, each additional vaccine by intranasal or oral	E	---	S	1491	$5.00

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IX. Hospital Coding for Evaluation and Management (E/M) Services

In the CY 2006 proposed rule (70 FR 42740), we again stated our concerns and directions for developing a set of national facility coding guidelines for emergency department and clinic visits. We noted that we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them. We also stated that we will notify the public through our listserve when these proposed guidelines become available, and instructed interested parties to subscribe to this listserve by going to the following CMS Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and following the directions to the OPPS listserve.

We received a number of public comments on our proposal.

Comment: Several commenters expressed disappointment that CMS has not yet proposed national E/M guidelines for facilities. While the majority of commenters were pleased that CMS is continuing to develop and test draft codes and guidelines, they were concerned that the ongoing lack of uniformity places hospitals at risk for

multiple interpretations of the level of service that should be coded, and hampers CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. One commenter emphasized that the implementation of a uniform set of national guidelines for E/M services is especially important because CMS uses the mid-level clinic visit (APC 0601) to scale the relative payment weights for all other services paid under the OPPS. A few commenters recommended that CMS implement the E/M guidelines drafted by the independent panel of experts from the AHA and the AHIMA. Two other commenters provided their own model guidelines for CMS to consider.

Several commenters reminded CMS that adoption of a new set of guidelines for E/M services will involve an enormous undertaking by large medical centers and that CMS had committed to providing a minimum of between 6 and 12 months' notice prior to implementation to allow providers adequate time to make necessary systems changes and educate their staff. The commenters also urged CMS to ensure adequate opportunity for the public to review and comment on the proposed guidelines before they are finalized.

Response: Over the past year, we have engaged a contractor to assist us with testing the validity and reliability of a slightly modified draft of the guidelines recommended by the independent Hospital Evaluation and Management Coding Panel of the AHA and AHIMA. We have contracted a study of these guidelines using a sample of hospital outpatient claims to analyze the potential financial impact of the proposed guidelines on classes of hospitals and on the OPPS, as well as the potential burden that adoption of such guidelines might impose on hospitals. Although we have made much progress in our efforts to develop a set of national facility guidelines for emergency department and clinic visits, we believe additional testing is necessary and essential to providing hospitals with the least burdensome standard for achieving uniformity and to yielding more accurate, meaningful information related to hospital resources upon which to set the OPPS payments for emergency department and clinic services. We are committed to the goal of paying appropriately under the OPPS for the costs of hospital E/M services across the levels of care. Therefore, we will continue to develop and test the draft codes and guidelines. However, we have not yet set a date for their implementation.

As stated in the CY 2006 OPPS proposed rule, we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site once we are satisfied with the results of the testing and have made appropriate modifications in light of these testing results. Furthermore, we will provide ample opportunity for the public to comment on such a major proposal. We will continue to be considerate of the time necessary to educate clinicians and coders on the use of the new codes and guidelines and for hospitals to modify their systems. We still anticipate providing a minimum notice of between 6 and 12 months prior to implementation of the new evaluation and management codes and guidelines.

Comment: One commenter expressed a number of concerns that the commenter believed were related to proposals on the manner in which the Medicare program uses CPT code definitions that have been adopted by the AMA as a basis to classify patients who receive emergency department services for payment purposes under the Medicare OPPS.

Response: In the CY 2006 OPPS proposed rule, we did not propose to make any changes related to the manner in which we use CPT code definitions as a basis to classify patients. We are not making any changes to our use of the CPT code definitions in this final rule with comment period. However, we remind the public that regulations implementing the HIPAA (42 CFR Parts 160 and 162) require that the HCPCS be used to report health care services, including outpatient services paid under the OPPS. The OPPS regulations at 42 CFR 419.2(a) establish HCPCS codes as the means for identifying services paid under the OPPS. The HIPAA regulations require that these codes be used in the manner described by the maintainer's guidelines. In accordance with our policy that was established in the April 7, 2000 final rule with comment period that implemented the OPPS, hospitals use internal guidelines only to distinguish among varying levels of resource intensity when determining an appropriate CPT code to bill for outpatient E/M services.

X. Payment for Blood and Blood Products

A. Background

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in the Transmittal also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In CY 2000, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From CY 2000 to CY 2002, payment rates for blood and blood products were updated for inflation. For CY 2003, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special dampening methodology to blood and blood products that had significant reductions in payment rates from CY 2002 to CY 2003, when median costs were first calculated from hospital claims. Using the dampening methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For CY 2004, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For CY 2005, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period that public comments on previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and APC Panel recommendations from its

February 2004 and September 2004 meetings, we conducted a thorough analysis of the OPPS CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCRs were almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For CY 2005, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 payment rate on a 50/50 blend of CY 2004 product-specific OPPS median costs and the CY 2005 simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

B. Proposed and Final Policy Changes for CY 2006

For CY 2006, we proposed to continue to make separate payments for blood and blood products under the OPPS through individual APCs for each product. We also proposed to establish payment rates for these blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilized hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges to costs, with an adjustment applied to some products. We continue to believe that using blood-specific CCRs applied to hospital claims data will result in reasonably accurate payments that more fully reflect hospitals' true costs of providing blood and blood products than our general methodology of defaulting to the overall hospital CCR when more specific CCRs are unavailable.

For blood and blood products whose CY 2006 simulated medians experienced a decrease of more than 10 percent in comparison to their CY 2005 payment medians, we proposed to limit the decrease in medians to 10 percent. Therefore, overall we proposed to base median costs for blood and blood products in CY 2006 on the greater of: (1) Simulated medians calculated using CY 2004 claims data; or (2) 90 percent of the APC payment median for CY 2005 for such products. We recognize that possible errors in hospital billing or coding for blood products in CY 2004 may have contributed to these decreases in medians. In particular, hospitals may have been uncertain about which of their many different costs for providing blood and blood products should be captured in their charges for the products, based on variations in the specific circumstances of the services they provided. In addition, the six products affected by the proposed CY 2006 adjustment policy all were relatively low volume with fewer than 7,000 units billed in CY 2004. Three of these products were affected by the low-volume payment adjustment for CY 2005 because there were less than 1,000 units billed, and their CY 2005 payment medians would have decreased without the adjustment. In the interim, as hospitals become more familiar with the comprehensive billing guidelines for blood and blood products that are described in Program Transmittal 496 (Change Request 3681 dated March 4, 2005), we acknowledge the need to protect beneficiaries' access to a safe blood supply and proposed to do so by limiting significant decreases in payment rates for blood and blood products from CY 2005 to CY 2006. We expect that our billing guidance will assist hospitals in more fully including all appropriate costs for providing blood and blood products in their charges for those products, so that our data for CY 2005, which will be used to set median costs for blood and blood products in the CY 2007 OPPS update, should more accurately capture the hospital costs associated with each different blood product.

Therefore, for CY 2006, we proposed to establish payment rates for blood and blood products under the OPPS using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816). For blood and blood products whose CY 2006 medians would have otherwise experienced a decrease of more than 10 percent in comparison with their CY 2005 payment rates, we proposed to adjust the simulated medians by limiting their decrease to 10 percent.

At the August 2005 APC Panel meeting, the Panel recommended that CMS use its CY 2005 payment rates as the floor for its CY 2006 payment rates for all blood and blood products. Specifically, the Panel recommended that CMS should pay the greater of: (1) The simulated median costs calculated from the CY 2004 hospitals claims data; or (2) the CY 2005 APC payment medians for these products. For reasons discussed in detail below, we are not adopting the Panel's recommendation for setting the CY 2006 payment rates for blood and blood products. Instead, for CY 2006, we are setting the final median costs for blood and blood products at the greater of: (1) The simulated median costs calculated from the CY 2004 hospital claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products.

We received numerous public comments concerning our proposed payment for blood and blood products.

Comment: Numerous commenters applauded our March 2005 issuance of comprehensive billing guidelines (Program Transmittal 496) for blood and blood products, stating that the guidelines clarified many areas of confusion for providers and should result in improved hospital coding of blood and blood products. Other commenters recommended that CMS release guidance on blood and blood products on an annual basis.

Response: We appreciate the comment and expect that the billing guidance that we issued in March 2005 will result in improved hospital coding of blood and blood products. We will continue to support educational efforts by interested organizations to clarify areas of confusion and improve accuracy of billing for hospitals related to the billing of blood and blood products. In addition, we will continue to issue guidance on billing for blood and blood products to provide clarification or additional explanation as needed, based on additional questions and issues that are brought to our attention.

Comment: Numerous commenters expressed concern that the proposed payment rates for several blood products had decreased from their CY

2005 payment rates. Commenters stated that such payment declines would likely jeopardize beneficiary access to these products. Most notably, according to several organizations providing blood and blood products to hospitals, the proposed CY 2006 payment rate for leukocyte-reduced red blood cells (HCPCS code P9016), the most commonly billed blood product in the hospital outpatient setting, is significantly below hospitals' actual acquisition costs. Commenters urged CMS to set the CY 2006 payment rates for blood and blood products at the greater of: (1) The simulated medians calculated using the CY 2004 claims data; or (2) the CY 2005 APC payment medians for these products.

Response: We are displaying in Table 33 of this final rule with comment period the list of blood product HCPCS codes with their final CY 2006 adjusted median costs. Overall, median costs from CY 2005 and CY 2006 were relatively stable, with significant increases and adjusted decreases for some specific blood products. In addition, we expect that as hospitals improve their billing and coding practices, medians based on historical hospital claims data should continue to become more consistent and reflective of all hospital costs associated with providing blood products to hospital outpatients. We agree with commenters that beneficiary access to the safest and most immediately available blood supply is critical to saving lives. In addition, we understand that, in most cases, the hospital costs related to providing blood and blood products stem mainly from the costs of processing and storing the blood. We also acknowledge that new blood testing due to technological advances and challenges associated with donor recruitment and retention may contribute to rising costs of blood and blood products. However, there may be other environmental forces, including improved efficiencies through new technologies and changes in the clinical circumstances surrounding outpatient hospital transfusions, that may reduce the costs of providing blood products. While the above-mentioned issues must all be carefully considered, we also remind commenters that the payment rates for services paid under the OPPS will naturally experience fluctuations from year to year. Such variation is inherent in any budget-neutral prospective payment system such as the OPPS, where payment rates are developed based on historical hospital claims data. However, when such fluctuations become large enough to potentially jeopardize access to services paid under the OPPS, we may acknowledge the need to balance these payment fluctuations with protecting beneficiary access to such services by moderating abrupt payment declines that occur over a 1-year period. We were concerned that our proposed allowance of a 10 percent decrease in median costs from the CY 2005 adjusted final medial costs might affect beneficiary access to these services. Therefore, for CY 2006, for blood and blood products whose CY 2006 simulated median costs would have otherwise experienced a decrease of more than 5 percent in comparison with their CY 2005 adjusted final median costs, we are adjusting the simulated medians by limiting their decrease to 5 percent. We applied this adjustment to 11 blood and blood product APCs for CY 2006. Table 33 of this final rule with comment period contains the adjusted payment medians for CY 2006. Those CY 2006 final median costs that we adjusted by moderating their decrease to 5 percent are indicated by an asterisk in the table. In summary, for the CY 2006 OPPS, the final median costs for blood and blood products are set at the greater of: (1) the simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products.

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Table 33.--CY 2006 Adjusted Final Median Costs for Blood and Blood Products by APC

APC	HCPCS	Description	CY 2006 Adjusted Final Median Cost
*0949	P9023	Frozen plasma, pooled, sd	$76.15
0950	P9010	Whole blood for transfusion	$117.91
*0952	P9012	Cryoprecipitate each unit	$47.10
0954	P9016	RBC leukocytes reduced	$163.16
0955	P9059	Plasma, frz between 8-24hour	$74.70
0956	P9043	Plasma protein fract,5%,50ml	$67.94
0957	P9019	Platelets, each unit	$51.50
0958	P9020	Plaelet rich plasma unit	$277.42
0959	P9021	Red blood cells unit	$121.48
*0960	P9022	Washed red blood cells unit	$189.22
*0966	P9048	Plasmaprotein fract,5%,250ml	$315.70
0967	P9011	Split unit of blood	$82.50
*0968	P9033	Platelets leukoreduced irrad	$150.58
0969	P9040	RBC leukoreduced irradiated	$218.04
1009	P9044	Cryoprecipitatereducedplasma	$74.52
1010	P9051	Blood, l/r, cmv-neg	$207.72
1011	P9052	Platelets, hla-m, l/r, unit	$609.48
1013	P9031	Platelets leukocytes reduced	$98.30
*1016	P9054	Blood, l/r, froz/degly/wash	$261.93
1017	P9055	Plt, aph/pher, l/r, cmv-neg	$526.00
*1018	P9056	Blood, l/r, irradiated	$178.37
1019	P9037	Plate pheres leukoredu irrad	$581.01
1020	P9053	Plt, pher, l/r cmv-neg, irr	$654.13
1021	P9057	RBC, frz/deg/wsh, l/r, irrad	$345.53
*1022	P9058	RBC, l/r, cmv-neg, irrad	$266.89
*9500	P9032	Platelets, irradiated	$86.55
9501	P9035	Platelet pheres leukoreduced	$493.12
*9502	P9036	Platelet pheresis irradiated	$325.87
9503	P9060	Fr frz plasma donor retested	$94.72
9504	P9039	RBC deglycerolized	$343.44
9505	P9038	RBC irradiated	$147.47
*9506	P9050	Granulocytes, pheresis unit	$994.64
9507	P9034	Platelets, pheresis	$434.01
9508	P9017	Plasma 1 donor frz w/in 8 hr	$70.40

*The asterisk (*) shown in this APC column denotes the APCs with adjusted median costs for CY 2006.

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Comment: While one commenter thanked CMS for providing hospitals with detailed billing guidance for blood and blood products when furnished under the hospital outpatient setting, the commenter requested additional clarification on whether hospitals should charge inpatients, as they do outpatients, for blood administration services. The commenter explained that some hospitals do not charge inpatients separately for blood administration services; rather they consider such services to be included in the room and board rate. The commenter urged CMS to instruct hospitals to establish a charge structure for blood transfusion and administration services that applies uniformly to both inpatients and outpatients.

Response: We appreciate the comment's recommendation. However, we do not consider the OPPS final rule, which addresses hospital outpatient payment policies, to be an appropriate forum for addressing detailed billing guidance for inpatient services. Rather, we encourage hospitals to consult their fiscal intermediaries with any concerns related to the billing of blood transfusion and administration services to inpatients.

Comment: One commenter supported our proposal to set CY 2006 OPPS payments for blood and blood products based on hospital claims data rather than blood industry data. This commenter recommended that if CMS does consider using external data in some fashion for setting the payment rates for blood and blood products, that

CMS proceed very cautiously in considering whether to utilize blood industry data. The commenter stated that it is crucial that the external data be valid, reliable, publicly available, reflective of geographic variations in costs, and subject to audit.

Response: Although we are not using external data for setting the CY 2006 payment rates for blood and blood products, we thank the commenter for the recommended and considered caution toward using such external data in this case.

After carefully considering all comments received on our proposed CY 2006 OPPS methodology for establishing APC payment for blood and blood products, we are adopting as final our proposal with modification. To ensure beneficiaries' access to a safe blood supply, we are adopting a payment adjustment policy that will limit significant decreases in APC payment rates for blood and blood products from CY 2005 to CY 2006 by not more than 5 percent rather than 10 percent as proposed. Therefore, for the CY 2006 OPPS, the final median costs for blood and blood products are set at the greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products, as reflected in Table 34 above.

For CY 2006, we also proposed to change the status indicator for CPT code 85060 (Blood smear, peripheral, interpretation by physician with written report) from ''X'' (separately paid under the OPPS) to ''B'' (not paid under the OPPS). When a hospital provides a physician interpretation of an abnormal peripheral blood smear interpretation for a hospital outpatient, the charge for the facility resources associated with the interpretation should be bundled into the charge reported for the ordered hematology lab service, such as CPT code 85007 (Blood count; blood smear, microscopic examination with manual differential WBC count) or CPT code 85008 (Blood count; blood smear, microscopic examination without manual differential WBC count), that are paid under the Clinical Laboratory Fee Schedule (CLFS). A physician interpretation of an abnormal peripheral blood smear is considered a routine part of the ordered hematology lab service, such as CPT codes 85007 and 85008 paid under the CLFS, so hospitals will receive duplicate payment for the facility resources associated with a physician's blood smear interpretation if we were to continue to pay separately for CPT code 85060 under the OPPS for hospital outpatients. Therefore, for CY 2006, we proposed to discontinue payment under the OPPS for CPT code 85060 by changing its status indicator from ''X'' to ''B.''

We did not receive any public comments on this proposal. Accordingly, we are finalizing our proposal to discontinue payment under the OPPS effective for services furnished on or after January 1, 2006, for CPT code 85060 by changing its status indicator from ''X'' to ''B.''

XI. Payment for Observation Services

A. Background

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. For a detailed discussion of the clinical and payment history of observation services under the OPPS, we refer readers to the November 1, 2002 final rule with comment period (67 FR 66794).

For a detailed discussion of our proposed changes to payments for observation services for CY 2006, we refer readers to the CY 2006 OPPS proposed rule at 70 FR 42742 through 42745. A summary of the proposed changes is included below, followed by our responses to the public comments, and our final policies for CY 2006.

B. Proposed and Final CY 2006 Coding Changes for Observation Services and Direct Admission to Observation

In response to comments received regarding the continuing administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services for purposes of billing correctly, and recommendations made by the APC Panel and participants at the February 2005 APC Panel meeting, in the CY 2006 OPPS proposed rule, we proposed two changes in observation coding and implementation of the OPPS payment policies for observation services in CY 2006. As we stated in the CY 2006 proposed rule (70 FR 42743), these administrative changes were prompted by the fact that CY 2004 hospital data do not reflect the CY 2005 policy changes implemented for separately payable observation services. We continued to receive incomplete and unreliable data as a result of inconsistent hospital reporting, with some hospitals reporting observation services per day, and others reporting each hour of observation as one unit. The CY 2006 proposed changes were an effort to ensure more consistent hospital billing for both separately payable and packaged observation services in order to guide our future analyses of observation care and to shift the administrative burden for determining separately payable observation services from hospitals to the OCE. We do not expect to see an increase in the number of separately payable observations services as a result of these changes.

First, we proposed to discontinue HCPCS codes G0244 (Observation care by facility to patient), G0263 (Direct admission with CHF, CP, asthma), and G0264 (Assessment other than CHF, CP, asthma) and to create two new HCPCS codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

- G0378—Hospital observation services, per hour (cited in the proposed rule as ''GXXXX'').
- G0379—Direct admission of patient for hospital observation care (cited in the proposed rule as ''GYYYY'').

Second, we proposed to shift determination of whether or not observation services are separately payable under APC 0339 (Observation) from the hospital billing department to the OPPS claims processing logic. That is, hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to ''observation status,'' regardless of the patient's condition. In addition to the HCPCS code G0378, hospitals would bill HCPCS code G0379 when observation services are the result of a direct admission to ''observation status'' without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services.

We proposed to assign both of these proposed new HCPCS codes a new status indicator ''Q'' (packaged service subject to separate payment based on criteria) that would trigger the OCE logic during the processing of the claim to determine if the observation service or direct admission service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services or direct admission to observation is appropriate in accordance with the criteria discussed in section

XI.C. or XI.D. of this preamble. In addition, we proposed to change the status indicator for CPT codes 99217 through 99220 and 99234 through 99236 from ''N'' (packaged) to ''B'' (code not recognized by the OPPS). We noted we would expect hospitals to use HCPCS code G0378 to accurately report all observation services provided to beneficiaries, whether the observation would be packaged or separately payable, to assist us in developing consistent and complete hospital claims data regarding the utilization and costs of observation services. The units of service reported with HCPCS code G0378 would equal the number of hours the patient is in observation status.

Comment: Several commenters expressed support for the proposed changes and CMS' and the APC Panel's efforts to streamline the billing process for observation services in hospitals. Nine commenters stated that they appreciated our proposal to shift the burden of determining if observation is separately payable from the hospitals to the OCE logic.

While most of these commenters approved the proposal to use the new HCPCS code G0378 to bill for hospital observation services, two commenters believed that HCPCS code G0378 is unnecessary. They recommended that providers should use CPT evaluation and management codes for observation care, specifically CPT codes 99218, 99219, and 99220. The commenters also suggested that CMS should require hospitals to provide the hour information in the unit field and develop edits for these codes to edit for the qualifying conditions. A third commenter requested clarification on why G-codes are needed at all.

Response: We disagree with the commenters that HCPCS code G0378 is unnecessary and disagree that the requirement of reporting the code per hour could be handled in the unit field for CPT observation codes. The CPT observation codes are per day codes by CPT definition. We believe that to instruct hospitals to bill multiple units of a per day code to report the hours of observation care provided would create confusion and many variances in claims reporting resulting in poor hospital claims data. Generally, we follow CPT instructions for coding, and in this case we believe that it would be most prudent to establish a per hour G-code for observation services to facilitate ease of coding observation services and to ensure that we will be able to obtain useful and consistent data from future claims.

Comment: Five commenters sought clarification of the language in section XI.B. of the CY 2006 proposed rule on page 70 FR 42743 where we stated that hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to ''observation status,'' regardless of the patient's status as inpatient or outpatient.

Response: We mistakenly included the word ''inpatient'' in this statement. The statement should instead read, ''Hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to 'observation status' regardless of the patient's condition.''

Comment: One commenter notified CMS of an omission on page 70 FR 42745, under section XI.C.3.a of the CY 2006 proposed rule. The commenter pointed out that we had omitted direct admission from the bulleted list of additional hospital services.

Response: We appreciate the commenter bringing this error to our attention. The omission was inadvertent. In this final rule with comment period, we have made the appropriate change to make the policy consistent with the CY 2005 OPPS payment policy. The corrected policy reads as follows for the billing of hospital observation services:

''Additional Hospital Services:

a. The hospital must provide on the same day or the day before and report on the same claim:

- An emergency department visit (APC 0610 or 0612); or
- A clinic visit (APC 0600, 0601, or 0602); or
- Critical care (APC 0620); or
- Direct admission to observation using HCPCS code G0379.''

Comment: Many commenters expressed overall approval for our proposed policy changes concerning the new G-codes for observation services and, specifically, approval of the new HCPCS code G0379 to report direct admission to observation when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care after being seen by a physician in the community.

However, seven commenters believed that HCPCS code G0379 would be unnecessary if CMS would alter the OCE logic to look for revenue codes 45X (Emergency Department) and 516 (urgent care) on claims for observation services coded with HCPCS code G0378. They reasoned that if one of these revenue codes is not on the claim, the OCE logic should determine that the observation services billed were as a result of a direct admission to observation care.

Response: While we appreciate this suggestion and we agree that the OCE logic could recognize these revenue codes, we will implement HCPCS code G0379 as proposed. The OCE logic has no method of identifying if the direct admission to observation care service was actually provided. For example, the observation care billed with HCPCS code G0378 may have been an error in coding by a hospital, or the hospital may have failed to bill for an emergency room or clinic visit on the same day on the same claim as the observation services. Because we plan to pay separately for HCPCS code G0379 in some circumstances and the OPPS pays for services that were provided and billed with HCPCS codes on claims, the HCPCS code G0379 is necessary for billing and possible separate payment. In addition, if hospitals did not appropriately bill HCPCS code G0379 with its associated charges in cases of direct admission to observation, we would have no direct way of calculating the median cost of the direct admission to observation to facilitate analysis of its median cost in comparison with the OPPS payment rate for that service. If the observation care itself was not separately payable, and there were no other separately payable services on the claim, there would be no billed direct admission service with which to package the observation care and other packaged costs on the claim. Thus, in the absence of a code on a claim reporting a direct admission to observation services billed as HCPCS code G0379, Medicare will not use the OCE logic to infer that the patient was previously seen by a physician outside of the hospital who ordered the direct admission of the patient for observation services.

In summary, while a few commenters questioned the necessity of creating new G-codes for reporting observation services and direct admission to observation, we agree with the many commenters who encouraged us to implement the new codes and to use the OCE logic to determine when observation services are separately payable for the CY 2006 OPPS. Like those commenters, we believe that this change will both reduce the administrative burden on hospitals and will improve CMS claims data which will allow us to continue to evaluate our payment policies for observation services under the OPPS.

C. Proposed and Final Criteria for Separate Payment for Direct Admission to Observation

Through claims processing logic, we proposed to continue paying for direct

admission to observation at a rate equal to that of a Low Level Clinic Visit (APC 0600) when a Medicare beneficiary seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339. In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service.
2. That no services with a status indicator ''T'' or ''V'' or Critical care (APC 0620) were provided on the same day of service as HCPCS code G0379.
3. The observation care does not qualify for separate payment under APC 0339.

Comment: One commenter disagreed with our proposal that no service with a status indicator of ''V'' (clinic or emergency department visit) can be on the claim when provided on the same day of service as HCPCS code G0379. The commenter stated that because OPPS services performed on the same date of service must be reported on the same claim, the hospital would not receive any payment for observation services for patients who receive a service in a provider-based clinic in the morning and later in the day are directly admitted to observation by their primary care practitioner for an unrelated reason. The commenter recommended that CMS eliminate the requirement that a hospital must combine separate outpatient encounters on a single claim.

Response: We appreciate the commenter's suggestion, but at this time we are not removing the requirement that services with status indicator ''V'' cannot be billed on the same claim with the same date of service as HCPCS code G0379 for direct admission to observation care for separate payment for HCPCS code G0379 to be made. We believe that the circumstances under which a patient would have a hospital visit (clinic or emergency room), sees a physician outside the hospital for an unrelated reason later in the same day, and then be directed on that same day to the same hospital where he or she had the first hospital visit for direct admission to observation for observation services that would be packaged (that is, not for chest pain, congestive heart failure, or asthma) but for which we would make separate payment for the direct admission to observation would be very rare. The OCE editing cannot deal with the complexity of this unusual sequence of events. Thus, if the observation services were not separately payable in such a scenario, payment for the direct admission to observation and the accompanying observation services would be packaged with payments for the other separately payable services on the claim, including the day's earlier hospital visit if all of these services were billed on the claim.

As discussed in the data section (section II.A.) of this final rule with comment period and in Change Request 4047, issued on October 14, 2005, some nonrepetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. We reiterate that it is vitally important that all of the charges that pertain to a nonrepetitive, separately paid procedure or service be reported on the same claim with that procedure or service. Only thus can we develop complete and accurate median costs for ratesetting purposes. We also emphasize that this relaxation of same day billing requirements for some nonrepetitive services does not apply to nonrepetitive services provided on the same day as either direct admission to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and ''T'' status procedures, are reported on the same claim. Further instruction on billing repetitive and nonrepetitive hospital services can be found in Change Request 4047 cited above.

Specifically with respect to the billing of HCPCS code G0379 for direct admission to observation care, we expect that hospitals will only bill this service if a patient is admitted directly to observation care after being seen by a physician in the community. Although our OCE logic is performed on a claim-by-claim basis, hospitals should not bill HCPCS code G0379 for direct admission to observation care on the same day as hospital clinic visits, emergency room visits, critical care services, and ''T'' status procedures that are related to the subsequent admission to observation care. Instead, hospitals should bill all of the services associated with the observation care, including hospital clinic visits, emergency room visits, critical care services, and ''T'' status procedures, on the same claim so that the OCE logic may appropriately determine the separately payable or packaged payment status of HCPCS codes G0378 and G0379.

In summary, we are implementing as final our proposed CY 2006 payment policies for observation services under the OPPS. We are also implementing the policy related to the new HCPCS code G0379 as proposed in order to continue paying for direct admission to observation at a rate equal to that of a Low Level Clinic Visit when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339.

D. Proposed and Final Criteria for Separately Payable Observation Services (APC 0339)

For CY 2006, we proposed to continue applying the existing CY 2005 criteria (69 FR 65830), which determine if hospitals may receive separate payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma. In addition, we proposed to continue our policy of packaging payment for all other observation services into the payments for the separately payable services with which the observation service is reported. As explained previously in section XI.B. of this preamble, the only changes we proposed are related to the code hospitals will use to report observation services, and the point at which a payment determination is made. Rather than requiring the hospital to determine prior to claims submission whether patient condition and the services furnished meet the criteria for payment of APC 0339, that determination would shift to the claims processing modules installed by the fiscal intermediaries to process all OPPS bills, thereby reducing the administrative burden on hospitals.

Criteria for separate observation service payments include documentation of specific ICD–9–CM diagnostic codes; the length of time a patient is in observation status; hospital services provided before, during, and after the patient receives observation care; and ongoing physician evaluation of the patient's status.

As we stated in Program Transmittal A–02–129 released in January 2003, we will continue to update any changes in the list of ICD–9–CM codes required for payment of HCPCS code G0378 resulting from the October 1 annual update of ICD–9–CM in the October quarterly update of the OPPS. The ICD–9–CM codes for CY 2006 through October 2006 are listed in Table 35. As we proposed, below are the criteria that we will continue using in CY 2006 to determine if hospitals may receive separate OPPS payment for medically necessary observation care provided to

a patient with congestive heart failure, chest pain, or asthma.

1. Diagnosis Requirements

a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.

b. The hospital bill must report as the reason for visit or principal diagnosis an appropriate ICD–9–CM code (as shown in Table 30 below) to reflect the condition.

c. The qualifying ICD–9–CM diagnosis code must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

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Table 34.--CY 2006 Eligible Diagnosis Codes for Billing Observation Services

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
Chest Pain	411.0	Postmyocardial infarction syndrome
	411.1	Intermediate coronary syndrome
	411.81	Coronary occlusion without myocardial infarction
	411.89	Other acute ischemic heart disease
	413.0	Angina decubitus
	413.1	Prinzmetal angina
	413.9	Other and unspecified angina pectoris
	786.05	Shortness of breath
	786.50	Chest pain, unspecified
	786.51	Precordial pain
	786.52	Painful respiration
	786.59	Other chest pain
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with acute exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with acute exacerbation
	493.21	Chronic obstructive asthma with status asthmaticus
	493.22	Chronic obstructive asthma with acute exacerbation
	493.91	Asthma, unspecified with status asthmaticus
	493.92	Asthma, unspecified with acute exacerbation
Heart Failure	391.8	Other acute rheumatic heart disease
	398.91	Rheumatic heart failure (congestive)
	402.01	Malignant hypertensive heart disease with congestive heart failure
	402.11	Benign hypertensive heart disease with congestive heart failure
	402.91	Unspecified hypertensive heart disease with congestive heart failure
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
	404.11	Benign hypertensive heart and renal disease with congestive heart failure
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
	404.93	Unspecified hypertensive heart and renal disease with heart and renal failure
	428.0	Congestive heart failure
	428.1	Left heart failure
	428.20	Unspecified systolic heart failure
	428.21	Acute systolic heart failure
	428.22	Chronic systolic heart failure
	428.23	Acute on chronic systolic heart failure
	428.30	Unspecified diastolic heart failure
	428.31	Acute diastolic heart failure
	428.32	Chronic diastolic heart failure
	428.33	Acute on chronic diastolic heart failure
	428.40	Unspecified combined systolic and diastolic heart failure
	428.41	Acute combined systolic and diastolic heart failure
	428.42	Chronic combined systolic and diastolic heart failure
	428.43	Acute on chronic combined systolic and diastolic heart failure
	428.9	Heart failure, unspecified

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2. Observation Time

a. Observation time must be documented in the medical record.

b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

a. The hospital must provide on the same day or the day before and report on the same claim:

- An emergency department visit (APC 0610, 0611, or 0612) or
- A clinic visit (APC 0600, 0601, or 0602); or
- Critical care (APC 0620); or
- Direct admission to observation services using HCPCS code G0379 (APC 0600).

b. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

The APC Panel met in August 2005 and made several recommendations for clarification of the observation policy, including that CMS offer further guidance regarding the definition of end-time of observation services, billing the new HCPCS G-codes in relation to the currently required evaluation and management visit codes, the typical length of observation time, and if the hospital has the ability to issue an Advance Beneficiary Notice (ABN) and under what circumstances.

We appreciate the consideration of the issues by the APC Panel and will continue to evaluate its recommendations as we gather claims data based on the new G-codes. We also appreciate the APC Panel's concern for clear coding and billing guidance. We will provide detailed guidance regarding billing for observation services in an upcoming Internet-only manual update and ''Medlearn Matters'' article. For further clarification, this guidance will also include a restatement of when observation hours begin and end, and a discussion of appropriate billing of the G-codes for observation services in relationship to other services also billed by hospitals. As we have stated before in reference to the appropriate duration of observation services, we believe that in the overwhelming majority of cases, decisions can be and are routinely made in less than 48 hours, and generally in less than 24 hours, regarding whether to release a beneficiary from the hospital following resolution of the reason for the outpatient visit or whether to admit the beneficiary as an inpatient (69 FR 65830, November 15, 2004).

In response to the APC Panel's recommendation for clarification concerning if and when a hospital may issue an ABN, all hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive OPPS payments for such observation services. We make separate payment for observation care only for the three conditions previously defined that also meet our specific criteria, and payments for all other reasonable and necessary observation services are packaged into the payments for other separately payable services provided to the patient on the same day. An ABN should not be issued in the context of reasonable and necessary observation services, whether packaged or not.

The APC Panel also recommended that CMS reevaluate expanding the list of diagnoses eligible for separate payment for observation.

We appreciate this recommendation by the APC Panel. While we believe that it is premature to expand the conditions for which we would separately pay for observation services, we believe that the coding changes we are finalizing for CY 2006 will result in more consistent and accurate hospital claims. The data gathered from these claims will allow further analysis of the appropriateness of expanding the number of separately payable conditions.

In addition, the APC Panel recommended that CMS establish a mechanism to reimburse separately for observation services when specific HCPCS codes with status indicator ''T'' are also on the claim with observation services on the day of or the day preceding observation care. The APC Panel believed that sometimes observation services could be provided on the same day as ''T'' status procedures, but be unassociated with those procedures, as the observation care could be related to treatment of chest pain, asthma, or congestive heart failure for which we might otherwise make separate payment.

Although we appreciate the discussion of the APC Panel and this recommendation, we believe that in most cases, where observation care is billed on a claim on the same date as a ''T'' status procedure, the observation services are most likely related to post-procedural observation for which we do not make separate payment. As we take on the administrative responsibility for determining which observation services we will pay separately for, we have limited ability to determine the temporal order of ''T'' status procedures in relationship to the observation services. In addition, considering that there are over 13,000 ''T'' status codes paid under the OPPS, it would be an extremely large administrative burden for us to individually evaluate each ''T'' status code to determine if there may be an exception to the rule in some clinical circumstances, where observation care would precede or be unassociated with the ''T'' status procedure. We will discuss this issue again with the APC Panel in future APC Panel meetings and will examine the utilization patterns and costs of procedure-related observation services in our claims data based on the new G-code reporting of observation care.

We note, as described earlier in the context of billing HCPCS code G0379 for direct admission to observation, that through Change Request 4047 issued on October 14, 2005, we have recently relaxed our previous requirement to bill all OPPS services provided on the same day on the same claim. In the case of observation care, because of the OCE claim-by-claim logic, in order for us to make proper determinations regarding packaging or separate payment for observation services consistent with our payment policy to make separate observation payment only for the three specified medical conditions, all services associated with the observation care, including hospital clinic visits, emergency room visits, critical care services, and ''T'' status procedures that may have resulted in the need for observation care, must be reported on the same claim.

Comment: Several commenters requested clarification of the billing process, such as how to bill observation services when the patient is seen over

the midnight hour. Three commenters requested that CMS issue further billing guidance in the form of prompt issuance of program transmittals and manual changes, as well as a possible training package for hospitals to use when training physicians so that physicians can receive the same instructions from all facilities to which they admit patients.

Response: We appreciate these suggestions and, as stated earlier, we will provide detailed guidance regarding billing for observation services in an upcoming Internet-only manual update and ''Medlearn Matters'' article.

Comment: Several commenters recommended that CMS reevaluate expanding the list of diagnoses eligible for separate payment for observation. One commenter requested that CMS consider adding the following diagnoses: 466.0—Acute bronchitis; 466.11 (Acute bronchitis due to RSV); 466.19 (Acute bronchitis due to oth infects organism); 491.21 (Chr obstructive bronchitis, w acute exacerbation); 491.22 (Chr obstructive bronchitis, w acute bronchitis); and 496 (Chr obstructive pulmonary disease). The commenter stated that the current asthma diagnoses that receive separate payment include some patients with chronic obstructive pulmonary disease (COPD), but not all patients with COPD, and that physicians are frequently nonspecific when stating a diagnosis, which then leads to a wide variety of assignments of asthma and COPD codes. In addition, the commenter reasoned that the care of a patient with asthma, bronchitis, or COPD is very similar as far as the diagnostic tests performed, medications ordered, and clinical care provided.

Response: Our separately payable observation policy includes only diagnoses directly related to asthma. While we acknowledge that some of these conditions may have similar symptoms or a similar clinical course to asthma, we do not consider these diagnoses codes to represent asthma. In addition, there may be significant differences in responses to treatment for patients with these other diagnoses. Therefore, we are not adding the suggested diagnoses at this time.

Comment: One commenter requested that CMS and the APC Panel study the possible expansion of the conditions for which separate payment would be provided to include the diagnoses of febrile neutropenia, chemotherapy hypersensitivity reaction, and hypovolemia, electrolyte imbalance. Another commenter requested that CMS consider adding the diagnosis codes for coronary artery disease as valid conditions for separate payment of observation.

Response: We appreciate the comments that we received from these commenters regarding possible additions to the list of diagnoses eligible for separate payment for observation services. Although we are not implementing in the CY 2006 OPPS the recommendations made by commenters and the APC Panel to expand separate payment for observation to include conditions in addition to congestive heart failure, asthma, and chest pain, we will continue to analyze our data based on the new G-codes and will study the feasibility and impact of such changes in eligible diagnoses as we consider future updates of the OPPS. We believe that the use of the new G-code for reporting hourly observation services should yield much more robust and reliable claims data upon which to base such further analyses.

Comment: One commenter recommended that CMS establish a mechanism to reimburse separately for observation services when specific HCPCS codes with status indicator ''T'' are also on the claim with observation services on the day of or the day preceding observation care. The commenter stated that the intensity and types of service for these types of procedures can be similar and that procedural complications or physician planned overnight observation can apply to status ''T'' procedures such as breast procedures and interventional radiology procedures. The commenter also expressed concern that patients initially in observation for chest pain may proceed to cardiac catheterization evaluations, and the current rule would seem to limit separate payment for observation services in this situation, even though the observation was for chest pain and it preceded the cardiac catheterization. The commenter requested that CMS either allow both ''S'' and ''T'' status services to be on the claim or discontinue this edit.

Response: Our changes in coding and OCE logic for CY 2006 do not affect the criteria for separately payable observation services. We do not intend to make separate payment for observation services following surgical or interventional procedures, and, in general, these services may be most readily identified by their ''T'' status under the OPPS. As we stated previously in response to a similar recommendation by the APC Panel, we believe that in most cases, where observation care is billed on a claim on the same date as a ''T'' status procedure, the observation services are most likely related to post-procedural observation for which we do not make separate payment. We refer the readers to the previous response for further explanation.

Comment: One commenter recommended that CMS reconsider requiring hospitals to report one of the ICD–9–CM diagnosis codes designated for payment of APC 0339 as the admitting or primary diagnosis on the hospital claim. The commenter was concerned that if we restrict the position of the diagnosis code to the admitting or principal field, many claims that otherwise meet the criteria for separate payment of observation services will not be payable because coding rules and the frequency by which Medicare beneficiaries with asthma, congestive heart failure, or chest pains have other presenting signs, symptoms, and clinical conditions will result in inappropriate placement of the requisite diagnosis code. The commenter recommended that CMS accept the required diagnosis in any diagnosis field.

Response: As we stated in the CY 2005 OPPS final rule with comment period, we do not agree that this requirement will result in many claims for APC 0339 not being paid. Rather, we believe that requiring hospitals to report the signs, symptoms, and conditions that are the reason for the patient's visit will enhance coding accuracy and ensure that Medicare is paying appropriately for APC 0339 by limiting separate payment to those observation services furnished to monitor asthma, chest pain, and congestive heart failure. If we were to accept the required ICD–9–CM diagnosis code as a secondary diagnosis, we would remain concerned that we may be making separate payment for observation for conditions other than asthma, congestive heart failure, or chest pain because these conditions are reported in the secondary diagnosis field even though they are not the clinical reason that the patient is receiving observation services.

In summary, after careful consideration of the comments we received related to the criteria required for separate payment of observation services (APC 0339), we have decided to continue using the criteria as proposed for CY 2006. We will analyze the data that will be gathered through the reporting of the new HCPCS codes G0378 and G0379 to further study the implications of expanding the list of conditions eligible for separate payment for observation services. In addition, we will be issuing additional guidance for reporting and billing observation services in the form of a change request

updating the Internet-only manual and a ''Medlearn Matters'' article.

XII. Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, 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.

In the April 7, 2000 final rule with comment period, 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 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 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), 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 with comment period (67 FR 66792), we removed 43 procedures from the inpatient list for payment under OPPS. We also 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 ambulatory surgical center (ASC) and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

In the November 7, 2003 final rule with comment period (68 FR 63465), no significant changes were made to the inpatient list. In the November 15, 2004 final rule with comment period (69 FR 65834), we removed 22 procedures from the inpatient list, effective for services furnished on or after January 1, 2005.

B. Proposed and Final Changes to the Inpatient List

For CY 2006 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65837) to identify a subset of procedures currently on the inpatient list that were being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of the removal of 26 procedures from the inpatient list at the February 2005 APC Panel meeting. The APC Panel recommended that these 26 procedures be removed from the list and further recommended that CMS consider CPT code 37183 (Remove hepatic shunt (TIPS)) for removal. We agreed with the APC Panel's recommendation that CPT code 37183 be removed from the inpatient list for CY 2006 and we proposed to remove it from the inpatient list. In addition, the APC Panel recommended that CMS review site of service data on laminectomy services, which currently have status indicator C and are on the inpatient list, to determine whether the procedures are being performed in the hospital outpatient setting with enough frequency to be assigned to APCs for payment under the OPPS.

However, subsequent to the APC Panel's February 2005 meeting, we conducted further clinical evaluations of three procedures (CPT codes 33420, 65273, and 59856) included among the 26 procedures that the APC Panel recommended for removal from the inpatient list. Upon further clinical evaluation of CPT code 33420 (Valvotomy, mitral valve; closed heart), we found that the utilization data suggesting that this procedure is an office-based procedure were errant. Additional sources of utilization data suggested that this procedure is predominately performed on an inpatient basis. Concomitant with not meeting our criteria of being performed on an outpatient basis in multiple hospitals and not appearing on the ASC list of approved procedures, we were not compelled to support the removal of this procedure from the inpatient list. For this reason, we proposed to retain CPT code 33420 on the inpatient list for CY 2006.

CPT codes 65273 and 59856 were similarly reevaluated because of our concern with the HCPCS long descriptors for these two codes. The long descriptors for these codes are as follows: CPT code 65273 (Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization) and CPT code 59856 (Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation). The long descriptors indicate that hospital admission or hospitalization is included in the codes for these two procedures, which leads us to believe that these two procedures do not meet the established criteria for removal from the inpatient list. The same code descriptor for CPT code 65273, but without hospitalization, is assigned to CPT code 65272, which is already separately payable under the OPPS. Therefore, we proposed to retain CPT codes 65273 and 59856 on the inpatient list for CY 2006.

In addition, we proposed to remove CPT code 62160 (Neuroendoscopy) from the inpatient list. Questions about this service have been raised to us by the hospital community because CPT code 62160 is an add-on CPT code (that is, a code that is commonly performed as an ''additional or supplemental'' procedure to the primary procedure). Two of the separately coded services that CPT indicates are to be used with the add-on code are currently payable under the OPPS. Further clinical evaluation of this add-on procedure and its use in various sites of service leads us to believe it is appropriate for removal from the inpatient list.

Therefore, for CY 2006, we proposed to remove 25 procedures from the inpatient list and to assign 23 of these procedures to clinically appropriate APCs. We did not propose to assign two of these procedures to APC groups, that is, CPT codes 00634 (Anesthesia for

procedures in lumbar region; chemonucleoysis) and 01190 (Anesthesia for obturator neurectomy; intrapelvic) because they are anesthesia procedures for which no separate payment is made under the OPPS. Payment for these two procedures will be packaged into the procedures with which they are billed. We proposed that the changes to the inpatient list would be effective for services furnished on or after January 1, 2006.

We received numerous public comments on our proposed assignment of procedures to the inpatient list for the CY 2006 OPPS.

Comment: No commenter objected to the removal of the 25 procedures from the inpatient list. However, commenters requested that CMS eliminate the inpatient list. Among the reasons cited in the comments is that physicians are not bound by the list for payment for their professional services but are the decisionmakers regarding where a procedure is performed. The commenters stated that physicians often are unaware of the payment restrictions placed on the hospital by the inpatient list or, because their payment is unaffected by the list's constraints, may not be concerned with the hospital's payment. They pointed out that these factors make implementation and administration of the inpatient list very difficult for hospitals.

The commenters requested that if CMS does retain the list, that CMS make a strong effort to educate physicians about the hospital issues related to the inpatient list by, at a minimum, posting the inpatient list and an explanation of it on CMS' physician Web sites and on carrier Web sites.

Commenters also stated that teaching hospitals, where many of the procedures that are on the inpatient list are performed on an outpatient basis for the first time, are affected by the policy more than are nonteaching hospitals, because there is usually a significant time gap between when the services are performed safely in teaching hospital outpatient departments and ''most'' hospital outpatient departments. They asserted that criteria should be revised to allow a procedure to be removed from the list when it can be performed safely in a hospital outpatient department rather than based on the number of outpatient departments in which it may be safely performed.

The commenters also urged CMS to establish an appeal process in the event that the list is not eliminated. They believe that a process that would allow for case-by-case review of the documentation for inpatient procedures that were performed in the outpatient department may serve to alleviate some hospital losses and provide information to CMS regarding procedures that may be good candidates for removal from the list.

Finally, the commenters once again stated that they strongly supported the February, 2004 APC Panel's recommendation that CMS eliminate the inpatient list.

Response: We are not eliminating the inpatient list at this time. We continue to believe that there are services that cannot be safely and effectively delivered to Medicare beneficiaries in the hospital outpatient setting. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries. Among the potential results of eliminating the list are long observation stays after some procedures and imposition of OPPS copayments, which could differ significantly from a beneficiary's inpatient cost-sharing responsibilities.

We believe that it is important for hospitals to educate physicians on Medicare services provided under the OPPS to avoid inadvertently providing services in a hospital outpatient setting that are more appropriately performed in an inpatient setting. However, we will follow up on the commenters' recommendations regarding what CMS may be able to do to supplement hospitals' physician education efforts.

Comment: Several commenters requested that CMS issue billing instructions for instances where hospitals have charges for an inpatient procedure performed in the outpatient department in addition to other services on the bill. Commenters were concerned that some fiscal intermediaries allow payment for the services other than the inpatient procedure, while other fiscal intermediaries do not. They also requested that CMS include in the proposed rule explanations for any new Category III CPT codes that CMS assigns to the inpatient list.

Response: Billing instructions are outside of the scope of the final rule, but we will look into the billing issues as suggested by the commenters. With regard to new Category III CPT codes released by the AMA on January 1 for implementation on July 1 of a given year, we refer the readers to section III.E. of this final rule for a description of our process for recognizing these codes and receiving public comments on their status under the OPPS. We will respond to those comments in the final rule, here for CY 2007. With regard to new Category III CPT codes released by the AMA on July 1 for implementation in January and new Category I CPT codes released in the fall for implementation in January, because of the timing of the release of these codes we are unable to provide discussions of those assignments in any proposed rule. Instead, consistent with current practice, we will continue to designate these codes with comment indicator ''NI'' in the final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPPS update. We believe that these processes provide ample opportunity for the public to comment regarding the assignments of new CPT codes to the inpatient list prior to our finalizing such assignments.

Comment: One commenter requested that CMS clarify that just because services are not on the inpatient list that does not mean they can only be provided in the outpatient setting.

Response: Many services payable under the OPPS may also be payable by Medicare when they are provided in other outpatient settings, including ASCs and physician offices, and in inpatient settings, depending on the clinical circumstances and health care delivery practices surrounding the care of specific Medicare beneficiaries. As we have stated previously, the OPPS inpatient list is a list of procedures that are only paid by Medicare when they are provided in an inpatient setting, and the absence of procedures from the inpatient list should not be interpreted as identifying those procedures as appropriately performed only in the outpatient setting.

Comment: Several commenters requested that CMS remove additional procedures from the inpatient list. In addition, the APC Panel recommended that CMS review site of service data on certain laminectomy services, which currently have status indicator C and are on the inpatient list, to determine whether the procedures are being performed in the hospital outpatient setting with enough frequency to be assigned to APCs for payment under the OPPS. None of the commenters provided us with specific evidence to support statements that the procedures were being performed on an outpatient basis in a safe and effective manner, nor did they suggest appropriate APC assignments for the procedures.

The commenters requested that the CPT codes for procedures shown in Table 35 below be removed from the inpatient list.

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Table 35.---Public Requests for Removal of Procedures from Inpatient List

CPT Code	Descriptor
22630	Arthrodesis, posterior interbody technique, incl. laminectomy and/or diskectomy to prepare interspace, single interspace; lumbar
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS)
44602	Suture, small intestine (enterorraphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation
44603	Suture, small intestine, (enterorraphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations
44604	Suture, large intestine, (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; (single or multiple perforations); without colostomy
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy
49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)
57282	Colpopexy, vaginal; extra-peritoneal approach
57283	Colpopexy, vaginal; intra-peritoneal approach
58260	Vaginal hysterectomy, for uterus 250 grams or less
58940	Oophorectomy, partial or total, unilateral or bilateral
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system
63043	Laminotomy (hemilaminectomy), w/decompression of nerve root(s)I including partial facetectomy, foraminotomy reexploration, single interspace; each add'l cervical interspace
63044	Laminotomy (hemilaminectomy), w/decompression of nerve root(s)I including partial facetectomy, foraminotomy reexploration, each add'l lumbar interspace
63050	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments
63051	Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including application of bridging bone graft and non-segmental fixation devices when performed)
63075	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

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Response: We carefully evaluated each of the 17 procedures the commenters requested for deletion from the inpatient list. With the exception of one of the procedures, we found that 16 of the procedures are performed on Medicare beneficiaries more than 90 percent of the time in the inpatient setting and are associated with more than 23 hour recovery times. Some of the procedures are associated with an expectation of 4 to 5 day hospital stays. Two of the codes (63043 and 63044) are for ''add-ons'' to procedures that are not included on the inpatient list (63040, Laminotomy (hemilaminectomy), with decompression of nerve root(s), including parital facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical and 63042, Laminotomy (hemilaminectomy), with decompression of nerve root(s), including parital facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar). We are retaining codes 63043 and 63044 on the inpatient list because when these ''add-on'' services are performed in addition to the base procedures, the resulting complete surgical sessions involve more extensive surgery, longer intraoperative times, longer recovery periods, and a higher frequency of performance in the inpatient setting, than do the base procedures alone that are not included on the inpatient list.

We will take this opportunity to remind the public that the determinations for inclusion on the inpatient list are made for the Medicare population. Thus, although some procedures may be routinely performed on an outpatient basis for younger

patients, their safe performance in the outpatient hospital setting may be much rarer for older individuals who are likely to have a number of comorbidities and slower recovery times. For procedures that are not included on the inpatient list, we rely on the practitioners' judgment to determine on a patient-by-patient basis whether or not a particular procedure would be most appropriately performed in the inpatient setting. We believe that these 16 procedures should remain on the inpatient list for the CY 2006 OPPS.

The one procedure that we believe is appropriate for deletion from the inpatient list is code 63075. We found evidence that this procedure is being performed safely in some outpatient settings with increasing frequency. We are deleting the procedure from the inpatient list and assigning it to APC 0208 (Laminotomies and Laminectomies) for CY 2006.

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Table 36.—Procedure Codes Removed from Inpatient List and APC Assignments, Effective January 1, 2006

HCPCS	Long Descriptor	New APC Assignment	Old Status Indicator	New Status Indicator
00634	ANESTHESIA FOR PROCEDURES IN LUMBAR REGION; CHEMONUCLEOLYSIS	n/a	C	N
01190	ANESTHESIA FOR OBTURATOR NEURECTOMY; INTRAPELVIC	n/a	C	N
20662	APPLICATION OF HALO, INCLUDING REMOVAL; PELVIC	0049	C	T
20663	APPLICATION OF HALO, INCLUDING REMOVAL; FEMORAL	0049	C	T
20822	REPLANTATION, DIGIT, EXCLUDING THUMB (INCLUDES DISTAL TIP TO SUBLIMIS TENDON INSERTION), COMPLETE AMPUTATION	0054	C	T
20972	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; METATARSAL	0056	C	T
20973	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; GREAT TOE WITH WEB SPACE	0056	C	T
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)	0256	C	T
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION (EG, PLAGIOCEPHALY, TRIGONOCEPHALY, BRACHYCEPHALY), WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)	0256	C	T
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION	0256	C	T
21408	OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT; WITH BONE GRAFTING	0256	C	T
	(INCLUDES OBTAINING GRAFT)			
21495	OPEN TREATMENT OF HYOID FRACTURE	0253	C	T
27475	ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS); DISTAL FEMUR	0050	C	T
31293	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH MEDIAL ORBITAL WALL AND INFERIOR ORBITAL WALL DECOMPRESSION	0075	C	T
31294	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH OPTIC NERVE DECOMPRESSION	0075	C	T
36510	CATHETERIZATION OF UMBILICAL VEIN FOR DIAGNOSIS OR THERAPY, NEWBORN	n/a	C	T
37183	REMOVE HEPATIC SHUNT (TIPS)	0229	C	T
37195	THROMBOLYSIS, CEREBRAL, BY INTRAVENOUS INFUSION	0676	C	T
54560	EXPLORATION FOR UNDESCENDED TESTIS WITH ABDOMINAL EXPLORATION	0183	C	T
55600	VESICULOTOMY;	0183	C	T
59100	HYSTEROTOMY, ABDOMINAL (EG, FOR HYDATIDIFORM MOLE, ABORTION)	0195	C	T
61334	EXPLORATION OF ORBIT (TRANSCRANIAL APPROACH); WITH REMOVAL OF FOREIGN BODY	0256	C	T
62160	NEUROENDOSCOPY	0122	C	T
63075	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	0208	C	T
64763	TRANSECTION OR AVULSION OF OBTURATOR NERVE, EXTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY	0220	C	T
64766	TRANSECTION OR AVULSION OF OBTURATOR NERVE, INTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY	0221	C	T

BILLING CODE 4210–01–C

C. Ancillary Outpatient Services When Patient Expires (-CA Modifier)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of a new HCPCS modifier -CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier when submitting a claim on bill type 13x for a procedure that is on the inpatient list and assigned the payment status indicator (SI) ''C.'' Conditions to be met for hospital payment for a claim reporting a service billed with modifier -CA include a patient with an emergent, life-threatening condition on whom a procedure on the inpatient list is performed on an emergency basis to resuscitate or stabilize the patient. For CY 2003, a single payment for otherwise payable outpatient services billed on a claim with a procedure appended with this new -CA modifier was made under APC 0977 (New Technology Level VIII, $1,000–$1,250), due to the lack of available claims data to establish a payment rate based on historical hospital costs.

As discussed in the November 7, 2003 final rule with comment period, we created APC 0375 to pay for services furnished on the same date as a procedure with SI ''C'' and billed with the modifier -CA (68 FR 63467) because we were concerned that payment under a New Technology APC would not result in an appropriate payment. Payment under a New Technology APC is a fixed amount that does not have a relative payment weight and, therefore, is not subject to recalibration based on hospital costs. In the absence of hospital claims data to determine costs, the clinical APC 0375 payment rate for CY 2004 was set at of $1,150, which was the payment amount for the newly structured New Technology APC that replaced APC 0977.

For CY 2005, payment for otherwise payable outpatient services furnished on the same date of service that a procedure with SI ''C'' was performed on an emergent basis on an outpatient who died before inpatient admission and where modifier -CA was appended to the inpatient procedure continued to be made under APC 0375 (Ancillary Outpatient Services When Patient Expires) at a payment rate of $3,217.47. As discussed in the November 15, 2004 final rule with comment period (69 FR 65841), the payment median was set in accordance with the same methodology we followed to set payment rates for the other procedural APCs in CY 2005, based on the relative payment weight calculated for APC 0375. A review of the 18 hospital claims utilized for ratesetting revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergency condition requiring immediate medical intervention, as well as a wide range of costs.

For CY 2006, we did not propose any changes to our payment policy for services billed on the same date as a ''C'' status procedure appended with modifier -CA. We proposed to continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier -CA, based on calculation of the relative payment weight for APC 0375, using charge data from CY 2004 claims for line items with a HCPCS code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code.

In accordance with this methodology, for the CY 2006 proposed rule, we calculated a median cost of $2,528.61 for APC 0375 for the aggregated otherwise payable outpatient hospital services based on 300 CY 2004 hospital claims reporting modifier -CA with an inpatient procedure. These 300 claims were billed by 218 different hospital providers, each submitting between 1 and 10 claims with modifier -CA appended to a ''C'' status procedure. This median cost for APC 0375 is relatively consistent with the median calculated for the CY 2005 OPPS update, and, as expected, the hospital claims once again show a wide range of costs. Nevertheless, we are concerned with the very large increase in the volume of hospital claims billed with the -CA modifier from CY 2003 to CY 2004, growing from 18 to 300 claims over that 1-year time period. We acknowledge that modifier -CA was first introduced in CY 2003, and in CY 2003 and CY 2004 hospitals may have been experiencing a learning curve with respect to its appropriate use on claims for services payable under the OPPS.

However, our clinical review for the proposed rule of the 300 claims reporting modifier -CA lends some support to our early concerns regarding the increased CY 2004 modifier volume and hospitals' possible incorrect use of the modifier for services that do not meet the payment conditions we established. Hospitals should be using this modifier only under circumstances described in section VI of Transmittal A–02–129, which provided specific billing guidance for the use of modifier -CA. In addition to expected use of the -CA modifier for exploratory laparotomies and insertions of intra-aortic balloon assist devices, other unanticipated examples of ''C'' status procedures reported with the -CA modifier by hospitals in CY 2004 include knee arthroplasty, thyroidectomy, repair of nonunion or malunion of the femur, and thromboendarterectomy of the carotid, vertebral, or subclavian arteries. Moreover, few of the claims also include a clinic or emergency room visit on the same date of service as the procedure appended with modifier -CA, as might be expected for some patients presenting to a hospital with serious medical conditions which require urgent interventions with inpatient procedures. We are concerned that some procedures reported by hospitals with the -CA modifier in CY 2004 may not have been provided to patients with emergent, life-threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient. Instead, those procedures may have been provided to hospital outpatients as scheduled inpatient procedures that were not emergency interventions for patients in critical or unstable condition and such circumstances would have been inconsistent with our billing and payment rules regarding correct use of the -CA modifier to receive payment for APC 0375. In light of these claims findings and our current analysis, we will continue to closely monitor hospital use of modifier -CA, following changes in the claims volume, noting inpatient procedures to which the -CA modifier is appended, examining other services billed on the same date as the inpatient procedure, and analyzing specific hospital patterns of billing for services with modifier -CA appended, to assess whether a proposal to change our policies regarding payment for APC 0375 would be warranted in the future or whether hospitals require further education regarding correct use of the modifier -CA.

We received several public comments concerning our proposed payment for APC 0375.

Comment: A few commenters indicated that the -CA modifier policy supports an important function for hospitals and should be retained. Commenters suggested that the increased use of the modifier noted by CMS may be due to hospitals only

recently becoming aware of the relatively new modifier.

In response to CMS' question about why few of the claims with a -CA modifier included a clinic or emergency department visit on the same date of service, the commenters speculated that perhaps the beneficiary came in for a scheduled procedure but due to complications, the physician finds it necessary to provide a service that they had not otherwise intended to perform in an outpatient setting and the patient then died prior to inpatient admission.

Response: Despite the comments we received, we remain concerned that, while our billing and payment rules indicate that the inpatient procedure on the claim should be performed on an emergency basis to stabilize the patient if the modifier -CA is to be reported, on many of our claims, the -CA modifier was appended to inpatient list procedures that would likely not have been emergency resuscitative procedures. We remind hospitals to review our billing and payment rules for using the -CA modifier described in section VI. Of Transmittal A–02–129. Hospitals should limit their use of the -CA modifier to only those claims where all of the conditions outlined are met.

After careful consideration of the public comments received, we have decided that we will make no change to our -CA modifier policy at this time. We will continue to monitor the use of the modifier and will continue to encourage educational efforts by interested parties regarding appropriate use of the -CA modifier on OPPS claims.

XIII. Indicator Assignments

A. Status Indicator Assignments

The payment status indicators (SIs) that we assign to HCPCS codes and APCs under the OPPS play an important role in determining 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. In the CY 2006 OPPS proposed rule, we provided for CY 2006 our proposed status indicator assignments for APCs in Addendum A, for the HCPCS codes in Addendum B, and the definitions of the status indicators in Addendum D1.

Specifically, for CY 2006, we proposed to use the following status indicators in the specified manner:

- ''A'' to indicate services that are billable to fiscal intermediaries but are paid under some payment method other than OPPS, such as under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the Medicare Physician Fee Schedule. Some, but not all, of these other payment systems are identified in Addendum D1.
- ''B'' to indicate the services that are billable to fiscal intermediaries but are not payable under the OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by fiscal intermediaries to other provider types when submitted on an appropriate bill type.
- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that is discontinued, effective January 1, 2006.
- ''E'' to indicate items or services that are not covered by Medicare or codes that are not recognized by Medicare.
- ''F'' to indicate acquisition of corneal tissue which is paid on a reasonable cost basis, certain CRNA services, and hepatitis B vaccines that are paid on a reasonable cost basis.
- ''G'' to indicate drugs and biologicals that are paid under the OPPS transitional pass-through rules.
- ''H'' to indicate pass-through devices, brachytherapy sources, and separately payable radiopharmaceuticals that are paid on a cost basis.
- ''K'' to indicate drugs and biologicals (including blood and blood products) that are paid in separate APCs under the OPPS, but that are not paid under the OPPS transitional pass-through rules.
- ''L'' to indicate flu and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply.
- ''M'' to indicate services that are only billable to carriers and not to fiscal intermediaries and that are not payable under the OPPS.
- ''N'' to indicate services that are paid under the OPPS, but for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS, but only in partial hospitalization programs.
- ''Q'' to indicate packaged services subject to separate payment under OPPS payment criteria.
- ''S'' to indicate significant procedures that are not discounted when multiple and that are subject to separate APC payment under the OPPS.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under the OPPS applies.
- ''V'' to indicate medical visits (including emergency department or clinic visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.
- ''Y'' to indicate nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary.

We proposed the payment status indicators identified above, of which indicators ''M'' and ''Q'' are new for CY 2006, for each HCPCS code and each APC listed in Addenda A and B and we requested comments on the appropriateness of the indicators that we proposed to assign.

We received numerous comments regarding the appropriateness of the status indicator assignment for specific HCPCS codes which we discuss in other related sections of this final rule with comment period. In addition, we received several general comments regarding the payment status indicators and their proposed uses, which are discussed below.

Comment: Several commenters recommended that CMS revise the definition of status indicator ''H'' which had been initially used only for pass-through device categories paid on a cost basis that were not subject to coinsurance. The commenters argued that the proposed expansion of ''H'' to include brachytherapy sources that are paid on a cost basis and radiopharmaceuticals that we proposed to pay on a cost basis for CY 2006 is inconsistent in classification because coinsurance applies to these items.

One commenter made recommendations regarding other status indicators. For indicator ''A,'' the commenter requested that CMS identify what fee schedule each HCPCS code is paid under. For indicator ''B,'' the commenter recommended that if the HCPCS code was paid to physicians, the same code should be paid to hospitals. The commenter also requested that CMS revise the definition of status indicator ''E'' to separately identify services that were not covered by Medicare according to statute from those not covered for other reasons. Lastly, the commenter asked whether hospitals could automatically follow the language in the ''C'' status indicator descriptor, which states, ''Not paid under the OPPS. Admit patient. Bill as inpatient.''

Response: We have established specific status indicators in the OPPS for the principal purpose of making appropriate payment for services under the OPPS because we must signal the claims processing system through the OCE software as to HCPCS codes that are paid under the OPPS and those codes to which particular OPPS payment policies apply.

With respect to those HCPCS codes proposed for CY 2006 with the status indicator ''H,'' all of those codes have individual APC assignments that are unique. Because the APCs for these items each contain only one HCPCS code, we have chosen to associate the application of coinsurance or the lack thereof within each of these APCs in our claims processing system. Therefore, in CY 2005, the APCs for pass-through device categories do not have associated coinsurance, whereas the APCs for brachytherapy sources are subject to a 20-percent coinsurance. Similarly, for separately payable radiopharmaceuticals in CY 2006, their APCs will be subject to a 20-percent coinsurance. Therefore, we have no operational need to establish a new status indicator to separately identify the coinsurance status of HCPCS codes paid on a cost basis under the OPPS. However, we will indicate that pass-through device categories receive separate cost-based pass-through payments that are not subject to coinsurance in the OPPS payment status description of status indicator ''H'' in Addendum D. We are finalizing for CY 2006 our proposed expansion of the definition of status indicator ''H'' to include radiopharmaceutical agents.

With respect to the comments concerning status indicators ''A'' and ''E,'' the OPPS has no administrative need to make the distinctions suggested by the commenter. Regarding HCPCS codes assigned status indicator ''B,'' in some cases such services may be paid to physicians and not to hospitals because the services are professional services only, not requiring hospital resources. In other cases, there may be alternate HCPCS codes that are recognized for the services under the OPPS. Therefore, we do not believe that status indicator ''B'' needs to be modified.

Lastly, status indicator ''C'' identifies services that are only paid in an inpatient setting because of the nature of the procedures, their associated recovery times, or the physical conditions of the patients. Therefore, these services are not paid by Medicare under the OPPS. While the OPPS payment status explanation suggests what a hospital might do regarding admission and billing for such services, hospitals must follow all of their own and Medicare's policies and procedures regarding inpatient hospital admissions and inpatient billing.

We are finalizing the definitions of status indicators ''H'' and ''K'' as noted in Table 37 below. Consequently, all pass-through device categories active in CY 2006 are assigned status indicator ''H'' and are not subject to coinsurance, while brachytherapy sources and radiopharmaceuticals assigned status indicator ''H'' will be subject to coinsurance.

TABLE 37.—CY 2006 DEFINITIONS OF STATUS INDICATORS ''H'' AND ''K''

Status indicator	Item/code/service	OPPS payment status
H	(1) Pass-Through Device Categories	(1) Separate cost-based pass-through payment; Not subject to coinsurance.
	(2) Brachytherapy Sources	(2) Separate cost-based nonpass-through payment.
	(3) Radiopharmaceutical Agents	(3) Separate cost-based nonpass-through payment.
K	Non-Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment.

We are also finalizing our policy regarding status indicator ''Q.'' HCPCS codes with status indicator ''Q'' are either separately payable or packaged, depending on the specific circumstances of their billing. Addendum B displays the APC assignments of those codes with ''Q'' status when they are separately payable. OCE claims processing logic will be applied to codes assigned status indicator ''Q'' in order to determine if the service will be packaged or separately payable. In the event that a code is separately payable, the HCPCS code will receive an APC payment that corresponds to the APC listed in Addendum B, and would be subject to any discounting policies applied to that APC (identified by the APC status indicator). For CY 2006, hospital observation G-codes are assigned ''Q'' status; specific discussion of the payment policy applying to these services can be found in section IX. of this final rule with comment period.

B. Comment Indicators for the CY 2006 OPPS Final Rule

In the CY 2006 proposed rule, we proposed to continue to use the two comment indicators finalized in the November 15, 2004 final rule with comment period (69 FR 65827 and 65828) to identify in this CY 2006 final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment will be accepted. The two comment indicators are listed below and in Addendum D2.

- ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
- ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

Comment: Several commenters expressed concern regarding changes in the proposed APC assignments for several codes (for example, CPT codes 63655 and 78700) that were not specifically addressed in the proposed rule. The commenters believed that the proposed new APC assignments for these codes were made in error.

Response: In general, changes in proposed APC assignments that were not discussed in detail in the proposed rule were made to improve clinical and resource homogeneity of the APC groups. We noted in the proposed rule that the payment status indicators for each APC and HCPCS code in Addenda A and B are subject to comment (70 FR 42748), and included the APC assignment of all individual HCPCS codes.

Specific changes based on APC Panel recommendations are noted in the related topic sections of this final rule with comment period under section I.D. We discuss other changes throughout the final rule to address particular interests or concerns of the public. Addendum B of this final rule with comment period provides the status indicator and, where applicable, the APC assignment for those HCPCS codes that are payable under the OPPS, as well as those HCPCS codes that are being discontinued in CY 2006. To facilitate review of these changes, we are establishing new comment indicator ''CH'' in this final rule with comment period to designate HCPCS codes in Addendum B whose status indicator or APC assignment, or both, for the upcoming year will change from what they are in the current year:

- ''CH''—Active HCPCS codes in current year and next calendar year;

status indicator and/or APC assignment have changed.

For example, in Addendum B of this final rule with comment period, the APC assignment and/or status indicator assignment for HCPCS codes flagged with comment indicator ''CH'' will be different for services furnished on or after January 1, 2006, than they were for services furnished on December 31, 2005. A HCPCS code showing comment indicator ''CH'' in Addendum B is not open to comment as they are so indicated only for the ease of the public to review the changes made from FY 2005 to CY 2006. Rather, in Addendum B of this final rule with comment period, only HCPCS codes flagged with comment indicator ''NI'' are subject to public comment.

XIV. Nonrecurring Policy Changes

A. Payments for Multiple Diagnostic Imaging Procedures

Currently, under the OPPS, hospitals billing for diagnostic imaging procedures receive full APC payments for each service on a claim, regardless of how many procedures are performed using a single imaging modality and whether or not contiguous areas of the body are studied in the same session. In its March 2005 Report to Congress, MedPAC recommended that the Secretary should improve Medicare coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services when they are performed on contiguous areas of the body (Recommendation 3–B). MedPAC pointed out that Medicare's payment rates are based on each service being provided independently and that the rates do not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session. Further, MedPAC stated that those efficiencies are especially likely when contiguous body areas are the focus of the imaging because the patient and equipment have already been prepared for the second and subsequent procedures, potentially yielding resource savings in areas such as clerical time, technical preparation, and supplies, elements of hospital costs for imaging procedures that are reflected in APC payment rates under the OPPS.

Under the OPPS, we have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient in the same operative session (§ 419.44(a) of the regulations). In such cases, full payment is made for the procedure with the highest APC payment rate, and each subsequent procedure is paid at 50 percent of its respective APC payment rate. In the proposed rule, we indicated that we believed that a similar policy for payment of diagnostic imaging services would be more appropriate than our current policy because it would lead to more appropriate payment for multiple imaging procedures of contiguous body areas that are performed during the same session.

In our efforts to determine whether or not such a policy would improve the accuracy of OPPS payments, in the CY 2006 OPPS proposed rule, we identified 11 ''families'' of imaging procedures by imaging modality (ultrasound, computerized tomography (CT) and computerized tomography angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)) and contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis), as displayed in Table 38. Using those families of procedures, we examined OPPS bills for CY 2004 and found that there were numerous claims reporting more than one imaging procedure within the same family provided to a beneficiary by a hospital on the same day.

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Table 38.--Multiple Imaging Procedures Families by Imaging Modality and Contiguous Body Area

Family	Imaging Modality/Contiguous Body Area
Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical	
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)	
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye
71270	Ct thorax w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
71275	Ct angiography, chest
72191	Ct angiography, pelv w/o & w/ dye
74175	Ct angiography, abdom w/o & w/ dye
75635	Ct angio abdominal arteries
0067T	Ct colonography; dx
Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	
70450	Ct head/brain w/o dye
70460	Ct head/brain w/ dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/ dye
70482	Ct orbit/ear/fossa w/o & w/ dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/ dye
70488	Ct maxillofacial w/o & w/ dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/ dye
70492	Ct soft tissue neck w/o & w/ dye
70496	Ct angiography, head
70498	Ct angiography, neck

Family	Imaging Modality/Contiguous Body Area
Family 4 MRI and MRA (Chest/Abd/Pelvis)	
71550	Mri chest w/o dye
71551	Mri chest w/ dye
71552	Mri chest w/o & w/ dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
C8900	MRA w/contrast, abdomen
C8901	MRA w/o contrast, abdomen
C8902	MRA w/o fol w/contrast, abd
C8903	MRI w/contrast, breast, unilateral
C8904	MRI w/o contrast, breast, unilateral
C8905	MRI w/o fol w/contrast, breast, uni
C8906	MRI w/contrast, breast, bilateral
C8907	MRI w/o contrast, breast, bilateral
C8908	MRI w/o fol w/contrast, breast, bilat
C8909	MRA w/contrast, chest
C8910	MRA w/o contrast, chest
C8911	MRA w/o fol w/contrast, chest
C8918	MRA w/contrast, pelvis
C8919	MRA w/o contrast, pelvis
C8920	MRA w/o fol w/contrast, pelvis
Family 5 MRI and MRA (Head/Brain/Neck)	
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/ dye
70543	Mri orbit/face/neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye

Family	Imaging Modality/Contiguous Body Area
70546	Mr angiography head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiography neck w/o & w/dye
Family 6 MRI and MRA (Spine)	
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
Family 7 CT Spine)	
72125	CT neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
Family 8 MRI and MRA (Lower Extremities)	
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
C8912	MRA w/contrast, lwr extremity
C8913	MRA w/o contrast, lwr extremity
C8914	MRA w/o fol w/contrast, lwr extremity
Family 9 CT and CTA (Lower Extremities)	
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
Family 10 Mr and MRI (Upper Extremities and Joints)	
73218	Mri upper extr w/o dye
73219	Mri upper extr w/dye
73220	Mri upper extremity w/o & w/dye
73221	Mri joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
Family 11 CT and CTA (Upper Extremities)	
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye

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For example, the imaging procedures described by CPT codes 72192 (Computed tomography, pelvis; without contrast material) and 74150 (Computed

tomography, abdomen; without contrast material) are for studies of two adjacent body regions. Appropriate diagnostic evaluation of many constellations of patients' signs and symptoms and potentially affected organ systems may involve assessment of pathology in both the abdomen and pelvis, body areas that are anatomically and functionally closely related. Therefore, both studies are frequently performed in the same session to provide the necessary clinical information to diagnose and treat a patient. Although each procedure, by itself, entails the use of hospital resources, including certain staff, equipment, and supplies, some of those resource costs are not incurred twice when the procedures are performed in the same session and, thus we believed, should not be paid as if they were. Beginning with the beneficiary's arrival in the outpatient department, costs are incurred only once for registering the patient, taking the patient to the procedure room, positioning the patient on the table for the CT scan, among others. We proposed a reduction because we believed that reducing the payment for the second and subsequent procedures within the identified families might result in more accurate payments with respect to the hospital resources utilized for multiple imaging procedures performed in the same session.

OPPS bills do not contain detailed information on the hospitals' costs that are incurred in furnishing imaging procedures. Much of the cost is packaged and included in the overall charges for the procedures. Even if bundled costs are reported with charges on separate lines either with HCPCS codes or with revenue codes, when there are multiple procedures on the claims, it is impossible for us to accurately attribute bundled costs to each procedure. However, at the time of issuance of the proposed rule, our analysis of CY 2004 hospital claims convinced us that some discounting of multiple imaging procedures is warranted. In order to determine the level of adjustment that would be appropriate for the second and subsequent procedures performed within a family in the same session, we used the MPFS methodology and data.

Under the resource-based practice expense methodology used for Medicare payments to physicians, specific practice expense inputs of clinical labor, supplies and equipment are used to calculate ''relative value units'' on which physician payments are based. When multiple images are acquired in a single session, most of the clinical labor activities are not performed twice and many of the supplies are not furnished twice. Specifically, we consider that the following clinical labor activities included in the ''technical component'' (TC) of the MPFS are not duplicated for subsequent procedures: Greeting, positioning and escorting the patient; providing education and obtaining consent; retrieving prior exams; setting up the IV; and preparing and cleaning the room. In addition, we consider that supplies, with the exception of film, are not duplicated for subsequent procedures. Equipment time and indirect costs are allocated based on clinical labor time in the physician payment methodology and therefore, we believe, these inputs should be reduced accordingly.

We performed analyses and found that excluding those practice expense inputs, along with the corresponding portion of equipment time and indirect costs, supported a 50-percent reduction in the payment for the TC portion of subsequent procedures. The items and services that make up hospitals' facility costs are generally very similar to those that are counted in the TC portion of the MPFS for diagnostic imaging procedures. We believed that the analytic justification for a 50-percent reduction of the TC for the second and subsequent imaging procedures using the MPFS input data also provided a basis for a similar relative reduction to payments for multiple imaging procedures performed in the hospital outpatient department. Therefore, we proposed to make a 50-percent reduction in the OPPS payments for some second and subsequent imaging procedures performed in the same session, similar to our policy of reducing payments for some second and subsequent surgical procedures.

We proposed to apply the multiple imaging procedure reduction only to individual services described by codes within one family, not across families. Reductions would apply when more than one procedure within the family is performed in the same session. For example, no reduction would apply to an MRI of the brain (CPT code 70552) in code Family 5, when performed in the same session as an MRI of the spinal canal and contents (CPT code 72142) in code Family 6. We proposed to make full payment for the procedure with the highest APC payment rate, and payment at 50 percent of the applicable APC payment rate for every additional procedure in the same family, when performed in the same session.

At its August 2005 meeting, the APC Panel heard testimony that provided evidence against proceeding with the proposal to discount for multiple diagnostic imaging procedures at this time based on logic that efficiencies related to multiple imaging procedures were already captured in the OPPS claims data. The Panel made its recommendation that CMS should postpone implementation of the policy for a year so that we may gather more data on the implications of those changes. The Panel also recommended that CMS work with the American College of Radiology and other stakeholders in that process.

Comment: Many commenters on the proposed rule requested that we postpone implementation of the proposed discounting policy until we perform further analyses and are able to find more substantial, supporting hospital-based data. The commenters stated that our use of the MPFS data was an inappropriate basis for estimating costs and cost efficiencies in the hospital outpatient department and that a 50-percent reduction for second and subsequent services provided in the same imaging session was unwarranted. Commenters stated that the hospital cost data used by CMS to set payment rates already reflect savings due to the efficiencies of performing multiple procedures during the same session, and that the proposed policy to discount second and subsequent procedures is actually tantamount to discounting those procedures twice.

In addition, other commenters suggested that a lower percentage reduction may be more accurate. Some commenters also provided specific recommendations for modifications to the procedures included in the families eligible for discounting. One commenter indicated that CMS had failed to consider differences in patient preparation requirements for some imaging procedures that would necessitate significant additional time between the two tests, even though they are being performed during the same session. The commenters asserted that any discounting payment policy would systematically disadvantage hospitals relative to other settings for imaging services and that the negative effect on rural hospitals, who commonly lease expensive capital equipment such as MRI machines, would result in discontinuation of essential diagnostic radiology services in many areas. Finally, the commenters identified implementation issues that we had not addressed in the proposed rule, such as defining what we meant as ''the same session.''

Response: After careful consideration of the public comments received, the results of additional analyses of CY 2004 OPPS claims data, and the APC

Panel recommendation, we have decided not to finalize our proposal to discount for multiple diagnostic imaging procedures at this time. In calculating median costs for outpatient imaging procedures in the radiology families we proposed for discounting, for most hospitals' claims, we used a hospital-specific diagnostic radiology CCR for the conversion of charges to costs. Some hospitals reported costs and charges in nonstandard cost centers for ultrasound, CT, or MRI services, and, in general, those modality-specific CCRs were lower than their CCRs for diagnostic radiology. Those lower CCRs were not inconsistent with hospitals' experiences of particular efficiencies in providing multiple ultrasound, CT, or MRI services in a single setting, without reductions in charges for those multiple procedure sessions.

For the majority of hospitals for which we used diagnostic radiology CCRs to convert charges to costs for ultrasound, CT, and MRI procedures, we were concerned about whether these CCRs were too general and broad to reflect the efficiencies of providing multiple imaging procedures on contiguous body parts. We found that the imaging procedures we identified as eligible for the proposed payment reductions accounted for approximately half of the total OPPS charges attributed by the OPPS to hospitals' diagnostic radiology cost centers. This result suggests that costs and charges related to ultrasound, CT, and MRI services in the 11 proposed families are significant contributors from the OPPS to hospitals' diagnostic radiology cost centers; we also recognize that costs and charges are incurred in diagnostic radiology cost centers for inpatients and patients not insured by Medicare. We have no way of knowing how patterns of costs and charges for those patients contribute to hospitals' diagnostic radiology CCRs, but we have no specific reason to believe that their patterns of services would be very different than those for Medicare beneficiaries in the hospital outpatient setting. Thus, it may be correct that our median costs for imaging services in the 11 families proposed for the reduction policy reflect a reduced median based, in part, on hospitals' provision of multiple scans in one session.

Although our analyses provided no definite answer regarding whether, and by how much, the OPPS median costs for single imaging services in the 11 proposed families are reduced due to existing hospital efficiencies related to multiple services as compared with the hypothetical median costs for actual single services, our analyses do not disprove the commenters' contentions that there are efficiencies already reflected in their hospital costs, and therefore, their CCRs and the median costs for the procedures. Further, the results of our initial analyses do support the recommendation that we should defer implementation of the proposed multiple imaging procedure reduction policy to perform additional analyses. Depending upon the results of our analyses, in a future rule we may propose revisions to the structure of our rates in order to ensure that these rates properly reflect the relative costs of initial and subsequent imaging procedures.

Comment: MedPAC expressed support of our multiple imaging discounting proposal and suggested that it would be preferable for CMS to be able to make the proposed reductions without the requirement for budget neutrality so that budget savings and lower cost sharing for beneficiaries would result. MedPAC realized that CMS is statutorily required to maintain budget neutrality in all changes made to the OPPS and, therefore, suggested that the Secretary offer a legislative proposal to Congress to allow us to capture potential savings.

Response: We appreciate MedPAC's support for our proposed policy. We are also appreciative of the preliminary work that MedPAC has provided in this area. We have carefully considered its suggestions, as well as those of other commenters, in determining whether to finalize our proposed multiple diagnostic imaging policy and will consider their suggestions regarding budget neutrality issues in our ongoing work on this issue.

Given the evidence presented by the commenters, the recommendation of the APC Panel, and our further analysis of this issue, we are convinced that additional analyses are in order. Therefore, during the coming year, we will perform analyses of relevant data to determine what, if any, changes in our median cost calculations for imaging services or discounting policies, or both, could be appropriate to enable us to make more accurate payments for diagnostic imaging services. To the extent feasible, as recommended by the APC Panel, we will look to the stakeholders in this policy for additional information and input concerning further development. As we have stated, in a future rule we may propose revisions to the structure of our rates in order to ensure that these rates properly reflect the relative costs of initial and subsequent imaging procedures.

B. Interrupted Procedure Payment Policies (Modifiers –52, –73, and –74)

1. Modifier –52

Since implementation of the OPPS in 2000, we have required hospitals to report modifiers –52, –73, and –74 to indicate procedures that were terminated before their completion. Modifier –52 indicates partial reduction or discontinuation of services that do not require anesthesia, while modifiers –73 and –74 are used for procedures requiring anesthesia, where the patient was taken to the treatment room and the procedure was discontinued before anesthesia administration or after anesthesia administration/procedure initiation, respectively. The elective cancellation of procedures is not reported. Hospitals are paid 50 percent of the APC payment for services with modifier –73 appended and 100 percent for procedures with modifier –52 or –74 reported, in accordance with § 419.44(b) of the regulations. In January 2005, we clarified, in Program Transmittal 442, the definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department in the context of reporting modifiers –73 and –74. The APC Panel considered the current OPPS payment policies for interrupted procedures at its February 2005 meeting and made a number of recommendations that are addressed in the following discussion.

Current OPPS policy requires providers to use modifier –52 to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and our current policy is to make full payment for procedures with a –52 modifier.

We have reconsidered our payment policy for interrupted or reduced services not requiring anesthesia and reported with a –52 modifier. At its February 2005 meeting, the APC Panel recommended continuing current OPPS payment policy at 100 percent of the APC payment for reduced services reported with modifier –52, although the APC Panel members acknowledged their limited familiarity with the specific outpatient hospital services and their clinical circumstances that would warrant the reporting of modifier –52. We examined our data to determine the

appropriateness of our current policy regarding payment for services that are reduced, and although some hospital resources are used to provide even an incomplete service, such as a radiology service, we are skeptical that it is accurate to pay the full rate for a discontinued or reduced radiological service. Compared to surgical procedures that require anesthesia, a number of general and procedure-specific supplies, and reserved procedure rooms that must be cleaned and prepared prior to performance of each specific procedure, the costs to the hospital outpatient department for the rooms and supplies typically associated with procedures not requiring anesthesia are much more limited. For example, the scheduling maintained for radiological services not requiring anesthesia generally exhibits greater flexibility than that for surgical procedures, and the procedure rooms are used for many unscheduled services that are fit in, when possible, between those that are scheduled. Consequently, we believe that the loss of revenue that may result from a surgical procedure being discontinued prior to its initiation in the procedure room is usually more substantial than that lost as the result of a discontinued service not requiring anesthesia, such as a radiology procedure. Nonetheless, under our current policy, Medicare makes the full APC payment for discontinued or reduced radiological procedures and only 50 percent of the APC payment for surgical procedures that are discontinued prior to initiation of the procedure or the administration of anesthesia.

Therefore, we proposed to pay 50 percent of the APC payment amount for a discontinued procedure that does not require anesthesia where modifier –52 is reported. We believed that this proposed payment would appropriately recognize the hospital's costs involved with the delivery of a typical reduced service, similar to our payment policies for interrupted procedures that require anesthesia.

We received many comments on our proposal to reduce by 50 percent the OPPS payment for claims for discontinued procedures reported with modifier –52.

Comment: All of the commenters requested that CMS continue to make full payment for those procedures. One argument presented by commenters was that the modifier cannot be used for elective cancellations, and that discontinuations are often associated with some unanticipated incident related to the beneficiary's clinical condition. They asserted that, in those cases, the provider must address the beneficiary's clinical needs and because of the costs incurred as a result of those interventions, no fewer resources are used during the attempt to complete the procedure than there would have been if it had been completed without complications.

In fact, many commenters asserted that failed attempts to complete procedures often result in much higher resource use than completed, uncomplicated procedures because the procedure's discontinuation may come after many supplies and much time were expended. Further, they stated that a reduction in the OPPS payment is unfair because there are many times that no other procedures can be performed during the period that was scheduled for the incomplete procedure.

Commenters also stated that CMS does not fully understand hospital operations and urged CMS to learn more before we implement such a payment reduction policy. They stated that there was no indication in the proposed rule that CMS conducted any analysis to support the proposed reduction. They believed that CMS must perform cost analyses regarding the procedures to which the modifier is applied in order to evaluate the types of other services delivered when procedures are interrupted and the resources expended in their delivery.

Further, the commenters believed there is still confusion among providers regarding how to use the –52 modifier, and suggested that CMS review the data to evaluate the potential financial impact of the proposed policy because it may be applied disproportionately to those providers who use the modifier appropriately.

Response: We have conducted analyses of our hospital claims data to examine the usage of the –52 modifier in CY 2004. Those analyses are the basis for our determination that a reduction in the OPPS payments for interrupted procedures reported with a –52 modifier is warranted. We discovered 120,000 procedures in the CY 2004 hospital claims data with a –52 modifier appended. That level of use seemed high, and more in-depth analysis revealed that, although most of the usage was for imaging procedures, some of the services reported with the –52 modifier were unexpected and inappropriate (that is, office visit and diagnostic colonoscopy).

The results of our data analysis appear, to some degree, to conflict with much of the anecdotal information presented by the commenters. Although the commenters asserted that many times, discontinuation of procedures is associated with emergency interventions and use of additional resources, the data did not indicate that this was likely to have been the primary reason for the procedures to which the –52 modifier was appended in CY 2004. The highest frequency use of the –52 modifier was among diagnostic imaging procedures that are typically not associated with adverse reactions (the top three procedures are imaging services without contrast), and we believe that there are some cost savings that result from not performing the entire procedure (for example, less film, less computer time, and less room time). As the claims for many of these procedures included little packaging and we found the line item charges for the services were not reduced when the –52 modifier was reported, we could generally not detect significant differences in costs for the same procedure, with and without the –52 modifier reported. However, because the line item charges for the services were typically similar for completed and interrupted procedures, we do not believe that our claims analysis had the potential to reflect any true hospital cost savings when procedures were discontinued. In general, we did not observe increased costs for claims for services reported with the –52 modifier. Further, some of the services that had the –52 modifier appended do not require significant supplies or procedure rooms, but, rather, are provided in examination rooms or other nonspecific areas of the outpatient department. Therefore, only minimal costs would be incurred by the hospital for an incomplete procedure.

Our data also indicated that the –52 modifier was often used inappropriately. For example, diagnostic colonoscopies ordinarily require anesthesia and, therefore, when discontinued, are to be reported using the –73 or –74 modifiers, rather than modifier –52. However, what we found in the hospital claims data was that diagnostic colonoscopy was the fifth most frequently reported procedure with the –52 modifier. We expect that the frequency of –52 modifier use with procedures in which anesthesia was administered will have decreased for CY 2005 as a result of our clarification regarding the use of modifiers –52, –73 and –74 published in Transmittal 442 issued in January 2005.

We have examined our data and given careful consideration to the public comments and the APC Panel's discussion and recommendations regarding OPPS payment policies for interrupted procedures. Given the nature of the procedures that were likely

reported appropriately with the –52 modifier in CY 2004, we continue to believe that there are considerable savings associated with their incomplete performance. We think that in the hospital outpatient setting, there are generally many opportunities to utilize the rooms and equipment that would otherwise be left unused as a result of discontinued procedures. We also believe that, although there may be occasional instances in which a discontinued procedure appropriately reported with the –52 modifier consumes more resources than one that is completed without interruption, those are unusual events and the vast majority of discontinued cases are significantly less costly than completed procedures. Therefore, we are finalizing our proposed policy to apply a 50 percent reduction to the APC payments for interrupted procedures reported with the –52 modifier in CY 2006.

Comment: One commenter requested that CMS give special consideration to capsule endoscopy of the esophagus if CMS makes final its proposal to reduce payment for procedures with the –52 modifier. The commenter indicated that the procedure is correctly coded using CPT 91110 (Gastrointestinal tract imaging, intraluminal (*e.g.*, capsule endoscopy), esophagus through ileum, with physician interpretation and report), with –52 appended to indicate that the ileum was not visualized, even in cases where visualization of the ileum was not intended. The commenter stated that, although the professional component costs are reduced if the ileum is not included in the test, the technical costs of the procedure are the same whether or not the ileum is visualized.

The commenter suggested several options for accommodating the capsule endoscopy of the esophagus procedure in case CMS goes forward with the proposed –52 modifier policy. These included exempting hospitals from reporting the modifier with CPT 91110, establishing an administrative exception so that intermediaries would not reduce payment under the OPPS for the procedure, and establishing a different code for the procedure that would obviate the need for the –52 modifier.

Response: We are finalizing our proposal to reduce payments for procedures to which the –52 modifier is appended. We do not believe that exempting the capsule endoscopy procedure from the reduction policy is practical or warranted, given our consideration of specific information available to use concerning the capsule endoscopy of the esophagus procedure and hospital cost and clinical information regarding other separately payable services under the OPPS. Moreover, even if we believed that it was appropriate, it is not feasible for us to selectively exempt individual procedures from the requirements of our OPPS payment policy for the –52 modifier, nor should providers knowingly misuse a CPT code in contradiction to CPT instructions.

While we do not establish HCPCS codes for new technology procedures that are described by existing HCPCS codes or combinations of HCPCS codes, we acknowledge that the commenter is concerned about the current CPT coding structure and its applicability to capsule endoscopy of the esophagus, along with the implications of the CY 2006 OPPS payment policy for services reported with the –52 modifier. As the AMA, through the CPT Editorial Panel, develops new CPT codes, provides coding instructions, and makes editorial changes to existing CPT codes, we encourage the commenter to bring its concerns about appropriate CPT coding for capsule endoscopy of the esophagus to the attention of the CPT Editorial Panel.

2. Modifiers –73 and –74

When a procedure requiring anesthesia is discontinued after the beneficiary was prepared for the procedure and taken to the room where it was to be performed but before the administration of anesthesia, hospitals currently report modifier –73 and receive 50 percent of the APC payment for the planned service. The APC Panel recommended that we make full APC payment for services with modifier –73 reported, because significant hospital resources were expended to prepare the patient and the treatment room or operating room for the procedure. Although the circumstances that require use of modifier –73 occur infrequently, we continue to believe that hospitals realize significant savings when procedures are discontinued prior to initiation but after the beneficiary is taken to the procedure room. We believe savings are recognized for treatment/operating room time, single use devices, drugs, equipment, supplies, and recovery room time. Thus, we believe our policy of paying 50 percent of the procedure's APC payment when modifier –73 is reported remains appropriate.

Further, in the CY 2006 proposed rule, we explored the possibility of applying a payment reduction for interrupted procedures in which anesthesia was to be used (and may have been administered) and the procedure was initiated. Currently, those cases are reported using modifier –74, and we make the full APC payment for the planned service.

The payment policy for interrupted procedures reported with modifier –74 was originally adopted because we believed that the facility costs incurred for discontinued procedures that were initiated to some degree were as significant to the hospital provider as for a completed procedure, including resources for patient preparation, operating room use, and recovery room care. However, we had come to question that underlying assumption, especially as many surgical procedures have come to require specialized and costly devices and equipment, and our APC payments include the costs for those devices and equipment. At the time of the CY 2006 proposed rule, we expressed our belief that there may be costs that are not incurred in the event of a procedure's discontinuation, if a hospital is managing its use of devices, supplies, and equipment efficiently and conservatively. For example, the patient's recovery time may be less than the recovery time would have been for the planned procedure, because less extensive surgery was performed or costly devices planned for the procedure may not be used.

The APC Panel recommended that we continue to pay 100 percent of the procedural APC payment when modifier –74 is appended to the surgical service because, in its opinion, procedures may frequently be terminated prior to completion because the patient is experiencing adverse effects from the surgical service or the anesthesia. The APC Panel speculated that, in fact, significant additional resources could be expended in such a situation to stabilize and treat the patient if a procedure were discontinued because of patient complications. However, we believed that many of such additional services, including critical care, drugs, blood and blood products, and x-rays that may be necessary to manage and treat such patients, are separately payable under the OPPS and thus the hospital's costs need not be paid through the APC payment for the planned procedure. Because the OPPS is paying for the time in the operating room, recovery room, outpatient department staff, and supplies related to the typical procedure, it seemed that those costs might be lower in those infrequent cases when the procedure is initiated but not completed. We acknowledged that the costs on claims reporting a service with modifier –74 might be particularly diverse, depending upon the point in the procedure when the service was interrupted. Thus, in the proposed rule,

we specifically invited comment on the clinical circumstances in which modifier –74 is used in the hospital outpatient department, and the degree to which hospitals may experience cost savings in such situations where procedures are not completed. We were specifically interested in comments regarding the disposition of devices and specialized equipment that are not used because a procedure is discontinued after its initiation. In particular, we were interested in obtaining information about when during the procedure the decision to discontinue is typically made.

We received numerous public comments on the use of modifiers–73 and –74 and the associated costs of procedures billed with one of those modifiers.

Comment: A number of commenters encouraged CMS to continue to make full OPPS payments for interrupted services requiring anesthesia that were coded with the –74 modifier to indicate that the procedures were interrupted after their initiation or after the administration of anesthesia. In response to the proposed rule in which we discussed our concerns about the appropriateness of our current policy of making full payment for those discontinued procedures, the commenters provided extensive detail about the variable clinical circumstances where the –74 modifier is correctly reported and provided examples of the hospital resources required in such circumstances. They believed that the resources were definitely not reduced because, in most cases, all supplies would have been opened, the patient would continue to require recovery time, and the operative session might actually be longer than usual because of patient complications or multiple unsuccessful attempts to complete a complicated procedure.

In addition, numerous commenters recommended that CMS make full APC payments for services reported with a –73 modifier because of significant hospital resources required to prepare patients for those procedures. The commenters pointed out that the current OPPS payment policy indicates that CMS makes 50 percent of the APC payment when a –73 modifier is appended to a procedure that requires anesthesia and was interrupted after the patient was taken into the treatment room but prior to the administration of anesthesia. The commenters provided multiple examples of the types of costs incurred by hospitals in such circumstances, noting that the procedure might have been interrupted because a patient required treatment for an evolving medical condition, requiring significant hospital resources. They added that sterile supplies may have been opened and other resources, including staff time and allocated procedure room time, used. The commenters recommended that CMS make 100 percent of the APC payment when a –73 modifier is reported with a procedure. In addition, several commenters requested that CMS modify the definition of when the –73 modifier is to be used. They indicated a preference that the modifier be used earlier, when a procedure is cancelled while a patient is still in a holding room or preoperative suite where the patient has been prepared for surgery, rather than being applicable only after the patient has been taken into the treatment room.

Response: We made no proposals to change our payment policies for procedures reported with modifiers –73 and –74 for CY 2006. We appreciate the detailed comments we received on hospitals' experiences with their use. We continue to believe that payment at 50 percent of the APC rate is appropriate for procedures reported with modifier –73, as we believe, in particular, that there are significant savings associated with decreased procedure or operating room times and markedly reduced recovery times. We do not believe it is appropriate to make procedural APC payments for services cancelled prior to a patient's entering the treatment or operating room. While specific hospital resources used in individual circumstances to prepare patients for surgery differ, in general, costs incurred in preoperative preparation are similar across surgical procedures (for example, establishment of intravenous access, pre-operative medication) and are unlikely to be closely related to the APC payments for the planned procedures. We expect that hospitals will continue to be cautious in expending resources preoperatively for procedures that may be cancelled prior to the patient entering the treatment room. Therefore, we will continue our current policy of a 50-percent reduction in the APC payment for services reported with the –73 modifier for the CY 2006 OPPS.

We also will maintain our current policy of paying 100 percent of the APC payment for procedures reported with the –74 modifier for CY 2006. We agree with the commenters that, in general, the clinical circumstances where the –74 modifier is reported may be particularly diverse and unpredictable. While we understand that any reductions in APC payments under such circumstances could pose some risk of the OPPS making inappropriate payments for hospital resources utilized for such discontinued procedures, we remain concerned that making the full APC payment could also be inappropriate if a discontinued procedure with the –74 modifier appended was a high cost service requiring an expensive device that was not actually utilized. In the future, we may further examine our hospital claims data to analyze cost information for procedures reported with and without the –74 modifier.

We will provide billing guidance for CY 2006 regarding modifiers –52, –73, and –74 to offer hospitals additional instructions regarding the appropriate use of the three modifiers in the OPPS. Our goal is to assure that hospitals understand and report these modifiers correctly so that they receive appropriate payments for the services they provide.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

1. Report to the Congress: Medicare Payment Policy (March 2005)

The Medicare Payment Advisory Commission (MedPAC) submits reports to Congress in March and June that summarize payment policy recommendations. The March 2005 MedPAC report included the following two recommendations relating specifically to the hospital OPPS:

a. Recommendation 1: The Congress should increase payment rates for the outpatient prospective payment system by the projected increase in the hospital market basket index less 0.4 percent for calendar year 2006. A discussion regarding hospital update payments, and the effect of the market basket update in relation to other factors influencing OPPS payment rates, is included in section II.C. (''Conversion Factor Update for CY 2006'') of this preamble.

b. Recommendation 2: The Congress should extend hold-harmless payments under the outpatient prospective payment system for rural sole community hospitals and other rural hospitals with 100 or fewer beds through calendar year 2006. A discussion of the expiration of the hold-harmless provision is included in section II.F. of this preamble. See also section II.G. (''Adjustment for Rural Hospitals'') of this preamble for a discussion of section 411 of Pub. L. 108–173.

2. Report to the Congress: Issues in a modernized Medicare Program—Payment for Pharmacy Handling Costs in Hospital Outpatient Departments (June 2005)

A discussion of the MedPAC recommendations relating to pharmacy overhead payments in the hospital outpatient department can be found in section V. of the preamble of this final rule with comment period.

B. APC Panel Recommendations

Recommendations made by the APC Panel are discussed in sections of this preamble that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's February 2005 and August 2005 meeting are available online at *http://www.cms.hhs.gov/faca/apc/default.asp.*

C. GAO Hospital Outpatient Drug Acquisition Cost Survey

A discussion of the June 30, 2005 GAO report entitled ''Medicare: Drug Purchase Prices for CMS Consideration in Hospital Outpatient Rate-Setting'' and section 621(a)(1) of the MMA is included in section V. of the preamble of this final rule with comment period.

XVI. Physician Oversight of Nonphysician Practitioners in Critical Access Hospitals

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, Pub. L. 105–33, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (COPs) under 42 CFR part 485, subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/ Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change in the Proposed Rule

Under the former EACH/RPCH program, physician oversight was required for services provided by nonphysician practitioners such as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) in a CAH. Under the MRHFP, the statute likewise requires physician oversight for nonphysician practitioners.

We note that under the EACH/RPCH program, we allowed for situations when the RPCH had an unusually high volume of outpatients (100 or more during a 2-week period) that were treated by nonphysician practitioners. We stated that it would be sufficient for a physician to review and sign a 25-percent sample of medical records for patients cared for by a nonphysician practitioner unless State practice and laws require higher standards for physician oversight for nonphysician practitioners.

However, the current regulation does not distinguish between inpatient and outpatient physician oversight. Although the CAH CoPs at § 485.631(b)(iv) provide that a doctor of medicine or osteopathy periodically reviews and signs the records of patients cared for by NPs, CNSs, or PAs, section 1820(c)(2)(B)(iv)(III) of the Act states that CAH inpatient care provided by a PA or NP is subject to the oversight of a physician. The review of outpatient records is not addressed in the statute. Presently, for patients cared for by nonphysician practitioners, the interpretative guidelines set forth in Appendix W of the State Operations Manual (CMS Publication 7) set parameters for inpatient and outpatient physician reviews. To maintain consistency from the EACH/RPCH program to the CAH program, we indicated in the Interpretative Guidelines that CAHs with a high volume of outpatients need to have a physician review and sign a random sample of 25 percent of outpatient medical records. Therefore, the interpretative guidelines allow a physician to review and sign a 25-percent sample of outpatient records for patients under the care of a nonphysician practitioner.

Nonphysician practitioners recently brought to our attention their concerns regarding their ability to practice under their State laws governing scope of practice. Particularly, the nonphysician practitioners believe the current regulations and guidelines impede their ability to practice in CAHs. Certified nurse midwives, NPs, and CNSs disagree with the need for a physician to review records of patients that have been in their care when State law permits them to practice independently.

MedPAC, in its June 2002 Report to Congress, stated that certified nurse midwives, NPs, CNSs, and PAs are health care practitioners who furnish many of the same health care services traditionally provided by physicians, such as diagnosing illnesses, performing physical examinations, ordering and interpreting laboratory tests, and providing preventive health services. In many States, advance practice nurses are permitted to practice independently or in collaboration with a physician. MedPAC reported that NPs have independent practice authority in 21 States, and CNSs have independent practice authority in 20 States. PAs, by law, must work under the supervision of a physician. Based on the American Medical Association's guidelines for PAs, the definition of supervision varies by State. Generally, the physician assistant is a representative of the physician, treating the patient in the style and manner developed and directed by the supervising physician.

MedPAC further reported that several studies have shown comparable patient outcomes for the services provided by physician and nonphysician practitioners. MedPAC reported that research conducted by Mundinger et al.[2] in 2000, Brown and Grimes[3] in 1993, Ryan in 1993,[4] and the Office of Technology Assessment[5] in 1986 has shown that nonphysician practitioners can perform about 80 percent of the services provided by primary care physicians with comparable quality. A randomized trial of physicians and NPs providing care in ambulatory care settings who had the same authority, responsibilities, productivity, and administrative requirements were shown to have comparable patient outcomes (see pages 5 and 11 of the June 2002 MedPAC report). Nonphysician practitioners are trained with the expectation that they will exercise a certain degree of autonomy when providing patient care. About 90 percent of NPs and 50 percent of PAs provide primary care.

We believe sufficient control and oversight of these nonphysician practitioners is generated by State laws which allow independent practice authority. However, we remain concerned that, in those States without independent practice laws, we have a responsibility to continue to ensure the

[2] Mundinger, M.O., Kane, R.I., Lenez, E.R., et al., Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians, A Randomized Trial, *The Journal of the American Medical Association,* January 5, 2000, Vol. 283, No. 1, pages 59–68.

[3] Brown, S.A. and Grimes, D.E., Nurse Practitioners and Certified Nurse Midwives: A Meta Analysis of Studies on Nurses in Primary Care Roles, American Nurses Association, Washington, DC, March 1993.

[4] Ryan, S.A., Nurse Practitioners: Educational Issues, Practice Styles, and Service Barriers. In Clawson, D.K., Osterweis, M., eds: The Role of Physician Assistants and Nurse Practitioners in Primary Health Care Association of Academic Health Centers, Washington, DC, 1993.

[5] Office of Technology Assessment, U.S. Congress: Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis, Health Technology Case Study 37, Washington, DC, U.S. Government Printing Office, 1986.

safety and quality of services provided to Medicare beneficiaries.

Therefore, in the CY 2006 OPPS proposed rule (70 FR 42753), we proposed to revise the regulation at § 485.631(b)(1)(iv) and to add new paragraphs (b)(1)(v) and (b)(1)(vi) to § 485.631 to defer to State law regarding the review of records for outpatients cared for by nonphysician practitioners. We proposed that if State law allows these practitioners to practice independently, we would not require physicians to review and sign medical records of outpatients cared for by these nonphysician practitioners in CAHs. However, for those States that do not allow independent practice of nonphysician practitioners, we proposed to continue to maintain the requirement that periodic review is performed by the physician on outpatient records under the care of a nonphysician practitioner in a CAH. We believe a review at least every 2 weeks provides a sufficient time period without unduly imposing an administrative burden on the physician or the CAH. In addition, we proposed to allow the CAH to determine the sample size of the reviewed records in accordance with current standards of practice to allow the CAH flexibility in adapting the review to its particular circumstances. Specifically, we proposed that the physician periodically (that is, at least once every 2 weeks) reviews and signs a sample of the outpatient records of nonphysician practitioners according to the facility policy and current standards of practice. We proposed to still require periodic review and oversight of all inpatient records by physicians.

C. Public Comments Received on the Proposed Rule and Our Responses

We received 11 public comments concerning our proposed revision of § 485.631(b)(1)(iv) and the addition of §§ 485.631(b)(1)(v) and (b)(1)(vi).

Comment: The majority of commenters supported our proposal to defer to State law regarding the need for physicians to review and sign the medical records for outpatients cared for by nonphysician practitioners in CAHs. The commenters also stated that CMS should extend the application of this policy to physician review of inpatient records for patients cared for by nonphysician practitioners.

Response: We appreciate the commenters' support of our proposed policy change to defer to State law for physician oversight of outpatients cared for by nonphysician practitioners in CAHs. However, we believe the statute is very specific as to the oversight requirement for inpatients treated by a nonphysician practitioner in a CAH. As we stated in the proposed rule, section 1820(c)(2)(B)(iv)(III) of the Act provides that CAH inpatient care provided by a PA, NP, or CNS is subject to the oversight of a physician. Therefore, we will still require physicians to periodically review and sign medical records of all inpatients cared for by a nonphysician practitioner.

Comment: Two commenters stated that, given the growing clinical independence of NPs, they have concern with CMS adding additional Federal requirements for patient record reviews that go beyond existing State licensure laws. Some commenters stated that most States do not use the term ''independent practice,'' but instead define independent practice as the practitioner functioning autonomously. Another commenter stated that some States do not address independent practice and, instead, describe their oversight agreement as a ''collaborative'' agreement between the physician and the nonphysician practitioner.

Response: We share the commenters' concern with imposing requirements that do not increase the safety and health outcomes of patients. We proposed the new policy to eliminate the requirement for a physician to review and sign all medical records of outpatients (or a random sample of 25 percent for CAHs with a high volume of outpatients) cared for by a nonphysician practitioner to provide CAHs with the flexibility to comply with State laws for outpatient oversight. We believe that sufficient control and oversight of nonphysician practitioners are generated by State laws.

We also believe that the proposed policy on physician oversight of outpatient care provided by nonphysician practitioners allows for collaborative arrangements. Nonphysician practitioners who are required by State law to have a collaborative agreement with a physician would be expected to follow any State law, current standards of practice, and the CAH's policies concerning physicians collaborating with nonphysician practitioners who provide care for outpatients. We further understand that, in many instances, the terms ''autonomous'' and ''independent'' are synonymous. Although PAs are not considered independent practitioners because they always work under physician supervision, PAs perform their duties with a high degree of autonomy in providing patient care and making medical decisions. Based on these comments, and to provide clarity, we are removing the word ''independently'' from the final regulation at § 485.63(b)(1)(v) and (vi) and further revising the regulation to state that, where State law requires record reviews or co-signatures, or both, by a collaborating physician, physicians must periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients who were cared for by nonphysician practitioners in accordance with the policies of the CAH and current standards of practice. In addition, where State law does not require record reviews or co-signatures, or both, by a collaborating physician, physician are not required to review and sign outpatient records of patients who were cared for by nonphysician practitioners.

D. Final Policy

After carefully considering the public comments received, we are adopting the proposed policy changes as final with the following modifications: We are revising the regulation at § 485.63(b)(1)(v) and (vi) by removing references to independent practice. We are further providing that physicians must review and sign a sample of outpatient records periodically, but not less than every 2 weeks, only if State law requires such record reviews or co-signatures, or both, by a collaborating physician.

XVII. Files Available to the Public Via the Internet

Addenda A and B to this final rule with comment period provide various data pertaining to CY 2006 payment for services under the OPPS. In previous years, we have listed in Addendum B hundreds of HCPCS codes describing services that are not paid under the hospital OPPS. To conserve resources and to make Addendum B more relevant to the OPPS, in this final rule with comment period that updates the OPPS for CY 2006, we are including in Addendum B only the HCPCS codes for services that are paid under the OPPS, as well as HCPCS codes that will be discontinued in CY 2006. The HCPCS codes published in Addendum B to this final rule with comment period, as well as HCPCS codes for items or services furnished in a hospital outpatient setting that are paid under a fee schedule or payment methodology other than the OPPS, and HCPCS codes for items or services not recognized or covered by Medicare, are available to the public on the CMS Web site at: *http://www.cms.hhs.gov/providers/hopps*.

For the convenience of the public, we are also including on this same CMS

Web site, in a format that can be readily downloaded and manipulated, a table that displays the HCPCS data in Addendum B sorted by APC assignment, which is identified on the Web site as Addendum C. In addition, we are including on the CMS Web site, in a format that can be easily downloaded and manipulated, Addendum A.

We note that in the CY 2006 OPPS proposed rule, we included, as Addenda H, I, J, K, L, M, N, and O, reprints of wage index related tables from the IPPS that would be used for the OPPS for CY 2006. In this final rule with comment period, we are not reprinting these tables as they were issued in the final FY 2006 IPPS rule, and corrected. Rather, we are providing a link on the CMS Web site at: *http://www.cms.hhs.gov/providers/hopps* to all of the FY 2006 IPPS wage index related tables, except for the table containing the out-migration wage adjustment data referenced in section II.D. of this preamble. The out-migration table is presented as Addendum L in this final rule with comment period. For additional assistance, contact Rebecca Kane, (410) 786–0378.

XVIII. Collection of Information Requirements

In the CY 2006 OPPS proposed rule, we solicited public comments on the following information collection requirement and the associated burden that is subject to the Paperwork Reduction Act of 1995 (PRA):

Section 485.631(b)(1)(iv), (b)(1)(v), and (b)(1)(vi)—Condition of Participation: Staffing and Staff Responsibilities

In the proposed rule, we proposed to revise § 485.631(b)(1)(iv) and add new §§ 485.631(b)(v) and (vi) of the regulations to require, as a condition of participation for a CAH, that a doctor of medicine or osteopathy (1) periodically review and sign the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants; and (2) periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policy and standard practice of the CAH when State law does not allow these nonphysician practitioners to practice independently. In addition, we proposed to provide that a doctor of medicine or osteopathy is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants when State law allows these nonphysician practitioners to practice independently.

Based on public comments received on the proposed policy changes in § 485.631(b)(1), in this final rule with comment period, we have revised the proposed section to remove the term ''independently'' and to specify that where State law requires record review or co-signatures, or both, by a collaborating physician, physicians must review and sign a sample of outpatient records of patients who were cared for by nonphysician practitioners in accordance with the policies of the CAH and current standards of practice. We refer the readers to section XVI.C. of this preamble for a fuller discussion of these final changes.

The information collection requirements associated with these provisions are subject to the PRA. However, the collection requirement is currently approved under OMB control number 0938–0328 with an expiration date of January 31, 2008.

XIX. Regulatory Impact Analysis

A. OPPS: General

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 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.

1. Executive Order 12866

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 that the effects of the provisions that will be implemented by this final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2006 compared to CY 2005 to be approximately $1.4 billion. Therefore, this final rule with comment period is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

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 (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.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we adopted in the November 15, 2004 final rule with comment period, for CY 2005 (consistent with the FY

2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule with comment period will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule with comment period will have a significant impact on a substantial number of small entities.

4. 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 a single expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million. This final rule with comment period does not mandate any requirements for State, local, or tribal governments. This final rule with comment period also does not impose unfunded mandates on the private sector of more than $120 million dollars.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 39, the impact analysis shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 1.9 percent under this final rule with comment period.

Comment: Several commenters noted that OPPS is the only major Medicare payment system that does not include a teaching adjustment and urged CMS to compare the unit costs of teaching hospitals with other types of hospitals in order to support a teaching adjustment to the OPPS. One commenter suggested that such a study was necessary in light of the lower average payment increase estimated for major teaching hospitals in the proposed rule, 0.6 percent. The commenter hypothesized that teaching hospitals are more dependent on pass-through, outlier, and device-dependent APC payments, for which payments are less stable than for other hospitals, and that this is one reason for an adjustment. Finally, the commenter cited the statement in the April 7, 2000 final rule, where CMS indicated that it would study cost and payment differentials among hospitals, including teaching facilities, once there was reliable claims data under the OPPS.

Response: We do not believe that a study of the unit costs of teaching hospitals relative to other classes of hospitals is necessary at this time. As we stated in our April 7, 2000 final rule, we believe it is important to monitor ongoing trends for specific classes of hospitals. However, we also believe that such studies are especially warranted when hospitals experience a negative increase in payments. In this specific instance, major teaching hospitals are projected to experience an overall increase in payments of 1.0 percent. This increase is lower than the market basket update to the conversion factor because it reflects extra payments for drugs authorized by Pub. L. 108–173 for 2 years that expire in CY 2006. For the past 2 years, teaching hospitals have been receiving more payment for drugs than budget neutrality would allow. The increase in total payments for teaching hospitals is less this year because the provision allowing extra drug payments expires. Without considering these expiring payments for drugs, major teaching hospitals are projected to receive a 3.5 percent increase in total payments and minor teaching hospitals are projected to experience an increase of 4.1 percent. In light of such large increases, we do not believe that a study of unit costs for teaching hospitals is necessary. In addition, we are not convinced that a reliance on pass-through, outlier, or device-dependent APCs is a reason to propose an adjustment. We believe that the source of payments is less important than total payments for each hospital.

B. Impact of Changes in This Final Rule With Comment Period

We are adopting as final several proposed changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2006, as we discuss in sections II.C. and II.D., respectively, of this preamble. We also are revising the relative APC payment weights using claims data from January 1, 2004, through December 31, 2004 and updated cost report information. In response to a provision in Pub. L. 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are increasing payments to rural SCHs. Section II.G. of this preamble provides greater detail on this rural adjustment. Finally, we are removing three device categories from pass-through payment status. In particular, section IV.C.1. of this preamble discusses the expiration of pass-through status for devices.

Under this final rule with comment period, the update change to the conversion factor as provided by statute will increase total OPPS payments by 3.7 percent in CY 2006. The inclusion in CY 2006 of payment for specific covered outpatient drugs within budget neutrality, and the expiration of additional drug payment outside budget neutrality, result in a net increase of 2.2 percent. The changes to the APC weights, changes to the wage indices, and the introduction of a payment adjustment for rural SCHs will not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 39 and described in more detail in this section.

C. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options that we have are discussed throughout this final rule with comment period. Some of the major issues discussed in this final rule with comment period and the options considered are discussed below.

1. Option Considered for Payment Policy for Separately Payable Drugs and Biologicals

As discussed in detail in section V.B.3 of this preamble, section 1833(t)(14)(A)(iii) of the Act requires

that payment for specified covered outpatient drugs in CY 2006, as adjusted for pharmacy overhead costs, be equal to the average acquisition cost for the drug for that year as determined by the Secretary and taking into account the hospital acquisition cost survey data collected by the GAO in CY 2004 and CY 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary.

The payment policy that we are adopting for CY 2006 is to pay for the acquisition and pharmacy overhead costs of all separately payable drugs and biologicals at the payment rates effective in the physician office setting as determined using the manufacturer's average sales price (ASP) methodology. (The payment rate in the physician office setting is ASP+6 percent.) These payment rates listed in this final rule with comment period are based on ASP data from the second quarter of 2005, which were used to set payment rates for drugs and biologicals in the physician office setting effective October 1, 2005, as these are the most recent numbers available to us during the development of this final rule with comment period. For the few drugs and biologicals, other than radiopharmaceuticals as discussed earlier, where ASP data are unavailable, we used the mean costs from the CY 2004 hospital claims data to determine their packaging status and for ratesetting. We believe that the ASP-based payment rates serve as the best proxy for the average acquisition and pharmacy overhead costs for the drug or biological because the rates calculated using the ASP methodology are based on the manufacturers' sales prices from the second quarter of CY 2005 and take into consideration information on sales prices to hospitals. Furthermore, payments for drugs and biologicals using the ASP methodology will allow for consistency of drug pricing between the physician offices and hospital outpatient departments.

In the CY 2006 proposed rule, we proposed paying for acquisition costs of drugs alone at the rate of ASP+6 percent, with an additional 2 percent of ASP for the pharmacy overhead costs of drugs. At that time, we also considered paying for separately payable drugs and biologicals (before payment for pharmacy overhead) at ASP+3 percent, based on the average relationship between the GAO mean purchase prices and ASP. We also considered ASP+8 percent (again before payment for pharmacy overhead) based on the average relationship between the mean costs from hospital claims data and ASP.

In the proposed rule, we did not set payment rates for separately payable drugs and biologicals at ASP+3 percent because the GAO data reflect hospital acquisition costs from a less recent period of time, as the midpoint of the time period when the survey was conducted is January 1, 2004, and it will be difficult to update the GAO mean purchase prices during CY 2006 and in future years. Because the changes in drug payments are required to be budget neutral by law, we note that paying for separately payable drugs and biologicals at ASP+3 percent relative to ASP+6 percent would have made available approximately an additional $60 million for other items and services paid under the OPPS.

In the proposed rule, we also did not use ASP+8 percent to set payment rates for drugs and biologicals in CY 2006. The statute specifies that CY 2006 payments for specified covered outpatient drugs are required to be equal to the ''average'' acquisition cost for the drug. Payment at ASP+8 percent for drugs or biologicals, which represented the average relationship between the mean cost from hospital claims data and ASP at the time of the proposed rule, would reflect the product's acquisition cost plus pharmacy overhead cost, instead of acquisition cost only. Therefore, we believed at that time that it would not be appropriate for us to use ASP+8 percent to set the payment rates for drugs and biologicals in CY 2006.

In this final rule with comment period, we have updated data on drug costs, and we have reviewed the available alternatives in the light of those data. Based on our updated data, the average relationship between the mean costs from hospital claims data and ASP is now ASP+6 percent, rather than ASP+8 percent as in the proposed rule. Therefore, in this final rule with comment period, we are adopting the policy of paying both for the acquisition and pharmacy overhead costs of separately payable drugs at a combined rate of ASP+6 percent. As in the proposed rule, we considered several alternatives. We again considered paying for separately payable drugs and biologicals at ASP+3 percent, reflecting the GAO survey data on drug costs. However, payment at this level would reflect only the acquisition costs of drugs and, therefore, would not be sufficient to pay for acquisition and overhead costs. We also considered paying for the acquisition costs of drugs alone at the proposed rate of ASP+6 percent. A commenter from MedPAC noted that, given that ASP values have declined in recent quarters and that the GAO's data did not fully reflect rebates, the proposed drug payment rates of ASP+6 percent could be too high. In addition, our more recent claims data indicate that this rate would represent excessive payment for acquisition costs of drugs alone. Instead, the hospital claims data suggest that ASP+6 percent is an appropriate rate for the acquisition and pharmacy overhead costs of drugs because pharmacy overhead costs are already built into hospital charges for drugs. Therefore, we are adopting that policy in this final rule with comment period.

Payment for drugs and biologicals under this methodology adds approximately $500 million to the amount of drug costs that was included in our budget neutrality calculation for the CY 2005 OPPS. The effect of the addition of this amount is offset by reductions in weights for other services that are largely a function of updated, reduced CCRs.

2. Payment Adjustment for Rural SCHs

In section II.G. of this preamble, we are finalizing a 7.1 percent payment adjustment increase for rural SCHs. Section 1833(t)(13)(A) of the Act instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient costs. In addition, under section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals, by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

For this final rule with comment period, we conducted the same analyses that we conducted for the proposed rule with updated data, and in addition, we examined the relative costliness of several classes of hospitals identified in public comments. We used regression analysis to analyze the differences in the outpatient cost per unit between rural and urban hospitals in order to compare costs after accounting for other factors that influence unit cost, including local labor supply, and complexity and volume of services.

As in the proposed rule, our initial regression analysis found that all rural hospitals give some indication of having higher cost per unit, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. In order to assess whether the small difference in costs was uniform across rural hospitals or whether all of the variation was

attributable to a specific class of rural hospitals, we included more specific categories of rural hospitals in our explanatory regression analysis. We divided rural hospitals into categories indicated by their eligibility for the expiring hold harmless provision: rural SCHs, small rural hospitals with 100 or fewer beds, and all other rural hospitals. Further analysis revealed that only rural SCHs are more costly than urban hospitals holding all other variables constant. We also examined the relative costliness of other types of hospitals suggested by public comments, including urban SCHs and MDHs. We observed no significant difference in the unit costs of small rural hospitals with 100 or fewer beds, all other rural hospitals, MDHs, urban SCHs, and all other urban hospitals. Therefore, we are adopting a 7.1 percent payment increase for rural SCHs on all services except drugs, biologicals, and those paid under pass-through for CY 2006.

3. Change in the Percentage of Total OPPS Payments Dedicated to Outlier Payments

In section II.H. of this preamble, we are changing the percentage of total OPPS payments dedicated to outlier payments to 1.0 percent in CY 2006 from the current policy of 2.0 percent. We also will continue using a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount, which we have applied since the beginning of the OPPS. In response to findings reported by the MedPAC in its March 2004 Report to Congress that the OPPS outlier policy based on a multiple threshold only targeted outlier payments to simple and low cost procedures. In the same report, MedPAC recommended eliminating the entire outlier policy from the OPPS because the OPPS pays by service rather than by case and, therefore, hospitals are already paid for every increased service associated with a costly case. In addition, cost variability is lower for expensive, complex procedures than less expensive and simpler procedures. We implemented the fixed-dollar threshold in the CY 2005 OPPS that targets outlier payments to complex and expensive procedures that ultimately could impact beneficiary access to services. Our decision to reduce the percentage of total payments dedicated to outlier payments continues to refine our outlier policy to improve its appropriateness for the OPPS. A reduction in the percentage of total payment set aside for outlier payments with the fixed-dollar threshold continues to target outlier payments to those services where one costly occurrence could pose a financial risk for hospitals, but limits these payments to the most complex and costly services. At 1.0 percent, the OPPS outlier policy becomes catastrophic insurance against an occurrence of a very costly service. At the same time, reducing the percentage of total payments dedicated to outlier payments increases the conversion factor, redistributing 1.0 percent of total payments to almost all services.

Alternatives to this policy are either to remain at 2.0 percent or to increase the percentage of payments dedicated to outliers to the statutory limit of 3.0 percent. Increasing the percentage of payments dedicated to outliers could target more payment to outliers, but is at odds with OPPS payment by service rather than case. It is not possible to eliminate outlier payments entirely without a statutory change.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the final policy changes, as well as the statutory changes that will be effective for CY 2006, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters.

E. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the payment of additional dollars in CY 2004 and CY 2005 to providers of OPPS services outside of the budget neutrality requirement for specified covered outpatient drugs. These provisions expire in CY 2006. Pub. L. 108–173 also provided for additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508 through CY 2007. Table 39 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure, wage indices, and adjustment for rural SCHs, which are budget neutral; the estimated distribution of increased payments in CY 2006 resulting from the combined impact of APC recalibration, wage effects, the rural SCH adjustment, and the market basket update to the conversion factor; and, finally, estimated payments considering all payments for CY 2006 relative to all payments for CY 2005, including the expiration of extra payment for specified covered outpatient drugs outside budget neutrality and the change in the percentage of total payments dedicated to outlier payments. Because the expiring payments for drugs were not budget neutral, most classes of hospitals will experience a positive update for CY 2006 that is lower than the market basket update. In essence, the presence of extra payment in previous years makes the increase for CY 2006 look artificially low. We also estimate that a few classes of hospitals may receive less payment in CY 2006. Because updates to the conversion factor, including the update of the market basket, the removal of additional money for pass-through payments, and a change in the percentage of total payments dedicated to outlier payments are applied uniformly, observed redistributions of payments in the impact table largely depends on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), the impact of the wage index changes on the hospital, and the impact of the payment adjustment for rural SCHs. However, total payments made under this system and the extent to which this final rule with comment period redistributes money during implementation would also depend on changes in volume, practice patterns, and the mix of services billed between CY 2005 and CY 2006, which CMS cannot forecast. Overall, the final OPPS rates for CY 2006 will have a positive effect for all hospitals paid under the OPPS. Adopted changes will result in a 2.2 percent increase in Medicare payments to all hospitals, exclusive of transitional pass-through payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-BBA ratio between payment and cost, suggests that adopted changes will result in a 2.3 percent increase in Medicare payments to all other hospitals.

To illustrate the impact of the CY 2006 changes adopted in this final rule with comment period, our analysis begins with a baseline simulation model that uses the final CY 2005 weights, the FY 2005 final post-reclassification IPPS wage indices, as subsequently corrected

and without additional increases resulting from section 508 reclassifications, and the final CY 2005 conversion factor. Columns 2, 3, and 4 in Table 39 reflect the independent effects of the APC reclassification and recalibration changes, updated wage indices, and the new adjustment for rural SCHs, respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of services codes among APC groups and the recalibration of APC weights based on a complete year of CY 2004 hospital OPPS claims data and more recent cost report data. This column also shows the impact of incorporating drug payment at 106 percent of ASP and, for radiopharmaceuticals, payment at cost, within budget neutrality. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2005 weights versus the final CY 2006 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage index used to calculate payment by applying the final FY 2006 IPPS wage index, as subsequently corrected. The OPPS wage index used in Column 3 does not include changes to the wage index for hospitals reclassified under section 508 of Pub. L. 108–173. We modeled the independent effect of updating the wage index by varying only the wage index, using the final CY 2006 scaled weights, and a CY 2005 conversion factor that included a budget neutrality adjustment for changes in wage effects between CY 2005 and CY 2006. Column 4 shows the budget neutral impact of adding a 7.1 percent adjustment to payment for services other than drugs, biologicals, and those receiving pass-through payments to rural SCHs. We modeled the independent effect of the payment adjustment for rural SCHs by varying only the presence of the rural adjustment, using CY 2006 scaled weights, the FY 2006 wage indices, and a CY 2005 conversion factor with budget neutrality adjustments for the new wage index and the adjustment for rural SCHs.

Column 5 demonstrates the combined ''budget neutral'' impact of APC recalibration, the wage index update, and the new adjustment for rural SCHs on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of budget neutrality adjustments and the market basket update by using the weights and wage indices for each year to model CY 2006 requirements, and using a CY 2005 conversion factor that included the market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs.

Finally, Column 6 depicts the full impact of the CY 2006 policy on each hospital group by including the effect of all the changes for CY 2006 and comparing them to all payments in CY 2005, including those required by Pub. L. 108–173. Column 6 shows the combined budget neutral effects of Columns 2 through 5, plus the impact of changing the percentage of total payments dedicated to outlier payments to 1.0 percent, the impact of changing the percentage of total payments dedicated to transitional pass-through payments to 0.17 percent, the impact of expiring payments for drugs added on top of OPPS payments in CY 2005 as a result of Pub. L. 108–173, and the continued presence of payment for wage index increases for hospitals reclassified under section 508 of Pub. L. 108–173.

We modeled the independent effect of all changes in Column 6 using the final weights for CY 2005 with additional money for drugs authorized by Pub. L. 108–173 and the final weights for CY 2006. The wage indices in each year include wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173. We used the final conversion factor for CY 2005 of $56.983 and the final CY 2006 conversion factor of $59.511. Column 6 also contains simulated outlier payments for each year. We used the charge inflation factor used in the final FY 2006 IPPS rule of 7.21 percent to increase individual costs on the CY 2004 claims to reflect CY 2005 dollars, and we used the most recent overall CCR for each hospital as calculated for the APC median setting process. Using the CY 2004 claims and a 7.21 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2005, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,175 will be 1.15 percent of total payments, which is .85 percent lower than the 2.0 percent that we projected in setting outlier policies for CY 2005. Outlier payments of only 1.15 percent appear in the CY 2005 comparison in Column 6. We used the same set of claims and a charge inflation factor of 14.94 percent to model the CY 2006 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,250.

Column 1: Total Number of Hospitals

Column 1 in Table 39 shows the total number of hospital providers (4,222) for which we were able to use CY 2004 hospital outpatient claims to model CY 2005 and CY 2006 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2005 or CY 2006 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section II.A. of this preamble. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. Finally, section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to the proportion of their pre-BBA payment relative to their costs. Because this final rule with comment period will not impact these hospitals negatively, we removed them from our impact analyses. We show the total number (4,162) of OPPS hospitals, excluding the hold-harmless cancer hospitals and children's hospitals, on the second line of the table.

Column 2: APC Recalibration

The combined effect of APC reclassification and recalibration, including the payment for drugs and biologicals at 106 percent of ASP for acquisition and pharmacy overhead costs, resulted in larger changes in Column 2 than are typically observed for APC recalibration. Overall, these changes have no impact on all urban hospitals, which show no projected change in payments, although some classes of urban hospitals experience decreases in payments. However, changes to the APC structure for CY 2006 tend to favor, slightly, urban hospitals that are not located in large urban areas. We estimate that large urban hospitals will experience a decline of 0.7 percent, while ''other'' urban hospitals experience an increase of 0.9 percent. Urban hospitals with between 0 and 99 beds and between 100 and 199 beds experience decreases, while the largest urban hospitals, those with beds greater than 500 experience increases of 0.7 percent. With regard to volume, all urban hospitals except those with the highest volume, experience decreases in payments. The lowest

volume hospitals experience the largest decrease of 5.4 percent. Urban hospitals providing the highest volume of services demonstrate a projected increase of 0.2 percent as a result of APC recalibration. Estimated decreases in payment for urban hospitals are also concentrated in some regions, specifically, New England, Pacific, South Atlantic, and Mountain, with the first two experiencing the largest decreases of 1.0 each. On the other hand, a few regions experience moderate increases. Urban hospitals in the East South Central and West North Central regions experience increases of 1.6 and 2.3 percent, respectively.

Overall, rural hospitals show a modest 0.2 percent decrease as a result of changes to the APC structure, and this 0.2 percent decrease appears to be concentrated in rural hospitals that are not rural SCHs, which experience a 0.6 percent increase. Notwithstanding a modest overall decline in payments, there is substantial variation among classes of rural hospitals. Specifically, rural hospitals with less than 100 beds and between 150 and 199 beds experience decreases, with hospitals having less than 50 beds experiencing the largest decrease of 1.6 percent. Rural hospitals with greater than 200 beds experience the largest increase of 1.6 percent. With regard to volume, all rural hospitals, except those with the highest volume, experience decreases in payments. The lowest volume hospitals experience the largest decrease of 5.7 percent. Rural hospitals providing the highest volume of services demonstrate a projected increase of 0.8 percent as a result of APC recalibration. Decreases for rural hospitals occur in every region except West North Central and the Middle Atlantic. The largest decreases are observed in the Pacific (−1.8 percent), New England (−1.4 percent), and West South Central (−1.4 percent) regions. On the other hand, rural hospitals in the Middle Atlantic and West North Central regions experience increases of 1.8 and 3.5 percent, respectively.

Among other classes of hospitals, the largest observed impacts resulting from APC recalibration include declines of 0.6 percent for nonteaching hospitals and increases of 0.4 percent for major teaching hospitals. Hospitals treating the most low-income patients (high DSH percentage) and the least low-income patients demonstrate declines of 0.2 percent. Urban hospitals that are treating DSH patients and are also teaching hospitals experience increases of 0.5 percent. We project that hospitals for which a DSH percentage is not available, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals will experience decreases in payments of 4.5 percent, and for the urban subset, 5.9 percent. Classifying hospitals by type of ownership suggests that proprietary and government hospitals will lose 1.1 and 0.1 percent, respectively, while voluntary hospitals will gain 0.2 percent.

Column 3: New Wage Indices

Changes introduced by the final FY 2006 IPPS wage indices will have a modest impact in CY 2006, increasing payments to rural hospitals slightly and having no effect overall on urban hospitals. We estimate that rural SCHs will experience an increase in payments of 0.1 percent, while all other rural hospitals experience an increase of 0.2 percent. With respect to volume, rural hospitals with the least volume and rural hospitals with moderate volume experience decreases of 0.1 and 0.2 percent, respectively. For both facility size and volume, no category of rural hospitals experiences an increase greater than 0.3 percent. Examining hospitals by region reveals slightly greater variability. We estimate that rural hospitals in several regions will experience decreases in payment up to 0.3 percent due to wage changes, including the Middle Atlantic, South Atlantic, West North Central, and West South Central regions. However, rural hospitals in the remaining regions experience increases. We estimate that the New England region will see the largest increase of 2.2 percent.

Overall, urban hospitals experience no change in payments as a result of the new wage indices. With respect to facility size, we estimate that urban hospitals with between 300 and 499 beds will experience a decrease in payments of 0.2 percent. Urban hospitals with less than 99 beds experience the largest increase of 0.2 percent. When categorized by volume, urban hospitals with the largest volumes experience no change in payment as a result of changes to the wage index, and urban hospitals with the lowest volume experience a 0.4 percent increase in payment. We estimate that urban hospitals in all but the Pacific, New England and the Middle Atlantic regions will experience modest decreases due to wage changes of no more than 0.5 percent (except for urban hospitals in Puerto Rico, with a decrease of 1 percent). Urban hospitals in the Pacific and New England regions will experience an increase of 1.2, and 0.2 percent, respectively. Urban hospitals in the Middle Atlantic region will experience no change in payments.

Looking across other categories of hospitals, we estimate that updating the wage index will lead major teaching hospitals to lose 0.2 percent and hospitals without graduate medical education programs are estimated to gain 0.1 percent. Hospitals serving between 0.0 and 0.10 percent of low-income patients lose up to 0.1 percent, whereas hospitals serving other percentages of low-income patients experience no change. Government, voluntary, and proprietary hospitals as classes will experience no change in payment due to wage changes.

Column 4: New Adjustment for Rural SCHs

As discussed in section II.G. of this preamble, we have increased payments for all services except drugs and biologicals to rural SCHs by 7.1 percent. This resulted in an adjustment to the conversion factor of 0.996. Targeting payments to these rural hospitals uniformly reduces payments to all other hospitals by 0.4 percent. The uniform reduction for all urban and other rural hospitals is evident in Column 4. The periodic appearance of a − 0.3 among urban classes of hospitals is due to the difference between the definition of rural used for this impact table and the broader definition of rural employed for the adjustment for rural SCHs. SCHs located in urban areas that are reclassified as rural for wage index purposes are eligible for the adjustment. The observed increase of 5.6 percent for rural SCHs is lower than 7.1 percent because drugs and biologicals do not receive the payment adjustment. The remaining classes of rural hospitals show variable increases that reflect the distribution of rural SCHs. The largest increases are observed among rural hospitals with small numbers of beds, with moderate volume, and regions in the western half of the country.

Column 5: All Budget Neutrality Changes and Market Basket Update

The addition of the market basket update alleviates any negative impacts on payments for CY 2006 created by the budget neutrality adjustments made in Columns 2, 3, and 4, with the exception of hospitals with the lowest volume of services and hospitals not paid under IPPS, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. In many instances, the redistribution of payments created by APC recalibration offset those introduced by updating the wage indices. However, in a few instances, negative APC recalibration changes compound a reduction in payment from updating the wage index. In addition,

all urban and rural hospitals that are not SCHs experience a decrease in payment of 0.4 percent as a result of the payment adjustment for rural SCHs.

We estimate that the cumulative impact of the budget neutrality adjustments and the addition of the market basket update will result in an increase in payments for urban hospitals of 3.3 percent, which is less than the market basket update of 3.7 percent. Large urban hospitals will experience an increase of 2.5 percent and other urban hospitals will experience an increase of 4.2 percent. Most other classes of urban hospitals experience updates lower than the market basket update. Urban hospitals with the lowest volume experience a negative market basket update, which is largely a function of the 5.4 percent decrease in payments attributable to changes to the APC structure. Urban hospitals with moderate volume will also lose the bulk of the market basket update as a result of a 2.9 percent decrease resulting from the APC recalibration and the addition of the payment adjustment for rural SCHs. The same compounding effect holds true for urban hospitals in the New England and South Atlantic regions and Puerto Rico, which experience the lowest overall increases of 2.5, 2.3, and 1.4 percent, respectively. Urban hospitals in the East South Central and West North Central regions experience increases in payment for CY 2006 above the market basket update.

We estimate that the cumulative impact of budget neutrality adjustments and the market basket update will result in an overall increase for rural hospitals of 5.7 percent, with rural SCHs experiencing an update of 10.2 percent and other rural hospitals experiencing an update of 2.9 percent. In general, rural hospitals with more than 50 beds and the highest volume rural hospitals experience increases of more than 5.3 percent, which generally results from the combined impact of increases in payment from APC recalibration, wage changes, and the new adjustment for rural SCHs. We estimate that low-volume rural hospitals will experience a decrease in payments of 1.1 percent, which results from the combined impact of decreased payments attributable to APC recalibration and wage index update that are larger than the estimated 1.2 percent increase from the adjustment for rural SCHs. Rural hospitals also demonstrate large increases by region. We estimate that all regions except East South Central will experience increases larger than the market basket update. For these regions, in aggregate, the payment adjustment for rural SCHs compensates for observed decreases in payment due to APC recalibration or the update for the wage indices.

The changes across columns for other classes of hospitals are fairly moderate and most show updates relatively close to the market basket update with the exception of hospitals not paid under the IPPS. These hospitals show negative payment updates as a result of negative payment changes for APC recalibration and the adjustment for rural SCHs. Proprietary hospitals also show an increase much less than the market basket as a result of negative payments under APC recalibration.

Column 6: All Changes for CY 2006

Column 6 compares all changes for CY 2006 to final payment for CY 2005 and includes any additional dollars resulting from provisions in Pub. L. 108–173 in both years, changes in outlier payment percentages and thresholds, and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 2.2 percent under this final rule with comment period in CY 2006 relative to total spending in CY 2005, which included Pub. L. 108–173 dollars for drugs and wage indices. When we excluded cancer and children's hospitals, which are held harmless, the gain is 2.3 percent. While hospitals receive the 3.7 percent increase due to the market basket update appearing in Column 5 and the additional 0.85 percent in outlier payments that we estimate as not being paid in CY 2005, we estimate that hospitals also experience an overall 2.25 percent loss due to the expiration of additional payment for drugs in CY 2005, as well as a 0.07 percent reduction due to the change in estimated pass-through payments for CY 2006. That is, without the net additional 0.78 (0.85–0.07) percent increase in outlier payments due to lower than expected payment for outliers in CY 2005, hospitals will receive a positive increase in payments of 1.5 percent. Paying the net additional 0.78 percent in CY 2006 increases overall gains to 2.2 (rounded 2.23) percent, which is lower than the market basket update. The change in the outlier thresholds has a small redistributive impact by class of hospital and the vast majority of redistributive impacts observed between Columns 5 and 6 can be attributed to the loss of additional payment for drugs outside budget neutrality required by Pub. L. 108–173. The redistributive impact of the change in the outlier target from 2 to 1 percent is discussed in greater detail under section XIX.F. of this preamble.

In general, urban hospitals appear to experience the largest negative impacts from the combined effects of losing additional payments for drugs, the decreases in payment from the payment adjustment for rural SCHs, and, frequently, negative changes in payments due to APC recalibration. We estimate that hospitals in large urban areas will gain 1.2 percent in CY 2006 and hospitals in other urban areas will gain 2.8 percent. We estimate that low-volume urban hospitals will experience a decrease in total payments of 1.0 percent between CY 2005 and CY 2006. This negative update includes the cumulative effect of negative payments from APC recalibration, a negative impact of the payment adjustment for rural SCHs, a loss of payments outside budget neutrality for drugs and a loss of some outlier payments. All other classes of urban hospitals show increases between 0.4 and 3.8 percent. We note that urban hospitals in the East South Central and West North Central regions are estimated to receive slightly more than the market basket in spite of expiring drug payments, the largest increases for urban hospitals.

Overall, rural hospitals experience larger increases than those observed for urban hospitals because the payment adjustment for rural SCHs tends to buffer the loss of payments for drugs from Pub. L. 108–173. However, this adjustment is only for rural SCHs. Overall, we estimate that rural hospitals will experience an increase in payments of 3.9 percent. However, we also estimate that rural SCHs will experience an increase of 7.6 percent, and that the other rural hospitals will only experience an increase of 1.5 percent. With the exception of low-volume rural hospitals, no category of rural hospitals experiences a decrease in payments between CY 2005 and CY 2006, and a few groups of rural hospitals show increases comparable to, or better than, the market basket. For example, rural hospitals with more than 100 beds experience increases of at least 4.1 percent. Rural hospitals with moderate to high volume experience increases of no less than 2.8 percent. Across the regions, all rural hospitals except those in the New England and East North Central regions experience increases in payments greater than 3.2 percent. Rural hospitals in the West North Central region experience an increase of 6.1 percent. We project that low-volume rural hospitals, like low-volume urban hospitals, will experience a decrease in payments of 2.2 percent (due to decreases in payments for mid-level and high-level emergency visits).

Among other classes of hospitals, we estimate that hospitals not paid under the IPPS (DSH Not Available) will experience decreases in payments between CY 2005 and CY 2006 of 1.5 percent. Factoring in expiring payments for drugs through Pub. L. 108–173, we estimate that major teaching hospitals will experience an increase of 1.0 percent.

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Table 39.—Impact of Changes for CY 2006 Hospital Outpatient Prospective Payment System

	(1)	(2)	(3)	(4)	(5)	(6)
	Number of Hospitals	APC Changes	New Wage Index	New Adjustment for Rural Sole Community Hospitals	Cumulative (cols 2,3,4) with Market Basket Update	All Changes
ALL HOSPITALS[1]	**4,222**	**0.0**	**0.0**	**0.0**	**3.7**	**2.2**
ALL HOSPITALS (excludes hospitals held harmless)	4,162	0.0	0.0	0.0	3.7	2.3
URBAN HOSPITALS	2,977	0.0	0.0	-0.4	3.3	2.0
LARGE URBAN (GT 1 MILL.)	1,619	-0.7	0.0	-0.4	2.5	1.2
OTHER URBAN (LE 1 MILL.)	1,358	0.9	0.0	-0.4	4.2	2.8
RURAL HOSPITALS	1,185	-0.2	0.2	2.0	5.7	3.9
SOLE COMMUNITY	455	0.6	0.1	5.6	10.2	7.6
OTHER RURAL	730	-0.7	0.2	-0.4	2.9	1.5
BEDS (URBAN)						
0 - 99 BEDS	972	-0.8	0.2	-0.3	2.8	2.4
100-199 BEDS	951	-0.6	0.1	-0.4	2.7	1.7
200-299 BEDS	486	0.2	0.0	-0.4	3.6	2.6
300-499 BEDS	406	0.2	-0.2	-0.4	3.3	1.9
500 + BEDS	162	0.7	-0.1	-0.4	3.9	1.5
BEDS (RURAL)						
0 - 49 BEDS	502	-1.6	0.2	2.3	4.7	3.1
50- 100 BEDS	401	-1.0	0.3	2.4	5.4	3.7
101- 149 BEDS	173	0.7	0.0	1.3	5.9	4.6
150- 199 BEDS	62	-0.4	0.0	1.9	5.3	4.1
200 + BEDS	47	1.6	0.2	1.8	7.5	4.2
VOLUME (URBAN)						
LT 5,000	590	-5.4	0.4	-0.4	-1.9	-1.0
5,000 - 10,999	170	-2.9	0.1	-0.4	0.5	0.7
11,000 - 20,999	304	-1.1	0.3	-0.3	2.5	2.1
21,000 - 42,999	557	-0.7	0.0	-0.4	2.6	2.2
GT 42,999	1,356	0.2	0.0	-0.4	3.5	2.0

	(1)	(2)	(3)	(4)	(5)	(6)
	Number of Hospitals	APC Changes	New Wage Index	New Adjustment for Rural Sole Community Hospitals	Cumulative (cols 2,3,4) with Market Basket Update	All Changes
VOLUME (RURAL)						
LT 5,000	100	-5.7	-0.1	1.2	-1.1	-2.2
5,000 - 10,999	152	-2.6	0.2	2.4	3.7	2.8
11,000 - 20,999	284	-1.7	-0.2	2.3	4.1	3.1
21,000 - 42,999	370	-1.3	0.2	2.1	4.7	3.4
GT 42,999	279	0.8	0.2	1.9	6.7	4.4
REGION (URBAN)						
NEW ENGLAND	164	-1.0	0.2	-0.4	2.5	1.0
MIDDLE ATLANTIC	392	0.4	0.0	-0.4	3.7	2.2
SOUTH ATLANTIC	451	-0.5	-0.5	-0.4	2.3	1.2
EAST NORTH CENTRAL	469	0.1	-0.2	-0.4	3.2	1.7
EAST SOUTH CENTRAL	199	1.6	-0.1	-0.4	4.8	3.8
WEST NORTH CENTRAL	190	2.3	-0.3	-0.3	5.4	3.8
WEST SOUTH CENTRAL	469	0.2	-0.1	-0.4	3.3	2.2
MOUNTAIN	170	-0.2	-0.3	-0.3	2.9	1.5
PACIFIC	422	-1.0	1.2	-0.4	3.4	2.0
PUERTO RICO	51	-0.8	-1.0	-0.4	1.4	0.4
REGION (RURAL)						
NEW ENGLAND	29	-1.4	2.2	1.3	5.7	2.2
MIDDLE ATLANTIC	76	1.8	-0.2	1.6	7.0	5.3
SOUTH ATLANTIC	181	-0.8	-0.3	1.8	4.4	3.2
EAST NORTH CENTRAL	161	-1.0	0.1	1.7	4.5	2.6
EAST SOUTH CENTRAL	199	-1.2	0.6	0.6	3.6	3.0
WEST NORTH CENTRAL	176	3.5	-0.3	2.5	9.6	6.1
WEST SOUTH CENTRAL	224	-1.4	-0.1	2.5	4.7	3.8
MOUNTAIN	87	-1.3	0.4	5.1	7.9	6.0
PACIFIC	52	-1.8	1.9	3.0	6.9	4.8
TEACHING STATUS						
NON-TEACHING	3,106	-0.6	0.1	0.3	3.5	2.4
MINOR	768	0.6	0.0	-0.2	4.1	2.8
MAJOR	288	0.4	-0.2	-0.4	3.5	1.0
DSH PATIENT PERCENT						
0	8	-0.3	0.7	-0.4	3.7	9.4
GT 0 - 0.10	441	0.1	-0.1	-0.3	3.4	2.2
0.10 - 0.16	555	0.0	0.0	0.2	4.0	3.0
0.16 - 0.23	798	0.1	0.0	0.1	3.9	2.4
0.23 - 0.35	951	0.1	0.0	0.0	3.8	2.2
GE 0.35	769	-0.2	0.0	-0.1	3.4	1.7
DSH NOT AVAILABLE[2] (Not IPPS)	640	-4.5	0.3	-0.4	-1.1	-1.5
URBAN TEACHING/DSH						

	(1)	(2)	(3)	(4)	(5)	(6)
	Number of Hospitals	APC Changes	New Wage Index	New Adjustment for Rural Sole Community Hospitals	Cumulative (cols 2,3,4) with Market Basket Update	All Changes
TEACHING & DSH	952	0.5	-0.1	-0.4	3.7	2.0
TEACHING/NO DSH	0	0.0	0.0	0.0	0.0	0.0
NO TEACHING/DSH	1,454	-0.5	0.1	-0.3	2.9	1.9
NO TEACHING/NO DSH	8	-0.3	0.7	-0.4	3.7	9.4
DSH NOT AVAILABLE[2] (Not IPPS)	563	-5.9	0.1	-0.4	-2.7	-2.5
TYPE OF OWNERSHIP						
VOLUNTARY	2,319	0.2	0.0	0.0	3.9	2.4
PROPRIETARY	1,158	-1.1	0.0	0.0	2.6	1.9
GOVERNMENT	685	-0.1	0.0	0.3	3.9	1.9

Column (1) shows total hospitals in CY 2006.
Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on CY 2004 hospital claims data.
Column (3) shows the impact of updating the wage index used to calculate payment by applying the FY 2006 hospital inpatient wage indices.
Column (4) shows the impact of the budget neutral rural adjustment.
Column (5) shows the impact of all budget neutrality adjustments and the addition of the market basket update.
Column (6) shows the additional adjustments to the conversion factor resulting from a change in the outlier pool and pass-through estimates, and adds outlier payments.
[1]These 4,222 hospitals include children and cancer hospitals which are held harmless to pre-BBA payments
[2]Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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F. Estimated Impact of the Change in Outlier Policy

As stated in section II.H. of this preamble, we are changing the percentage of payments that we have set aside for outlier payments from 2.0 percent to 1.0 percent. In order to accommodate this reduction in outlier payments, we increased the fixed-dollar threshold to $1,250. This threshold changed from the $1,575 in the proposed rule because we used updated claims, final rule APC payment rates, an updated charge inflation factor of 14.94 percent, and each hospital's overall CCR that we calculate as part of our APC median estimation process.

Table 40 shows the impact of reducing the amount of total aggregate OPPS payments set aside for outlier payments to 1.0 percent of CY 2006 payments. Column 2 compares estimated CY 2006 total payments with a 1.0 percent outlier policy and an additional 1.0 percent of total payments in the conversion factor with estimated CY 2006 total payment under a 2.0 percent policy. Using updated claims data, a new charge inflation factor, new APC payment rates, and CCRs, we estimate that the fixed-dollar threshold associated with a 2.0 percent outlier policy would have been $550. We used this fixed-dollar threshold to model the 2.0 percent outlier policy. All other components of the payment system are held constant, including the multiple threshold of 1.75 times the APC payment rate. This impact differs from any impact attributable to outlier payments in Table 40 because the comparison here is within estimates of CY 2006 and not across CY 2005 and CY 2006. We expect that this policy change would slightly redistribute payments away from hospitals receiving a lot of outlier payments to hospitals generally not receiving outlier payments. We also would expect the losses to be concentrated in a few classes of hospitals and the benefits to be diffused across all other classes of hospitals.

Table 40 depicts small changes in total payments across all classes of hospitals from reducing the amount of total payments set aside for outlier payments from 2.0 percent to 1.0 percent. As expected, modest reductions in total payments are observed for hospitals that probably receive a larger percentage of their total payments as outlier payments, including major teaching hospitals and large urban hospitals. We estimate that major teaching hospitals will experience a decrease of 0.7 percent in total payments and that large urban hospitals will experience a decrease of 0.1 percent in total payments. These same hospitals are also responsible for the 0.4 percent decrease in total payments for urban hospitals with more than 500 beds, the 0.1 percent decrease for teaching hospitals with a disproportionate share of low-income patients, and the 0.5 percent decrease for hospitals serving a large percentage of low-income patients. Also evident are slight increases in total payments for most other hospitals arising from the increase in the conversion factor. For example, rural hospitals gain 0.2 percent overall. The

decreases in total payments for low-volume rural and low-volume urban hospitals appear to be attributable to a concentrated loss of outlier payments for moderate cost and moderate complexity services that fail to meet the higher fixed-dollar threshold.

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Table 40.—Impact of Changes in Outlier Percentages for CY 2006 Hospital Outpatient Prospective Payment System

	(1) Number of Hospitals	(2) Percent Change in Total 2006 Payments
ALL HOSPITALS[1]	4,222	0.0
ALL HOSPITALS (excludes hospitals held harmless)	4,162	0.0
URBAN HOSPS	2,977	0.0
LARGE URBAN (GT 1 MILL.)	1,619	-0.1
OTHER URBAN (LE 1 MILL.)	1,358	0.2
RURAL HOSPS	1,185	0.2
SOLE COMMUNITY	455	0.2
OTHER RURAL	730	0.2
BEDS (URBAN)		
0 - 99 BEDS	972	-0.1
100-199 BEDS	951	0.1
200-299 BEDS	486	0.2
300-499 BEDS	406	0.1
500 + BEDS	162	-0.4
BEDS (RURAL)		
0 - 49 BEDS	502	-0.4
50- 100 BEDS	401	0.2
101- 149 BEDS	173	0.5
150- 199 BEDS	62	0.2
200 + BEDS	47	0.5
VOLUME (URBAN)		
LT 5,000	590	-0.3
5,000 - 10,999	170	-0.5
11,000 - 20,999	304	-0.3
21,000 - 42,999	557	0.1
GT 42,999	1,356	0.0
VOLUME (RURAL)		
LT 5,000	100	-0.8
5,000 - 10,999	152	-0.8
11,000 - 20,999	284	-0.3
21,000 - 42,999	370	0.1
GT 42,999	279	0.4
REGION (URBAN)		
NEW ENGLAND	164	-0.3
MIDDLE ATLANTIC	392	-0.4
SOUTH ATLANTIC	451	0.3
EAST NORTH CENT.	469	0.0
EAST SOUTH CENT.	199	0.5
WEST NORTH CENT.	190	0.3
WEST SOUTH CENT.	469	0.1
MOUNTAIN	170	0.1
PACIFIC	422	-0.2
PUERTO RICO	51	-0.3
REGION (RURAL)		
NEW ENGLAND	29	0.1
MIDDLE ATLANTIC	76	0.1
SOUTH ATLANTIC	181	0.4
EAST NORTH CENT.	161	0.1
EAST SOUTH CENT.	199	0.5
WEST NORTH CENT.	176	0.2
WEST SOUTH CENT.	224	0.2
MOUNTAIN	87	-0.4
PACIFIC	52	-0.6
TEACHING STATUS		
NON-TEACHING	3,106	0.2
MINOR	768	0.2
MAJOR	288	-0.7
DSH PATIENT PERCENT		

	(1)	(2)
	Number of Hospitals	**Percent Change in Total 2006 Payments**
0	8	-0.3
GT 0 - 0.10	441	0.0
0.10 - 0.16	555	0.2
0.16 - 0.23	798	0.2
0.23 - 0.35	951	0.2
GE 0.35	769	-0.5
DSH NOT AVAILABLE[2] (Not IPPS)	640	-0.2
URBAN TEACHING/DSH		
TEACHING & DSH	952	-0.1
TEACHING/NO DSH	0	0.0
NO TEACHING/DSH	1,454	0.2
NO TEACHING/NO DSH	8	-0.3
DSH NOT AVAILABLE[2] (Not IPPS)	563	0.1
TYPE OF OWNERSHIP		
VOLUNTARY	2,319	0.0
PROPRIETARY	1,158	0.4
GOVERNMENT	685	-0.2

Column (1) shows total number of hospitals in CY 2006.
Column (2) shows the impact of reducing outlier payments from 2 percent to 1 percent of total OPPS payments. This column does not include payments under section 508 of Pub. L. 108-173 (MMA).
[1] The 4,222 hospitals include children's and cancer hospitals which are held harmless to pre-BBA payments.
[2] Complete DSH numbers are not available for providers that are not paid under the IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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G. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a–4.pdf*, in Table 41 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule with comment period. This table provides our best estimate of the increase in Medicare payments under the OPPS as a result of the changes presented in this final rule with comment period based on the data for 4,222 hospitals. All expenditures are classified as transfers to Medicare providers (that is, OPPS).

TABLE 41.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2005 TO CY 2006

Category	Transfers
Annualized Monetized Transfers	$660 Billion.
From Whom to Whom	Federal Government to OPPS Medicare Providers.
Category	Reduction in Costs.
Annualized Monetized Reduction	$436 Million.
From Whom to Whom	Reduction in Payments from Beneficiaries to Federal Government.
Total	$1.1 Billion.

H. Estimated Impacts of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted copayment in CY 2005 was $11.22. In this final rule with comment period, the minimum unadjusted copayment for APC 601 is $12.05 because the OPPS payment for the service will increase under this final rule with comment period, and there is no national unadjusted copayment. In

another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2005 OPPS, the national unadjusted copayment in CY 2005 was $234.20, and the minimum unadjusted copayment was $106.47. In this final rule with comment period, the national unadjusted copayment for APC 0037 is $228.76 because the national unadjusted copayment is limited to 40 percent of the APC payment rate for CY 2006, as discussed in section II. of the preamble to this final rule with comment period. The minimum unadjusted copayment for APC 0037 is $114.38. However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For 2006, the inpatient deductible is $952.

In order to better understand the impact of changes in copayment on beneficiaries we modeled the percent change in total copayment liability using CY 2004 claims. We estimate that total beneficiary liability for copayments will decline as an overall percentage of total payments from 33 percent in CY 2005 to 29 percent in CY 2006. This represents a decline in beneficiary liability of more than $400 million from the CY 2005 OPPS to the CY 2006 OPPS.

Conclusion

The changes in this final rule with comment period will affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but almost all hospitals will experience positive updates in OPPS payments in CY 2006. Table 39 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 2.2 percent increase in payments for CY 2006, after considering the expiring provision for additional drug payment under Pub. L. 108–173 and a change in the percentage of total payments dedicated to outliers and transitional pass-through payments, exclusive of transitional pass-through payments, across various classes of hospitals. The accompanying discussion, in combination with the rest of this final rule with comment period constitutes a regulatory impact analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XX. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

As established in regulations, HCPCS codes are used to identify services for which predetermined amounts are paid under the OPPS (42 CFR 419.2(a)). The HCPCS is a national coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medial providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are five-digit numeric codes, and Category II codes which are temporary codes to track emerging technology, services, and procedures, as we discuss elsewhere in this preamble.

AMA issues an annual update of the CPT code set each fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a calendar year basis. Annual coding changes are not available to the public until the fall immediately preceding the annual January update of the OPPS. Because of the timing of the release of these codes, it is impracticable for us to provide prior notice and solicit comment on these codes in advance of the publication of the annual final rule that implements the OPPS update. Yet it is imperative that these codes be accounted for and recognized timely under the OPPS for payment because services represented by these codes will be provided to Medicare beneficiaries by outpatient hospital departments once issued by the applicable group. Moreover, as we explain above, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including outpatient services paid under the OPPS. Therefore, we believe it would be contrary to the public interest to delay recognition of these codes as payment could not then be made for those services provided under these codes and public access to these services would be impeded.

Therefore, for good cause, we waive notice and comment rulemaking procedures with respect to these codes noted in Addendum B with the status indicator ''NI.'' However, we are providing a 60-day public comment period on these codes.

List of Subjects

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule with comment period, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ A. Part 419 is amended as follows:

■ 1. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

■ 2. Section 419.43 is amended by adding a new paragraph (g) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(g) *Payment adjustment for certain rural hospitals.* (1) *General rule.* CMS provides for additional payment for covered hospital outpatient services not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—

(i) Is a sole community hospital under § 412.92 of this chapter; and

(ii) Is located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under § 412.103 of this chapter.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *Excluded services and groups.* Drugs and biologicals that are paid

under a separate APC and devices of brachytheraphy consisting of a seed or seeds (including a radioactive source) are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

(5) *Copayment.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating copayment amounts.

(6) *Outliers.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating outlier payments.

■ 3. Section 419.66 is amended by revising paragraph (c)(1) to read as follows:

§ 419.66 Transitional pass-through payments: Medical devices.

* * * * *

(c) *Criteria for establishing device categories.* * * *

(1) CMS determines that a device to be included in the category is not appropriately described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ B. Part 485 is amended as follows:

■ 1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 485.631 is amended by—

■ a. Republishing paragraph (b)(1) introductory text.

■ b. Revising paragraph (b)(1)(iv).

■ c. Adding new paragraphs (b)(1)(v) and (b)(1)(vi).

The revision and additions read as follows:

§ 485.631 Condition of participation: Staffing and staff responsibilities.

* * * * *

(b) *Standard: Responsibilities of the doctor of medicine or osteopathy.* (1) The doctor of medicine or osteopathy—

* * * * *

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically, but not less than every 2 weeks, reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policies of the CAH and according to current standards of practice where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(vi) Is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants where State law does not require record reviews or co-signatures, or both, by a collaborating physician.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 26, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2005.

Michael O. Leavitt,

Secretary.

Editorial Note: The following Addenda will not be published in the Code of Federal Regulations.

BILLING CODE 4120–01–P

Addendum A.—List of Ambulatory Payment Classifications (APCs) With Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2006

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.3998	$ 23.79	$ 7.00	$ 4.76
0002	Level I Fine Needle Biopsy/Aspiration	T	0.9357	$ 55.68	.	$ 11.14
0003	Bone Marrow Biopsy/Aspiration	T	2.6756	$ 159.23	.	$ 31.85
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7771	$ 105.76	$ 22.36	$ 21.15
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.5834	$ 213.25	$ 71.59	$ 42.65
0006	Level I Incision & Drainage	T	1.5100	$ 89.86	$ 21.76	$ 17.97
0007	Level II Incision & Drainage	T	11.6717	$ 694.59	.	$ 138.92
0008	Level III Incision and Drainage	T	16.2953	$ 969.75	.	$ 193.95
0009	Nail Procedures	T	0.7513	$ 44.71	.	$ 8.94
0010	Level I Destruction of Lesion	T	0.5923	$ 35.25	$ 9.65	$ 7.05
0011	Level II Destruction of Lesion	T	2.2274	$ 132.55	$ 26.98	$ 26.51
0012	Level I Debridement & Destruction	T	0.8477	$ 50.45	$ 11.18	$ 10.09
0013	Level II Debridement & Destruction	T	1.0603	$ 63.10	$ 13.07	$ 12.62
0015	Level III Debridement & Destruction	T	1.6338	$ 97.23	$ 20.13	$ 19.45
0016	Level IV Debridement & Destruction	T	2.5080	$ 149.25	$ 32.68	$ 29.85
0017	Level VI Debridement & Destruction	T	17.9937	$ 1,070.82	$ 227.84	$ 214.16
0018	Biopsy of Skin/Puncture of Lesion	T	1.1010	$ 65.52	$ 16.04	$ 13.10
0019	Level I Excision/ Biopsy	T	4.1481	$ 246.86	$ 71.87	$ 49.37
0020	Level II Excision/ Biopsy	T	6.9410	$ 413.07	$ 107.67	$ 82.61
0021	Level III Excision/ Biopsy	T	14.9984	$ 892.57	$ 219.48	$ 178.51
0022	Level IV Excision/ Biopsy	T	19.5716	$ 1,164.73	$ 354.45	$ 232.95
0023	Exploration Penetrating Wound	T	4.7662	$ 283.64	.	$ 56.73
0024	Level I Skin Repair	T	1.5513	$ 92.32	$ 30.23	$ 18.46
0025	Level II Skin Repair	T	5.3051	$ 315.71	$ 101.85	$ 63.14
0027	Level IV Skin Repair	T	18.1956	$ 1,082.84	$ 329.72	$ 216.57
0028	Level I Breast Surgery	T	19.4351	$ 1,156.60	$ 303.74	$ 231.32
0029	Level II Breast Surgery	T	31.4826	$ 1,873.56	$ 632.64	$ 374.71
0030	Level III Breast Surgery	T	39.9779	$ 2,379.12	$ 763.55	$ 475.82
0033	Partial Hospitalization	P	4.1322	$ 245.91	.	$ 49.18
0035	Venous Cutdown	T	0.0834	$ 4.96	.	$ 0.99
0036	Level II Fine Needle Biopsy/Aspiration	T	2.1838	$ 129.96	.	$ 25.99
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	9.6103	$ 571.92	$ 228.76	$ 114.38
0039	Level I Implantation of Neurostimulator	S	194.9690	$11,602.80	.	$ 2,320.56

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	S	50.8322	$ 3,025.08	.	$ 605.02
0041	Level I Arthroscopy	T	28.0686	$ 1,670.39	.	$ 334.08
0042	Level II Arthroscopy	T	44.2075	$ 2,630.83	$ 804.74	$ 526.17
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.7200	$ 102.36	.	$ 20.47
0045	Bone/Joint Manipulation Under Anesthesia	T	14.3413	$ 853.47	$ 268.47	$ 170.69
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	37.8852	$ 2,254.59	$ 535.76	$ 450.92
0047	Arthroplasty without Prosthesis	T	31.2345	$ 1,858.80	$ 537.03	$ 371.76
0048	Level I Arthroplasty with Prosthesis	T	43.3955	$ 2,582.51	$ 570.30	$ 516.50
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.3891	$ 1,213.38	.	$ 242.68
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	23.9367	$ 1,424.50	.	$ 284.90
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	36.6106	$ 2,178.73	.	$ 435.75
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	43.5555	$ 2,592.03	.	$ 518.41
0053	Level I Hand Musculoskeletal Procedures	T	15.6396	$ 930.73	$ 253.49	$ 186.15
0054	Level II Hand Musculoskeletal Procedures	T	25.1321	$ 1,495.64	.	$ 299.13
0055	Level I Foot Musculoskeletal Procedures	T	19.9374	$ 1,186.49	$ 355.34	$ 237.30
0056	Level II Foot Musculoskeletal Procedures	T	40.5436	$ 2,412.79	.	$ 482.56
0057	Bunion Procedures	T	27.3981	$ 1,630.49	$ 475.91	$ 326.10
0058	Level I Strapping and Cast Application	S	1.0803	$ 64.29	.	$ 12.86
0060	Manipulation Therapy	S	0.5011	$ 29.82	.	$ 5.96
0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	S	93.4063	$ 5,558.70	.	$ 1,111.74
0068	CPAP Initiation	S	1.2435	$ 74.00	$ 29.48	$ 14.80
0069	Thoracoscopy	T	30.9541	$ 1,842.11	$ 591.64	$ 368.42
0070	Thoracentesis/Lavage Procedures	T	3.2141	$ 191.27	.	$ 38.25
0071	Level I Endoscopy Upper Airway	T	0.8034	$ 47.81	$ 11.31	$ 9.56
0072	Level II Endoscopy Upper Airway	T	1.4448	$ 85.98	$ 21.27	$ 17.20
0073	Level III Endoscopy Upper Airway	T	4.2171	$ 250.96	$ 73.38	$ 50.19
0074	Level IV Endoscopy Upper Airway	T	15.4603	$ 920.06	$ 295.70	$ 184.01
0075	Level V Endoscopy Upper Airway	T	21.2258	$ 1,263.17	$ 445.92	$ 252.63
0076	Level I Endoscopy Lower Airway	T	9.4030	$ 559.58	$ 189.82	$ 111.92
0077	Level I Pulmonary Treatment	S	0.3428	$ 20.40	$ 7.74	$ 4.08
0078	Level II Pulmonary Treatment	S	1.0229	$ 60.87	$ 14.55	$ 12.17
0079	Ventilation Initiation and Management	S	2.2410	$ 133.36	.	$ 26.67

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0080	Diagnostic Cardiac Catheterization	T	36.3392	$ 2,162.58	$ 838.92	$ 432.52
0081	Non-Coronary Angioplasty or Atherectomy	T	42.2664	$ 2,515.32	.	$ 503.06
0082	Coronary Atherectomy	T	91.3717	$ 5,437.62	$ 1,169.67	$ 1,087.52
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	55.2741	$ 3,289.42	.	$ 657.88
0084	Level I Electrophysiologic Evaluation	S	9.6108	$ 571.95	.	$ 114.39
0085	Level II Electrophysiologic Evaluation	T	34.2055	$ 2,035.60	$ 426.25	$ 407.12
0086	Ablate Heart Dysrhythm Focus	T	42.0498	$ 2,502.43	$ 812.36	$ 500.49
0087	Cardiac Electrophysiologic Recording/Mapping	T	33.0075	$ 1,964.31	.	$ 392.86
0088	Thrombectomy	T	36.5126	$ 2,172.90	$ 655.22	$ 434.58
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	117.0463	$ 6,965.54	$ 1,682.28	$ 1,393.11
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	90.2017	$ 5,367.99	$ 1,612.80	$ 1,073.60
0091	Level II Vascular Ligation	T	28.8805	$ 1,718.71	$ 348.23	$ 343.74
0092	Level I Vascular Ligation	T	26.5104	$ 1,577.66	$ 505.37	$ 315.53
0093	Vascular Reconstruction/Fistula Repair without Device	T	23.3101	$ 1,387.21	.	$ 277.44
0094	Level I Resuscitation and Cardioversion	S	2.4582	$ 146.29	$ 46.29	$ 29.26
0095	Cardiac Rehabilitation	S	0.5822	$ 34.65	$ 13.86	$ 6.93
0096	Non-Invasive Vascular Studies	S	1.6020	$ 95.34	$ 38.13	$ 19.07
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0211	$ 60.77	$ 23.79	$ 12.15
0098	Injection of Sclerosing Solution	T	1.1444	$ 68.10	.	$ 13.62
0099	Electrocardiograms	S	0.3769	$ 22.43	.	$ 4.49
0100	Cardiac Stress Tests	X	2.4833	$ 147.78	$ 41.44	$ 29.56
0101	Tilt Table Evaluation	S	4.2112	$ 250.61	$ 100.24	$ 50.12
0103	Miscellaneous Vascular Procedures	T	15.0428	$ 895.21	$ 223.63	$ 179.04
0104	Transcatheter Placement of Intracoronary Stents	T	80.7852	$ 4,807.61	.	$ 961.52
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	21.9865	$ 1,308.44	$ 370.40	$ 261.69
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	55.9362	$ 3,328.82	.	$ 665.76
0107	Insertion of Cardioverter-Defibrillator	T	279.4800	$16,632.13	$ 3,344.78	$ 3,326.43
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	375.2863	$22,333.66	.	$ 4,466.73
0109	Removal of Implanted Devices	T	11.1714	$ 664.82	.	$ 132.96
0110	Transfusion	S	3.6419	$ 216.73	.	$ 43.35
0111	Blood Product Exchange	S	12.0768	$ 718.70	$ 198.40	$ 143.74
0112	Apheresis, Photopheresis, and Plasmapheresis	S	26.3750	$ 1,569.60	$ 433.29	$ 313.92
0113	Excision Lymphatic System	T	21.4112	$ 1,274.20	.	$ 254.84
0114	Thyroid/Lymphadenectomy Procedures	T	40.4596	$ 2,407.79	$ 485.91	$ 481.56

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0115	Cannula/Access Device Procedures	T	36.9806	$ 2,200.75	$ 459.35	$ 440.15
0116	Chemotherapy Administration by Other Technique Except Infusion	S	1.1488	$ 68.37	.	$ 13.67
0117	Chemotherapy Administration by Infusion Only	S	3.1766	$ 189.04	$ 42.54	$ 37.81
0120	Infusion Therapy Except Chemotherapy	S	2.0293	$ 120.77	$ 28.21	$ 24.15
0121	Level I Tube changes and Repositioning	T	2.2374	$ 133.15	$ 43.80	$ 26.63
0122	Level II Tube changes and Repositioning	T	6.9179	$ 411.69	$ 84.43	$ 82.34
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	24.4820	$ 1,456.95	.	$ 291.39
0125	Refilling of Infusion Pump	T	1.9021	$ 113.20	.	$ 22.64
0127	Stereotactic Radiosurgery	S	122.7483	$ 7,304.87	.	$ 1,460.97
0130	Level I Laparoscopy	T	31.8753	$ 1,896.93	$ 659.53	$ 379.39
0131	Level II Laparoscopy	T	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
0132	Level III Laparoscopy	T	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
0140	Esophageal Dilation without Endoscopy	T	5.2970	$ 315.23	$ 91.40	$ 63.05
0141	Level I Upper GI Procedures	T	8.0662	$ 480.03	$ 143.38	$ 96.01
0142	Small Intestine Endoscopy	T	9.0564	$ 538.96	$ 152.78	$ 107.79
0143	Lower GI Endoscopy	T	8.5588	$ 509.34	$ 186.06	$ 101.87
0146	Level I Sigmoidoscopy and Anoscopy	T	4.7086	$ 280.21	$ 64.40	$ 56.04
0147	Level II Sigmoidoscopy and Anoscopy	T	7.9652	$ 474.02	.	$ 94.80
0148	Level I Anal/Rectal Procedures	T	3.5047	$ 208.57	$ 53.79	$ 41.71
0149	Level III Anal/Rectal Procedures	T	18.0878	$ 1,076.42	$ 293.06	$ 215.28
0150	Level IV Anal/Rectal Procedures	T	23.8736	$ 1,420.74	$ 437.12	$ 284.15
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.6171	$ 1,107.92	$ 245.46	$ 221.58
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	18.2391	$ 1,085.43	.	$ 217.09
0153	Peritoneal and Abdominal Procedures	T	22.4936	$ 1,338.62	$ 397.95	$ 267.72
0154	Hernia/Hydrocele Procedures	T	28.6432	$ 1,704.59	$ 464.85	$ 340.92
0155	Level II Anal/Rectal Procedures	T	15.9499	$ 949.19	.	$ 189.84
0156	Level II Urinary and Anal Procedures	T	2.6123	$ 155.46	$ 40.52	$ 31.09
0157	Colorectal Cancer Screening: Barium Enema	S	2.1344	$ 127.02	.	$ 25.40
0158	Colorectal Cancer Screening: Colonoscopy	T	7.5542	$ 449.56	.	$ 112.39
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	3.6322	$ 216.16	.	$ 54.04
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.9387	$ 412.93	$ 105.06	$ 82.59
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	18.5804	$ 1,105.74	$ 249.36	$ 221.15
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.3383	$ 1,388.89	.	$ 277.78
0163	Level IV Cystourethroscopy and other	T	33.5963	$ 1,999.35	.	$ 399.87

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Genitourinary Procedures					
0164	Level I Urinary and Anal Procedures	T	1.1600	$ 69.03	$ 16.96	$ 13.81
0165	Level III Urinary and Anal Procedures	T	16.5343	$ 983.97	.	$ 196.79
0166	Level I Urethral Procedures	T	17.7635	$ 1,057.12	$ 218.73	$ 211.42
0168	Level II Urethral Procedures	T	28.1985	$ 1,678.12	$ 388.16	$ 335.62
0169	Lithotripsy	T	42.4073	$ 2,523.70	$ 1,009.47	$ 504.74
0170	Dialysis	S	5.9448	$ 353.78	.	$ 70.76
0180	Circumcision	T	19.7721	$ 1,176.66	$ 304.87	$ 235.33
0181	Penile Procedures	T	30.9472	$ 1,841.70	$ 621.82	$ 368.34
0183	Testes/Epididymis Procedures	T	23.3500	$ 1,389.58	.	$ 277.92
0184	Prostate Biopsy	T	4.4432	$ 264.42	$ 96.27	$ 52.88
0188	Level II Female Reproductive Proc	T	1.2615	$ 75.07	.	$ 15.01
0189	Level III Female Reproductive Proc	T	2.3805	$ 141.67	.	$ 28.33
0190	Level I Hysteroscopy	T	20.9198	$ 1,244.96	$ 424.28	$ 248.99
0191	Level I Female Reproductive Proc	T	0.1702	$ 10.13	$ 2.85	$ 2.03
0192	Level IV Female Reproductive Proc	T	4.1597	$ 247.55	.	$ 49.51
0193	Level V Female Reproductive Proc	T	14.6385	$ 871.15	.	$ 174.23
0194	Level VIII Female Reproductive Proc	T	20.6573	$ 1,229.34	$ 397.84	$ 245.87
0195	Level IX Female Reproductive Proc	T	26.7972	$ 1,594.73	$ 483.80	$ 318.95
0196	Dilation and Curettage	T	17.0012	$ 1,011.76	$ 338.23	$ 202.35
0197	Infertility Procedures	T	3.0721	$ 182.82	.	$ 36.56
0198	Pregnancy and Neonatal Care Procedures	T	1.3622	$ 81.07	$ 32.19	$ 16.21
0200	Level VII Female Reproductive Proc	T	18.9518	$ 1,127.84	$ 263.69	$ 225.57
0201	Level VI Female Reproductive Proc	T	17.4749	$ 1,039.95	$ 329.65	$ 207.99
0202	Level X Female Reproductive Proc	T	41.2319	$ 2,453.75	$ 981.50	$ 490.75
0203	Level IV Nerve Injections	T	10.0965	$ 600.85	$ 240.33	$ 120.17
0204	Level I Nerve Injections	T	2.2667	$ 134.89	$ 40.13	$ 26.98
0206	Level II Nerve Injections	T	5.4011	$ 321.42	$ 75.55	$ 64.28
0207	Level III Nerve Injections	T	6.0140	$ 357.90	$ 86.92	$ 71.58
0208	Laminotomies and Laminectomies	T	42.5200	$ 2,530.41	.	$ 506.08
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.2895	$ 671.85	$ 268.73	$ 134.37
0212	Nervous System Injections	T	2.7712	$ 164.92	$ 65.96	$ 32.98
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.2509	$ 133.95	$ 53.58	$ 26.79
0214	Electroencephalogram	S	1.1863	$ 70.60	$ 28.24	$ 14.12
0215	Level I Nerve and Muscle Tests	S	0.6025	$ 35.86	$ 14.34	$ 7.17
0216	Level III Nerve and Muscle Tests	S	2.5976	$ 154.59	.	$ 30.92
0218	Level II Nerve and Muscle Tests	S	1.1138	$ 66.28	.	$ 13.26
0220	Level I Nerve Procedures	T	17.3203	$ 1,030.75	.	$ 206.15
0221	Level II Nerve Procedures	T	31.0536	$ 1,848.03	$ 463.62	$ 369.61
0222	Implantation of Neurological Device	T	192.4950	$11,455.57	.	$ 2,291.11
0223	Implantation or Revision of Pain	T	28.5636	$ 1,699.85	.	$ 339.97

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Management Catheter					
0224	Implantation of Reservoir/Pump/Shunt	T	41.1421	$ 2,448.41	.	$ 489.68
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	250.8484	$14,928.24	.	$ 2,985.65
0226	Implantation of Drug Infusion Reservoir	T	72.5804	$ 4,319.33	.	$ 863.87
0227	Implantation of Drug Infusion Device	T	155.0431	$ 9,226.77	.	$ 1,845.35
0228	Creation of Lumbar Subarachnoid Shunt	T	46.4126	$ 2,762.06	.	$ 552.41
0229	Transcatherter Placement of Intravascular Shunts	T	66.3380	$ 3,947.84	.	$ 789.57
0230	Level I Eye Tests & Treatments	S	0.7902	$ 47.03	$ 14.97	$ 9.41
0231	Level III Eye Tests & Treatments	S	1.9167	$ 114.06	.	$ 22.81
0232	Level I Anterior Segment Eye Procedures	T	6.9204	$ 411.84	$ 103.17	$ 82.37
0233	Level II Anterior Segment Eye Procedures	T	14.6645	$ 872.70	$ 266.33	$ 174.54
0234	Level III Anterior Segment Eye Procedures	T	22.0521	$ 1,312.34	$ 511.31	$ 262.47
0235	Level I Posterior Segment Eye Procedures	T	4.7925	$ 285.21	$ 69.52	$ 57.04
0236	Level II Posterior Segment Eye Procedures	T	16.9771	$ 1,010.32	.	$ 202.06
0237	Level III Posterior Segment Eye Procedures	T	28.7866	$ 1,713.12	.	$ 342.62
0238	Level I Repair and Plastic Eye Procedures	T	2.6031	$ 154.91	.	$ 30.98
0239	Level II Repair and Plastic Eye Procedures	T	7.0583	$ 420.05	.	$ 84.01
0240	Level III Repair and Plastic Eye Procedures	T	18.0194	$ 1,072.35	$ 315.31	$ 214.47
0241	Level IV Repair and Plastic Eye Procedures	T	23.1681	$ 1,378.76	$ 384.47	$ 275.75
0242	Level V Repair and Plastic Eye Procedures	T	30.3478	$ 1,806.03	$ 597.36	$ 361.21
0243	Strabismus/Muscle Procedures	T	22.0338	$ 1,311.25	$ 431.39	$ 262.25
0244	Corneal Transplant	T	38.2309	$ 2,275.16	$ 803.26	$ 455.03
0245	Level I Cataract Procedures without IOL Insert	T	13.0344	$ 775.69	$ 217.05	$ 155.14
0246	Cataract Procedures with IOL Insert	T	23.3185	$ 1,387.71	$ 495.96	$ 277.54
0247	Laser Eye Procedures Except Retinal	T	5.0255	$ 299.07	$ 104.31	$ 59.81
0248	Laser Retinal Procedures	T	4.7199	$ 280.89	$ 95.08	$ 56.18
0249	Level II Cataract Procedures without IOL Insert	T	27.6388	$ 1,644.81	$ 524.67	$ 328.96
0250	Nasal Cauterization/Packing	T	1.2241	$ 72.85	$ 25.50	$ 14.57
0251	Level I ENT Procedures	T	2.0789	$ 123.72	.	$ 24.74
0252	Level II ENT Procedures	T	8.1033	$ 482.24	$ 113.41	$ 96.45
0253	Level III ENT Procedures	T	16.0740	$ 956.58	$ 282.29	$ 191.32

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0254	Level IV ENT Procedures	T	23.3114	$ 1,387.28	$ 321.35	$ 277.46
0256	Level V ENT Procedures	T	37.0000	$ 2,201.91	.	$ 440.38
0258	Tonsil and Adenoid Procedures	T	21.8761	$ 1,301.87	$ 437.25	$ 260.37
0259	Level VI ENT Procedures	T	393.7337	$23,431.49	$ 8,698.43	$ 4,686.30
0260	Level I Plain Film Except Teeth	X	0.7296	$ 43.42	.	$ 8.68
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.2416	$ 73.89	.	$ 14.78
0262	Plain Film of Teeth	X	0.8019	$ 47.72	.	$ 9.54
0263	Level I Miscellaneous Radiology Procedures	X	1.6979	$ 101.04	$ 23.77	$ 20.21
0264	Level II Miscellaneous Radiology Procedures	X	3.4542	$ 205.56	$ 79.41	$ 41.11
0265	Level I Diagnostic Ultrasound	S	0.9930	$ 59.09	$ 23.63	$ 11.82
0266	Level II Diagnostic Ultrasound	S	1.5883	$ 94.52	$ 37.80	$ 18.90
0267	Level III Diagnostic Ultrasound	S	2.5543	$ 152.01	$ 60.80	$ 30.40
0268	Ultrasound Guidance Procedures	S	1.0460	$ 62.25	.	$ 12.45
0269	Level III Echocardiogram Except Transesophageal	S	3.1761	$ 189.01	$ 75.60	$ 37.80
0270	Transesophageal Echocardiogram	S	5.9369	$ 353.31	$ 141.32	$ 70.66
0272	Level I Fluoroscopy	X	1.3291	$ 79.10	$ 31.64	$ 15.82
0274	Myelography	S	2.9160	$ 173.53	$ 69.41	$ 34.71
0275	Arthrography	S	3.4927	$ 207.85	$ 69.09	$ 41.57
0276	Level I Digestive Radiology	S	1.4693	$ 87.44	$ 34.97	$ 17.49
0277	Level II Digestive Radiology	S	2.2951	$ 136.58	$ 54.63	$ 27.32
0278	Diagnostic Urography	S	2.5559	$ 152.10	$ 60.84	$ 30.42
0279	Level II Angiography and Venography	S	8.6988	$ 517.67	$ 150.03	$ 103.53
0280	Level III Angiography and Venography	S	20.4187	$ 1,215.14	$ 353.85	$ 243.03
0282	Miscellaneous Computerized Axial Tomography	S	1.5934	$ 94.82	$ 37.92	$ 18.96
0283	Computerized Axial Tomography with Contrast Material	S	4.2921	$ 255.43	$ 102.17	$ 51.09
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras	S	6.2342	$ 371.00	$ 148.40	$ 74.20
0288	Bone Density:Axial Skeleton	S	1.2216	$ 72.70	.	$ 14.54
0296	Level I Therapeutic Radiologic Procedures	S	2.2684	$ 134.99	$ 53.99	$ 27.00
0297	Level II Therapeutic Radiologic Procedures	S	5.0977	$ 303.37	$ 121.34	$ 60.67
0299	Miscellaneous Radiation Treatment	S	5.7678	$ 343.25	.	$ 68.65
0300	Level I Radiation Therapy	S	1.4660	$ 87.24	.	$ 17.45
0301	Level II Radiation Therapy	S	2.2056	$ 131.26	.	$ 26.25
0302	Computer Assisted Navigational Procedures	S	4.6992	$ 279.65	$ 105.94	$ 55.93
0303	Treatment Device Construction	X	2.8241	$ 168.07	$ 66.95	$ 33.61
0304	Level I Therapeutic Radiation Treatment	X	1.7323	$ 103.09	$ 41.23	$ 20.62

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Preparation					
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9335	$ 234.09	$ 91.38	$ 46.82
0306	Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation	S	13.4521	$ 800.55	$ 320.21	$ 160.11
0307	Myocardial Positron Emission Tomography (PET) imaging, multiple studies	S	41.7549	$ 2,484.88	$ 993.95	$ 496.98
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.8818	$ 826.12	$ 325.27	$ 165.22
0312	Radioelement Applications	S	5.5674	$ 331.32	.	$ 66.26
0313	Brachytherapy	S	13.0202	$ 774.85	.	$ 154.97
0314	Hyperthermic Therapies	S	5.5840	$ 332.31	$ 98.36	$ 66.46
0315	Level II Implantation of Neurostimulator	T	312.3876	$18,590.50	.	$ 3,718.10
0320	Electroconvulsive Therapy	S	5.2528	$ 312.60	$ 80.06	$ 62.52
0321	Biofeedback and Other Training	S	1.3651	$ 81.24	$ 21.72	$ 16.25
0322	Brief Individual Psychotherapy	S	1.2304	$ 73.22	.	$ 14.64
0323	Extended Individual Psychotherapy	S	1.6398	$ 97.59	$ 20.35	$ 19.52
0324	Family Psychotherapy	S	2.3119	$ 137.58	.	$ 27.52
0325	Group Psychotherapy	S	1.3434	$ 79.95	$ 17.47	$ 15.99
0330	Dental Procedures	S	9.3925	$ 558.96	.	$ 111.79
0332	Computerized Axial Tomography and Computerized Angiography without Contras	S	3.1608	$ 188.10	$ 75.24	$ 37.62
0333	Computerized Axial Tomography and Computerized Angiography without Contrast followed by Contrast	S	5.1053	$ 303.82	$ 121.52	$ 60.76
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.0997	$ 303.49	$ 121.39	$ 60.70
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont	S	5.8678	$ 349.20	$ 139.68	$ 69.84
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed	S	8.5070	$ 506.26	$ 202.50	$ 101.25
0339	Observation	Q	7.1429	$ 425.08	.	$ 85.02
0340	Minor Ancillary Procedures	X	0.6137	$ 36.52	.	$ 7.30
0341	Skin Tests	X	0.1035	$ 6.16	$ 2.46	$ 1.23
0342	Level I Pathology	X	0.1450	$ 8.63	$ 3.45	$ 1.73
0343	Level III Pathology	X	0.4553	$ 27.10	$ 10.84	$ 5.42
0344	Level IV Pathology	X	0.7584	$ 45.13	$ 15.66	$ 9.03
0345	Level I Transfusion Laboratory Procedures	X	0.2170	$ 12.91	$ 2.87	$ 2.58
0346	Level II Transfusion Laboratory Procedures	X	0.3314	$ 19.72	$ 4.39	$ 3.94

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0347	Level III Transfusion Laboratory Procedures	X	0.8243	$ 49.05	$ 12.11	$ 9.81
0348	Fertility Laboratory Procedures	X	0.7607	$ 45.27	.	$ 9.05
0350	Administration of flu and PPV vaccine	X	0.3917	$ 23.31	.	$ -
0352	Level I Injections	X	0.1368	$ 8.14	.	$ 1.63
0353	Level II Injections	X	0.3917	$ 23.31	.	$ 4.66
0359	Level III Injections	X	0.8036	$ 47.82	.	$ 9.56
0360	Level I Alimentary Tests	X	1.4235	$ 84.71	$ 33.88	$ 16.94
0361	Level II Alimentary Tests	X	3.5671	$ 212.28	$ 83.23	$ 42.46
0362	Contact Lens and Spectacle Services	X	2.2654	$ 134.82	.	$ 26.96
0363	Level I Otorhinolaryngologic Function Tests	X	0.8707	$ 51.82	$ 17.44	$ 10.36
0364	Level I Audiometry	X	0.4548	$ 27.07	$ 7.06	$ 5.41
0365	Level II Audiometry	X	1.1928	$ 70.98	$ 18.52	$ 14.20
0366	Level III Audiometry	X	1.6829	$ 100.15	$ 26.14	$ 20.03
0367	Level I Pulmonary Test	X	0.6539	$ 38.91	$ 14.80	$ 7.78
0368	Level II Pulmonary Tests	X	0.9568	$ 56.94	$ 22.77	$ 11.39
0369	Level III Pulmonary Tests	X	2.7046	$ 160.95	$ 44.18	$ 32.19
0370	Allergy Tests	X	2.8133	$ 167.42	.	$ 33.48
0372	Therapeutic Phlebotomy	X	0.5580	$ 33.21	$ 10.09	$ 6.64
0373	Level I Neuropsychological Testing	X	1.2514	$ 74.47	.	$ 14.89
0374	Monitoring Psychiatric Drugs	X	1.1270	$ 67.07	.	$ 13.41
0375	Ancillary Outpatient Services When Patient Expires	S	45.7015	$ 2,719.74	.	$ 543.95
0376	Level II Cardiac Imaging	S	5.0315	$ 299.43	$ 119.77	$ 59.89
0377	Level III Cardiac Imaging	S	6.6729	$ 397.11	$ 158.84	$ 79.42
0378	Level II Pulmonary Imaging	S	5.4064	$ 321.74	$ 128.69	$ 64.35
0379	Injection adenosine 6 MG	K		$ 32.63	.	$ 6.53
0381	Single Allergy Tests	X	0.1925	$ 11.46	$ 2.41	$ 2.29
0382	Level II Neuropsychological Testing	X	3.4127	$ 203.09	$ 81.23	$ 40.62
0384	GI Procedures with Stents	T	26.8955	$ 1,600.58	$ 335.19	$ 320.12
0385	Level I Prosthetic Urological Procedures	S	73.7498	$ 4,388.92	.	$ 877.78
0386	Level II Prosthetic Urological Procedures	S	126.9292	$ 7,553.68	.	$ 1,510.74
0387	Level II Hysteroscopy	T	32.3170	$ 1,923.22	$ 655.55	$ 384.64
0388	Discography	S	12.1712	$ 724.32	$ 289.72	$ 144.86
0389	Level I Non-imaging Nuclear Medicine	S	1.4276	$ 84.96	$ 33.98	$ 16.99
0390	Level I Endocrine Imaging	S	2.4663	$ 146.77	$ 58.70	$ 29.35
0391	Level II Endocrine Imaging	S	2.7803	$ 165.46	$ 66.18	$ 33.09
0392	Level II Non-imaging Nuclear Medicine	S	3.5231	$ 209.66	$ 83.86	$ 41.93
0393	Red Cell/Plasma Studies	S	3.4467	$ 205.12	$ 82.04	$ 41.02
0394	Hepatobiliary Imaging	S	4.3107	$ 256.53	$ 102.61	$ 51.31
0395	GI Tract Imaging	S	3.7696	$ 224.33	$ 89.73	$ 44.87
0396	Bone Imaging	S	3.9921	$ 237.57	$ 95.02	$ 47.51

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0397	Vascular Imaging	S	2.0829	$ 123.96	$ 49.58	$ 24.79
0398	Level I Cardiac Imaging	S	4.2038	$ 250.17	$ 100.06	$ 50.03
0399	Nuclear Medicine Add-on Imaging	S	1.5039	$ 89.50	$ 35.80	$ 17.90
0400	Hematopoietic Imaging	S	3.9160	$ 233.05	$ 93.22	$ 46.61
0401	Level I Pulmonary Imaging	S	3.3166	$ 197.37	$ 78.94	$ 39.47
0402	Brain Imaging	S	5.1709	$ 307.73	$ 123.09	$ 61.55
0403	CSF Imaging	S	3.5015	$ 208.38	$ 83.35	$ 41.68
0404	Renal and Genitourinary Studies Level I	S	3.6558	$ 217.56	$ 87.02	$ 43.51
0405	Renal and Genitourinary Studies Level II	S	4.1493	$ 246.93	$ 98.77	$ 49.39
0406	Tumor/Infection Imaging	S	4.1397	$ 246.36	$ 98.54	$ 49.27
0407	Radionuclide Therapy	S	3.8758	$ 230.65	$ 92.26	$ 46.13
0409	Red Blood Cell Tests	X	0.1210	$ 7.20	$ 2.20	$ 1.44
0411	Respiratory Procedures	S	0.3922	$ 23.34	.	$ 4.67
0412	IMRT Treatment Delivery	S	5.3573	$ 318.82	.	$ 63.76
0415	Level II Endoscopy Lower Airway	T	22.0722	$ 1,313.54	$ 459.92	$ 262.71
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve	S	16.4464	$ 978.74	.	$ 195.75
0417	Computerized Reconstruction	S	3.9600	$ 235.66	.	$ 47.13
0418	Insertion of Left Ventricular Pacing Elect.	T	169.3514	$10,078.27	.	$ 2,015.65
0421	Prolonged Physiologic Monitoring	X	1.6026	$ 95.37	.	$ 19.07
0422	Level II Upper GI Procedures	T	24.0525	$ 1,431.39	$ 448.81	$ 286.28
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	39.5881	$ 2,355.93	.	$ 471.19
0425	Level II Arthroplasty with Prosthesis	T	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
0426	Level II Strapping and Cast Application	S	2.2146	$ 131.79	.	$ 26.36
0427	Level III Tube Changes and Repositioning	T	10.0109	$ 595.76	.	$ 119.15
0428	Level III Sigmoidoscopy and Anoscopy	T	20.0871	$ 1,195.40	.	$ 239.08
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	42.0802	$ 2,504.23	.	$ 500.85
0430	Level IV Nerve and Muscle Tests	T	10.8452	$ 645.41	.	$ 129.08
0432	Health and Behavior Services	S	0.6396	$ 38.06	.	$ 7.61
0433	Level II Pathology	X	0.2493	$ 14.84	$ 5.93	$ 2.97
0434	Cardiac Defect Repair	T	86.4834	$ 5,146.71	.	$ 1,029.34
0600	Low Level Clinic Visits	V	0.8800	$ 52.37	.	$ 10.47
0601	Mid Level Clinic Visits	V	1.0125	$ 60.25	.	$ 12.05
0602	High Level Clinic Visits	V	1.4731	$ 87.67	.	$ 17.53
0610	Low Level Emergency Visits	V	1.2399	$ 73.79	$ 18.71	$ 14.76
0611	Mid Level Emergency Visits	V	2.1707	$ 129.18	$ 34.26	$ 25.84
0612	High Level Emergency Visits	V	3.7772	$ 224.78	$ 51.89	$ 44.96
0620	Critical Care	S	8.0276	$ 477.73	$ 131.61	$ 95.55
0621	Level I Vascular Access Procedures	T	8.2313	$ 489.85	.	$ 97.97
0622	Level II Vascular Access Procedures	T	21.2464	$ 1,264.39	.	$ 252.88
0623	Level III Vascular Access Procedures	T	27.1472	$ 1,615.56	.	$ 323.11

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0648	Breast Reconstruction with Prosthesis	T	53.5307	$ 3,185.67	.	$ 637.13
0651	Complex Interstitial Radiation Source Application	S	11.1948	$ 666.21	.	$ 133.24
0652	Insertion of Intraperitoneal Catheters	T	29.3648	$ 1,747.53	.	$ 349.51
0653	Vascular Reconstruction/Fistula Repair with Device	T	36.9427	$ 2,198.50	.	$ 439.70
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	112.0279	$ 6,666.89	.	$ 1,333.38
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	136.8448	$ 8,143.77	.	$ 1,628.75
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	108.1459	$ 6,435.87	.	$ 1,287.17
0657	Placement of Tissue Clips	S	1.6092	$ 95.77	.	$ 19.15
0658	Percutaneous Breast Biopsies	T	5.9888	$ 356.40	.	$ 71.28
0659	Hyperbaric Oxygen	S	1.5155	$ 90.19	.	$ 18.04
0660	Level II Otorhinolaryngologic Function Tests	X	1.5488	$ 92.17	$ 29.07	$ 18.43
0661	Level V Pathology	X	3.1514	$ 187.54	$ 75.01	$ 37.51
0662	CT Angiography	S	4.9944	$ 297.22	$ 118.88	$ 59.44
0664	Level I Proton Beam Radiation Therapy	S	15.9286	$ 947.93	.	$ 189.59
0665	Bone Density:AppendicularSkeleton	S	0.6381	$ 37.97	.	$ 7.59
0667	Level II Proton Beam Radiation Therapy	S	19.0566	$ 1,134.08	.	$ 226.82
0668	Level I Angiography and Venography	S	6.3104	$ 375.54	$ 88.26	$ 75.11
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	S	28.7546	$ 1,711.22	$ 536.10	$ 342.24
0671	Level II Echocardiogram Except Transesophageal	S	1.6763	$ 99.76	$ 39.90	$ 19.95
0672	Level IV Posterior Segment Eye Procedures	T	36.8773	$ 2,194.61	.	$ 438.92
0673	Level IV Anterior Segment Eye Procedures	T	29.0835	$ 1,730.79	$ 649.56	$ 346.16
0674	Prostate Cryoablation	T	111.3747	$ 6,628.02	.	$ 1,325.60
0675	Prostatic Thermotherapy	T	44.8197	$ 2,667.27	.	$ 533.45
0676	Thrombolysis and Thrombectomy	T	2.2742	$ 135.34	.	$ 27.07
0678	External Counterpulsation	T	1.7600	$ 104.74	.	$ 20.95
0679	Level II Resuscitation and Cardioversion	S	5.4992	$ 327.26	$ 95.30	$ 65.45
0680	Insertion of Patient Activated Event Recorders	S	74.9052	$ 4,457.68	.	$ 891.54
0681	Knee Arthroplasty	T	135.4643	$ 8,061.62	$ 2,081.48	$ 1,612.32
0682	Level V Debridement & Destruction	T	6.7313	$ 400.59	$ 158.65	$ 80.12
0683	Level II Photochemotherapy	S	1.9289	$ 114.79	$ 25.79	$ 22.96
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	6.0034	$ 357.27	$ 115.47	$ 71.45
0686	Level III Skin Repair	T	13.4973	$ 803.24	.	$ 160.65
0687	Revision/Removal of Neurostimulator Electrodes	T	19.1962	$ 1,142.39	$ 456.95	$ 228.48

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0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	42.8588	$ 2,550.57	$ 1,020.22	$ 510.11
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5608	$ 33.37	.	$ 6.67
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3645	$ 21.69	$ 8.67	$ 4.34
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5464	$ 151.54	$ 60.61	$ 30.31
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	1.9774	$ 117.68	$ 30.16	$ 23.54
0693	Breast Reconstruction	T	42.2886	$ 2,516.64	$ 798.17	$ 503.33
0694	Mohs Surgery	T	3.8832	$ 231.09	$ 62.65	$ 46.22
0695	Level VII Debridement & Destruction	T	20.2372	$ 1,204.34	$ 266.59	$ 240.87
0697	Level I Echocardiogram Except Transesophageal	S	1.5121	$ 89.99	$ 35.99	$ 18.00
0698	Level II Eye Tests & Treatments	S	1.2378	$ 73.66	$ 16.52	$ 14.73
0699	Level IV Eye Tests & Treatments	T	8.9556	$ 532.96	.	$ 106.59
0700	Antepartum Manipulation	T	4.1398	$ 246.36	.	$ 49.27
0701	Sr89 strontium	H			.	.
0702	Sm 153 lexidronm	H			.	.
0704	In111 satumomab	H			.	.
0705	Tc99m tetrofosmin	H			.	.
0726	Dexrazoxane HCl injection	K		$ 200.08	.	$ 40.02
0728	Filgrastim 300 mcg injection	K		$ 177.81	.	$ 35.56
0730	Pamidronate disodium /30 MG	K		$ 40.63	.	$ 8.13
0731	Sargramostim injection	K		$ 21.87	.	$ 4.37
0732	Mesna injection	K		$ 10.55	.	$ 2.11
0735	Ampho b cholesteryl sulfate	K		$ 12.00	.	$ 2.40
0736	Amphotericin b liposome inj	K		$ 18.18	.	$ 3.64
0737	Nitrogen N-13 ammonia	H			.	.
0738	Rasburicase	G		$ 111.34	.	$ 22.27
0750	Dolasetron mesylate	K		$ 6.52	.	$ 1.30
0763	Dolasetron mesylate oral	K		$ 48.24	.	$ 9.65
0764	Granisetron HCl injection	K		$ 7.14	.	$ 1.43
0765	Granisetron HCl 1 mg oral	K		$ 35.13	.	$ 7.03
0768	Ondansetron hcl injection	K		$ 3.85	.	$ 0.77
0769	Ondansetron HCl 8mg oral	K		$ 32.77	.	$ 6.55
0800	Leuprolide acetate /3.75 MG	K		$ 434.89	.	$ 86.98
0802	Etoposide oral 50 MG	K		$ 37.17	.	$ 7.43
0807	Aldesleukin/single use vial	K		$ 724.63	.	$ 144.93
0809	Bcg live intravesical vac	K		$ 115.78	.	$ 23.16
0810	Goserelin acetate implant	K		$ 175.04	.	$ 35.01
0811	Carboplatin injection	K		$ 35.25	.	$ 7.05
0812	Carmus bischl nitro inj	K		$ 139.14	.	$ 27.83
0814	Asparaginase injection	K		$ 54.17	.	$ 10.83

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0819	Dacarbazine 100 mg inj	K		$ 5.20	.	$ 1.04
0820	Daunorubicin	K		$ 23.90	.	$ 4.78
0821	Daunorubicin citrate liposom	K		$ 56.51	.	$ 11.30
0823	Docetaxel	K		$ 293.64	.	$ 58.73
0827	Floxuridine injection	K		$ 60.41	.	$ 12.08
0828	Gemcitabine HCl	K		$ 115.89	.	$ 23.18
0830	Irinotecan injection	K		$ 126.92	.	$ 25.38
0831	Ifosfomide injection	K		$ 34.68	.	$ 6.94
0832	Idarubicin hcl injection	K		$ 286.84	.	$ 57.37
0834	Interferon alfa-2a inj	K		$ 32.87	.	$ 6.57
0835	Inj cosyntropin per 0.25 MG	K		$ 67.82	.	$ 13.56
0836	Interferon alfa-2b inj	K		$ 13.30	.	$ 2.66
0838	Interferon gamma 1-b inj	K		$ 272.44	.	$ 54.49
0840	Inj melphalan hydrochl 50 MG	K		$ 753.64	.	$ 150.73
0842	Fludarabine phosphate inj	K		$ 262.87	.	$ 52.57
0843	Pegaspargase/singl dose vial	K		$ 1,611.20	.	$ 322.24
0844	Pentostatin injection	K		$ 1,900.52	.	$ 380.10
0849	Rituximab cancer treatment	K		$ 455.92	.	$ 91.18
0850	Streptozocin injection	K		$ 154.68	.	$ 30.94
0851	Thiotepa injection	K		$ 47.96	.	$ 9.59
0852	Topotecan	K		$ 763.80	.	$ 152.76
0855	Vinorelbine tartrate/10 mg	K		$ 42.83	.	$ 8.57
0856	Porfimer sodium	K		$ 2,464.57	.	$ 492.91
0857	Bleomycin sulfate injection	K		$ 48.71	.	$ 9.74
0858	Inj cladribine per 1 MG	K		$ 37.94	.	$ 7.59
0860	Plicamycin (mithramycin) inj	K	1.0311	$ 61.36	.	$ 12.27
0861	Leuprolide acetate injeciton	K		$ 10.00	.	$ 2.00
0862	Mitomycin 5 MG inj	K		$ 22.29	.	$ 4.46
0863	Paclitaxel injection	K		$ 13.33	.	$ 2.67
0864	Mitoxantrone hydrochl / 5 MG	K		$ 323.80	.	$ 64.76
0865	Interferon alfa-n3 inj	K		$ 8.60	.	$ 1.72
0868	Oral aprepitant	G		$ 4.64	.	$ 0.93
0876	Caffeine citrate injection	K		$ 3.37	.	$ 0.67
0884	Rho d immune globulin inj	K		$ 84.99	.	$ 17.00
0887	Azathioprine parenteral	K		$ 49.96	.	$ 9.99
0888	Cyclosporine oral 100 mg	K		$ 3.48	.	$ 0.70
0890	Lymphocyte immune globulin	K		$ 295.72	.	$ 59.14
0891	Tacrolimus oral per 1 MG	K		$ 3.45	.	$ 0.69
0892	Edetate calcium disodium inj	K		$ 40.38	.	$ 8.08
0893	Calcitonin salmon injection	K		$ 37.81	.	$ 7.56
0895	Deferoxamine mesylate inj	K		$ 15.38	.	$ 3.08
0900	Alglucerase injection	K		$ 39.22	.	$ 7.84
0901	Alpha 1 proteinase inhibitor	K		$ 3.28	.	$ 0.66
0902	Botulinum toxin a per unit	K		$ 4.91	.	$ 0.98

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0903	Cytomegalovirus imm IV /vial	K		$ 722.68	.	$ 144.54
0906	RSV-ivig	K		$ 16.18	.	$ 3.24
0910	Interferon beta-1b / .25 MG	K		$ 85.95	.	$ 17.19
0911	Inj streptokinase /250000 IU	K		$ 79.50	.	$ 15.90
0912	Interferon alfacon-1	K		$ 3.92	.	$ 0.78
0913	Ganciclovir long act implant	K		$ 4,240.00	.	$ 848.00
0916	Injection imiglucerase /unit	K		$ 3.91	.	$ 0.78
0917	Adenosine injection	K		$ 70.27	.	$ 14.05
0925	Factor viii	K		$ 0.65	.	$ 0.13
0926	Factor VIII (porcine)	K		$ 1.86	.	$ 0.37
0927	Factor viii recombinant	K		$ 1.05	.	$ 0.21
0928	Factor ix complex	K		$ 0.66	.	$ 0.13
0929	Anti-inhibitor	K		$ 1.30	.	$ 0.26
0930	Antithrombin iii injection	K		$ 1.64	.	$ 0.33
0931	Factor IX non-recombinant	K		$ 0.87	.	$ 0.17
0932	Factor IX recombinant	K		$ 0.98	.	$ 0.20
0935	Clonidine hydrochloride	K		$ 63.34	.	$ 12.67
0949	Frozen plasma, pooled, sd	K	1.2810	$ 76.23	.	$ 15.25
0950	Whole blood for transfusion	K	1.9835	$ 118.04	.	$ 23.61
0952	Cryoprecipitate each unit	K	0.7923	$ 47.15	.	$ 9.43
0954	RBC leukocytes reduced	K	2.7446	$ 163.33	.	$ 32.67
0955	Plasma, frz between 8-24hour	K	1.2566	$ 74.78	.	$ 14.96
0956	Plasma protein fract,5%,50ml	K	1.1429	$ 68.02	.	$ 13.60
0957	Platelets, each unit	K	0.8663	$ 51.55	.	$ 10.31
0958	Plaelet rich plasma unit	K	4.6668	$ 277.73	.	$ 55.55
0959	Red blood cells unit	K	2.0435	$ 121.61	.	$ 24.32
0960	Washed red blood cells unit	K	3.1830	$ 189.42	.	$ 37.88
0961	Albumin (human),5%, 50ml	K	0.4987	$ 29.68	.	$ 5.94
0963	Albumin (human), 5%, 250 ml	K	1.2907	$ 76.81	.	$ 15.36
0964	Albumin (human), 25%, 20 ml	K	0.4839	$ 28.80	.	$ 5.76
0965	Albumin (human), 25%, 50ml	K	1.0966	$ 65.26	.	$ 13.05
0966	Plasmaprotein fract,5%,250ml	K	5.3107	$ 316.05	.	$ 63.21
0967	Blood split unit	K	1.3878	$ 82.59	.	$ 16.52
0968	Platelets leukoreduced irrad	K	2.5330	$ 150.74	.	$ 30.15
0969	RBC leukoreduced irradiated	K	3.6678	$ 218.27	.	$ 43.65
1009	Cryoprecipitatereducedplasma	K	1.2536	$ 74.60	.	$ 14.92
1010	Blood, l/r, cmv-neg	K	3.4943	$ 207.95	.	$ 41.59
1011	Platelets, hla-m, l/r, unit	K	10.2526	$ 610.14	.	$ 122.03
1013	Platelets leukocytes reduced	K	1.6536	$ 98.41	.	$ 19.68
1016	Blood, l/r, froz/degly/wash	K	4.4061	$ 262.21	.	$ 52.44
1017	Plt, aph/pher, l/r, cmv-neg	K	8.8483	$ 526.57	.	$ 105.31
1018	Blood, l/r, irradiated	K	3.0005	$ 178.56	.	$ 35.71
1019	Plate pheres leukoredu irrad	K	9.7736	$ 581.64	.	$ 116.33
1020	Plt, pher, l/r cmv-neg, irr	K	11.0037	$ 654.84	.	$ 130.97

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1021	RBC, frz/deg/wsh, l/r, irrad	K	5.8125	$ 345.91	.	$ 69.18
1022	RBC, l/r, cmv-neg, irrad	K	4.4896	$ 267.18	.	$ 53.44
1045	I131 iodobenguate, dx	H			.	.
1052	Injection, voriconazole	K		$ 4.57	.	$ 0.91
1064	Th I131 so iodide cap millic	H			.	.
1065	I131 iodide sol, dx	H			.	.
1083	Adalimumab injection	K		$ 293.98	.	$ 58.80
1084	Denileukin diftitox, 300 mcg	K		$ 1,252.93	.	$ 250.59
1085	Gallium nitrate injection	K		$ 1.25	.	$ 0.25
1086	Temozolomide	K		$ 7.22	.	$ 1.44
1088	Iodine I-131 iodide cap, dx	H			.	.
1096	Tc99m exametazime	H			.	.
1150	I131 iodide sol, rx	H			.	.
1166	Cytarabine liposome	K		$ 382.72	.	$ 76.54
1167	Inj, epirubicin hcl, 2 mg	K		$ 24.76	.	$ 4.95
1178	BUSULFAN IV, 6 Mg	K	0.1795	$ 10.68	.	$ 2.14
1203	Verteporfin injection	K		$ 8.96	.	$ 1.79
1207	Octreotide injection, depot	K		$ 87.31	.	$ 17.46
1210	Inj dihydroergotamine mesylt	K		$ 27.28	.	$ 5.46
1280	Corticotropin injection	K		$ 107.18	.	$ 21.44
1330	Ergonovine maleate injection	K	0.5564	$ 33.11	.	$ 6.62
1436	Etidronate disodium inj	K		$ 71.69	.	$ 14.34
1491	New Technology - Level IA ($0-$10)	S		$ 5.00	$ 2.00	$ 1.00
1492	New Technology - Level IB ($10-$20)	S		$ 15.00	.	$ 3.00
1493	New Technology - Level IC ($20-$30)	S		$ 25.00	.	$ 5.00
1494	New Technology - Level ID ($30-$40)	S		$ 35.00	.	$ 7.00
1495	New Technology - Level IE ($40-$50)	S		$ 45.00	.	$ 9.00
1496	New Technology - Level IA ($0-$10)	T		$ 5.00	.	$ 1.00
1497	New Technology - Level IB($10-$20)	T		$ 15.00	.	$ 3.00
1498	New Technology - Level IC ($20-$30)	T		$ 25.00	.	$ 5.00
1499	New Technology - Level ID($30-$40)	T		$ 35.00	.	$ 7.00
1500	New Technology - Level IE ($40-$50)	T		$ 45.00	.	$ 9.00
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

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 XVII ($1500- $1600)	S		$ 1,550.00	.	$ 310.00
1518	New Technology - Level XVIII ($1600- $1700)	S		$ 1,650.00	.	$ 330.00
1519	New Technology - Level IXX ($1700- $1800)	S		$ 1,750.00	.	$ 350.00
1520	New Technology - Level XX ($1800- $1900)	S		$ 1,850.00	.	$ 370.00
1521	New Technology - Level XXI ($1900- $2000)	S		$ 1,950.00	.	$ 390.00
1522	New Technology - Level XXII ($2000- $2500)	S		$ 2,250.00	.	$ 450.00
1523	New Technology - Level XXIII ($2500- $3000)	S		$ 2,750.00	.	$ 550.00
1524	New Technology - Level XIV ($3000- $3500)	S		$ 3,250.00	.	$ 650.00
1525	New Technology - Level XXV ($3500- $4000)	S		$ 3,750.00	.	$ 750.00
1526	New Technology - Level XXVI ($4000- $4500)	S		$ 4,250.00	.	$ 850.00
1527	New Technology - Level XXVII ($4500- $5000)	S		$ 4,750.00	.	$ 950.00
1528	New Technology - Level XXVIII ($5000- $5500)	S		$ 5,250.00	.	$ 1,050.00
1529	New Technology - Level XXIX ($5500- $6000)	S		$ 5,750.00	.	$ 1,150.00
1530	New Technology - Level XXX ($6000- $6500)	S		$ 6,250.00	.	$ 1,250.00
1531	New Technology - Level XXXI ($6500- $7000)	S		$ 6,750.00	.	$ 1,350.00
1532	New Technology - Level XXXII ($7000- $7500)	S		$ 7,250.00	.	$ 1,450.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1533	New Technology - Level XXXIII ($7500-$8000)	S		$ 7,750.00	.	$ 1,550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		$ 8,250.00	.	$ 1,650.00
1535	New Technology - Level XXXV ($8500-$9000)	S		$ 8,750.00	.	$ 1,750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S		$ 9,250.00	.	$ 1,850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S		$ 9,750.00	.	$ 1,950.00
1539	New Technology - Level II ($50 - $100)	T		$ 75.00	.	$ 15.00
1540	New Technology - Level III ($100 - $200)	T		$ 150.00	.	$ 30.00
1541	New Technology - Level IV ($200 - $300)	T		$ 250.00	.	$ 50.00
1542	New Technology - Level V ($300 - $400)	T		$ 350.00	.	$ 70.00
1543	New Technology - Level VI ($400 - $500)	T		$ 450.00	.	$ 90.00
1544	New Technology - Level VII ($500 - $600)	T		$ 550.00	.	$ 110.00
1545	New Technology - Level VIII ($600 - $700)	T		$ 650.00	.	$ 130.00
1546	New Technology - Level IX ($700 - $800)	T		$ 750.00	.	$ 150.00
1547	New Technology - Level X ($800 - $900)	T		$ 850.00	.	$ 170.00
1548	New Technology - Level XI ($900 - $1000)	T		$ 950.00	.	$ 190.00
1549	New Technology - Level XII ($1000 - $1100)	T		$ 1,050.00	.	$ 210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		$ 1,150.00	.	$ 230.00
1551	New Technology-Level XIV ($1200-$1300)	T		$ 1,250.00	.	$ 250.00
1552	New Technology - Level XV ($1300 - $1400)	T		$ 1,350.00	.	$ 270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		$ 1,450.00	.	$ 290.00
1554	New Technology - Level XVII ($1500-$1600)	T		$ 1,550.00	.	$ 310.00
1555	New Technology - Level XVIII ($1600-$1700)	T		$ 1,650.00	.	$ 330.00
1556	New Technology - Level XIX ($1700-$1800)	T		$ 1,750.00	.	$ 350.00
1557	New Technology - Level XX ($1800-$1900)	T		$ 1,850.00	.	$ 370.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1558	New Technology - Level XXI ($1900-$2000)	T		$ 1,950.00	.	$ 390.00
1559	New Technology - Level XXII ($2000-$2500)	T		$ 2,250.00	.	$ 450.00
1560	New Technology - Level XXIII ($2500-$3000)	T		$ 2,750.00	.	$ 550.00
1561	New Technology - Level XXIV ($3000-$3500)	T		$ 3,250.00	.	$ 650.00
1562	New Technology - Level XXV ($3500-$4000)	T		$ 3,750.00	.	$ 750.00
1563	New Technology - Level XXVI ($4000-$4500)	T		$ 4,250.00	.	$ 850.00
1564	New Technology - Level XXVII ($4500-$5000)	T		$ 4,750.00	.	$ 950.00
1565	New Technology - Level XXVIII ($5000-$5500)	T		$ 5,250.00	.	$ 1,050.00
1566	New Technology - Level XXIX ($5500-$6000)	T		$ 5,750.00	.	$ 1,150.00
1567	New Technology - Level XXX ($6000-$6500)	T		$ 6,250.00	.	$ 1,250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		$ 6,750.00	.	$ 1,350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		$ 7,250.00	.	$ 1,450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		$ 7,750.00	.	$ 1,550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		$ 8,250.00	.	$ 1,650.00
1572	New Technology - Level XXXV ($8500-$9000)	T		$ 8,750.00	.	$ 1,750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T		$ 9,250.00	.	$ 1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$ 9,750.00	.	$ 1,950.00
1600	Tc99m sestamibi	H			.	.
1602	Tc99m apcitide	H			.	.
1603	TL201 thallium	H			.	.
1604	In111 capromab	H			.	.
1605	Abciximab injection	K		$ 486.98	.	$ 97.40
1606	Injection anistreplase 30 u	K		$ 2,268.46	.	$ 453.69
1607	Eptifibatide injection	K		$ 13.13	.	$ 2.63
1608	Etanercept injection	K		$ 149.62	.	$ 29.92
1609	Rho(D) immune globulin h, sd	K		$ 13.73	.	$ 2.75
1612	Daclizumab, parenteral	K		$ 367.61	.	$ 73.52
1613	Trastuzumab	K		$ 54.39	.	$ 10.88
1629	Nonmetabolic act d/e tissue	K		$ 10.69	.	$ 2.14
1630	Hep b ig, im	K		$ 122.68	.	$ 24.54

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1631	Baclofen intrathecal trial	K		$ 70.74	.	$ 14.15
1632	Metabolic active D/E tissue	K		$ 26.91	.	$ 5.38
1633	Alefacept	K		$ 26.56	.	$ 5.31
1634	Td vaccine no prsrv >/= 7 im	K		$ 35.00	.	$ 7.00
1635	Oxacillin sodium injeciton	K		$ 1.70	.	$ 0.34
1636	Yellow fever vaccine, sc	K		$ 50.74	.	$ 10.15
1637	Hyaluronidase injection	K		$ 50.15	.	$ 10.03
1638	Dimecaprol injection	K		$ 21.85	.	$ 4.37
1639	Aurothioglucose injeciton	K		$ 24.50	.	$ 4.90
1640	Injection, methylene blue	K		$ 3.05	.	$ 0.61
1641	Tc99m depreotide	H			.	.
1642	In111 ibritumomab, dx	H			.	.
1643	Y90 ibritumomab, rx	H			.	.
1644	I131 tositumomab, dx	H			.	.
1645	I131 tositumomab, rx	H			.	.
1646	In111 oxyquinoline	H			.	.
1647	In111 pentetate	H			.	.
1648	Tc99m arcitumomab	H			.	.
1649	Tc99m gluceptate	H			.	.
1650	Tc99m succimer	H			.	.
1651	F18 fdg	H			.	.
1652	Cr51 chromate	H			.	.
1653	I125 iothalamate, dx	H			.	.
1654	Rb82 rubidium	H			.	.
1655	Tinzaparin sodium injection	K		$ 2.31	.	$ 0.46
1670	Tetanus immune globulin inj	K		$ 85.67	.	$ 17.13
1671	Ga67 gallium	H			.	.
1672	Tc99m bicisate	H			.	.
1673	Tc99m labeled rbc	H			.	.
1674	Tc99m mertiatide	H			.	.
1675	P32 Na phosphate	H			.	.
1676	P32 chromic phosphate	H			.	.
1677	In111 pentetreotide	H			.	.
1678	Tc99m fanolesomab	H			.	.
1679	Technetium TC-99m aerosol	H			.	.
1680	Acetylcysteine injection	K		$ 52.00	.	$ 10.40
1681	Amikacin sulfate injection	K		$ 12.50	.	$ 2.50
1682	Aprotonin, 10,000 kiu	K		$ 2.31	.	$ 0.46
1683	Basiliximab	K		$ 1,420.76	.	$ 284.15
1684	Corticorelin ovine triflutal	K		$ 3.76	.	$ 0.75
1685	Darbepoetin alfa, non-esrd	K		$ 3.01	.	$ 0.60
1686	Epoetin alfa, non-esrd	K		$ 9.22	.	$ 1.84
1687	Digoxin immune fab (ovine)	K		$ 546.93	.	$ 109.39
1688	Ethanolamine oleate	K		$ 79.35	.	$ 15.87

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1689	Fomepizole	K		$ 11.88	.	$ 2.38
1690	Hemin	K	0.0670	$ 3.99	.	$ 0.80
1691	Iron dextran 165 injection	K		$ 11.80	.	$ 2.36
1692	Iron dextran 267 injection	K		$ 10.20	.	$ 2.04
1693	Lepiridin	K		$ 146.92	.	$ 29.38
1694	Ziconotide injection	G		$ 6.45	.	$ 1.29
1695	Nesiritide injection	K		$ 29.89	.	$ 5.98
1696	Palifermin injection	K		$ 11.00	.	$ 2.20
1697	Pegaptanib sodium injection	G		$ 1,054.70	.	$ 210.94
1698	Pentastarch 10% solution	K		$ 12.72	.	$ 2.54
1699	Sincalide injection	K		$ 27.58	.	$ 5.52
1700	Inj secretin synthetic human	K		$ 20.31	.	$ 4.06
1701	Treprostinil injection	K		$ 54.02	.	$ 10.80
1702	Ovine, up to 999 USP units	K		$ 129.87	.	$ 25.97
1703	Ovine, 1000 USP units	K		$ 108.33	.	$ 21.67
1704	Inj Vonwillebrand factor iu	K		$ 0.87	.	$ 0.17
1705	Factor viia	K		$ 1.02	.	$ 0.20
1706	Hyaluron/deriv intra-art inj	K		$ 7.20	.	$ 1.44
1707	Non-human, metabolic tissue	K		$ 1.01	.	$ 0.20
1708	Oral dexamethasone	K		$ 0.22	.	$ 0.04
1709	Azacitidine injection	K		$ 4.04	.	$ 0.81
1710	Clofarabine injection	G		$ 116.87	.	$ 23.37
1711	Histrelin implant	K		$ 5,000.00	.	$ 1,000.00
1712	Paclitaxel injection	G		$ 8.32	.	$ 1.66
1713	Inj Fe-based MR contrast, ml	K		$ 30.41	.	$ 6.08
1714	HOCM <=149 mg/ml iodine	K		$ 0.06	.	$ 0.01
1715	HOCM 200-249mg/ml iodine	K		$ 0.09	.	$ 0.02
1716	Brachytx source, Gold 198	H			.	.
1717	Brachytx source, HDR Ir-192	H			.	.
1718	Brachytx source, Iodine 125	H			.	.
1719	Brachytx sour,Non-HDR Ir-192	H			.	.
1720	Brachytx sour, Palladium 103	H			.	.
1734	HOCM 250-299mg/ml iodine	K		$ 0.15	.	$ 0.03
1735	HOCM 300-349mg/ml iodine	K		$ 0.14	.	$ 0.03
1736	HOCM 350-399mg/ml iodine	K		$ 0.38	.	$ 0.08
1737	HOCM >= 400 mg/ml iodine	K		$ 0.20	.	$ 0.04
1738	Oxaliplatin	K		$ 8.53	.	$ 1.71
1739	Pegademase bovine, 25 iu	K		$ 166.07	.	$ 33.21
1740	Diazoxide injection	K		$ 111.70	.	$ 22.34
1741	Urofollitropin, 75 iu	K		$ 48.45	.	$ 9.69
2210	Methyldopate hcl injection	K		$ 9.79	.	$ 1.96
2616	Brachytx source, Yttrium-90	H			.	.
2632	Brachytx sol, I-125, per mCi	H			.	.
2633	Brachytx source, Cesium-131	H			.	.

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
2634	Brachytx source, HA, I-125	H			.	.
2635	Brachytx source, HA, P-103	H			.	.
2636	Brachytx linear source, P-103	H			.	.
2637	Brachytx, Ytterbium-169	H			.	.
2730	Pralidoxime chloride inj	K		$ 91.90	.	$ 18.38
2731	Immune globulin, powder	K		$ 21.28	.	$ 4.26
2732	Immune globulin, liquid	K		$ 28.15	.	$ 5.63
2770	Quinupristin/dalfopristin	K		$ 103.11	.	$ 20.62
2940	Somatrem injection	K	0.5982	$ 35.60	.	$ 7.12
3030	Sumatriptan succinate / 6 MG	K		$ 50.99	.	$ 10.20
7000	Amifostine	K		$ 439.31	.	$ 87.86
7005	Gonadorelin hydroch/ 100 mcg	K		$ 180.30	.	$ 36.06
7011	Oprelvekin injection	K		$ 247.77	.	$ 49.55
7015	Oral busulfan	K		$ 1.96	.	$ 0.39
7028	Fosphenytoin, 50 mg	K		$ 5.32	.	$ 1.06
7034	Somatropin injection	K		$ 43.87	.	$ 8.77
7035	Teniposide, 50 mg	K		$ 264.05	.	$ 52.81
7036	Urokinase 250,000 IU inj	K		$ 457.73	.	$ 91.55
7038	Monoclonal antibodies	K		$ 864.56	.	$ 172.91
7041	Tirofiban HCl	K		$ 7.86	.	$ 1.57
7042	Capecitabine, oral, 150 mg	K		$ 3.51	.	$ 0.70
7043	Infliximab injection	K		$ 53.43	.	$ 10.69
7045	Inj trimetrexate glucoronate	K		$ 146.85	.	$ 29.37
7046	Doxorubicin hcl liposome inj	K		$ 364.53	.	$ 72.91
7048	Alteplase recombinant	K		$ 31.44	.	$ 6.29
7049	Filgrastim 480 mcg injection	K		$ 279.57	.	$ 55.91
7051	Leuprolide acetate implant	K		$ 2,371.75	.	$ 474.35
7308	Aminolevulinic acid hcl top	K		$ 101.87	.	$ 20.37
7515	Cyclosporine oral 25 mg	K		$ 0.91	.	$ 0.18
9001	Linezolid injection	K		$ 23.72	.	$ 4.74
9002	Tenecteplase injection	K		$ 2,064.24	.	$ 412.85
9003	Palivizumab, per 50 mg	K	4.3120	$ 256.61	.	$ 51.32
9004	Gemtuzumab ozogamicin	K		$ 2,248.15	.	$ 449.63
9005	Reteplase injection	K		$ 1,278.84	.	$ 255.77
9006	Tacrolimus injection	K		$ 136.86	.	$ 27.37
9012	Arsenic trioxide	K		$ 33.25	.	$ 6.65
9015	Mycophenolate mofetil oral	K		$ 2.54	.	$ 0.51
9018	Botulinum toxin type B	K		$ 7.80	.	$ 1.56
9019	Caspofungin acetate	K		$ 32.52	.	$ 6.50
9020	Sirolimus, oral	K		$ 6.83	.	$ 1.37
9022	IM inj interferon beta 1-a	K		$ 93.07	.	$ 18.61
9023	Rho d immune globulin 50 mcg	K		$ 24.51	.	$ 4.90
9024	Amphotericin b lipid complex	K		$ 11.24	.	$ 2.25
9030	Amphotericin B	K		$ 22.94	.	$ 4.59

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9031	Arbutamine HCl injection	K		$ 160.00	.	$ 32.00
9032	Baclofen 10 MG injection	K		$ 190.29	.	$ 38.06
9033	Cidofovir injection	K		$ 768.71	.	$ 153.74
9038	Inj estrogen conjugate 25 MG	K		$ 56.71	.	$ 11.34
9040	Intraocular Fomivirsen na	K		$ 212.00	.	$ 42.40
9042	Glucagon hydrochloride/1 MG	K		$ 64.92	.	$ 12.98
9044	Ibutilide fumarate injection	K		$ 249.56	.	$ 49.91
9046	Iron sucrose injection	K		$ 0.36	.	$ 0.07
9047	Itraconazole injection	K		$ 36.30	.	$ 7.26
9051	Urea injection	K	0.6353	$ 37.81	.	$ 7.56
9054	Metabolically active tissue	K		$ 15.51	.	$ 3.10
9055	Injectable human tissue	K		$ 5.35	.	$ 1.07
9100	I131 serum albumin, dx	H			.	.
9104	Antithymocyte globuln rabbit	K		$ 312.17	.	$ 62.43
9108	Thyrotropin injection	K		$ 699.27	.	$ 139.85
9110	Alemtuzumab injection	K		$ 511.52	.	$ 102.30
9112	Inj perflutren lip micros,ml	K		$ 61.88	.	$ 12.38
9115	Zoledronic acid	K		$ 200.03	.	$ 40.01
9119	Pentastarch 10% solution	K		$ 2,078.07	.	$ 415.61
9120	Injection, Fulvestrant	K		$ 81.33	.	$ 16.27
9121	Injection, argatroban	K	0.2176	$ 12.95	.	$ 2.59
9122	Triptorelin pamoate	K		$ 372.86	.	$ 74.57
9124	Daptomycin injection	G		$ 0.29	.	$ 0.06
9125	Risperidone, long acting	G		$ 4.69	.	$ 0.94
9126	Injection, Natalizumab, 1 MG	G		$ 6.39	.	$ 1.28
9133	Rabies ig, im/sc	K		$ 63.14	.	$ 12.63
9134	Rabies ig, heat treated	K		$ 70.47	.	$ 14.09
9135	Varicella-zoster ig, im	K		$ 76.19	.	$ 15.24
9136	Adenovirus vaccine, type 4	K	0.8674	$ 51.62	.	$ 10.32
9137	Bcg vaccine, percut	K		$ 116.33	.	$ 23.27
9138	Hep a/hep b vacc, adult im	K	0.9250	$ 55.05	.	$ 11.01
9139	Rabies vaccine, im	K		$ 137.59	.	$ 27.52
9140	Rabies vaccine, id	K	1.5048	$ 89.55	.	$ 17.91
9141	Measles-rubella vaccine, sc	K	1.0220	$ 60.82	.	$ 12.16
9142	Chicken pox vaccine, sc	K		$ 67.07	.	$ 13.41
9143	Meningococcal vaccine, sc	K		$ 82.66	.	$ 16.53
9144	Encephalitis vaccine, sc	K		$ 84.60	.	$ 16.92
9145	Meningococcal vaccine, im	K	0.9025	$ 53.71	.	$ 10.74
9146	Tc99m disofenin	H			.	.
9148	I123 iodide cap, dx	H			.	.
9149	I131 max 100uCi	H			.	.
9150	I125 serum albumin, dx	H			.	.
9156	Nonmetabolic active tissue	K		$ 63.37	.	$ 12.67
9157	LOCM <=149 mg/ml iodine, 1ml	K		$ 0.24	.	$ 0.05

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9158	LOCM 150-199mg/ml iodine,1ml	K		$ 1.79	.	$ 0.36
9159	LOCM 200-249mg/ml iodine,1ml	K		$ 1.30	.	$ 0.26
9160	LOCM 250-299mg/ml iodine,1ml	K		$ 0.30	.	$ 0.06
9161	LOCM 300-349mg/ml iodine,1ml	K		$ 0.34	.	$ 0.07
9162	LOCM 350-399mg/ml iodine,1ml	K		$ 0.23	.	$ 0.05
9163	LOCM >= 400 mg/ml iodine,1ml	K		$ 0.19	.	$ 0.04
9164	Inj Gad-base MR contrast, ml	K		$ 2.93	.	$ 0.59
9165	Oral MR contrast, 100 ml	K		$ 8.97	.	$ 1.79
9166	Dyphylline injection	K		$ 8.05	.	$ 1.61
9167	Valrubicin, 200 mg	K		$ 369.60	.	$ 73.92
9169	Anthrax vaccine, sc	K		$ 126.46	.	$ 25.29
9170	Lyme disease vaccine, im	K	0.9161	$ 54.52	.	$ 10.90
9202	Inj octafluoropropane mic,ml	K		$ 41.43	.	$ 8.29
9203	Inj perflexane lip micros,ml	K		$ 13.25	.	$ 2.65
9207	Bortezomib injection	K		$ 29.02	.	$ 5.80
9208	Agalsidase beta injection	K		$ 127.17	.	$ 25.43
9209	Laronidase injection	K		$ 23.87	.	$ 4.77
9210	Palonosetron HCl	K		$ 17.99	.	$ 3.60
9213	Pemetrexed injection	G		$ 40.67	.	$ 8.13
9214	Bevacizumab injection	G		$ 57.11	.	$ 11.42
9215	Cetuximab injection	G		$ 49.76	.	$ 9.95
9216	Abarelix injection	G		$ 67.78	.	$ 13.56
9217	Leuprolide acetate suspnsion	K		$ 224.42	.	$ 44.88
9219	Mycophenolic acid	G		$ 2.16	.	$ 0.43
9220	Sodium hyaluronate	G		$ 193.59	.	$ 38.72
9221	Graftjacket Reg Matrix	G		$ 1,307.48	.	$ 261.50
9222	Graftjacket SftTis	G		$ 883.21	.	$ 176.64
9224	Injection, galsulfase	K		$ 1,522.15	.	$ 304.43
9225	Fluocinolone acetonide	G		$19,345.00	.	$ 3,869.00
9300	Omalizumab injection	G		$ 15.88	.	$ 3.18
9500	Platelets, irradiated	K	1.4559	$ 86.64	.	$ 17.33
9501	Platelet pheres leukoreduced	K	8.2952	$ 493.66	.	$ 98.73
9502	Platelet pheresis irradiated	K	5.4817	$ 326.22	.	$ 65.24
9503	Fr frz plasma donor retested	K	1.5934	$ 94.82	.	$ 18.96
9504	RBC deglycerolized	K	5.7773	$ 343.81	.	$ 68.76
9505	RBC irradiated	K	2.4807	$ 147.63	.	$ 29.53
9506	Granulocytes, pheresis unit	K	16.7317	$ 995.72	.	$ 199.14
9507	Platelets, pheresis	K	7.3009	$ 434.48	.	$ 86.90
9508	Plasma 1 donor frz w/in 8 hr	K	1.1842	$ 70.47	.	$ 14.09

Addendum B.—Payment Status by HCPCS Code and Related Information – Calendar Year 2006

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00190	Anesth, face/skull bone surg		N					
00210	Anesth, open head surgery		N					
00212	Anesth, skull drainage		N					
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					
00300	Anesth, head/neck/ptrunk		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
00450	Anesth, surgery of shoulder		N					
00454	Anesth, collar bone biopsy		N					
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00500	Anesth, esophageal surgery		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					
00541	Anesth, one lung ventilation		N					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00600	Anesth, spine, cord surgery		N					
00620	Anesth, spine, cord surgery		N					
00630	Anesth, spine, cord surgery		N					
00634	Anesth for chemonucleolysis	CH	N					
00635	Anesth, lumbar puncture		N					
00640	Anesth, spine manipulation		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
00730	Anesth, abdominal wall surg		N					
00740	Anesth, upper gi visualize		N					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
00770	Anesth, blood vessel repair		N					
00790	Anesth, surg upper abdomen		N					
00797	Anesth, surgery for obesity		N					
00800	Anesth, abdominal wall surg		N					
00810	Anesth, low intestine scope		N					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair< 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					
00842	Anesth, amniocentesis		N					
00851	Anesth, tubal ligation		N					
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth, abdomen vessel surg		N					
00902	Anesth, anorectal surgery		N					
00906	Anesth, removal of vulva		N					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					
00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
00930	Anesth, testis suspension		N					
00938	Anesth, insert penis device		N					
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
01112	Anesth, bone aspirate/bx		N					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01160	Anesth, pelvis procedure		N					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal	CH	N					
01200	Anesth, hip joint procedure		N					
01202	Anesth, arthroscopy of hip		N					
01210	Anesth, hip joint surgery		N					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
01270	Anesth, thigh arteries surg		N					
01320	Anesth, knee area surgery		N					
01340	Anesth, knee area procedure		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01360	Anesth, knee area surgery		N					
01380	Anesth, knee joint procedure		N					
01382	Anesth, dx knee arthroscopy		N					
01390	Anesth, knee area procedure		N					
01392	Anesth, knee area surgery		N					
01400	Anesth, knee joint surgery		N					
01420	Anesth, knee joint casting		N					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
01440	Anesth, knee arteries surg		N					
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01490	Anesth, lower leg casting		N					
01500	Anesth, leg arteries surg		N					
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
01610	Anesth, surgery of shoulder		N					
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
01630	Anesth, surgery of shoulder		N					
01650	Anesth, shoulder artery surg		N					
01670	Anesth, shoulder vein surg		N					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
01710	Anesth, elbow area surgery		N					
01712	Anesth, uppr arm tendon surg		N					
01714	Anesth, uppr arm tendon surg		N					
01716	Anesth, biceps tendon repair		N					
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
01758	Anesth, humeral lesion surg		N					
01760	Anesth, elbow replacement		N					
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01905	Anes, spine inject, x-ray/re		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01964	Anesth, abortion procedures	CH	D					
01965	Anesth, inc/missed ab proc	NI	N					
01966	Anesth, induced ab procedure	NI	N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01995	Regional anesthesia limb		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
10021	Fna w/o image		T	0002	0.9357	$ 55.68		$ 11.14
10022	Fna w/image		T	0036	2.1838	$ 129.96		$ 25.99
10040	Acne surgery		T	0010	0.5923	$ 35.25	$ 9.65	$ 7.05
10060	Drainage of skin abscess		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
10061	Drainage of skin abscess		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
10080	Drainage of pilonidal cyst		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
10081	Drainage of pilonidal cyst		T	0007	11.6717	$ 694.59		$ 138.92
10120	Remove foreign body		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
10121	Remove foreign body		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
10140	Drainage of hematoma/fluid		T	0007	11.6717	$ 694.59		$ 138.92
10160	Puncture drainage of lesion		T	0018	1.1010	$ 65.52	$ 16.04	$ 13.10
10180	Complex drainage, wound	CH	T	0008	16.2953	$ 969.75		$ 193.95
11000	Debride infected skin	CH	T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11001	Debride infected skin add-on		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11010	Debride skin, fx		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11011	Debride skin/muscle, fx		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11012	Debride skin/muscle/bone, fx		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11040	Debride skin, partial		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
11041	Debride skin, full		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
11042	Debride skin/tissue		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
11043	Debride tissue/muscle		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
11044	Debride tissue/muscle/bone		T	0682	6.7313	$ 400.59	$ 158.65	$ 80.12
11055	Trim skin lesion		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11056	Trim skin lesions, 2 to 4		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11057	Trim skin lesions, over 4		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11100	Biopsy, skin lesion		T	0018	1.1010	$ 65.52	$ 16.04	$ 13.10
11101	Biopsy, skin add-on		T	0018	1.1010	$ 65.52	$ 16.04	$ 13.10
11200	Removal of skin tags		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11201	Remove skin tags add-on		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
11300	Shave skin lesion		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11301	Shave skin lesion		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11302	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11303	Shave skin lesion		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
11305	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11306	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11307	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11308	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11310	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11311	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11312	Shave skin lesion		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11313	Shave skin lesion		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11423	Exc h-f-nk-sp b9+marg 2.1-3	CH	T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11446	Exc face-mm b9+marg > 4 cm		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11450	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11451	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11462	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11463	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11470	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11471	Removal, sweat gland lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11623	Exc h-f-nk-sp mlg+marg 2.1-3		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11640	Exc face-mm malig+marg 0.5 <	CH	T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11641	Exc face-mm malig+marg 0.6-1	CH	T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11642	Exc face-mm malig+marg 1.1-2		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11643	Exc face-mm malig+marg 2.1-3		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
11644	Exc face-mm malig+marg 3.1-4		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
11646	Exc face-mm mlg+marg > 4 cm		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11719	Trim nail(s)		T	0009	0.7513	$ 44.71		$ 8.94
11720	Debride nail, 1-5		T	0009	0.7513	$ 44.71		$ 8.94
11721	Debride nail, 6 or more		T	0009	0.7513	$ 44.71		$ 8.94

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11730	Removal of nail plate		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
11732	Remove nail plate, add-on		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11740	Drain blood from under nail		T	0009	0.7513	$ 44.71		$ 8.94
11750	Removal of nail bed		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11752	Remove nail bed/finger tip		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11755	Biopsy, nail unit		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11760	Repair of nail bed		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11762	Reconstruction of nail bed		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11765	Excision of nail fold, toe		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
11770	Removal of pilonidal lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11771	Removal of pilonidal lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11772	Removal of pilonidal lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11900	Injection into skin lesions		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11901	Added skin lesions injection		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
11920	Correct skin color defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11921	Correct skin color defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11922	Correct skin color defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11950	Therapy for contour defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11951	Therapy for contour defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11952	Therapy for contour defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11954	Therapy for contour defects		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
11960	Insert tissue expander(s)		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
11970	Replace tissue expander		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
11971	Remove tissue expander(s)		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
11976	Removal of contraceptive cap		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
11980	Implant hormone pellet(s)		X	0340	0.6137	$ 36.52		$ 7.30
11981	Insert drug implant device		X	0340	0.6137	$ 36.52		$ 7.30
11982	Remove drug implant device		X	0340	0.6137	$ 36.52		$ 7.30
11983	Remove/insert drug implant		X	0340	0.6137	$ 36.52		$ 7.30
12001	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12002	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12004	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12005	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12006	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12007	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12011	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12013	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12014	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12015	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12016	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12017	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12018	Repair superficial wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12020	Closure of split wound		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12021	Closure of split wound		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12031	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12032	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12034	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12035	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12036	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12037	Layer closure of wound(s)		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
12041	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12042	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12044	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12045	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12046	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12047	Layer closure of wound(s)		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
12051	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12052	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12053	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12054	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12055	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12056	Layer closure of wound(s)		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
12057	Layer closure of wound(s)		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
13100	Repair of wound or lesion		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
13101	Repair of wound or lesion		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
13102	Repair wound/lesion add-on		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13120	Repair of wound or lesion		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13121	Repair of wound or lesion		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13122	Repair wound/lesion add-on		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13131	Repair of wound or lesion		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13132	Repair of wound or lesion		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13133	Repair wound/lesion add-on		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13150	Repair of wound or lesion		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
13151	Repair of wound or lesion		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13152	Repair of wound or lesion		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
13153	Repair wound/lesion add-on		T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
13160	Late closure of wound		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
14000	Skin tissue rearrangement	CH	T	0686	13.4973	$ 803.24		$ 160.65
14001	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
14020	Skin tissue rearrangement	CH	T	0686	13.4973	$ 803.24		$ 160.65
14021	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
14040	Skin tissue rearrangement	CH	T	0686	13.4973	$ 803.24		$ 160.65
14041	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
14060	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
14061	Skin tissue rearrangement	CH	T	0686	13.4973	$ 803.24		$ 160.65
14300	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
14350	Skin tissue rearrangement		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15000	Wound prep, 1st 100 sq cm		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15001	Wound prep, addl 100 sq cm		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15040	Harvest cultured skin graft	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15050	Skin pinch graft		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15100	Skin splt grft, trnk/arm/leg		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15101	Skin splt grft t/a/l, add-on		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15110	Epidrm autogrft trnk/arm/leg	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15111	Epidrm autogrft t/a/l add-on	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15115	Epidrm a-grft face/nck/hf/g	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15116	Epidrm a-grft f/n/hf/g addl	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15120	Skn splt a-grft fac/nck/hf/g		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15121	Skn splt a-grft f/n/hf/g add		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15130	Derm autograft, trnk/arm/leg	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15131	Derm autograft t/a/l add-on	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15135	Derm autograft face/nck/hf/g	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15136	Derm autograft, f/n/hf/g add	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15150	Cult epiderm grft t/arm/leg	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15151	Cult epiderm grft t/a/l addl	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15152	Cult epiderm graft t/a/l +%	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15155	Cult epiderm graft, f/n/hf/g	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15156	Cult epidrm grft f/n/hfg add	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15157	Cult epiderm grft f/n/hfg +%	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15170	Cell graft trunk/arms/legs	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15171	Cell graft t/arm/leg add-on	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15175	Acellular graft, f/n/hf/g	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15176	Acell graft, f/n/hf/g add-on	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15200	Skin full graft, trunk		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15201	Skin full graft trunk add-on		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15220	Skin full graft sclp/arm/leg		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15221	Skin full graft add-on		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15240	Skin full grft face/genit/hf	CH	T	0686	13.4973	$ 803.24		$ 160.65
15241	Skin full graft add-on		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15260	Skin full graft een & lips	CH	T	0686	13.4973	$ 803.24		$ 160.65
15261	Skin full graft add-on		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15300	Apply skinallogrft, t/arm/lg	NI	T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15301	Apply sknallogrft t/a/l addl	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15320	Apply skin allogrft f/n/hf/g	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15321	Aply sknallogrft f/n/hfg add	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15330	Aply acell alogrft t/arm/leg	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15331	Aply acell grft t/a/l add-on	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15335	Apply acell graft, f/n/hf/g	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15336	Aply acell grft f/n/hf/g add	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15340	Apply cult skin substitute	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15341	Apply cult skin sub add-on	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15342	Cultured skin graft, 25 cm	CH	D					
15343	Culture skn graft addl 25 cm	CH	D					
15350	Skin homograft	CH	D					
15351	Skin homograft add-on	CH	D					
15360	Apply cult derm sub, t/a/l	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15361	Aply cult derm sub t/a/l add	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15365	Apply cult derm sub f/n/hf/g	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15366	Apply cult derm f/hf/g add	NI	T	0024	1.5513	$ 92.32	$ 30.23	$ 18.46
15400	Apply skin xenograft, t/a/l		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15401	Apply skn xenogrft t/a/l add		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15420	Apply skin xgraft, f/n/hf/g	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15421	Apply skn xgrft f/n/hf/g add	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15430	Apply acellular xenograft	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15431	Apply acellular xgraft add	NI	T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15570	Form skin pedicle flap		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15572	Form skin pedicle flap		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15574	Form skin pedicle flap		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15576	Form skin pedicle flap	CH	T	0686	13.4973	$ 803.24		$ 160.65
15600	Skin graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15610	Skin graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15620	Skin graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15630	Skin graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15650	Transfer skin pedicle flap		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15732	Muscle-skin graft, head/neck		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15734	Muscle-skin graft, trunk		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15736	Muscle-skin graft, arm		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15738	Muscle-skin graft, leg		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15740	Island pedicle flap graft	CH	T	0686	13.4973	$ 803.24		$ 160.65
15750	Neurovascular pedicle graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15760	Composite skin graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15770	Derma-fat-fascia graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15775	Hair transplant punch grafts		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15776	Hair transplant punch grafts		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15780	Abrasion treatment of skin		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15781	Abrasion treatment of skin		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
15782	Abrasion treatment of skin		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
15783	Abrasion treatment of skin		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
15786	Abrasion, lesion, single		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
15787	Abrasion, lesions, add-on		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
15788	Chemical peel, face, epiderm		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
15789	Chemical peel, face, dermal		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15792	Chemical peel, nonfacial		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
15793	Chemical peel, nonfacial		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
15810	Salabrasion	CH	D					
15811	Salabrasion	CH	D					
15819	Plastic surgery, neck		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15820	Revision of lower eyelid		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15821	Revision of lower eyelid		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15822	Revision of upper eyelid		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15823	Revision of upper eyelid		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15824	Removal of forehead wrinkles		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15825	Removal of neck wrinkles		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15826	Removal of brow wrinkles		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15828	Removal of face wrinkles		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15829	Removal of skin wrinkles		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15831	Excise excessive skin tissue		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15832	Excise excessive skin tissue		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15833	Excise excessive skin tissue		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15834	Excise excessive skin tissue		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15835	Excise excessive skin tissue		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
15836	Excise excessive skin tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
15837	Excise excessive skin tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
15838	Excise excessive skin tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
15839	Excise excessive skin tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
15840	Graft for face nerve palsy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15841	Graft for face nerve palsy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15842	Flap for face nerve palsy	CH	T	0686	13.4973	$ 803.24		$ 160.65
15845	Skin and muscle repair, face		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15850	Removal of sutures		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
15851	Removal of sutures		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
15852	Dressing change not for burn		X	0340	0.6137	$ 36.52		$ 7.30
15860	Test for blood flow in graft		X	0359	0.8036	$ 47.82		$ 9.56
15876	Suction assisted lipectomy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15877	Suction assisted lipectomy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15878	Suction assisted lipectomy	CH	T	0686	13.4973	$ 803.24		$ 160.65
15879	Suction assisted lipectomy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15920	Removal of tail bone ulcer		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
15922	Removal of tail bone ulcer		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15931	Remove sacrum pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15933	Remove sacrum pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15934	Remove sacrum pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15935	Remove sacrum pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15936	Remove sacrum pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15937	Remove sacrum pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15940	Remove hip pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15941	Remove hip pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15944	Remove hip pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15945	Remove hip pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15946	Remove hip pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15950	Remove thigh pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15951	Remove thigh pressure sore		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
15952	Remove thigh pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15953	Remove thigh pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15956	Remove thigh pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15958	Remove thigh pressure sore		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
15999	Removal of pressure sore		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
16000	Initial treatment of burn(s)		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
16010	Treatment of burn(s)	CH	D					
16015	Treatment of burn(s)	CH	D					
16020	Dress/debrid p-thick burn, s		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
16025	Dress/debrid p-thick burn, m		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
16030	Dress/debrid p-thick burn, l		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17000	Destroy benign/premlg lesion		T	0010	0.5923	$ 35.25	$ 9.65	$ 7.05
17003	Destroy lesions, 2-14		T	0010	0.5923	$ 35.25	$ 9.65	$ 7.05
17004	Destroy lesions, 15 or more		T	0011	2.2274	$ 132.55	$ 26.98	$ 26.51
17106	Destruction of skin lesions		T	0011	2.2274	$ 132.55	$ 26.98	$ 26.51
17107	Destruction of skin lesions		T	0011	2.2274	$ 132.55	$ 26.98	$ 26.51
17108	Destruction of skin lesions		T	0011	2.2274	$ 132.55	$ 26.98	$ 26.51
17110	Destruct lesion, 1-14	CH	T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17111	Destruct lesion, 15 or more	CH	T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17250	Chemical cautery, tissue		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17260	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17261	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17262	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17263	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17264	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17266	Destruction of skin lesions		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
17270	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17271	Destruction of skin lesions		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17272	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17273	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17274	Destruction of skin lesions		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
17276	Destruction of skin lesions		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
17280	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17281	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17282	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17283	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17284	Destruction of skin lesions		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
17286	Destruction of skin lesions		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
17304	1 stage mohs, up to 5 spec		T	0694	3.8832	$ 231.09	$ 62.65	$ 46.22
17305	2 stage mohs, up to 5 spec		T	0694	3.8832	$ 231.09	$ 62.65	$ 46.22
17306	3 stage mohs, up to 5 spec		T	0694	3.8832	$ 231.09	$ 62.65	$ 46.22
17307	Mohs addl stage up to 5 spec		T	0694	3.8832	$ 231.09	$ 62.65	$ 46.22
17310	Mohs any stage > 5 spec each		T	0694	3.8832	$ 231.09	$ 62.65	$ 46.22
17340	Cryotherapy of skin		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
17360	Skin peel therapy		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17380	Hair removal by electrolysis		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
17999	Skin tissue procedure		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
19000	Drainage of breast lesion		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
19001	Drain breast lesion add-on		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
19020	Incision of breast lesion	CH	T	0008	16.2953	$ 969.75		$ 193.95
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0005	3.5834	$ 213.25	$ 71.59	$ 42.65
19101	Biopsy of breast, open		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19102	Bx breast percut w/image		T	0005	3.5834	$ 213.25	$ 71.59	$ 42.65
19103	Bx breast percut w/device		T	0658	5.9888	$ 356.40		$ 71.28
19110	Nipple exploration		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19112	Excise breast duct fistula		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19120	Removal of breast lesion		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19125	Excision, breast lesion		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19126	Excision, addl breast lesion		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19140	Removal of breast tissue		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19160	Partial mastectomy		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19162	P-mastectomy w/ln removal		T	0693	42.2886	$ 2,516.64	$ 798.17	$ 503.33
19180	Removal of breast		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19182	Removal of breast		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19240	Removal of breast		T	0030	39.9779	$ 2,379.12	$ 763.55	$ 475.82
19260	Removal of chest wall lesion		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		S	0657	1.6092	$ 95.77		$ 19.15
19296	Place po breast cath for rad		S	1524		$ 3,250.00		$ 650.00
19297	Place breast cath for rad		S	1523		$ 2,750.00		$ 550.00
19298	Place breast rad tube/caths		S	1524		$ 3,250.00		$ 650.00
19316	Suspension of breast		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19318	Reduction of large breast		T	0693	42.2886	$ 2,516.64	$ 798.17	$ 503.33
19324	Enlarge breast		T	0693	42.2886	$ 2,516.64	$ 798.17	$ 503.33
19325	Enlarge breast with implant		T	0648	53.5307	$ 3,185.67		$ 637.13
19328	Removal of breast implant		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19330	Removal of implant material		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19340	Immediate breast prosthesis		T	0030	39.9779	$ 2,379.12	$ 763.55	$ 475.82
19342	Delayed breast prosthesis		T	0648	53.5307	$ 3,185.67		$ 637.13
19350	Breast reconstruction		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
19355	Correct inverted nipple(s)		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19357	Breast reconstruction		T	0648	53.5307	$ 3,185.67		$ 637.13
19366	Breast reconstruction		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19370	Surgery of breast capsule		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19371	Removal of breast capsule		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19380	Revise breast reconstruction		T	0030	39.9779	$ 2,379.12	$ 763.55	$ 475.82
19396	Design custom breast implant		T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
19499	Breast surgery procedure		T	0028	19.4351	$ 1,156.60	$ 303.74	$ 231.32
20000	Incision of abscess		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
20005	Incision of deep abscess		T	0049	20.3891	$ 1,213.38		$ 242.68
20100	Explore wound, neck		T	0023	4.7662	$ 283.64		$ 56.73
20101	Explore wound, chest		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
20102	Explore wound, abdomen		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
20103	Explore wound, extremity		T	0023	4.7662	$ 283.64		$ 56.73
20150	Excise epiphyseal bar		T	0051	36.6106	$ 2,178.73		$ 435.75
20200	Muscle biopsy		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
20205	Deep muscle biopsy		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
20206	Needle biopsy, muscle		T	0005	3.5834	$ 213.25	$ 71.59	$ 42.65
20220	Bone biopsy, trocar/needle		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
20225	Bone biopsy, trocar/needle		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
20240	Bone biopsy, excisional		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
20245	Bone biopsy, excisional		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
20250	Open bone biopsy		T	0049	20.3891	$ 1,213.38		$ 242.68
20251	Open bone biopsy		T	0049	20.3891	$ 1,213.38		$ 242.68
20500	Injection of sinus tract		T	0251	2.0789	$ 123.72		$ 24.74
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
20525	Removal of foreign body		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
20526	Ther injection, carp tunnel		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20550	Inj tendon sheath/ligament		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20551	Inj tendon origin/insertion		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20552	Inj trigger point, 1/2 muscl		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20553	Inject trigger points, =/> 3		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20600	Drain/inject, joint/bursa		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20605	Drain/inject, joint/bursa		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20610	Drain/inject, joint/bursa		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20612	Aspirate/inj ganglion cyst		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
20615	Treatment of bone cyst		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
20650	Insert and remove bone pin		T	0049	20.3891	$ 1,213.38		$ 242.68
20662	Application of pelvis brace	CH	T	0049	20.3891	$ 1,213.38		$ 242.68

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20663	Application of thigh brace	CH	T	0049	20.3891	$ 1,213.38		$ 242.68
20665	Removal of fixation device		X	0340	0.6137	$ 36.52		$ 7.30
20670	Removal of support implant		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
20680	Removal of support implant		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
20690	Apply bone fixation device		T	0050	23.9367	$ 1,424.50		$ 284.90
20692	Apply bone fixation device		T	0050	23.9367	$ 1,424.50		$ 284.90
20693	Adjust bone fixation device		T	0049	20.3891	$ 1,213.38		$ 242.68
20694	Remove bone fixation device		T	0049	20.3891	$ 1,213.38		$ 242.68
20822	Replantation digit, complete	CH	T	0054	25.1321	$ 1,495.64		$ 299.13
20900	Removal of bone for graft		T	0050	23.9367	$ 1,424.50		$ 284.90
20902	Removal of bone for graft		T	0050	23.9367	$ 1,424.50		$ 284.90
20910	Remove cartilage for graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
20912	Remove cartilage for graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
20920	Removal of fascia for graft	CH	T	0686	13.4973	$ 803.24		$ 160.65
20922	Removal of fascia for graft		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
20924	Removal of tendon for graft		T	0050	23.9367	$ 1,424.50		$ 284.90
20926	Removal of tissue for graft	CH	T	0686	13.4973	$ 803.24		$ 160.65
20950	Fluid pressure, muscle		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
20972	Bone/skin graft, metatarsal	CH	T	0056	40.5436	$ 2,412.79		$ 482.56
20973	Bone/skin graft, great toe	CH	T	0056	40.5436	$ 2,412.79		$ 482.56
20975	Electrical bone stimulation		X	0340	0.6137	$ 36.52		$ 7.30
20982	Ablate, bone tumor(s) perq		T	1557		$ 1,850.00		$ 370.00
20999	Musculoskeletal surgery		T	0049	20.3891	$ 1,213.38		$ 242.68
21010	Incision of jaw joint		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21015	Resection of facial tumor		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21025	Excision of bone, lower jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21026	Excision of facial bone(s)		T	0256	37.0000	$ 2,201.91		$ 440.38
21029	Contour of face bone lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
21030	Excise max/zygoma b9 tumor		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21031	Remove exostosis, mandible		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21032	Remove exostosis, maxilla		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21034	Excise max/zygoma mlg tumor		T	0256	37.0000	$ 2,201.91		$ 440.38
21040	Excise mandible lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21044	Removal of jaw bone lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
21046	Remove mandible cyst complex		T	0256	37.0000	$ 2,201.91		$ 440.38
21047	Excise lwr jaw cyst w/repair		T	0256	37.0000	$ 2,201.91		$ 440.38
21048	Remove maxilla cyst complex		T	0256	37.0000	$ 2,201.91		$ 440.38
21049	Excis uppr jaw cyst w/repair		T	0256	37.0000	$ 2,201.91		$ 440.38
21050	Removal of jaw joint		T	0256	37.0000	$ 2,201.91		$ 440.38
21060	Remove jaw joint cartilage		T	0256	37.0000	$ 2,201.91		$ 440.38
21070	Remove coronoid process		T	0256	37.0000	$ 2,201.91		$ 440.38
21076	Prepare face/oral prosthesis		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21077	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21079	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21080	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21081	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21082	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21083	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21084	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21085	Prepare face/oral prosthesis		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21086	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21087	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21088	Prepare face/oral prosthesis		T	0256	37.0000	$ 2,201.91		$ 440.38
21089	Prepare face/oral prosthesis		T	0251	2.0789	$ 123.72		$ 24.74
21100	Maxillofacial fixation		T	0256	37.0000	$ 2,201.91		$ 440.38
21110	Interdental fixation		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21121	Reconstruction of chin		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21122	Reconstruction of chin		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21123	Reconstruction of chin		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21125	Augmentation, lower jaw bone		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21127	Augmentation, lower jaw bone		T	0256	37.0000	$ 2,201.91		$ 440.38
21137	Reduction of forehead		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21138	Reduction of forehead		T	0256	37.0000	$ 2,201.91		$ 440.38
21139	Reduction of forehead		T	0256	37.0000	$ 2,201.91		$ 440.38
21150	Reconstruct midface, lefort	CH	T	0256	37.0000	$ 2,201.91		$ 440.38
21175	Reconstruct orbit/forehead	CH	T	0256	37.0000	$ 2,201.91		$ 440.38
21181	Contour cranial bone lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21195	Reconst lwr jaw w/o fixation	CH	T	0256	37.0000	$ 2,201.91		$ 440.38
21198	Reconstr lwr jaw segment		T	0256	37.0000	$ 2,201.91		$ 440.38
21199	Reconstr lwr jaw w/advance		T	0256	37.0000	$ 2,201.91		$ 440.38
21206	Reconstruct upper jaw bone		T	0256	37.0000	$ 2,201.91		$ 440.38
21208	Augmentation of facial bones		T	0256	37.0000	$ 2,201.91		$ 440.38
21209	Reduction of facial bones		T	0256	37.0000	$ 2,201.91		$ 440.38
21210	Face bone graft		T	0256	37.0000	$ 2,201.91		$ 440.38
21215	Lower jaw bone graft		T	0256	37.0000	$ 2,201.91		$ 440.38
21230	Rib cartilage graft		T	0256	37.0000	$ 2,201.91		$ 440.38
21235	Ear cartilage graft		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21240	Reconstruction of jaw joint		T	0256	37.0000	$ 2,201.91		$ 440.38
21242	Reconstruction of jaw joint		T	0256	37.0000	$ 2,201.91		$ 440.38
21243	Reconstruction of jaw joint		T	0256	37.0000	$ 2,201.91		$ 440.38
21244	Reconstruction of lower jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21245	Reconstruction of jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21246	Reconstruction of jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21248	Reconstruction of jaw		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21249	Reconstruction of jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21260	Revise eye sockets		T	0256	37.0000	$ 2,201.91		$ 440.38
21261	Revise eye sockets		T	0256	37.0000	$ 2,201.91		$ 440.38
21263	Revise eye sockets		T	0256	37.0000	$ 2,201.91		$ 440.38
21267	Revise eye sockets		T	0256	37.0000	$ 2,201.91		$ 440.38
21270	Augmentation, cheek bone		T	0256	37.0000	$ 2,201.91		$ 440.38
21275	Revision, orbitofacial bones		T	0256	37.0000	$ 2,201.91		$ 440.38
21280	Revision of eyelid		T	0256	37.0000	$ 2,201.91		$ 440.38
21282	Revision of eyelid		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21295	Revision of jaw muscle/bone		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21296	Revision of jaw muscle/bone		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21299	Cranio/maxillofacial surgery		T	0251	2.0789	$ 123.72		$ 24.74
21300	Treatment of skull fracture		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21310	Treatment of nose fracture		T	0251	2.0789	$ 123.72		$ 24.74
21315	Treatment of nose fracture		T	0251	2.0789	$ 123.72		$ 24.74
21320	Treatment of nose fracture		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21325	Treatment of nose fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21330	Treatment of nose fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21335	Treatment of nose fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21336	Treat nasal septal fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
21337	Treat nasal septal fracture		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21338	Treat nasoethmoid fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21339	Treat nasoethmoid fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21340	Treatment of nose fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21345	Treat nose/jaw fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21355	Treat cheek bone fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21356	Treat cheek bone fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21390	Treat eye socket fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21400	Treat eye socket fracture		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21401	Treat eye socket fracture		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21406	Treat eye socket fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21407	Treat eye socket fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21408	Treat eye socket fracture	CH	T	0256	37.0000	$ 2,201.91		$ 440.38
21421	Treat mouth roof fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21440	Treat dental ridge fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21445	Treat dental ridge fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21450	Treat lower jaw fracture		T	0251	2.0789	$ 123.72		$ 24.74
21451	Treat lower jaw fracture		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21452	Treat lower jaw fracture		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21453	Treat lower jaw fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21454	Treat lower jaw fracture		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
21461	Treat lower jaw fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21462	Treat lower jaw fracture		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21465	Treat lower jaw fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21470	Treat lower jaw fracture		T	0256	37.0000	$ 2,201.91		$ 440.38
21480	Reset dislocated jaw		T	0251	2.0789	$ 123.72		$ 24.74
21485	Reset dislocated jaw		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21490	Repair dislocated jaw		T	0256	37.0000	$ 2,201.91		$ 440.38
21493	Treat hyoid bone fracture	CH	D					
21494	Treat hyoid bone fracture	CH	D					
21495	Treat hyoid bone fracture	CH	T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21497	Interdental wiring		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
21499	Head surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
21501	Drain neck/chest lesion		T	0008	16.2953	$ 969.75		$ 193.95
21502	Drain chest lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
21550	Biopsy of neck/chest		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
21555	Remove lesion, neck/chest		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
21556	Remove lesion, neck/chest		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
21557	Remove tumor, neck/chest		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
21600	Partial removal of rib		T	0050	23.9367	$ 1,424.50		$ 284.90
21610	Partial removal of rib		T	0050	23.9367	$ 1,424.50		$ 284.90
21685	Hyoid myotomy & suspension		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
21700	Revision of neck muscle		T	0049	20.3891	$ 1,213.38		$ 242.68
21720	Revision of neck muscle		T	0049	20.3891	$ 1,213.38		$ 242.68
21725	Revision of neck muscle		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
21742	Repair stern/nuss w/o scope		T	0051	36.6106	$ 2,178.73		$ 435.75
21743	Repair sternum/nuss w/scope		T	0051	36.6106	$ 2,178.73		$ 435.75
21800	Treatment of rib fracture		T	0043	1.7200	$ 102.36		$ 20.47
21805	Treatment of rib fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
21820	Treat sternum fracture		T	0043	1.7200	$ 102.36		$ 20.47
21899	Neck/chest surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
21920	Biopsy soft tissue of back		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
21925	Biopsy soft tissue of back		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
21930	Remove lesion, back or flank		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
21935	Remove tumor, back		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
22100	Remove part of neck vertebra		T	0208	42.5200	$ 2,530.41		$ 506.08
22101	Remove part, thorax vertebra		T	0208	42.5200	$ 2,530.41		$ 506.08
22102	Remove part, lumbar vertebra		T	0208	42.5200	$ 2,530.41		$ 506.08
22103	Remove extra spine segment		T	0208	42.5200	$ 2,530.41		$ 506.08
22222	Revision of thorax spine		T	0208	42.5200	$ 2,530.41		$ 506.08
22305	Treat spine process fracture		T	0043	1.7200	$ 102.36		$ 20.47
22310	Treat spine fracture		T	0043	1.7200	$ 102.36		$ 20.47
22315	Treat spine fracture		T	0043	1.7200	$ 102.36		$ 20.47
22505	Manipulation of spine		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
22520	Percut vertebroplasty thor		T	0050	23.9367	$ 1,424.50		$ 284.90
22521	Percut vertebroplasty lumb		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22522	Percut vertebroplasty add'l		T	0050	23.9367	$ 1,424.50		$ 284.90
22523	Percut kyphoplasty, thor	NI	T	0052	43.5555	$ 2,592.03		$ 518.41
22524	Percut kyphoplasty, lumbar	NI	T	0052	43.5555	$ 2,592.03		$ 518.41
22525	Percut kyphoplasty, add-on	NI	T	0052	43.5555	$ 2,592.03		$ 518.41
22612	Lumbar spine fusion		T	0208	42.5200	$ 2,530.41		$ 506.08
22614	Spine fusion, extra segment		T	0208	42.5200	$ 2,530.41		$ 506.08
22899	Spine surgery procedure		T	0043	1.7200	$ 102.36		$ 20.47
22900	Remove abdominal wall lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
22999	Abdomen surgery procedure		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
23000	Removal of calcium deposits		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
23020	Release shoulder joint		T	0051	36.6106	$ 2,178.73		$ 435.75
23030	Drain shoulder lesion		T	0008	16.2953	$ 969.75		$ 193.95
23031	Drain shoulder bursa		T	0008	16.2953	$ 969.75		$ 193.95
23035	Drain shoulder bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
23040	Exploratory shoulder surgery		T	0050	23.9367	$ 1,424.50		$ 284.90
23044	Exploratory shoulder surgery		T	0050	23.9367	$ 1,424.50		$ 284.90
23065	Biopsy shoulder tissues		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
23066	Biopsy shoulder tissues		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
23075	Removal of shoulder lesion		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
23076	Removal of shoulder lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
23077	Remove tumor of shoulder		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
23100	Biopsy of shoulder joint		T	0049	20.3891	$ 1,213.38		$ 242.68
23101	Shoulder joint surgery		T	0050	23.9367	$ 1,424.50		$ 284.90
23105	Remove shoulder joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
23106	Incision of collarbone joint		T	0050	23.9367	$ 1,424.50		$ 284.90
23107	Explore treat shoulder joint		T	0050	23.9367	$ 1,424.50		$ 284.90
23120	Partial removal, collar bone		T	0051	36.6106	$ 2,178.73		$ 435.75
23125	Removal of collar bone		T	0051	36.6106	$ 2,178.73		$ 435.75
23130	Remove shoulder bone, part		T	0051	36.6106	$ 2,178.73		$ 435.75
23140	Removal of bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
23145	Removal of bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23146	Removal of bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23150	Removal of humerus lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23155	Removal of humerus lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23156	Removal of humerus lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23170	Remove collar bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23172	Remove shoulder blade lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23174	Remove humerus lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23180	Remove collar bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23182	Remove shoulder blade lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23184	Remove humerus lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
23190	Partial removal of scapula		T	0050	23.9367	$ 1,424.50		$ 284.90
23195	Removal of head of humerus		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23330	Remove shoulder foreign body		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
23331	Remove shoulder foreign body		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	36.6106	$ 2,178.73		$ 435.75
23397	Muscle transfers		T	0052	43.5555	$ 2,592.03		$ 518.41
23400	Fixation of shoulder blade		T	0050	23.9367	$ 1,424.50		$ 284.90
23405	Incision of tendon & muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
23406	Incise tendon(s) & muscle(s)		T	0050	23.9367	$ 1,424.50		$ 284.90
23410	Repair rotator cuff, acute		T	0052	43.5555	$ 2,592.03		$ 518.41
23412	Repair rotator cuff, chronic		T	0052	43.5555	$ 2,592.03		$ 518.41
23415	Release of shoulder ligament		T	0051	36.6106	$ 2,178.73		$ 435.75
23420	Repair of shoulder		T	0052	43.5555	$ 2,592.03		$ 518.41
23430	Repair biceps tendon		T	0052	43.5555	$ 2,592.03		$ 518.41
23440	Remove/transplant tendon		T	0052	43.5555	$ 2,592.03		$ 518.41
23450	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23455	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23460	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23462	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23465	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23466	Repair shoulder capsule		T	0052	43.5555	$ 2,592.03		$ 518.41
23470	Reconstruct shoulder joint		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
23480	Revision of collar bone		T	0051	36.6106	$ 2,178.73		$ 435.75
23485	Revision of collar bone		T	0051	36.6106	$ 2,178.73		$ 435.75
23490	Reinforce clavicle		T	0051	36.6106	$ 2,178.73		$ 435.75
23491	Reinforce shoulder bones		T	0051	36.6106	$ 2,178.73		$ 435.75
23500	Treat clavicle fracture		T	0043	1.7200	$ 102.36		$ 20.47
23505	Treat clavicle fracture		T	0043	1.7200	$ 102.36		$ 20.47
23515	Treat clavicle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23520	Treat clavicle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
23525	Treat clavicle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
23530	Treat clavicle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23532	Treat clavicle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23540	Treat clavicle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
23545	Treat clavicle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
23550	Treat clavicle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23552	Treat clavicle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23570	Treat shoulder blade fx		T	0043	1.7200	$ 102.36		$ 20.47
23575	Treat shoulder blade fx		T	0043	1.7200	$ 102.36		$ 20.47
23585	Treat scapula fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23600	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
23605	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
23615	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23616	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23620	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
23625	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
23630	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23650	Treat shoulder dislocation		T	0043	1.7200	$ 102.36		$ 20.47
23655	Treat shoulder dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
23660	Treat shoulder dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23665	Treat dislocation/fracture		T	0043	1.7200	$ 102.36		$ 20.47
23670	Treat dislocation/fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23675	Treat dislocation/fracture		T	0043	1.7200	$ 102.36		$ 20.47
23680	Treat dislocation/fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
23700	Fixation of shoulder		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
23800	Fusion of shoulder joint		T	0051	36.6106	$ 2,178.73		$ 435.75
23802	Fusion of shoulder joint		T	0051	36.6106	$ 2,178.73		$ 435.75
23921	Amputation follow-up surgery		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
23929	Shoulder surgery procedure		T	0043	1.7200	$ 102.36		$ 20.47
23930	Drainage of arm lesion		T	0008	16.2953	$ 969.75		$ 193.95
23931	Drainage of arm bursa	CH	T	0008	16.2953	$ 969.75		$ 193.95
23935	Drain arm/elbow bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
24000	Exploratory elbow surgery		T	0050	23.9367	$ 1,424.50		$ 284.90
24006	Release elbow joint		T	0050	23.9367	$ 1,424.50		$ 284.90
24065	Biopsy arm/elbow soft tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
24066	Biopsy arm/elbow soft tissue		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
24075	Remove arm/elbow lesion		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
24076	Remove arm/elbow lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
24077	Remove tumor of arm/elbow		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
24100	Biopsy elbow joint lining		T	0049	20.3891	$ 1,213.38		$ 242.68
24101	Explore/treat elbow joint		T	0050	23.9367	$ 1,424.50		$ 284.90
24102	Remove elbow joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
24105	Removal of elbow bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
24110	Remove humerus lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
24115	Remove/graft bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24116	Remove/graft bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24120	Remove elbow lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
24125	Remove/graft bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24126	Remove/graft bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24130	Removal of head of radius		T	0050	23.9367	$ 1,424.50		$ 284.90
24134	Removal of arm bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24136	Remove radius bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24138	Remove elbow bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
24140	Partial removal of arm bone		T	0050	23.9367	$ 1,424.50		$ 284.90
24145	Partial removal of radius		T	0050	23.9367	$ 1,424.50		$ 284.90
24147	Partial removal of elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24149	Radical resection of elbow		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24150	Extensive humerus surgery		T	0052	43.5555	$ 2,592.03		$ 518.41
24151	Extensive humerus surgery		T	0052	43.5555	$ 2,592.03		$ 518.41
24152	Extensive radius surgery		T	0052	43.5555	$ 2,592.03		$ 518.41
24153	Extensive radius surgery		T	0052	43.5555	$ 2,592.03		$ 518.41
24155	Removal of elbow joint		T	0051	36.6106	$ 2,178.73		$ 435.75
24160	Remove elbow joint implant		T	0050	23.9367	$ 1,424.50		$ 284.90
24164	Remove radius head implant		T	0050	23.9367	$ 1,424.50		$ 284.90
24200	Removal of arm foreign body		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
24201	Removal of arm foreign body		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
24301	Muscle/tendon transfer		T	0050	23.9367	$ 1,424.50		$ 284.90
24305	Arm tendon lengthening		T	0050	23.9367	$ 1,424.50		$ 284.90
24310	Revision of arm tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
24320	Repair of arm tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
24330	Revision of arm muscles		T	0051	36.6106	$ 2,178.73		$ 435.75
24331	Revision of arm muscles		T	0051	36.6106	$ 2,178.73		$ 435.75
24332	Tenolysis, triceps		T	0049	20.3891	$ 1,213.38		$ 242.68
24340	Repair of biceps tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
24341	Repair arm tendon/muscle		T	0051	36.6106	$ 2,178.73		$ 435.75
24342	Repair of ruptured tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
24343	Repr elbow lat ligmnt w/tiss		T	0050	23.9367	$ 1,424.50		$ 284.90
24344	Reconstruct elbow lat ligmnt		T	0051	36.6106	$ 2,178.73		$ 435.75
24345	Repr elbw med ligmnt w/tissu		T	0050	23.9367	$ 1,424.50		$ 284.90
24346	Reconstruct elbow med ligmnt		T	0051	36.6106	$ 2,178.73		$ 435.75
24350	Repair of tennis elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24351	Repair of tennis elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24352	Repair of tennis elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24354	Repair of tennis elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24356	Revision of tennis elbow		T	0050	23.9367	$ 1,424.50		$ 284.90
24360	Reconstruct elbow joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
24361	Reconstruct elbow joint		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
24362	Reconstruct elbow joint		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
24363	Replace elbow joint		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
24365	Reconstruct head of radius		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
24366	Reconstruct head of radius		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
24400	Revision of humerus		T	0050	23.9367	$ 1,424.50		$ 284.90
24410	Revision of humerus		T	0050	23.9367	$ 1,424.50		$ 284.90
24420	Revision of humerus		T	0051	36.6106	$ 2,178.73		$ 435.75
24430	Repair of humerus		T	0051	36.6106	$ 2,178.73		$ 435.75
24435	Repair humerus with graft		T	0051	36.6106	$ 2,178.73		$ 435.75
24470	Revision of elbow joint		T	0051	36.6106	$ 2,178.73		$ 435.75
24495	Decompression of forearm		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24498	Reinforce humerus		T	0051	36.6106	$ 2,178.73		$ 435.75
24500	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24505	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24515	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24516	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24530	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24535	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24538	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24545	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24546	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24560	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24565	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24566	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24575	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24576	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24577	Treat humerus fracture		T	0043	1.7200	$ 102.36		$ 20.47
24579	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24582	Treat humerus fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24586	Treat elbow fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24587	Treat elbow fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24600	Treat elbow dislocation		T	0043	1.7200	$ 102.36		$ 20.47
24605	Treat elbow dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
24615	Treat elbow dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24620	Treat elbow fracture		T	0043	1.7200	$ 102.36		$ 20.47
24635	Treat elbow fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24640	Treat elbow dislocation		T	0043	1.7200	$ 102.36		$ 20.47
24650	Treat radius fracture		T	0043	1.7200	$ 102.36		$ 20.47
24655	Treat radius fracture		T	0043	1.7200	$ 102.36		$ 20.47
24665	Treat radius fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24666	Treat radius fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24670	Treat ulnar fracture		T	0043	1.7200	$ 102.36		$ 20.47
24675	Treat ulnar fracture		T	0043	1.7200	$ 102.36		$ 20.47
24685	Treat ulnar fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
24800	Fusion of elbow joint		T	0051	36.6106	$ 2,178.73		$ 435.75
24802	Fusion/graft of elbow joint		T	0051	36.6106	$ 2,178.73		$ 435.75
24925	Amputation follow-up surgery		T	0049	20.3891	$ 1,213.38		$ 242.68
24935	Revision of amputation		T	0052	43.5555	$ 2,592.03		$ 518.41
24999	Upper arm/elbow surgery		T	0043	1.7200	$ 102.36		$ 20.47
25000	Incision of tendon sheath		T	0049	20.3891	$ 1,213.38		$ 242.68
25001	Incise flexor carpi radialis		T	0049	20.3891	$ 1,213.38		$ 242.68
25020	Decompress forearm 1 space		T	0049	20.3891	$ 1,213.38		$ 242.68
25023	Decompress forearm 1 space		T	0050	23.9367	$ 1,424.50		$ 284.90
25024	Decompress forearm 2 spaces		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25025	Decompress forearm 2 spaces		T	0050	23.9367	$ 1,424.50		$ 284.90
25028	Drainage of forearm lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
25031	Drainage of forearm bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
25035	Treat forearm bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
25040	Explore/treat wrist joint		T	0050	23.9367	$ 1,424.50		$ 284.90
25065	Biopsy forearm soft tissues		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
25066	Biopsy forearm soft tissues		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
25075	Removal forearm lesion subcu		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
25076	Removal forearm lesion deep		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
25077	Remove tumor, forearm/wrist		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
25085	Incision of wrist capsule		T	0049	20.3891	$ 1,213.38		$ 242.68
25100	Biopsy of wrist joint		T	0049	20.3891	$ 1,213.38		$ 242.68
25101	Explore/treat wrist joint		T	0050	23.9367	$ 1,424.50		$ 284.90
25105	Remove wrist joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
25107	Remove wrist joint cartilage		T	0050	23.9367	$ 1,424.50		$ 284.90
25110	Remove wrist tendon lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
25111	Remove wrist tendon lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
25112	Reremove wrist tendon lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
25115	Remove wrist/forearm lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
25116	Remove wrist/forearm lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
25118	Excise wrist tendon sheath		T	0050	23.9367	$ 1,424.50		$ 284.90
25119	Partial removal of ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25120	Removal of forearm lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25125	Remove/graft forearm lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25126	Remove/graft forearm lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25130	Removal of wrist lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25135	Remove & graft wrist lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25136	Remove & graft wrist lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25145	Remove forearm bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
25150	Partial removal of ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25151	Partial removal of radius		T	0050	23.9367	$ 1,424.50		$ 284.90
25170	Extensive forearm surgery		T	0052	43.5555	$ 2,592.03		$ 518.41
25210	Removal of wrist bone		T	0054	25.1321	$ 1,495.64		$ 299.13
25215	Removal of wrist bones		T	0054	25.1321	$ 1,495.64		$ 299.13
25230	Partial removal of radius		T	0050	23.9367	$ 1,424.50		$ 284.90
25240	Partial removal of ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	20.3891	$ 1,213.38		$ 242.68
25250	Removal of wrist prosthesis		T	0050	23.9367	$ 1,424.50		$ 284.90
25251	Removal of wrist prosthesis		T	0050	23.9367	$ 1,424.50		$ 284.90
25259	Manipulate wrist w/anesthes		T	0043	1.7200	$ 102.36		$ 20.47
25260	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
25263	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25265	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
25270	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
25272	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
25274	Repair forearm tendon/muscle		T	0050	23.9367	$ 1,424.50		$ 284.90
25275	Repair forearm tendon sheath		T	0050	23.9367	$ 1,424.50		$ 284.90
25280	Revise wrist/forearm tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
25290	Incise wrist/forearm tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
25295	Release wrist/forearm tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
25300	Fusion of tendons at wrist		T	0050	23.9367	$ 1,424.50		$ 284.90
25301	Fusion of tendons at wrist		T	0050	23.9367	$ 1,424.50		$ 284.90
25310	Transplant forearm tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
25312	Transplant forearm tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
25315	Revise palsy hand tendon(s)		T	0051	36.6106	$ 2,178.73		$ 435.75
25316	Revise palsy hand tendon(s)		T	0051	36.6106	$ 2,178.73		$ 435.75
25320	Repair/revise wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25332	Revise wrist joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
25335	Realignment of hand		T	0051	36.6106	$ 2,178.73		$ 435.75
25337	Reconstruct ulna/radioulnar		T	0051	36.6106	$ 2,178.73		$ 435.75
25350	Revision of radius		T	0051	36.6106	$ 2,178.73		$ 435.75
25355	Revision of radius		T	0051	36.6106	$ 2,178.73		$ 435.75
25360	Revision of ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25365	Revise radius & ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25370	Revise radius or ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25375	Revise radius & ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25390	Shorten radius or ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25391	Lengthen radius or ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25392	Shorten radius & ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25393	Lengthen radius & ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25394	Repair carpal bone, shorten		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
25400	Repair radius or ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25405	Repair/graft radius or ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25415	Repair radius & ulna		T	0050	23.9367	$ 1,424.50		$ 284.90
25420	Repair/graft radius & ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25425	Repair/graft radius or ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25426	Repair/graft radius & ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25430	Vasc graft into carpal bone		T	0054	25.1321	$ 1,495.64		$ 299.13
25431	Repair nonunion carpal bone		T	0054	25.1321	$ 1,495.64		$ 299.13
25440	Repair/graft wrist bone		T	0051	36.6106	$ 2,178.73		$ 435.75
25441	Reconstruct wrist joint		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
25442	Reconstruct wrist joint		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
25443	Reconstruct wrist joint		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
25444	Reconstruct wrist joint		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
25445	Reconstruct wrist joint		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25446	Wrist replacement		T	0425	104.7352	$ 6,232.90	$ 1,378.01	$ 1,246.58
25447	Repair wrist joint(s)		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
25449	Remove wrist joint implant		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
25450	Revision of wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25455	Revision of wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25490	Reinforce radius		T	0051	36.6106	$ 2,178.73		$ 435.75
25491	Reinforce ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25492	Reinforce radius and ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25500	Treat fracture of radius		T	0043	1.7200	$ 102.36		$ 20.47
25505	Treat fracture of radius		T	0043	1.7200	$ 102.36		$ 20.47
25515	Treat fracture of radius		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25520	Treat fracture of radius		T	0043	1.7200	$ 102.36		$ 20.47
25525	Treat fracture of radius		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25526	Treat fracture of radius		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25530	Treat fracture of ulna		T	0043	1.7200	$ 102.36		$ 20.47
25535	Treat fracture of ulna		T	0043	1.7200	$ 102.36		$ 20.47
25545	Treat fracture of ulna		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25560	Treat fracture radius & ulna		T	0043	1.7200	$ 102.36		$ 20.47
25565	Treat fracture radius & ulna		T	0043	1.7200	$ 102.36		$ 20.47
25574	Treat fracture radius & ulna		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25575	Treat fracture radius/ulna		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25600	Treat fracture radius/ulna		T	0043	1.7200	$ 102.36		$ 20.47
25605	Treat fracture radius/ulna		T	0043	1.7200	$ 102.36		$ 20.47
25611	Treat fracture radius/ulna		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25620	Treat fracture radius/ulna		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25622	Treat wrist bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
25624	Treat wrist bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
25628	Treat wrist bone fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25630	Treat wrist bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
25635	Treat wrist bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
25645	Treat wrist bone fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25650	Treat wrist bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
25651	Pin ulnar styloid fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25652	Treat fracture ulnar styloid		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25660	Treat wrist dislocation		T	0043	1.7200	$ 102.36		$ 20.47
25670	Treat wrist dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25671	Pin radioulnar dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25675	Treat wrist dislocation		T	0043	1.7200	$ 102.36		$ 20.47
25676	Treat wrist dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25680	Treat wrist fracture		T	0043	1.7200	$ 102.36		$ 20.47
25685	Treat wrist fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
25690	Treat wrist dislocation		T	0043	1.7200	$ 102.36		$ 20.47
25695	Treat wrist dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25800	Fusion of wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25805	Fusion/graft of wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25810	Fusion/graft of wrist joint		T	0051	36.6106	$ 2,178.73		$ 435.75
25820	Fusion of hand bones		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
25825	Fuse hand bones with graft		T	0054	25.1321	$ 1,495.64		$ 299.13
25830	Fusion, radioulnar jnt/ulna		T	0051	36.6106	$ 2,178.73		$ 435.75
25907	Amputation follow-up surgery		T	0049	20.3891	$ 1,213.38		$ 242.68
25922	Amputate hand at wrist		T	0049	20.3891	$ 1,213.38		$ 242.68
25929	Amputation follow-up surgery	CH	T	0686	13.4973	$ 803.24		$ 160.65
25999	Forearm or wrist surgery		T	0043	1.7200	$ 102.36		$ 20.47
26010	Drainage of finger abscess		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
26011	Drainage of finger abscess		T	0007	11.6717	$ 694.59		$ 138.92
26020	Drain hand tendon sheath		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26025	Drainage of palm bursa		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26030	Drainage of palm bursa(s)		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26034	Treat hand bone lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26035	Decompress fingers/hand		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26037	Decompress fingers/hand		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26040	Release palm contracture		T	0054	25.1321	$ 1,495.64		$ 299.13
26045	Release palm contracture		T	0054	25.1321	$ 1,495.64		$ 299.13
26055	Incise finger tendon sheath		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26060	Incision of finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26070	Explore/treat hand joint		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26075	Explore/treat finger joint		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26080	Explore/treat finger joint		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26100	Biopsy hand joint lining		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26105	Biopsy finger joint lining		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26110	Biopsy finger joint lining		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26115	Removal hand lesion subcut		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
26116	Removal hand lesion, deep		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
26117	Remove tumor, hand/finger		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
26121	Release palm contracture		T	0054	25.1321	$ 1,495.64		$ 299.13
26123	Release palm contracture		T	0054	25.1321	$ 1,495.64		$ 299.13
26125	Release palm contracture	CH	T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26130	Remove wrist joint lining		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26135	Revise finger joint, each		T	0054	25.1321	$ 1,495.64		$ 299.13
26140	Revise finger joint, each		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26145	Tendon excision, palm/finger		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26160	Remove tendon sheath lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26170	Removal of palm tendon, each		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26180	Removal of finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26185	Remove finger bone		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26200	Remove hand bone lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26205	Remove/graft bone lesion		T	0054	25.1321	$ 1,495.64		$ 299.13
26210	Removal of finger lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26215	Remove/graft finger lesion		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26230	Partial removal of hand bone		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26235	Partial removal, finger bone		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26236	Partial removal, finger bone		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26250	Extensive hand surgery		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26255	Extensive hand surgery		T	0054	25.1321	$ 1,495.64		$ 299.13
26260	Extensive finger surgery		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26261	Extensive finger surgery		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26262	Partial removal of finger		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26320	Removal of implant from hand		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
26340	Manipulate finger w/anesth		T	0043	1.7200	$ 102.36		$ 20.47
26350	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26352	Repair/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26356	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26357	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26358	Repair/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26370	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26372	Repair/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26373	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26390	Revise hand/finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26392	Repair/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26410	Repair hand tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26412	Repair/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26415	Excision, hand/finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26416	Graft hand or finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26418	Repair finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26420	Repair/graft finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26426	Repair finger/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26428	Repair/graft finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26432	Repair finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26433	Repair finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26434	Repair/graft finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26437	Realignment of tendons		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26440	Release palm/finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26442	Release palm & finger tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26445	Release hand/finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26449	Release forearm/hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26450	Incision of palm tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26455	Incision of finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26460	Incise hand/finger tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26471	Fusion of finger tendons		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26474	Fusion of finger tendons		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26476	Tendon lengthening		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26477	Tendon shortening		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26478	Lengthening of hand tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26479	Shortening of hand tendon		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26480	Transplant hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26483	Transplant/graft hand tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26485	Transplant palm tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26489	Transplant/graft palm tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26490	Revise thumb tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26492	Tendon transfer with graft		T	0054	25.1321	$ 1,495.64		$ 299.13
26494	Hand tendon/muscle transfer		T	0054	25.1321	$ 1,495.64		$ 299.13
26496	Revise thumb tendon		T	0054	25.1321	$ 1,495.64		$ 299.13
26497	Finger tendon transfer		T	0054	25.1321	$ 1,495.64		$ 299.13
26498	Finger tendon transfer		T	0054	25.1321	$ 1,495.64		$ 299.13
26499	Revision of finger		T	0054	25.1321	$ 1,495.64		$ 299.13
26500	Hand tendon reconstruction		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26502	Hand tendon reconstruction		T	0054	25.1321	$ 1,495.64		$ 299.13
26504	Hand tendon reconstruction		T	0054	25.1321	$ 1,495.64		$ 299.13
26508	Release thumb contracture		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26510	Thumb tendon transfer		T	0054	25.1321	$ 1,495.64		$ 299.13
26516	Fusion of knuckle joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26517	Fusion of knuckle joints		T	0054	25.1321	$ 1,495.64		$ 299.13
26518	Fusion of knuckle joints		T	0054	25.1321	$ 1,495.64		$ 299.13
26520	Release knuckle contracture		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26525	Release finger contracture		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26530	Revise knuckle joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
26531	Revise knuckle with implant		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
26535	Revise finger joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
26536	Revise/implant finger joint		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
26540	Repair hand joint		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26541	Repair hand joint with graft		T	0054	25.1321	$ 1,495.64		$ 299.13
26542	Repair hand joint with graft		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26545	Reconstruct finger joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26546	Repair nonunion hand		T	0054	25.1321	$ 1,495.64		$ 299.13
26548	Reconstruct finger joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26550	Construct thumb replacement		T	0054	25.1321	$ 1,495.64		$ 299.13
26555	Positional change of finger		T	0054	25.1321	$ 1,495.64		$ 299.13
26560	Repair of web finger		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26561	Repair of web finger		T	0054	25.1321	$ 1,495.64		$ 299.13
26562	Repair of web finger		T	0054	25.1321	$ 1,495.64		$ 299.13
26565	Correct metacarpal flaw		T	0054	25.1321	$ 1,495.64		$ 299.13
26567	Correct finger deformity		T	0054	25.1321	$ 1,495.64		$ 299.13

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26568	Lengthen metacarpal/finger		T	0054	25.1321	$ 1,495.64		$ 299.13
26580	Repair hand deformity	CH	T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26587	Reconstruct extra finger		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26590	Repair finger deformity	CH	T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26591	Repair muscles of hand		T	0054	25.1321	$ 1,495.64		$ 299.13
26593	Release muscles of hand		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26596	Excision constricting tissue	CH	T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26600	Treat metacarpal fracture		T	0043	1.7200	$ 102.36		$ 20.47
26605	Treat metacarpal fracture		T	0043	1.7200	$ 102.36		$ 20.47
26607	Treat metacarpal fracture		T	0043	1.7200	$ 102.36		$ 20.47
26608	Treat metacarpal fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26615	Treat metacarpal fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26641	Treat thumb dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26645	Treat thumb fracture		T	0043	1.7200	$ 102.36		$ 20.47
26650	Treat thumb fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26665	Treat thumb fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26670	Treat hand dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26675	Treat hand dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26676	Pin hand dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26685	Treat hand dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26686	Treat hand dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26700	Treat knuckle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26705	Treat knuckle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26706	Pin knuckle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26715	Treat knuckle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26720	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26725	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26727	Treat finger fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26735	Treat finger fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26740	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26742	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26746	Treat finger fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26750	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26755	Treat finger fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
26756	Pin finger fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26765	Treat finger fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26770	Treat finger dislocation		T	0043	1.7200	$ 102.36		$ 20.47
26775	Treat finger dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
26776	Pin finger dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26785	Treat finger dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
26820	Thumb fusion with graft		T	0054	25.1321	$ 1,495.64		$ 299.13
26841	Fusion of thumb		T	0054	25.1321	$ 1,495.64		$ 299.13
26842	Thumb fusion with graft		T	0054	25.1321	$ 1,495.64		$ 299.13

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26843	Fusion of hand joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26844	Fusion/graft of hand joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26850	Fusion of knuckle		T	0054	25.1321	$ 1,495.64		$ 299.13
26852	Fusion of knuckle with graft		T	0054	25.1321	$ 1,495.64		$ 299.13
26860	Fusion of finger joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26861	Fusion of finger jnt, add-on		T	0054	25.1321	$ 1,495.64		$ 299.13
26862	Fusion/graft of finger joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26863	Fuse/graft added joint		T	0054	25.1321	$ 1,495.64		$ 299.13
26910	Amputate metacarpal bone		T	0054	25.1321	$ 1,495.64		$ 299.13
26951	Amputation of finger/thumb		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26952	Amputation of finger/thumb		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
26989	Hand/finger surgery		T	0043	1.7200	$ 102.36		$ 20.47
26990	Drainage of pelvis lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
26991	Drainage of pelvis bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
27000	Incision of hip tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27001	Incision of hip tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27003	Incision of hip tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27033	Exploration of hip joint		T	0051	36.6106	$ 2,178.73		$ 435.75
27035	Denervation of hip joint		T	0052	43.5555	$ 2,592.03		$ 518.41
27040	Biopsy of soft tissues		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
27041	Biopsy of soft tissues		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
27047	Remove hip/pelvis lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27048	Remove hip/pelvis lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27049	Remove tumor, hip/pelvis		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27050	Biopsy of sacroiliac joint		T	0049	20.3891	$ 1,213.38		$ 242.68
27052	Biopsy of hip joint		T	0049	20.3891	$ 1,213.38		$ 242.68
27060	Removal of ischial bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
27062	Remove femur lesion/bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
27065	Removal of hip bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
27066	Removal of hip bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
27067	Remove/graft hip bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
27080	Removal of tail bone		T	0050	23.9367	$ 1,424.50		$ 284.90
27086	Remove hip foreign body		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
27087	Remove hip foreign body		T	0049	20.3891	$ 1,213.38		$ 242.68
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27097	Revision of hip tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27098	Transfer tendon to pelvis		T	0050	23.9367	$ 1,424.50		$ 284.90
27100	Transfer of abdominal muscle		T	0051	36.6106	$ 2,178.73		$ 435.75
27105	Transfer of spinal muscle		T	0051	36.6106	$ 2,178.73		$ 435.75
27110	Transfer of iliopsoas muscle		T	0051	36.6106	$ 2,178.73		$ 435.75
27111	Transfer of iliopsoas muscle		T	0051	36.6106	$ 2,178.73		$ 435.75
27193	Treat pelvic ring fracture		T	0043	1.7200	$ 102.36		$ 20.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27194	Treat pelvic ring fracture		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27200	Treat tail bone fracture		T	0043	1.7200	$ 102.36		$ 20.47
27202	Treat tail bone fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27216	Treat pelvic ring fracture		T	0050	23.9367	$ 1,424.50		$ 284.90
27220	Treat hip socket fracture		T	0043	1.7200	$ 102.36		$ 20.47
27230	Treat thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27235	Treat thigh fracture		T	0050	23.9367	$ 1,424.50		$ 284.90
27238	Treat thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27246	Treat thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27250	Treat hip dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27252	Treat hip dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27256	Treat hip dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27257	Treat hip dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27265	Treat hip dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27266	Treat hip dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27275	Manipulation of hip joint		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27299	Pelvis/hip joint surgery		T	0043	1.7200	$ 102.36		$ 20.47
27301	Drain thigh/knee lesion		T	0008	16.2953	$ 969.75		$ 193.95
27305	Incise thigh tendon & fascia		T	0049	20.3891	$ 1,213.38		$ 242.68
27306	Incision of thigh tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27307	Incision of thigh tendons		T	0049	20.3891	$ 1,213.38		$ 242.68
27310	Exploration of knee joint		T	0050	23.9367	$ 1,424.50		$ 284.90
27315	Partial removal, thigh nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
27320	Partial removal, thigh nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
27323	Biopsy, thigh soft tissues		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
27324	Biopsy, thigh soft tissues		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27327	Removal of thigh lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27328	Removal of thigh lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27329	Remove tumor, thigh/knee		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27330	Biopsy, knee joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
27331	Explore/treat knee joint		T	0050	23.9367	$ 1,424.50		$ 284.90
27332	Removal of knee cartilage		T	0050	23.9367	$ 1,424.50		$ 284.90
27333	Removal of knee cartilage		T	0050	23.9367	$ 1,424.50		$ 284.90
27334	Remove knee joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
27335	Remove knee joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
27340	Removal of kneecap bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
27345	Removal of knee cyst		T	0049	20.3891	$ 1,213.38		$ 242.68
27347	Remove knee cyst		T	0049	20.3891	$ 1,213.38		$ 242.68
27350	Removal of kneecap		T	0050	23.9367	$ 1,424.50		$ 284.90
27355	Remove femur lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
27356	Remove femur lesion/graft		T	0050	23.9367	$ 1,424.50		$ 284.90
27357	Remove femur lesion/graft		T	0050	23.9367	$ 1,424.50		$ 284.90
27358	Remove femur lesion/fixation		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27360	Partial removal, leg bone(s)		T	0050	23.9367	$ 1,424.50		$ 284.90
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27380	Repair of kneecap tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27381	Repair/graft kneecap tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27385	Repair of thigh muscle		T	0049	20.3891	$ 1,213.38		$ 242.68
27386	Repair/graft of thigh muscle		T	0049	20.3891	$ 1,213.38		$ 242.68
27390	Incision of thigh tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27391	Incision of thigh tendons		T	0049	20.3891	$ 1,213.38		$ 242.68
27392	Incision of thigh tendons		T	0049	20.3891	$ 1,213.38		$ 242.68
27393	Lengthening of thigh tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27394	Lengthening of thigh tendons		T	0050	23.9367	$ 1,424.50		$ 284.90
27395	Lengthening of thigh tendons		T	0051	36.6106	$ 2,178.73		$ 435.75
27396	Transplant of thigh tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27397	Transplants of thigh tendons		T	0051	36.6106	$ 2,178.73		$ 435.75
27400	Revise thigh muscles/tendons		T	0051	36.6106	$ 2,178.73		$ 435.75
27403	Repair of knee cartilage		T	0050	23.9367	$ 1,424.50		$ 284.90
27405	Repair of knee ligament		T	0051	36.6106	$ 2,178.73		$ 435.75
27407	Repair of knee ligament		T	0051	36.6106	$ 2,178.73		$ 435.75
27409	Repair of knee ligaments		T	0051	36.6106	$ 2,178.73		$ 435.75
27412	Autochondrocyte implant knee		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
27415	Osteochondral knee allograft		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
27418	Repair degenerated kneecap		T	0051	36.6106	$ 2,178.73		$ 435.75
27420	Revision of unstable kneecap		T	0051	36.6106	$ 2,178.73		$ 435.75
27422	Revision of unstable kneecap		T	0051	36.6106	$ 2,178.73		$ 435.75
27424	Revision/removal of kneecap		T	0051	36.6106	$ 2,178.73		$ 435.75
27425	Lat retinacular release open		T	0050	23.9367	$ 1,424.50		$ 284.90
27427	Reconstruction, knee		T	0052	43.5555	$ 2,592.03		$ 518.41
27428	Reconstruction, knee		T	0052	43.5555	$ 2,592.03		$ 518.41
27429	Reconstruction, knee		T	0052	43.5555	$ 2,592.03		$ 518.41
27430	Revision of thigh muscles		T	0051	36.6106	$ 2,178.73		$ 435.75
27435	Incision of knee joint		T	0051	36.6106	$ 2,178.73		$ 435.75
27437	Revise kneecap		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27438	Revise kneecap with implant		T	0048	43.3955	$ 2,582.51	$ 570.30	$ 516.50
27440	Revision of knee joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27441	Revision of knee joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27442	Revision of knee joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27443	Revision of knee joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27446	Revision of knee joint		T	0681	135.4643	$ 8,061.62	$ 2,081.48	$ 1,612.32
27475	Surgery to stop leg growth	CH	T	0050	23.9367	$ 1,424.50		$ 284.90
27496	Decompression of thigh/knee		T	0049	20.3891	$ 1,213.38		$ 242.68
27497	Decompression of thigh/knee		T	0049	20.3891	$ 1,213.38		$ 242.68
27498	Decompression of thigh/knee		T	0049	20.3891	$ 1,213.38		$ 242.68

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27499	Decompression of thigh/knee		T	0049	20.3891	$ 1,213.38		$ 242.68
27500	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27501	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27502	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27503	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27508	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27509	Treatment of thigh fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27510	Treatment of thigh fracture		T	0043	1.7200	$ 102.36		$ 20.47
27516	Treat thigh fx growth plate		T	0043	1.7200	$ 102.36		$ 20.47
27517	Treat thigh fx growth plate		T	0043	1.7200	$ 102.36		$ 20.47
27520	Treat kneecap fracture		T	0043	1.7200	$ 102.36		$ 20.47
27524	Treat kneecap fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27530	Treat knee fracture		T	0043	1.7200	$ 102.36		$ 20.47
27532	Treat knee fracture		T	0043	1.7200	$ 102.36		$ 20.47
27538	Treat knee fracture(s)		T	0043	1.7200	$ 102.36		$ 20.47
27550	Treat knee dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27552	Treat knee dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27560	Treat kneecap dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27562	Treat kneecap dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27566	Treat kneecap dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27570	Fixation of knee joint		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27594	Amputation follow-up surgery		T	0049	20.3891	$ 1,213.38		$ 242.68
27599	Leg surgery procedure		T	0043	1.7200	$ 102.36		$ 20.47
27600	Decompression of lower leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27601	Decompression of lower leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27602	Decompression of lower leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27603	Drain lower leg lesion	CH	T	0008	16.2953	$ 969.75		$ 193.95
27604	Drain lower leg bursa		T	0049	20.3891	$ 1,213.38		$ 242.68
27605	Incision of achilles tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
27606	Incision of achilles tendon		T	0049	20.3891	$ 1,213.38		$ 242.68
27607	Treat lower leg bone lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
27610	Explore/treat ankle joint		T	0050	23.9367	$ 1,424.50		$ 284.90
27612	Exploration of ankle joint		T	0050	23.9367	$ 1,424.50		$ 284.90
27613	Biopsy lower leg soft tissue		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
27614	Biopsy lower leg soft tissue		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27615	Remove tumor, lower leg		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27618	Remove lower leg lesion		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
27619	Remove lower leg lesion		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
27620	Explore/treat ankle joint		T	0050	23.9367	$ 1,424.50		$ 284.90
27625	Remove ankle joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
27626	Remove ankle joint lining		T	0050	23.9367	$ 1,424.50		$ 284.90
27630	Removal of tendon lesion		T	0049	20.3891	$ 1,213.38		$ 242.68
27635	Remove lower leg bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27637	Remove/graft leg bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
27638	Remove/graft leg bone lesion		T	0050	23.9367	$ 1,424.50		$ 284.90
27640	Partial removal of tibia		T	0051	36.6106	$ 2,178.73		$ 435.75
27641	Partial removal of fibula		T	0050	23.9367	$ 1,424.50		$ 284.90
27647	Extensive ankle/heel surgery		T	0051	36.6106	$ 2,178.73		$ 435.75
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27652	Repair/graft achilles tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27654	Repair of achilles tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27656	Repair leg fascia defect		T	0049	20.3891	$ 1,213.38		$ 242.68
27658	Repair of leg tendon, each		T	0049	20.3891	$ 1,213.38		$ 242.68
27659	Repair of leg tendon, each		T	0049	20.3891	$ 1,213.38		$ 242.68
27664	Repair of leg tendon, each		T	0049	20.3891	$ 1,213.38		$ 242.68
27665	Repair of leg tendon, each		T	0050	23.9367	$ 1,424.50		$ 284.90
27675	Repair lower leg tendons		T	0049	20.3891	$ 1,213.38		$ 242.68
27676	Repair lower leg tendons		T	0050	23.9367	$ 1,424.50		$ 284.90
27680	Release of lower leg tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27681	Release of lower leg tendons		T	0050	23.9367	$ 1,424.50		$ 284.90
27685	Revision of lower leg tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27686	Revise lower leg tendons		T	0050	23.9367	$ 1,424.50		$ 284.90
27687	Revision of calf tendon		T	0050	23.9367	$ 1,424.50		$ 284.90
27690	Revise lower leg tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27691	Revise lower leg tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27692	Revise additional leg tendon		T	0051	36.6106	$ 2,178.73		$ 435.75
27695	Repair of ankle ligament		T	0050	23.9367	$ 1,424.50		$ 284.90
27696	Repair of ankle ligaments		T	0050	23.9367	$ 1,424.50		$ 284.90
27698	Repair of ankle ligament		T	0050	23.9367	$ 1,424.50		$ 284.90
27700	Revision of ankle joint		T	0047	31.2345	$ 1,858.80	$ 537.03	$ 371.76
27704	Removal of ankle implant		T	0049	20.3891	$ 1,213.38		$ 242.68
27705	Incision of tibia		T	0051	36.6106	$ 2,178.73		$ 435.75
27707	Incision of fibula		T	0049	20.3891	$ 1,213.38		$ 242.68
27709	Incision of tibia & fibula		T	0050	23.9367	$ 1,424.50		$ 284.90
27730	Repair of tibia epiphysis		T	0050	23.9367	$ 1,424.50		$ 284.90
27732	Repair of fibula epiphysis		T	0050	23.9367	$ 1,424.50		$ 284.90
27734	Repair lower leg epiphyses		T	0050	23.9367	$ 1,424.50		$ 284.90
27740	Repair of leg epiphyses		T	0050	23.9367	$ 1,424.50		$ 284.90
27742	Repair of leg epiphyses		T	0051	36.6106	$ 2,178.73		$ 435.75
27745	Reinforce tibia		T	0051	36.6106	$ 2,178.73		$ 435.75
27750	Treatment of tibia fracture		T	0043	1.7200	$ 102.36		$ 20.47
27752	Treatment of tibia fracture		T	0043	1.7200	$ 102.36		$ 20.47
27756	Treatment of tibia fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27758	Treatment of tibia fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27759	Treatment of tibia fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27760	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27762	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27766	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27780	Treatment of fibula fracture		T	0043	1.7200	$ 102.36		$ 20.47
27781	Treatment of fibula fracture		T	0043	1.7200	$ 102.36		$ 20.47
27784	Treatment of fibula fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27786	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27788	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27792	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27808	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27810	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27814	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27816	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27818	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
27822	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27823	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27824	Treat lower leg fracture		T	0043	1.7200	$ 102.36		$ 20.47
27825	Treat lower leg fracture		T	0043	1.7200	$ 102.36		$ 20.47
27826	Treat lower leg fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27827	Treat lower leg fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27828	Treat lower leg fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27829	Treat lower leg joint		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27830	Treat lower leg dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27831	Treat lower leg dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27832	Treat lower leg dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27840	Treat ankle dislocation		T	0043	1.7200	$ 102.36		$ 20.47
27842	Treat ankle dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27846	Treat ankle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27848	Treat ankle dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
27860	Fixation of ankle joint		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
27870	Fusion of ankle joint, open		T	0051	36.6106	$ 2,178.73		$ 435.75
27871	Fusion of tibiofibular joint		T	0051	36.6106	$ 2,178.73		$ 435.75
27884	Amputation follow-up surgery		T	0049	20.3891	$ 1,213.38		$ 242.68
27889	Amputation of foot at ankle		T	0050	23.9367	$ 1,424.50		$ 284.90
27892	Decompression of leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27893	Decompression of leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27894	Decompression of leg		T	0049	20.3891	$ 1,213.38		$ 242.68
27899	Leg/ankle surgery procedure		T	0043	1.7200	$ 102.36		$ 20.47
28001	Drainage of bursa of foot		T	0007	11.6717	$ 694.59		$ 138.92
28002	Treatment of foot infection		T	0049	20.3891	$ 1,213.38		$ 242.68
28003	Treatment of foot infection		T	0049	20.3891	$ 1,213.38		$ 242.68
28005	Treat foot bone lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28008	Incision of foot fascia		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28010	Incision of toe tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28011	Incision of toe tendons		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28020	Exploration of foot joint		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28022	Exploration of foot joint		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28024	Exploration of toe joint		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28030	Removal of foot nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
28035	Decompression of tibia nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
28043	Excision of foot lesion		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
28045	Excision of foot lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28046	Resection of tumor, foot		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28050	Biopsy of foot joint lining		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28052	Biopsy of foot joint lining		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28054	Biopsy of toe joint lining		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28060	Partial removal, foot fascia	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28062	Removal of foot fascia	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28070	Removal of foot joint lining	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28072	Removal of foot joint lining	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28080	Removal of foot lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28086	Excise foot tendon sheath		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28088	Excise foot tendon sheath		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28090	Removal of foot lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28092	Removal of toe lesions		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28100	Removal of ankle/heel lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28102	Remove/graft foot lesion		T	0056	40.5436	$ 2,412.79		$ 482.56
28103	Remove/graft foot lesion		T	0056	40.5436	$ 2,412.79		$ 482.56
28104	Removal of foot lesion		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28106	Remove/graft foot lesion		T	0056	40.5436	$ 2,412.79		$ 482.56
28107	Remove/graft foot lesion		T	0056	40.5436	$ 2,412.79		$ 482.56
28108	Removal of toe lesions		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28110	Part removal of metatarsal	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28111	Part removal of metatarsal		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28112	Part removal of metatarsal		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28113	Part removal of metatarsal		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28114	Removal of metatarsal heads		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28116	Revision of foot		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28118	Removal of heel bone		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28119	Removal of heel spur		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28120	Part removal of ankle/heel		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28122	Partial removal of foot bone		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28124	Partial removal of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28126	Partial removal of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28130	Removal of ankle bone		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28140	Removal of metatarsal		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28150	Removal of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28153	Partial removal of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28160	Partial removal of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28171	Extensive foot surgery		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28173	Extensive foot surgery		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28175	Extensive foot surgery		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28190	Removal of foot foreign body		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
28192	Removal of foot foreign body		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
28193	Removal of foot foreign body		T	0020	6.9410	$ 413.07	$ 107.67	$ 82.61
28200	Repair of foot tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28202	Repair/graft of foot tendon	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28208	Repair of foot tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28210	Repair/graft of foot tendon		T	0056	40.5436	$ 2,412.79		$ 482.56
28220	Release of foot tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28222	Release of foot tendons		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28225	Release of foot tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28226	Release of foot tendons		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28230	Incision of foot tendon(s)		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28232	Incision of toe tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28234	Incision of foot tendon		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28238	Revision of foot tendon		T	0056	40.5436	$ 2,412.79		$ 482.56
28240	Release of big toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28250	Revision of foot fascia	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28260	Release of midfoot joint	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28261	Revision of foot tendon	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28262	Revision of foot and ankle	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28264	Release of midfoot joint		T	0056	40.5436	$ 2,412.79		$ 482.56
28270	Release of foot contracture		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28272	Release of toe joint, each		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28280	Fusion of toes		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28285	Repair of hammertoe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28286	Repair of hammertoe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28288	Partial removal of foot bone	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28289	Repair hallux rigidus	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28290	Correction of bunion	CH	T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28292	Correction of bunion		T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28293	Correction of bunion		T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28294	Correction of bunion	CH	T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28296	Correction of bunion	CH	T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28297	Correction of bunion		T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28298	Correction of bunion	CH	T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28299	Correction of bunion		T	0057	27.3981	$ 1,630.49	$ 475.91	$ 326.10
28300	Incision of heel bone		T	0056	40.5436	$ 2,412.79		$ 482.56

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28302	Incision of ankle bone	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28304	Incision of midfoot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28305	Incise/graft midfoot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28306	Incision of metatarsal	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28307	Incision of metatarsal	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28308	Incision of metatarsal	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28309	Incision of metatarsals		T	0056	40.5436	$ 2,412.79		$ 482.56
28310	Revision of big toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28312	Revision of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28313	Repair deformity of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28315	Removal of sesamoid bone		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28320	Repair of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28322	Repair of metatarsals		T	0056	40.5436	$ 2,412.79		$ 482.56
28340	Resect enlarged toe tissue		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28341	Resect enlarged toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28344	Repair extra toe(s)	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28345	Repair webbed toe(s)	CH	T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28360	Reconstruct cleft foot		T	0056	40.5436	$ 2,412.79		$ 482.56
28400	Treatment of heel fracture		T	0043	1.7200	$ 102.36		$ 20.47
28405	Treatment of heel fracture		T	0043	1.7200	$ 102.36		$ 20.47
28406	Treatment of heel fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28415	Treat heel fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28420	Treat/graft heel fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28430	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
28435	Treatment of ankle fracture		T	0043	1.7200	$ 102.36		$ 20.47
28436	Treatment of ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28445	Treat ankle fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28450	Treat midfoot fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
28455	Treat midfoot fracture, each		T	0043	1.7200	$ 102.36		$ 20.47
28456	Treat midfoot fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28465	Treat midfoot fracture, each		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28470	Treat metatarsal fracture		T	0043	1.7200	$ 102.36		$ 20.47
28475	Treat metatarsal fracture		T	0043	1.7200	$ 102.36		$ 20.47
28476	Treat metatarsal fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28485	Treat metatarsal fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28490	Treat big toe fracture		T	0043	1.7200	$ 102.36		$ 20.47
28495	Treat big toe fracture		T	0043	1.7200	$ 102.36		$ 20.47
28496	Treat big toe fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28505	Treat big toe fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28510	Treatment of toe fracture		T	0043	1.7200	$ 102.36		$ 20.47
28515	Treatment of toe fracture		T	0043	1.7200	$ 102.36		$ 20.47
28525	Treat toe fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28530	Treat sesamoid bone fracture		T	0043	1.7200	$ 102.36		$ 20.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28531	Treat sesamoid bone fracture		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28540	Treat foot dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28545	Treat foot dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
28546	Treat foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28555	Repair foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28570	Treat foot dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28575	Treat foot dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28576	Treat foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28585	Repair foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28600	Treat foot dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28605	Treat foot dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28606	Treat foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28615	Repair foot dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28630	Treat toe dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28635	Treat toe dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
28636	Treat toe dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28645	Repair toe dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28660	Treat toe dislocation		T	0043	1.7200	$ 102.36		$ 20.47
28665	Treat toe dislocation		T	0045	14.3413	$ 853.47	$ 268.47	$ 170.69
28666	Treat toe dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28675	Repair of toe dislocation		T	0046	37.8852	$ 2,254.59	$ 535.76	$ 450.92
28705	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28715	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28725	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28730	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28735	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28737	Revision of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28740	Fusion of foot bones		T	0056	40.5436	$ 2,412.79		$ 482.56
28750	Fusion of big toe joint		T	0056	40.5436	$ 2,412.79		$ 482.56
28755	Fusion of big toe joint		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28760	Fusion of big toe joint		T	0056	40.5436	$ 2,412.79		$ 482.56
28810	Amputation toe & metatarsal		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28820	Amputation of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28825	Partial amputation of toe		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
28890	High energy eswt, plantar f	NI	T	1547		$ 850.00		$ 170.00
28899	Foot/toes surgery procedure		T	0043	1.7200	$ 102.36		$ 20.47
29000	Application of body cast	CH	S	0058	1.0803	$ 64.29		$ 12.86
29010	Application of body cast		S	0426	2.2146	$ 131.79		$ 26.36
29015	Application of body cast		S	0426	2.2146	$ 131.79		$ 26.36
29020	Application of body cast		S	0058	1.0803	$ 64.29		$ 12.86
29025	Application of body cast	CH	S	0058	1.0803	$ 64.29		$ 12.86
29035	Application of body cast		S	0426	2.2146	$ 131.79		$ 26.36
29040	Application of body cast		S	0058	1.0803	$ 64.29		$ 12.86

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29044	Application of body cast		S	0426	2.2146	$ 131.79		$ 26.36
29046	Application of body cast		S	0426	2.2146	$ 131.79		$ 26.36
29049	Application of figure eight		S	0058	1.0803	$ 64.29		$ 12.86
29055	Application of shoulder cast		S	0426	2.2146	$ 131.79		$ 26.36
29058	Application of shoulder cast		S	0058	1.0803	$ 64.29		$ 12.86
29065	Application of long arm cast		S	0426	2.2146	$ 131.79		$ 26.36
29075	Application of forearm cast		S	0426	2.2146	$ 131.79		$ 26.36
29085	Apply hand/wrist cast	CH	S	0058	1.0803	$ 64.29		$ 12.86
29086	Apply finger cast	CH	S	0058	1.0803	$ 64.29		$ 12.86
29105	Apply long arm splint		S	0058	1.0803	$ 64.29		$ 12.86
29125	Apply forearm splint		S	0058	1.0803	$ 64.29		$ 12.86
29126	Apply forearm splint		S	0058	1.0803	$ 64.29		$ 12.86
29130	Application of finger splint		S	0058	1.0803	$ 64.29		$ 12.86
29131	Application of finger splint		S	0058	1.0803	$ 64.29		$ 12.86
29200	Strapping of chest		S	0058	1.0803	$ 64.29		$ 12.86
29220	Strapping of low back		S	0058	1.0803	$ 64.29		$ 12.86
29240	Strapping of shoulder		S	0058	1.0803	$ 64.29		$ 12.86
29260	Strapping of elbow or wrist		S	0058	1.0803	$ 64.29		$ 12.86
29280	Strapping of hand or finger		S	0058	1.0803	$ 64.29		$ 12.86
29305	Application of hip cast		S	0426	2.2146	$ 131.79		$ 26.36
29325	Application of hip casts		S	0426	2.2146	$ 131.79		$ 26.36
29345	Application of long leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29355	Application of long leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29358	Apply long leg cast brace		S	0426	2.2146	$ 131.79		$ 26.36
29365	Application of long leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29405	Apply short leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29425	Apply short leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29435	Apply short leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29440	Addition of walker to cast	CH	S	0058	1.0803	$ 64.29		$ 12.86
29445	Apply rigid leg cast		S	0426	2.2146	$ 131.79		$ 26.36
29450	Application of leg cast		S	0058	1.0803	$ 64.29		$ 12.86
29505	Application, long leg splint		S	0058	1.0803	$ 64.29		$ 12.86
29515	Application lower leg splint		S	0058	1.0803	$ 64.29		$ 12.86
29520	Strapping of hip		S	0058	1.0803	$ 64.29		$ 12.86
29530	Strapping of knee		S	0058	1.0803	$ 64.29		$ 12.86
29540	Strapping of ankle and/or ft		S	0058	1.0803	$ 64.29		$ 12.86
29550	Strapping of toes		S	0058	1.0803	$ 64.29		$ 12.86
29580	Application of paste boot		S	0058	1.0803	$ 64.29		$ 12.86
29590	Application of foot splint		S	0058	1.0803	$ 64.29		$ 12.86
29700	Removal/revision of cast		S	0058	1.0803	$ 64.29		$ 12.86
29705	Removal/revision of cast		S	0058	1.0803	$ 64.29		$ 12.86
29710	Removal/revision of cast		S	0426	2.2146	$ 131.79		$ 26.36
29715	Removal/revision of cast		S	0058	1.0803	$ 64.29		$ 12.86

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29720	Repair of body cast		S	0058	1.0803	$ 64.29		$ 12.86
29730	Windowing of cast		S	0058	1.0803	$ 64.29		$ 12.86
29740	Wedging of cast		S	0058	1.0803	$ 64.29		$ 12.86
29750	Wedging of clubfoot cast		S	0058	1.0803	$ 64.29		$ 12.86
29799	Casting/strapping procedure		S	0058	1.0803	$ 64.29		$ 12.86
29800	Jaw arthroscopy/surgery	CH	T	0041	28.0686	$ 1,670.39		$ 334.08
29804	Jaw arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29805	Shoulder arthroscopy, dx		T	0041	28.0686	$ 1,670.39		$ 334.08
29806	Shoulder arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29807	Shoulder arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29819	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29820	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29821	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29822	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29823	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29824	Shoulder arthroscopy/surgery	CH	T	0041	28.0686	$ 1,670.39		$ 334.08
29825	Shoulder arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29826	Shoulder arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29827	Arthroscop rotator cuff repr		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29830	Elbow arthroscopy		T	0041	28.0686	$ 1,670.39		$ 334.08
29834	Elbow arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29835	Elbow arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29836	Elbow arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29837	Elbow arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29838	Elbow arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29840	Wrist arthroscopy		T	0041	28.0686	$ 1,670.39		$ 334.08
29843	Wrist arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29844	Wrist arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29845	Wrist arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29846	Wrist arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29847	Wrist arthroscopy/surgery	CH	T	0041	28.0686	$ 1,670.39		$ 334.08
29848	Wrist endoscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29850	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29851	Knee arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29855	Tibial arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29856	Tibial arthroscopy/surgery	CH	T	0041	28.0686	$ 1,670.39		$ 334.08
29860	Hip arthroscopy, dx		T	0041	28.0686	$ 1,670.39		$ 334.08
29861	Hip arthroscopy/surgery	CH	T	0041	28.0686	$ 1,670.39		$ 334.08
29862	Hip arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29863	Hip arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29866	Autgrft implnt, knee w/scope		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29867	Allgrft implnt, knee w/scope		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29868	Meniscal trnspl, knee w/scpe		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29870	Knee arthroscopy, dx		T	0041	28.0686	$ 1,670.39		$ 334.08
29871	Knee arthroscopy/drainage		T	0041	28.0686	$ 1,670.39		$ 334.08
29873	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29874	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29875	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29876	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29877	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29879	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29880	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29881	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29882	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29883	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29884	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29885	Knee arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29886	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29887	Knee arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29888	Knee arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29889	Knee arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29891	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29892	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29893	Scope, plantar fasciotomy		T	0055	19.9374	$ 1,186.49	$ 355.34	$ 237.30
29894	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29895	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29897	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29898	Ankle arthroscopy/surgery		T	0041	28.0686	$ 1,670.39		$ 334.08
29899	Ankle arthroscopy/surgery		T	0042	44.2075	$ 2,630.83	$ 804.74	$ 526.17
29900	Mcp joint arthroscopy, dx		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
29901	Mcp joint arthroscopy, surg		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
29902	Mcp joint arthroscopy, surg		T	0053	15.6396	$ 930.73	$ 253.49	$ 186.15
29999	Arthroscopy of joint		T	0041	28.0686	$ 1,670.39		$ 334.08
30000	Drainage of nose lesion		T	0251	2.0789	$ 123.72		$ 24.74
30020	Drainage of nose lesion		T	0251	2.0789	$ 123.72		$ 24.74
30100	Intranasal biopsy		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30110	Removal of nose polyp(s)		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30115	Removal of nose polyp(s)		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30117	Removal of intranasal lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30118	Removal of intranasal lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
30120	Revision of nose		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30124	Removal of nose lesion		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30125	Removal of nose lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
30130	Excise inferior turbinate		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30140	Resect inferior turbinate		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
30150	Partial removal of nose		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30160	Removal of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30200	Injection treatment of nose		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30210	Nasal sinus therapy		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30220	Insert nasal septal button		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30300	Remove nasal foreign body		X	0340	0.6137	$ 36.52		$ 7.30
30310	Remove nasal foreign body		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30320	Remove nasal foreign body		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30400	Reconstruction of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30410	Reconstruction of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30420	Reconstruction of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30430	Revision of nose		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
30435	Revision of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30450	Revision of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30460	Revision of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30462	Revision of nose		T	0256	37.0000	$ 2,201.91		$ 440.38
30465	Repair nasal stenosis		T	0256	37.0000	$ 2,201.91		$ 440.38
30520	Repair of nasal septum		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
30540	Repair nasal defect		T	0256	37.0000	$ 2,201.91		$ 440.38
30545	Repair nasal defect		T	0256	37.0000	$ 2,201.91		$ 440.38
30560	Release of nasal adhesions		T	0251	2.0789	$ 123.72		$ 24.74
30580	Repair upper jaw fistula		T	0256	37.0000	$ 2,201.91		$ 440.38
30600	Repair mouth/nose fistula		T	0256	37.0000	$ 2,201.91		$ 440.38
30620	Intranasal reconstruction		T	0256	37.0000	$ 2,201.91		$ 440.38
30630	Repair nasal septum defect		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
30801	Ablate inf turbinate, superf		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30802	Cauterization, inner nose		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
30901	Control of nosebleed		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
30903	Control of nosebleed		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
30905	Control of nosebleed		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
30906	Repeat control of nosebleed		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
30915	Ligation, nasal sinus artery		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
30920	Ligation, upper jaw artery		T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
30930	Ther fx, nasal inf turbinate		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
30999	Nasal surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
31000	Irrigation, maxillary sinus		T	0251	2.0789	$ 123.72		$ 24.74
31002	Irrigation, sphenoid sinus		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
31020	Exploration, maxillary sinus		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31030	Exploration, maxillary sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31032	Explore sinus, remove polyps		T	0256	37.0000	$ 2,201.91		$ 440.38
31040	Exploration behind upper jaw		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31050	Exploration, sphenoid sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31051	Sphenoid sinus surgery		T	0256	37.0000	$ 2,201.91		$ 440.38
31070	Exploration of frontal sinus		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31075	Exploration of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31080	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31081	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31084	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31085	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31086	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31087	Removal of frontal sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31090	Exploration of sinuses		T	0256	37.0000	$ 2,201.91		$ 440.38
31200	Removal of ethmoid sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31201	Removal of ethmoid sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31205	Removal of ethmoid sinus		T	0256	37.0000	$ 2,201.91		$ 440.38
31231	Nasal endoscopy, dx		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31233	Nasal/sinus endoscopy, dx		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31235	Nasal/sinus endoscopy, dx		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31237	Nasal/sinus endoscopy, surg		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31238	Nasal/sinus endoscopy, surg		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31239	Nasal/sinus endoscopy, surg		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31240	Nasal/sinus endoscopy, surg		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31254	Revision of ethmoid sinus		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31255	Removal of ethmoid sinus		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31256	Exploration maxillary sinus		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31267	Endoscopy, maxillary sinus		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31276	Sinus endoscopy, surgical		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31287	Nasal/sinus endoscopy, surg		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31288	Nasal/sinus endoscopy, surg		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31292	Nasal/sinus endoscopy, surg		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31293	Nasal/sinus endoscopy, surg	CH	T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31294	Nasal/sinus endoscopy, surg	CH	T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31299	Sinus surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
31300	Removal of larynx lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31320	Diagnostic incision, larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31400	Revision of larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31420	Removal of epiglottis		T	0256	37.0000	$ 2,201.91		$ 440.38
31500	Insert emergency airway		S	0094	2.4582	$ 146.29	$ 46.29	$ 29.26
31502	Change of windpipe airway		T	0121	2.2374	$ 133.15	$ 43.80	$ 26.63
31505	Diagnostic laryngoscopy		T	0071	0.8034	$ 47.81	$ 11.31	$ 9.56
31510	Laryngoscopy with biopsy		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31511	Remove foreign body, larynx		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31512	Removal of larynx lesion		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31513	Injection into vocal cord		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31515	Laryngoscopy for aspiration		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31520	Dx laryngoscopy, newborn		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31525	Dx laryngoscopy excl nb		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31526	Dx laryngoscopy w/oper scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31527	Laryngoscopy for treatment		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31528	Laryngoscopy and dilation		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31529	Laryngoscopy and dilation		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31530	Laryngoscopy w/fb removal		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31531	Laryngoscopy w/fb & op scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31535	Laryngoscopy w/biopsy		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31536	Laryngoscopy w/bx & op scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31540	Laryngoscopy w/exc of tumor		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31541	Larynscop w/tumr exc + scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31545	Remove vc lesion w/scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31546	Remove vc lesion scope/graft		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31560	Laryngoscop w/arytenoidectom		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31561	Larynscop, remve cart + scop		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31570	Laryngoscope w/vc inj		T	0074	15.4603	$ 920.06	$ 295.70	$ 184.01
31571	Laryngoscop w/vc inj + scope		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31575	Diagnostic laryngoscopy		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31576	Laryngoscopy with biopsy		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31577	Remove foreign body, larynx		T	0073	4.2171	$ 250.96	$ 73.38	$ 50.19
31578	Removal of larynx lesion		T	0075	21.2258	$ 1,263.17	$ 445.92	$ 252.63
31579	Diagnostic laryngoscopy		T	0073	4.2171	$ 250.96	$ 73.38	$ 50.19
31580	Revision of larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31582	Revision of larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31585	Treat larynx fracture	CH	D					
31586	Treat larynx fracture	CH	D					
31588	Revision of larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31590	Reinnervate larynx		T	0256	37.0000	$ 2,201.91		$ 440.38
31595	Larynx nerve surgery		T	0256	37.0000	$ 2,201.91		$ 440.38
31599	Larynx surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
31600	Incision of windpipe		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31601	Incision of windpipe		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31603	Incision of windpipe		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
31605	Incision of windpipe		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
31610	Incision of windpipe		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31611	Surgery/speech prosthesis		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31612	Puncture/clear windpipe		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31613	Repair windpipe opening		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31614	Repair windpipe opening		T	0256	37.0000	$ 2,201.91		$ 440.38
31615	Visualization of windpipe		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31620	Endobronchial us add-on		S	0670	28.7546	$ 1,711.22	$ 536.10	$ 342.24
31622	Dx bronchoscope/wash		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31623	Dx bronchoscope/brush		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31624	Dx bronchoscope/lavage		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31625	Bronchoscopy w/biopsy(s)		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31628	Bronchoscopy/lung bx, each		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31629	Bronchoscopy/needle bx, each		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31630	Bronchoscopy dilate/fx repr		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31631	Bronchoscopy, dilate w/stent		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31632	Bronchoscopy/lung bx, add'l		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31633	Bronchoscopy/needle bx add'l		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31635	Bronchoscopy w/fb removal		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31636	Bronchoscopy, bronch stents		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31637	Bronchoscopy, stent add-on		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31638	Bronchoscopy, revise stent		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31640	Bronchoscopy w/tumor excise		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31641	Bronchoscopy, treat blockage		T	0415	22.0722	$ 1,313.54	$ 459.92	$ 262.71
31643	Diag bronchoscope/catheter		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31645	Bronchoscopy, clear airways		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31646	Bronchoscopy, reclear airway		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31656	Bronchoscopy, inj for x-ray		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
31700	Insertion of airway catheter		T	0072	1.4448	$ 85.98	$ 21.27	$ 17.20
31708	Instill airway contrast dye		N					
31710	Insertion of airway catheter		N					
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.2171	$ 250.96	$ 73.38	$ 50.19
31720	Clearance of airways		T	0071	0.8034	$ 47.81	$ 11.31	$ 9.56
31730	Intro, windpipe wire/tube		T	0073	4.2171	$ 250.96	$ 73.38	$ 50.19
31750	Repair of windpipe		T	0256	37.0000	$ 2,201.91		$ 440.38
31755	Repair of windpipe		T	0256	37.0000	$ 2,201.91		$ 440.38
31785	Remove windpipe lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31820	Closure of windpipe lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
31825	Repair of windpipe defect		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31830	Revise windpipe scar		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
31899	Airways surgical procedure		T	0076	9.4030	$ 559.58	$ 189.82	$ 111.92
32000	Drainage of chest		T	0070	3.2141	$ 191.27		$ 38.25
32002	Treatment of collapsed lung		T	0070	3.2141	$ 191.27		$ 38.25
32005	Treat lung lining chemically		T	0070	3.2141	$ 191.27		$ 38.25
32019	Insert pleural catheter	CH	T	0427	10.0109	$ 595.76		$ 119.15
32020	Insertion of chest tube		T	0070	3.2141	$ 191.27		$ 38.25
32201	Drain, percut, lung lesion		T	0070	3.2141	$ 191.27		$ 38.25
32400	Needle biopsy chest lining		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
32405	Biopsy, lung or mediastinum		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
32420	Puncture/clear lung		T	0070	3.2141	$ 191.27		$ 38.25
32520	Remove lung & revise chest	CH	D					
32522	Remove lung & revise chest	CH	D					
32525	Remove lung & revise chest	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32601	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32602	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32603	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32604	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32605	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32606	Thoracoscopy, diagnostic		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
32960	Therapeutic pneumothorax		T	0070	3.2141	$ 191.27		$ 38.25
32999	Chest surgery procedure		T	0070	3.2141	$ 191.27		$ 38.25
33010	Drainage of heart sac		T	0070	3.2141	$ 191.27		$ 38.25
33011	Repeat drainage of heart sac		T	0070	3.2141	$ 191.27		$ 38.25
33206	Insertion of heart pacemaker		T	0089	117.0463	$ 6,965.54	$ 1,682.28	$ 1,393.11
33207	Insertion of heart pacemaker		T	0089	117.0463	$ 6,965.54	$ 1,682.28	$ 1,393.11
33208	Insertion of heart pacemaker		T	0655	136.8448	$ 8,143.77		$ 1,628.75
33210	Insertion of heart electrode		T	0106	55.9362	$ 3,328.82		$ 665.76
33211	Insertion of heart electrode		T	0106	55.9362	$ 3,328.82		$ 665.76
33212	Insertion of pulse generator		T	0090	90.2017	$ 5,367.99	$ 1,612.80	$ 1,073.60
33213	Insertion of pulse generator		T	0654	112.0279	$ 6,666.89		$ 1,333.38
33214	Upgrade of pacemaker system		T	0655	136.8448	$ 8,143.77		$ 1,628.75
33215	Reposition pacing-defib lead		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33216	Insert lead pace-defib, one		T	0106	55.9362	$ 3,328.82		$ 665.76
33217	Insert lead pace-defib, dual		T	0106	55.9362	$ 3,328.82		$ 665.76
33218	Repair lead pace-defib, one		T	0106	55.9362	$ 3,328.82		$ 665.76
33220	Repair lead pace-defib, dual		T	0106	55.9362	$ 3,328.82		$ 665.76
33222	Revise pocket, pacemaker		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
33223	Revise pocket, pacing-defib		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
33224	Insert pacing lead & connect		T	0418	169.3514	$10,078.27		$ 2,015.65
33225	L ventric pacing lead add-on	CH	T	0418	169.3514	$10,078.27		$ 2,015.65
33226	Reposition l ventric lead		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33233	Removal of pacemaker system		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33234	Removal of pacemaker system		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33235	Removal pacemaker electrode		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33241	Remove pulse generator		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33244	Remove eltrd, transven		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
33282	Implant pat-active ht record		S	0680	74.9052	$ 4,457.68		$ 891.54
33284	Remove pat-active ht record		T	0109	11.1714	$ 664.82		$ 132.96
33508	Endoscopic vein harvest		N					
33918	Repair pulmonary atresia	CH	D					
33919	Repair pulmonary atresia	CH	D					
33999	Cardiac surgery procedure		T	0070	3.2141	$ 191.27		$ 38.25
34101	Removal of artery clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34111	Removal of arm artery clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34201	Removal of artery clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34203	Removal of leg artery clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
34421	Removal of vein clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34471	Removal of vein clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34490	Removal of vein clot		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34501	Repair valve, femoral vein		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34510	Transposition of vein valve		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34520	Cross-over vein graft		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
34530	Leg vein fusion		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35011	Repair defect of artery		T	0653	36.9427	$ 2,198.50		$ 439.70
35161	Repair defect of artery		D					
35162	Repair artery rupture		D					
35180	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35184	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35188	Repair blood vessel lesion		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35190	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35201	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35206	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35207	Repair blood vessel lesion		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35226	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35231	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35236	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35256	Repair blood vessel lesion		T	0093	23.3101	$ 1,387.21		$ 277.44
35261	Repair blood vessel lesion		T	0653	36.9427	$ 2,198.50		$ 439.70
35266	Repair blood vessel lesion		T	0653	36.9427	$ 2,198.50		$ 439.70
35286	Repair blood vessel lesion		T	0653	36.9427	$ 2,198.50		$ 439.70
35321	Rechanneling of artery		T	0093	23.3101	$ 1,387.21		$ 277.44
35458	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35459	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35460	Repair venous blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35470	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35471	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35472	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35473	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35474	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35475	Repair arterial blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35476	Repair venous blockage		T	0081	42.2664	$ 2,515.32		$ 503.06
35484	Atherectomy, open		T	0081	42.2664	$ 2,515.32		$ 503.06
35485	Atherectomy, open		T	0081	42.2664	$ 2,515.32		$ 503.06
35490	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06
35491	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06
35492	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06
35493	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06
35494	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06
35495	Atherectomy, percutaneous		T	0081	42.2664	$ 2,515.32		$ 503.06

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35500	Harvest vein for bypass	CH	T	0081	42.2664	$ 2,515.32		$ 503.06
35572	Harvest femoropopliteal vein		N					
35582	Vein bypass graft		D					
35685	Bypass graft patency/patch		T	0093	23.3101	$ 1,387.21		$ 277.44
35686	Bypass graft/av fist patency		T	0093	23.3101	$ 1,387.21		$ 277.44
35761	Exploration of artery/vein		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
35860	Explore limb vessels		T	0093	23.3101	$ 1,387.21		$ 277.44
35875	Removal of clot in graft		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35876	Removal of clot in graft		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35879	Revise graft w/vein		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35881	Revise graft w/vein		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
35903	Excision, graft, extremity		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36261	Revision of infusion pump	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36262	Removal of infusion pump	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		T	0035	0.0834	$ 4.96		$ 0.99
36425	Vein access cutdown > 1 yr		T	0035	0.0834	$ 4.96		$ 0.99
36430	Blood transfusion service		S	0110	3.6419	$ 216.73		$ 43.35
36440	Bl push transfuse, 2 yr or <		S	0110	3.6419	$ 216.73		$ 43.35
36450	Bl exchange/transfuse, nb		S	0110	3.6419	$ 216.73		$ 43.35
36455	Bl exchange/transfuse non-nb		S	0110	3.6419	$ 216.73		$ 43.35
36460	Transfusion service, fetal		S	0110	3.6419	$ 216.73		$ 43.35
36468	Injection(s), spider veins		T	0098	1.1444	$ 68.10		$ 13.62
36469	Injection(s), spider veins		T	0098	1.1444	$ 68.10		$ 13.62
36470	Injection therapy of vein		T	0098	1.1444	$ 68.10		$ 13.62
36471	Injection therapy of veins		T	0098	1.1444	$ 68.10		$ 13.62
36475	Endovenous rf, 1st vein	CH	T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
36476	Endovenous rf, vein add-on	CH	T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
36478	Endovenous laser, 1st vein	CH	T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
36479	Endovenous laser vein addon	CH	T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein	CH	N					
36511	Apheresis wbc		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
36512	Apheresis rbc		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
36513	Apheresis platelets		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
36514	Apheresis plasma		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
36515	Apheresis, adsorp/reinfuse	CH	S	0112	26.3750	$ 1,569.60	$ 433.29	$ 313.92
36516	Apheresis, selective		S	0112	26.3750	$ 1,569.60	$ 433.29	$ 313.92
36522	Photopheresis		S	0112	26.3750	$ 1,569.60	$ 433.29	$ 313.92
36540	Collect blood venous device		N					
36550	Declot vascular device	CH	T	0676	2.2742	$ 135.34		$ 27.07
36555	Insert non-tunnel cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36556	Insert non-tunnel cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36557	Insert tunneled cv cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36558	Insert tunneled cv cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36560	Insert tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36561	Insert tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36563	Insert tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36565	Insert tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36566	Insert tunneled cv cath		T	1564		$ 4,750.00		$ 950.00
36568	Insert picc cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36569	Insert picc cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36570	Insert picvad cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36571	Insert picvad cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36575	Repair tunneled cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36576	Repair tunneled cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36578	Replace tunneled cv cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36580	Replace cvad cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36581	Replace tunneled cv cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36582	Replace tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36583	Replace tunneled cv cath	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36584	Replace picc cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36585	Replace picvad cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36589	Removal tunneled cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36590	Removal tunneled cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36595	Mech remov tunneled cv cath	CH	T	0622	21.2464	$ 1,264.39		$ 252.88
36596	Mech remov tunneled cv cath	CH	T	0621	8.2313	$ 489.85		$ 97.97
36597	Reposition venous catheter	CH	T	0621	8.2313	$ 489.85		$ 97.97
36598	Inj w/fluor, eval cv device	NI	X	0340	0.6137	$ 36.52		$ 7.30
36600	Withdrawal of arterial blood		N					
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery	CH	T	0623	27.1472	$ 1,615.56		$ 323.11
36680	Insert needle, bone cavity		T	0002	0.9357	$ 55.68		$ 11.14
36800	Insertion of cannula		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36810	Insertion of cannula		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36815	Insertion of cannula		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36818	Av fuse, uppr arm, cephalic		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36819	Av fuse, uppr arm, basilic		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36820	Av fusion/forearm vein		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36821	Av fusion direct any site		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36825	Artery-vein autograft		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36830	Artery-vein nonautograft		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36831	Open thrombect av fistula		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36832	Av fistula revision, open		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36833	Av fistula revision		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36834	Repair A-V aneurysm		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36835	Artery to vein shunt		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36838	Dist revas ligation, hemo		T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
36860	External cannula declotting	CH	T	0676	2.2742	$ 135.34		$ 27.07
36861	Cannula declotting		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
36870	Percut thrombect av fistula		T	0653	36.9427	$ 2,198.50		$ 439.70
37183	Remove hepatic shunt (tips)	CH	T	0229	66.3380	$ 3,947.84		$ 789.57
37184	Prim art mech thrombectomy	NI	T	0653	36.9427	$ 2,198.50		$ 439.70
37185	Prim art m-thrombect add-on	NI	T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
37186	Sec art m-thrombect add-on	NI	T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
37187	Venous mech thrombectomy	NI	T	0653	36.9427	$ 2,198.50		$ 439.70
37188	Venous m-thrombectomy add-on	NI	T	0653	36.9427	$ 2,198.50		$ 439.70
37195	Thrombolytic therapy, stroke	CH	T	0676	2.2742	$ 135.34		$ 27.07

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37200	Transcatheter biopsy		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
37201	Transcatheter therapy infuse		T	0676	2.2742	$ 135.34		$ 27.07
37202	Transcatheter therapy infuse	CH	T	0676	2.2742	$ 135.34		$ 27.07
37203	Transcatheter retrieval		T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
37204	Transcatheter occlusion		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
37205	Transcath iv stent, percut		T	0229	66.3380	$ 3,947.84		$ 789.57
37206	Transcath iv stent/perc addl		T	0229	66.3380	$ 3,947.84		$ 789.57
37207	Transcath iv stent, open		T	0229	66.3380	$ 3,947.84		$ 789.57
37208	Transcath iv stent/open addl		T	0229	66.3380	$ 3,947.84		$ 789.57
37209	Change iv cath at thromb tx		T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
37250	Iv us first vessel add-on		S	0416	16.4464	$ 978.74		$ 195.75
37251	Iv us each add vessel add-on		S	0416	16.4464	$ 978.74		$ 195.75
37500	Endoscopy ligate perf veins		T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37501	Vascular endoscopy procedure		T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37565	Ligation of neck vein		T	0093	23.3101	$ 1,387.21		$ 277.44
37600	Ligation of neck artery		T	0093	23.3101	$ 1,387.21		$ 277.44
37605	Ligation of neck artery		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37606	Ligation of neck artery		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37607	Ligation of a-v fistula		T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37609	Temporal artery procedure		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
37615	Ligation of neck artery		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37620	Revision of major vein		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37650	Revision of major vein		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37700	Revise leg vein		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37718	Ligate/strip short leg vein	NI	T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37720	Removal of leg vein	CH	D					
37722	Ligate/strip long leg vein	NI	T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37730	Removal of leg veins	CH	D					
37735	Removal of leg veins/lesion		T	0092	26.5104	$ 1,577.66	$ 505.37	$ 315.53
37760	Ligation, leg veins, open		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37765	Phleb veins - extrem - to 20		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37766	Phleb veins - extrem 20+		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37780	Revision of leg vein		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37785	Ligate/divide/excise vein		T	0091	28.8805	$ 1,718.71	$ 348.23	$ 343.74
37790	Penile venous occlusion		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
37799	Vascular surgery procedure	CH	T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
38120	Laparoscopy, splenectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
38129	Laparoscope proc, spleen		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
38206	Harvest auto stem cells		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
38220	Bone marrow aspiration		T	0003	2.6756	$ 159.23		$ 31.85

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38221	Bone marrow biopsy		T	0003	2.6756	$ 159.23		$ 31.85
38230	Bone marrow collection	CH	S	0123	24.4820	$ 1,456.95		$ 291.39
38240	Bone marrow/stem transplant		S	0123	24.4820	$ 1,456.95		$ 291.39
38241	Bone marrow/stem transplant		S	0123	24.4820	$ 1,456.95		$ 291.39
38242	Lymphocyte infuse transplant		S	0111	12.0768	$ 718.70	$ 198.40	$ 143.74
38300	Drainage, lymph node lesion	CH	T	0007	11.6717	$ 694.59		$ 138.92
38305	Drainage, lymph node lesion		T	0008	16.2953	$ 969.75		$ 193.95
38308	Incision of lymph channels		T	0113	21.4112	$ 1,274.20		$ 254.84
38500	Biopsy/removal, lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38505	Needle biopsy, lymph nodes		T	0005	3.5834	$ 213.25	$ 71.59	$ 42.65
38510	Biopsy/removal, lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38520	Biopsy/removal, lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38525	Biopsy/removal, lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38530	Biopsy/removal, lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38542	Explore deep node(s), neck		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
38550	Removal, neck/armpit lesion		T	0113	21.4112	$ 1,274.20		$ 254.84
38555	Removal, neck/armpit lesion		T	0113	21.4112	$ 1,274.20		$ 254.84
38570	Laparoscopy, lymph node biop		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
38571	Laparoscopy, lymphadenectomy		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
38572	Laparoscopy, lymphadenectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
38589	Laparoscope proc, lymphatic		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
38700	Removal of lymph nodes, neck		T	0113	21.4112	$ 1,274.20		$ 254.84
38720	Removal of lymph nodes, neck		T	0113	21.4112	$ 1,274.20		$ 254.84
38740	Remove armpit lymph nodes		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
38745	Remove armpit lymph nodes		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
38760	Remove groin lymph nodes		T	0113	21.4112	$ 1,274.20		$ 254.84
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		N					
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.6419	$ 216.73		$ 43.35
39400	Visualization of chest		T	0069	30.9541	$ 1,842.11	$ 591.64	$ 368.42
40490	Biopsy of lip		T	0251	2.0789	$ 123.72		$ 24.74
40500	Partial excision of lip		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40510	Partial excision of lip		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40520	Partial excision of lip		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40525	Reconstruct lip with flap		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40527	Reconstruct lip with flap		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40530	Partial removal of lip		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40650	Repair lip		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40652	Repair lip		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40654	Repair lip		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40700	Repair cleft lip/nasal		T	0256	37.0000	$ 2,201.91		$ 440.38
40701	Repair cleft lip/nasal		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40702	Repair cleft lip/nasal		T	0256	37.0000	$ 2,201.91		$ 440.38
40720	Repair cleft lip/nasal		T	0256	37.0000	$ 2,201.91		$ 440.38
40761	Repair cleft lip/nasal		T	0256	37.0000	$ 2,201.91		$ 440.38
40799	Lip surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
40800	Drainage of mouth lesion		T	0251	2.0789	$ 123.72		$ 24.74
40801	Drainage of mouth lesion		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40804	Removal, foreign body, mouth		X	0340	0.6137	$ 36.52		$ 7.30
40805	Removal, foreign body, mouth		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40806	Incision of lip fold		T	0251	2.0789	$ 123.72		$ 24.74
40808	Biopsy of mouth lesion		T	0251	2.0789	$ 123.72		$ 24.74
40810	Excision of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40812	Excise/repair mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40814	Excise/repair mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40816	Excision of mouth lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40818	Excise oral mucosa for graft		T	0251	2.0789	$ 123.72		$ 24.74
40819	Excise lip or cheek fold		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40820	Treatment of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
40830	Repair mouth laceration		T	0251	2.0789	$ 123.72		$ 24.74
40831	Repair mouth laceration		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
40840	Reconstruction of mouth		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40842	Reconstruction of mouth		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40843	Reconstruction of mouth		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
40844	Reconstruction of mouth		T	0256	37.0000	$ 2,201.91		$ 440.38
40845	Reconstruction of mouth		T	0256	37.0000	$ 2,201.91		$ 440.38
40899	Mouth surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
41000	Drainage of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41005	Drainage of mouth lesion		T	0251	2.0789	$ 123.72		$ 24.74
41006	Drainage of mouth lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41007	Drainage of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41008	Drainage of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41009	Drainage of mouth lesion		T	0251	2.0789	$ 123.72		$ 24.74
41010	Incision of tongue fold		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41015	Drainage of mouth lesion		T	0251	2.0789	$ 123.72		$ 24.74
41016	Drainage of mouth lesion		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41017	Drainage of mouth lesion		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41018	Drainage of mouth lesion		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41100	Biopsy of tongue		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41105	Biopsy of tongue		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41108	Biopsy of floor of mouth		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41110	Excision of tongue lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41112	Excision of tongue lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41113	Excision of tongue lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41114	Excision of tongue lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41115	Excision of tongue fold		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41116	Excision of mouth lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41120	Partial removal of tongue		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41250	Repair tongue laceration		T	0251	2.0789	$ 123.72		$ 24.74
41251	Repair tongue laceration		T	0251	2.0789	$ 123.72		$ 24.74
41252	Repair tongue laceration		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41500	Fixation of tongue		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41510	Tongue to lip surgery		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41520	Reconstruction, tongue fold		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41599	Tongue and mouth surgery		T	0251	2.0789	$ 123.72		$ 24.74
41800	Drainage of gum lesion		T	0251	2.0789	$ 123.72		$ 24.74
41805	Removal foreign body, gum		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41806	Removal foreign body,jawbone		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41820	Excision, gum, each quadrant		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41821	Excision of gum flap		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
41822	Excision of gum lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41823	Excision of gum lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41825	Excision of gum lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41826	Excision of gum lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41827	Excision of gum lesion		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41828	Excision of gum lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41830	Removal of gum tissue		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41850	Treatment of gum lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41870	Gum graft		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41872	Repair gum		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
41874	Repair tooth socket		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
41899	Dental surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
42000	Drainage mouth roof lesion		T	0251	2.0789	$ 123.72		$ 24.74
42100	Biopsy roof of mouth		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
42104	Excision lesion, mouth roof		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42106	Excision lesion, mouth roof		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42107	Excision lesion, mouth roof		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42120	Remove palate/lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
42140	Excision of uvula		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
42145	Repair palate, pharynx/uvula		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42160	Treatment mouth roof lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42180	Repair palate		T	0251	2.0789	$ 123.72		$ 24.74
42182	Repair palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42200	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42205	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42210	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42215	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42220	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42225	Reconstruct cleft palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42226	Lengthening of palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42227	Lengthening of palate		T	0256	37.0000	$ 2,201.91		$ 440.38
42235	Repair palate		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42260	Repair nose to lip fistula		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42280	Preparation, palate mold		T	0251	2.0789	$ 123.72		$ 24.74
42281	Insertion, palate prosthesis		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42299	Palate/uvula surgery		T	0251	2.0789	$ 123.72		$ 24.74
42300	Drainage of salivary gland		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42305	Drainage of salivary gland		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42310	Drainage of salivary gland		T	0251	2.0789	$ 123.72		$ 24.74
42320	Drainage of salivary gland		T	0251	2.0789	$ 123.72		$ 24.74
42325	Create salivary cyst drain	CH	D					
42326	Create salivary cyst drain	CH	D					
42330	Removal of salivary stone		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42335	Removal of salivary stone		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42340	Removal of salivary stone		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42400	Biopsy of salivary gland		T	0005	3.5834	$ 213.25	$ 71.59	$ 42.65
42405	Biopsy of salivary gland		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42408	Excision of salivary cyst		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42409	Drainage of salivary cyst		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42410	Excise parotid gland/lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
42415	Excise parotid gland/lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
42420	Excise parotid gland/lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
42425	Excise parotid gland/lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
42440	Excise submaxillary gland		T	0256	37.0000	$ 2,201.91		$ 440.38
42450	Excise sublingual gland		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42500	Repair salivary duct		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42505	Repair salivary duct		T	0256	37.0000	$ 2,201.91		$ 440.38
42507	Parotid duct diversion		T	0256	37.0000	$ 2,201.91		$ 440.38
42508	Parotid duct diversion		T	0256	37.0000	$ 2,201.91		$ 440.38
42509	Parotid duct diversion		T	0256	37.0000	$ 2,201.91		$ 440.38
42510	Parotid duct diversion		T	0256	37.0000	$ 2,201.91		$ 440.38
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42650	Dilation of salivary duct		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
42660	Dilation of salivary duct		T	0251	2.0789	$ 123.72		$ 24.74
42665	Ligation of salivary duct		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42699	Salivary surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
42700	Drainage of tonsil abscess		T	0251	2.0789	$ 123.72		$ 24.74
42720	Drainage of throat abscess		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42725	Drainage of throat abscess		T	0256	37.0000	$ 2,201.91		$ 440.38
42800	Biopsy of throat		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42802	Biopsy of throat		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42804	Biopsy of upper nose/throat		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42806	Biopsy of upper nose/throat		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42808	Excise pharynx lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42809	Remove pharynx foreign body		X	0340	0.6137	$ 36.52		$ 7.30
42810	Excision of neck cyst		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42815	Excision of neck cyst		T	0256	37.0000	$ 2,201.91		$ 440.38
42820	Remove tonsils and adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42821	Remove tonsils and adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42825	Removal of tonsils		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42826	Removal of tonsils		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42830	Removal of adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42831	Removal of adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42835	Removal of adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42836	Removal of adenoids		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42842	Extensive surgery of throat		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42844	Extensive surgery of throat		T	0256	37.0000	$ 2,201.91		$ 440.38
42860	Excision of tonsil tags		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42870	Excision of lingual tonsil		T	0258	21.8761	$ 1,301.87	$ 437.25	$ 260.37
42890	Partial removal of pharynx		T	0256	37.0000	$ 2,201.91		$ 440.38
42892	Revision of pharyngeal walls		T	0256	37.0000	$ 2,201.91		$ 440.38
42900	Repair throat wound		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
42950	Reconstruction of throat		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42955	Surgical opening of throat		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
42960	Control throat bleeding		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
42962	Control throat bleeding		T	0256	37.0000	$ 2,201.91		$ 440.38
42970	Control nose/throat bleeding		T	0250	1.2241	$ 72.85	$ 25.50	$ 14.57
42972	Control nose/throat bleeding		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
42999	Throat surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
43020	Incision of esophagus		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
43030	Throat muscle surgery		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
43130	Removal of esophagus pouch		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
43200	Esophagus endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43201	Esoph scope w/submucous inj		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43202	Esophagus endoscopy, biopsy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43204	Esoph scope w/sclerosis inj		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43205	Esophagus endoscopy/ligation		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43215	Esophagus endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43216	Esophagus endoscopy/lesion		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43217	Esophagus endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43219	Esophagus endoscopy		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
43220	Esoph endoscopy, dilation		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43226	Esoph endoscopy, dilation		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43227	Esoph endoscopy, repair		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43228	Esoph endoscopy, ablation		T	0422	24.0525	$ 1,431.39	$ 448.81	$ 286.28
43231	Esoph endoscopy w/us exam		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43232	Esoph endoscopy w/us fn bx		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43234	Upper GI endoscopy, exam		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43235	Uppr gi endoscopy, diagnosis		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43236	Uppr gi scope w/submuc inj		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43237	Endoscopic us exam, esoph		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43239	Upper GI endoscopy, biopsy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43240	Esoph endoscope w/drain cyst		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43241	Upper GI endoscopy with tube		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43243	Upper gi endoscopy & inject		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43244	Upper GI endoscopy/ligation		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43245	Uppr gi scope dilate strictr		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43246	Place gastrostomy tube		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43247	Operative upper GI endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43248	Uppr gi endoscopy/guide wire		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43249	Esoph endoscopy, dilation		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43250	Upper GI endoscopy/tumor		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43251	Operative upper GI endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43255	Operative upper GI endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43256	Uppr gi endoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
43257	Uppr gi scope w/thrml txmnt		T	0422	24.0525	$ 1,431.39	$ 448.81	$ 286.28
43258	Operative upper GI endoscopy		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43259	Endoscopic ultrasound exam		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43260	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43261	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43262	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43263	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43264	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43265	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43267	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43268	Endo cholangiopancreatograph		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
43269	Endo cholangiopancreatograph		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
43271	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43272	Endo cholangiopancreatograph		T	0151	18.6171	$ 1,107.92	$ 245.46	$ 221.58
43280	Laparoscopy, fundoplasty		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
43289	Laparoscope proc, esoph		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
43450	Dilate esophagus		T	0140	5.2970	$ 315.23	$ 91.40	$ 63.05
43453	Dilate esophagus		T	0140	5.2970	$ 315.23	$ 91.40	$ 63.05
43456	Dilate esophagus		T	0140	5.2970	$ 315.23	$ 91.40	$ 63.05

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43458	Dilate esophagus		T	0140	5.2970	$ 315.23	$ 91.40	$ 63.05
43499	Esophagus surgery procedure		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43510	Surgical opening of stomach		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43600	Biopsy of stomach		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43638	Removal of stomach, partial	CH	D					
43639	Removal of stomach, partial	CH	D					
43651	Laparoscopy, vagus nerve		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
43652	Laparoscopy, vagus nerve		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
43653	Laparoscopy, gastrostomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
43659	Laparoscope proc, stom		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
43750	Place gastrostomy tube		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43752	Nasal/orogastric w/stent		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
43760	Change gastrostomy tube		T	0121	2.2374	$ 133.15	$ 43.80	$ 26.63
43761	Reposition gastrostomy tube	CH	T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
43830	Place gastrostomy tube		T	0422	24.0525	$ 1,431.39	$ 448.81	$ 286.28
43831	Place gastrostomy tube		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43870	Repair stomach opening		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
43886	Revise gastric port, open		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
43887	Remove gastric port, open		T	0025	5.3051	$ 315.71	$ 101.85	$ 63.14
43888	Change gastric port, open		T	0686	13.4973	$ 803.24		$ 160.65
43999	Stomach surgery procedure		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
44100	Biopsy of bowel		T	0141	8.0662	$ 480.03	$ 143.38	$ 96.01
44180	Lap, enterolysis	NI	T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
44186	Lap, jejunostomy	NI	T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
44200	Laparoscopy, enterolysis	CH	D					
44201	Laparoscopy, jejunostomy	CH	D					
44206	Lap part colectomy w/stoma		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
44207	L colectomy/coloproctostomy		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
44208	L colectomy/coloproctostomy		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
44213	Lap, mobil splenic fl add-on	NI	T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
44238	Laparoscope proc, intestine		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
44239	Laparoscope proc, rectum	CH	D					
44312	Revision of ileostomy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
44340	Revision of colostomy		T	0027	18.1956	$ 1,082.84	$ 329.72	$ 216.57
44360	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44361	Small bowel endoscopy/biopsy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44363	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44364	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44365	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44366	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44369	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44370	Small bowel endoscopy/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
44372	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44373	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44376	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44377	Small bowel endoscopy/biopsy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44378	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44379	S bowel endoscope w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
44380	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44382	Small bowel endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44383	Ileoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
44385	Endoscopy of bowel pouch		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44386	Endoscopy, bowel pouch/biop		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44388	Colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44389	Colonoscopy with biopsy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44390	Colonoscopy for foreign body		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44391	Colonoscopy for bleeding		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44392	Colonoscopy & polypectomy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44393	Colonoscopy, lesion removal		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44394	Colonoscopy w/snare		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
44397	Colonoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
44500	Intro, gastrointestinal tube		T	0121	2.2374	$ 133.15	$ 43.80	$ 26.63
44701	Intraop colon lavage add-on		N					
44799	Unlisted procedure intestine		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
44901	Drain app abscess, percut		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
44970	Laparoscopy, appendectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
44979	Laparoscope proc, app		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
45000	Drainage of pelvic abscess		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
45005	Drainage of rectal abscess		T	0155	15.9499	$ 949.19		$ 189.84
45020	Drainage of rectal abscess		T	0155	15.9499	$ 949.19		$ 189.84
45100	Biopsy of rectum		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
45108	Removal of anorectal lesion		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45150	Excision of rectal stricture		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
45160	Excision of rectal lesion		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45170	Excision of rectal lesion		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45190	Destruction, rectal tumor		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45300	Proctosigmoidoscopy dx		T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45303	Proctosigmoidoscopy dilate	CH	T	0147	7.9652	$ 474.02		$ 94.80
45305	Proctosigmoidoscopy w/bx	CH	T	0147	7.9652	$ 474.02		$ 94.80
45307	Proctosigmoidoscopy fb	CH	T	0428	20.0871	$ 1,195.40		$ 239.08
45308	Proctosigmoidoscopy removal		T	0147	7.9652	$ 474.02		$ 94.80
45309	Proctosigmoidoscopy removal		T	0147	7.9652	$ 474.02		$ 94.80
45315	Proctosigmoidoscopy removal		T	0147	7.9652	$ 474.02		$ 94.80
45317	Proctosigmoidoscopy bleed		T	0147	7.9652	$ 474.02		$ 94.80
45320	Proctosigmoidoscopy ablate	CH	T	0428	20.0871	$ 1,195.40		$ 239.08
45321	Proctosigmoidoscopy volvul	CH	T	0428	20.0871	$ 1,195.40		$ 239.08

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45327	Proctosigmoidoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
45330	Diagnostic sigmoidoscopy		T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45331	Sigmoidoscopy and biopsy		T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45332	Sigmoidoscopy w/fb removal		T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45333	Sigmoidoscopy & polypectomy		T	0147	7.9652	$ 474.02		$ 94.80
45334	Sigmoidoscopy for bleeding		T	0147	7.9652	$ 474.02		$ 94.80
45335	Sigmoidoscopy w/submuc inj	CH	T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45337	Sigmoidoscopy & decompress	CH	T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
45338	Sigmoidoscopy w/tumr remove		T	0147	7.9652	$ 474.02		$ 94.80
45339	Sigmoidoscopy w/ablate tumr		T	0147	7.9652	$ 474.02		$ 94.80
45340	Sig w/balloon dilation		T	0147	7.9652	$ 474.02		$ 94.80
45341	Sigmoidoscopy w/ultrasound		T	0147	7.9652	$ 474.02		$ 94.80
45342	Sigmoidoscopy w/us guide bx		T	0147	7.9652	$ 474.02		$ 94.80
45345	Sigmoidoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
45355	Surgical colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45378	Diagnostic colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45379	Colonoscopy w/fb removal		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45380	Colonoscopy and biopsy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45381	Colonoscopy, submucous inj		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45382	Colonoscopy/control bleeding		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45383	Lesion removal colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45384	Lesion remove colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45385	Lesion removal colonoscopy		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45386	Colonoscopy dilate stricture		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45387	Colonoscopy w/stent		T	0384	26.8955	$ 1,600.58	$ 335.19	$ 320.12
45391	Colonoscopy w/endoscope us		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45392	Colonoscopy w/endoscopic fnb		T	0143	8.5588	$ 509.34	$ 186.06	$ 101.87
45499	Laparoscope proc, rectum	NI	T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
45500	Repair of rectum		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
45505	Repair of rectum		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45520	Treatment of rectal prolapse		T	0098	1.1444	$ 68.10		$ 13.62
45541	Correct rectal prolapse		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45560	Repair of rectocele		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
45900	Reduction of rectal prolapse		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
45905	Dilation of anal sphincter		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
45910	Dilation of rectal narrowing		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
45915	Remove rectal obstruction		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
45990	Surg dx exam, anorectal	NI	T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
45999	Rectum surgery procedure		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46020	Placement of seton		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46030	Removal of rectal marker		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46040	Incision of rectal abscess		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46045	Incision of rectal abscess		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46050	Incision of anal abscess		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46060	Incision of rectal abscess		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46070	Incision of anal septum		T	0155	15.9499	$ 949.19		$ 189.84
46080	Incision of anal sphincter		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46083	Incise external hemorrhoid		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46200	Removal of anal fissure		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46210	Removal of anal crypt		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46211	Removal of anal crypts		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46220	Removal of anal tag		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46221	Ligation of hemorrhoid(s)		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46230	Removal of anal tags		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46250	Hemorrhoidectomy		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46255	Hemorrhoidectomy		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46257	Remove hemorrhoids & fissure		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46258	Remove hemorrhoids & fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46260	Hemorrhoidectomy		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46261	Remove hemorrhoids & fissure		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46262	Remove hemorrhoids & fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46270	Removal of anal fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46275	Removal of anal fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46280	Removal of anal fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46285	Removal of anal fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46288	Repair anal fistula		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46320	Removal of hemorrhoid clot		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46500	Injection into hemorrhoid(s)		T	0155	15.9499	$ 949.19		$ 189.84
46505	Chemodenervation anal musc	NI	T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46600	Diagnostic anoscopy		X	0340	0.6137	$ 36.52		$ 7.30
46604	Anoscopy and dilation		T	0147	7.9652	$ 474.02		$ 94.80
46606	Anoscopy and biopsy	CH	T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
46608	Anoscopy, remove for body		T	0147	7.9652	$ 474.02		$ 94.80
46610	Anoscopy, remove lesion	CH	T	0428	20.0871	$ 1,195.40		$ 239.08
46611	Anoscopy		T	0147	7.9652	$ 474.02		$ 94.80
46612	Anoscopy, remove lesions	CH	T	0428	20.0871	$ 1,195.40		$ 239.08
46614	Anoscopy, control bleeding	CH	T	0146	4.7086	$ 280.21	$ 64.40	$ 56.04
46615	Anoscopy	CH	T	0428	20.0871	$ 1,195.40		$ 239.08
46700	Repair of anal stricture		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46706	Repr of anal fistula w/glue		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46750	Repair of anal sphincter		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46753	Reconstruction of anus		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46754	Removal of suture from anus		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46760	Repair of anal sphincter		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46761	Repair of anal sphincter		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46762	Implant artificial sphincter		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46900	Destruction, anal lesion(s)		T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
46910	Destruction, anal lesion(s)		T	0017	17.9937	$ 1,070.82	$ 227.84	$ 214.16
46916	Cryosurgery, anal lesion(s)		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
46917	Laser surgery, anal lesions		T	0695	20.2372	$ 1,204.34	$ 266.59	$ 240.87
46922	Excision of anal lesion(s)		T	0695	20.2372	$ 1,204.34	$ 266.59	$ 240.87
46924	Destruction, anal lesion(s)		T	0695	20.2372	$ 1,204.34	$ 266.59	$ 240.87
46934	Destruction of hemorrhoids		T	0155	15.9499	$ 949.19		$ 189.84
46935	Destruction of hemorrhoids		T	0155	15.9499	$ 949.19		$ 189.84
46936	Destruction of hemorrhoids		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46937	Cryotherapy of rectal lesion		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46938	Cryotherapy of rectal lesion		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46940	Treatment of anal fissure		T	0149	18.0878	$ 1,076.42	$ 293.06	$ 215.28
46942	Treatment of anal fissure		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
46945	Ligation of hemorrhoids		T	0155	15.9499	$ 949.19		$ 189.84
46946	Ligation of hemorrhoids		T	0155	15.9499	$ 949.19		$ 189.84
46947	Hemorrhoidopexy by stapling		T	0150	23.8736	$ 1,420.74	$ 437.12	$ 284.15
46999	Anus surgery procedure		T	0148	3.5047	$ 208.57	$ 53.79	$ 41.71
47000	Needle biopsy of liver		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
47001	Needle biopsy, liver add-on		N					
47011	Percut drain, liver lesion		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
47370	Laparo ablate liver tumor rf	CH	T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
47371	Laparo ablate liver cryosurg		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
47379	Laparoscope procedure, liver		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
47382	Percut ablate liver rf		T	0423	39.5881	$ 2,355.93		$ 471.19
47399	Liver surgery procedure		T	0002	0.9357	$ 55.68		$ 11.14
47490	Incision of gallbladder		T	0152	18.2391	$ 1,085.43		$ 217.09
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	18.2391	$ 1,085.43		$ 217.09
47511	Insert bile duct drain		T	0152	18.2391	$ 1,085.43		$ 217.09
47525	Change bile duct catheter	CH	T	0427	10.0109	$ 595.76		$ 119.15
47530	Revise/reinsert bile tube	CH	T	0427	10.0109	$ 595.76		$ 119.15
47552	Biliary endoscopy thru skin		T	0152	18.2391	$ 1,085.43		$ 217.09
47553	Biliary endoscopy thru skin		T	0152	18.2391	$ 1,085.43		$ 217.09
47554	Biliary endoscopy thru skin		T	0152	18.2391	$ 1,085.43		$ 217.09
47555	Biliary endoscopy thru skin		T	0152	18.2391	$ 1,085.43		$ 217.09
47556	Biliary endoscopy thru skin		T	0152	18.2391	$ 1,085.43		$ 217.09
47560	Laparoscopy w/cholangio		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
47561	Laparo w/cholangio/biopsy		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
47562	Laparoscopic cholecystectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
47563	Laparo cholecystectomy/graph		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
47564	Laparo cholecystectomy/explr		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
47579	Laparoscope proc, biliary		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47630	Remove bile duct stone		T	0152	18.2391	$ 1,085.43		$ 217.09
47999	Bile tract surgery procedure		T	0152	18.2391	$ 1,085.43		$ 217.09
48102	Needle biopsy, pancreas		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
48511	Drain pancreatic pseudocyst		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
48999	Pancreas surgery procedure		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
49021	Drain abdominal abscess		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
49041	Drain, percut, abdom abscess		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
49061	Drain, percut, retroper absc		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
49080	Puncture, peritoneal cavity		T	0070	3.2141	$ 191.27		$ 38.25
49081	Removal of abdominal fluid		T	0070	3.2141	$ 191.27		$ 38.25
49085	Remove abdomen foreign body		T	0153	22.4936	$ 1,338.62	$ 397.95	$ 267.72
49180	Biopsy, abdominal mass		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
49200	Removal of abdominal lesion		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49250	Excision of umbilicus		T	0153	22.4936	$ 1,338.62	$ 397.95	$ 267.72
49320	Diag laparo separate proc		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49321	Laparoscopy, biopsy		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49322	Laparoscopy, aspiration		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49323	Laparo drain lymphocele		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49329	Laparo proc, abdm/per/oment		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49400	Air injection into abdomen		N					
49419	Insrt abdom cath for chemotx		T	0115	36.9806	$ 2,200.75	$ 459.35	$ 440.15
49420	Insert abdom drain, temp		T	0652	29.3648	$ 1,747.53		$ 349.51
49421	Insert abdom drain, perm		T	0652	29.3648	$ 1,747.53		$ 349.51
49422	Remove perm cannula/catheter		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
49423	Exchange drainage catheter	CH	T	0427	10.0109	$ 595.76		$ 119.15
49424	Assess cyst, contrast inject		N					
49426	Revise abdomen-venous shunt		T	0153	22.4936	$ 1,338.62	$ 397.95	$ 267.72
49427	Injection, abdominal shunt		N					
49429	Removal of shunt		T	0105	21.9865	$ 1,308.44	$ 370.40	$ 261.69
49491	Rpr hern preemie reduc		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49492	Rpr ing hern premie, blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49495	Rpr ing hernia baby, reduc		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49496	Rpr ing hernia baby, blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49500	Rpr ing hernia, init, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49501	Rpr ing hernia, init blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49505	Prp i/hern init reduc >5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49507	Prp i/hern init block >5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49520	Rerepair ing hernia, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49521	Rerepair ing hernia, blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49525	Repair ing hernia, sliding		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49540	Repair lumbar hernia		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49550	Rpr rem hernia, init, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49553	Rpr fem hernia, init blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49555	Rerepair fem hernia, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49557	Rerepair fem hernia, blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49560	Rpr ventral hern init, reduc		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49561	Rpr ventral hern init, block		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49565	Rerepair ventrl hern, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49566	Rerepair ventrl hern, block		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49568	Hernia repair w/mesh		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49570	Rpr epigastric hern, reduce		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49572	Rpr epigastric hern, blocked		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49580	Rpr umbil hern, reduc < 5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49582	Rpr umbil hern, block < 5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49585	Rpr umbil hern, reduc > 5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49587	Rpr umbil hern, block > 5 yr		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49590	Repair spigelian hernia		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49600	Repair umbilical lesion		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
49650	Laparo hernia repair initial		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
49651	Laparo hernia repair recur		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
49659	Laparo proc, hernia repair		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
49999	Abdomen surgery procedure		T	0153	22.4936	$ 1,338.62	$ 397.95	$ 267.72
50020	Renal abscess, open drain		T	0162	23.3383	$ 1,388.89		$ 277.78
50021	Renal abscess, percut drain		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
50080	Removal of kidney stone	CH	T	0429	42.0802	$ 2,504.23		$ 500.85
50081	Removal of kidney stone	CH	T	0429	42.0802	$ 2,504.23		$ 500.85
50200	Biopsy of kidney		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
50382	Change ureter stent, percut	NI	T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50384	Remove ureter stent, percut	NI	T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50387	Change ext/int ureter stent	NI	T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
50389	Remove renal tube w/fluoro	NI	T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
50390	Drainage of kidney lesion		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
50391	Instll rx agnt into rnal tub		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
50392	Insert kidney drain		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50393	Insert ureteral tube		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50396	Measure kidney pressure		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
50398	Change kidney tube		T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
50541	Laparo ablate renal cyst		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
50542	Laparo ablate renal mass	CH	T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
50543	Laparo partial nephrectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
50544	Laparoscopy, pyeloplasty		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
50549	Laparoscope proc, renal		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
50551	Kidney endoscopy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50553	Kidney endoscopy		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50555	Kidney endoscopy & biopsy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50557	Kidney endoscopy & treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
50559	Renal endoscopy/radiotracer		D					
50561	Kidney endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50562	Renal scope w/tumor resect		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50570	Kidney endoscopy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50572	Kidney endoscopy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50574	Kidney endoscopy & biopsy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50575	Kidney endoscopy		T	0163	33.5963	$ 1,999.35		$ 399.87
50576	Kidney endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50578	Renal endoscopy/radiotracer		D					
50590	Fragmenting of kidney stone		T	0169	42.4073	$ 2,523.70	$ 1,009.47	$ 504.74
50592	Perc rf ablate renal tumor	NI	T	0423	39.5881	$ 2,355.93		$ 471.19
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
50688	Change of ureter tube/stent		T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
50690	Injection for ureter x-ray		N					
50945	Laparoscopy ureterolithotomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
50947	Laparo new ureter/bladder		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
50948	Laparo new ureter/bladder		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
50949	Laparoscope proc, ureter		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
50951	Endoscopy of ureter		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50953	Endoscopy of ureter		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50955	Ureter endoscopy & biopsy		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50957	Ureter endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50959	Ureter endoscopy & tracer		D					
50961	Ureter endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50970	Ureter endoscopy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50972	Ureter endoscopy & catheter		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
50974	Ureter endoscopy & biopsy		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50976	Ureter endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
50978	Ureter endoscopy & tracer		D					
50980	Ureter endoscopy & treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
51000	Drainage of bladder		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51005	Drainage of bladder		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51010	Drainage of bladder		T	0165	16.5343	$ 983.97		$ 196.79
51020	Incise & treat bladder		T	0162	23.3383	$ 1,388.89		$ 277.78
51030	Incise & treat bladder		T	0162	23.3383	$ 1,388.89		$ 277.78
51040	Incise & drain bladder		T	0162	23.3383	$ 1,388.89		$ 277.78
51045	Incise bladder/drain ureter		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
51050	Removal of bladder stone		T	0162	23.3383	$ 1,388.89		$ 277.78
51065	Remove ureter calculus		T	0162	23.3383	$ 1,388.89		$ 277.78
51080	Drainage of bladder abscess	CH	T	0008	16.2953	$ 969.75		$ 193.95

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51500	Removal of bladder cyst		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
51520	Removal of bladder lesion		T	0162	23.3383	$ 1,388.89		$ 277.78
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51701	Insert bladder catheter	CH	X	0340	0.6137	$ 36.52		$ 7.30
51702	Insert temp bladder cath	CH	X	0340	0.6137	$ 36.52		$ 7.30
51703	Insert bladder cath, complex	CH	T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51705	Change of bladder tube		T	0121	2.2374	$ 133.15	$ 43.80	$ 26.63
51710	Change of bladder tube		T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
51715	Endoscopic injection/implant	CH	T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
51720	Treatment of bladder lesion		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
51725	Simple cystometrogram		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
51726	Complex cystometrogram		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
51736	Urine flow measurement		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51741	Electro-uroflowmetry, first		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51772	Urethra pressure profile	CH	T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
51784	Anal/urinary muscle study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51785	Anal/urinary muscle study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51792	Urinary reflex study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51795	Urine voiding pressure study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51797	Intraabdominal pressure test		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
51798	Us urine capacity measure		X	0340	0.6137	$ 36.52		$ 7.30
51880	Repair of bladder opening		T	0162	23.3383	$ 1,388.89		$ 277.78
51990	Laparo urethral suspension		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
51992	Laparo sling operation		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
51999	Laparoscope proc, bladder	NI	T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
52000	Cystoscopy		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
52001	Cystoscopy, removal of clots		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
52005	Cystoscopy & ureter catheter		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52007	Cystoscopy and biopsy		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52010	Cystoscopy & duct catheter		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
52204	Cystoscopy		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52214	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52224	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52234	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52235	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52240	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52250	Cystoscopy and radiotracer		T	0162	23.3383	$ 1,388.89		$ 277.78
52260	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52265	Cystoscopy and treatment		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
52270	Cystoscopy & revise urethra		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52275	Cystoscopy & revise urethra		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52276	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52277	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52281	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52282	Cystoscopy, implant stent		T	0163	33.5963	$ 1,999.35		$ 399.87
52283	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52285	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52290	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52300	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52301	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52305	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52310	Cystoscopy and treatment		T	0160	6.9387	$ 412.93	$ 105.06	$ 82.59
52315	Cystoscopy and treatment		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52317	Remove bladder stone		T	0162	23.3383	$ 1,388.89		$ 277.78
52318	Remove bladder stone		T	0162	23.3383	$ 1,388.89		$ 277.78
52320	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52325	Cystoscopy, stone removal		T	0162	23.3383	$ 1,388.89		$ 277.78
52327	Cystoscopy, inject material		T	0162	23.3383	$ 1,388.89		$ 277.78
52330	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52332	Cystoscopy and treatment		T	0162	23.3383	$ 1,388.89		$ 277.78
52334	Create passage to kidney		T	0162	23.3383	$ 1,388.89		$ 277.78
52341	Cysto w/ureter stricture tx		T	0162	23.3383	$ 1,388.89		$ 277.78
52342	Cysto w/up stricture tx		T	0162	23.3383	$ 1,388.89		$ 277.78
52343	Cysto w/renal stricture tx		T	0162	23.3383	$ 1,388.89		$ 277.78
52344	Cysto/uretero, stricture tx		T	0162	23.3383	$ 1,388.89		$ 277.78
52345	Cysto/uretero w/up stricture		T	0162	23.3383	$ 1,388.89		$ 277.78
52346	Cystouretero w/renal strict		T	0162	23.3383	$ 1,388.89		$ 277.78
52347	Cystoscopy, resect ducts		D					
52351	Cystouretero & or pyeloscope		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52352	Cystouretero w/stone remove		T	0162	23.3383	$ 1,388.89		$ 277.78
52353	Cystouretero w/lithotripsy		T	0163	33.5963	$ 1,999.35		$ 399.87
52354	Cystouretero w/biopsy		T	0162	23.3383	$ 1,388.89		$ 277.78
52355	Cystouretero w/excise tumor		T	0162	23.3383	$ 1,388.89		$ 277.78
52400	Cystouretero w/congen repr		T	0162	23.3383	$ 1,388.89		$ 277.78
52402	Cystourethro cut ejacul duct		T	0162	23.3383	$ 1,388.89		$ 277.78
52450	Incision of prostate		T	0162	23.3383	$ 1,388.89		$ 277.78
52500	Revision of bladder neck		T	0162	23.3383	$ 1,388.89		$ 277.78
52510	Dilation prostatic urethra		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
52601	Prostatectomy (TURP)		T	0163	33.5963	$ 1,999.35		$ 399.87
52606	Control postop bleeding		T	0162	23.3383	$ 1,388.89		$ 277.78
52612	Prostatectomy, first stage		T	0163	33.5963	$ 1,999.35		$ 399.87
52614	Prostatectomy, second stage		T	0163	33.5963	$ 1,999.35		$ 399.87
52620	Remove residual prostate		T	0163	33.5963	$ 1,999.35		$ 399.87

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52630	Remove prostate regrowth		T	0163	33.5963	$ 1,999.35		$ 399.87
52640	Relieve bladder contracture		T	0162	23.3383	$ 1,388.89		$ 277.78
52647	Laser surgery of prostate	CH	T	0429	42.0802	$ 2,504.23		$ 500.85
52648	Laser surgery of prostate	CH	T	0429	42.0802	$ 2,504.23		$ 500.85
52700	Drainage of prostate abscess		T	0162	23.3383	$ 1,388.89		$ 277.78
53000	Incision of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53010	Incision of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53020	Incision of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53025	Incision of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53040	Drainage of urethra abscess	CH	T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53060	Drainage of urethra abscess		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53080	Drainage of urinary leakage		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53085	Drainage of urinary leakage		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53200	Biopsy of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53210	Removal of urethra		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53215	Removal of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53220	Treatment of urethra lesion		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53230	Removal of urethra lesion		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53235	Removal of urethra lesion		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53240	Surgery for urethra pouch		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53250	Removal of urethra gland		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53260	Treatment of urethra lesion		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53265	Treatment of urethra lesion		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53270	Removal of urethra gland	CH	T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53275	Repair of urethra defect		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53400	Revise urethra, stage 1		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53405	Revise urethra, stage 2		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53410	Reconstruction of urethra		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53420	Reconstruct urethra, stage 1		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53425	Reconstruct urethra, stage 2		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53430	Reconstruction of urethra		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53431	Reconstruct urethra/bladder		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53440	Male sling procedure		S	0385	73.7498	$ 4,388.92		$ 877.78
53442	Remove/revise male sling	CH	T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53444	Insert tandem cuff		S	0385	73.7498	$ 4,388.92		$ 877.78
53445	Insert uro/ves nck sphincter		S	0386	126.9292	$ 7,553.68		$ 1,510.74
53446	Remove uro sphincter		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53447	Remove/replace ur sphincter		S	0386	126.9292	$ 7,553.68		$ 1,510.74
53449	Repair uro sphincter		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53450	Revision of urethra		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53460	Revision of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53500	Urethrlys, transvag w/ scope		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53502	Repair of urethra injury		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53505	Repair of urethra injury	CH	T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53510	Repair of urethra injury		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53515	Repair of urethra injury		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53520	Repair of urethra defect		T	0168	28.1985	$ 1,678.12	$ 388.16	$ 335.62
53600	Dilate urethra stricture		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
53601	Dilate urethra stricture		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
53605	Dilate urethra stricture		T	0161	18.5804	$ 1,105.74	$ 249.36	$ 221.15
53620	Dilate urethra stricture		T	0165	16.5343	$ 983.97		$ 196.79
53621	Dilate urethra stricture		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
53660	Dilation of urethra		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
53661	Dilation of urethra		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
53665	Dilation of urethra		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
53850	Prostatic microwave thermotx		T	0675	44.8197	$ 2,667.27		$ 533.45
53852	Prostatic rf thermotx		T	0675	44.8197	$ 2,667.27		$ 533.45
53853	Prostatic water thermother		T	0162	23.3383	$ 1,388.89		$ 277.78
53899	Urology surgery procedure		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
54000	Slitting of prepuce		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
54001	Slitting of prepuce		T	0166	17.7635	$ 1,057.12	$ 218.73	$ 211.42
54015	Drain penis lesion	CH	T	0008	16.2953	$ 969.75		$ 193.95
54050	Destruction, penis lesion(s)		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
54055	Destruction, penis lesion(s)		T	0017	17.9937	$ 1,070.82	$ 227.84	$ 214.16
54056	Cryosurgery, penis lesion(s)		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
54057	Laser surg, penis lesion(s)		T	0017	17.9937	$ 1,070.82	$ 227.84	$ 214.16
54060	Excision of penis lesion(s)		T	0017	17.9937	$ 1,070.82	$ 227.84	$ 214.16
54065	Destruction, penis lesion(s)		T	0695	20.2372	$ 1,204.34	$ 266.59	$ 240.87
54100	Biopsy of penis		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
54105	Biopsy of penis		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
54110	Treatment of penis lesion		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54111	Treat penis lesion, graft		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54112	Treat penis lesion, graft		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54115	Treatment of penis lesion		T	0008	16.2953	$ 969.75		$ 193.95
54120	Partial removal of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54150	Circumcision		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54152	Circumcision		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54160	Circumcision		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54161	Circumcision		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54162	Lysis penil circumic lesion		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54163	Repair of circumcision		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54164	Frenulotomy of penis		T	0180	19.7721	$ 1,176.66	$ 304.87	$ 235.33
54200	Treatment of penis lesion		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
54205	Treatment of penis lesion		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54220	Treatment of penis lesion		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
54230	Prepare penis study		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54231	Dynamic cavernosometry		T	0165	16.5343	$ 983.97		$ 196.79
54235	Penile injection		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
54240	Penis study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
54250	Penis study		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
54300	Revision of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54304	Revision of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54308	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54312	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54316	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54318	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54322	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54324	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54326	Reconstruction of urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54328	Revise penis/urethra		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54340	Secondary urethral surgery		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54344	Secondary urethral surgery		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54348	Secondary urethral surgery		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54352	Reconstruct urethra/penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54360	Penis plastic surgery		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54380	Repair penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54385	Repair penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54400	Insert semi-rigid prosthesis		S	0385	73.7498	$ 4,388.92		$ 877.78
54401	Insert self-contd prosthesis		S	0386	126.9292	$ 7,553.68		$ 1,510.74
54405	Insert multi-comp penis pros		S	0386	126.9292	$ 7,553.68		$ 1,510.74
54406	Remove muti-comp penis pros		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54408	Repair multi-comp penis pros		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54410	Remove/replace penis prosth		S	0386	126.9292	$ 7,553.68		$ 1,510.74
54415	Remove self-contd penis pros		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54416	Remv/repl penis contain pros		S	0386	126.9292	$ 7,553.68		$ 1,510.74
54420	Revision of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54435	Revision of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54440	Repair of penis		T	0181	30.9472	$ 1,841.70	$ 621.82	$ 368.34
54450	Preputial stretching		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
54500	Biopsy of testis		T	0037	9.6103	$ 571.92	$ 228.76	$ 114.38
54505	Biopsy of testis		T	0183	23.3500	$ 1,389.58		$ 277.92
54512	Excise lesion testis		T	0183	23.3500	$ 1,389.58		$ 277.92
54520	Removal of testis		T	0183	23.3500	$ 1,389.58		$ 277.92
54522	Orchiectomy, partial		T	0183	23.3500	$ 1,389.58		$ 277.92
54530	Removal of testis		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
54550	Exploration for testis		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
54560	Exploration for testis	CH	T	0183	23.3500	$ 1,389.58		$ 277.92
54600	Reduce testis torsion		T	0183	23.3500	$ 1,389.58		$ 277.92
54620	Suspension of testis		T	0183	23.3500	$ 1,389.58		$ 277.92

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54640	Suspension of testis		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
54660	Revision of testis		T	0183	23.3500	$ 1,389.58		$ 277.92
54670	Repair testis injury		T	0183	23.3500	$ 1,389.58		$ 277.92
54680	Relocation of testis(es)		T	0183	23.3500	$ 1,389.58		$ 277.92
54690	Laparoscopy, orchiectomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
54692	Laparoscopy, orchiopexy		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
54699	Laparoscope proc, testis		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
54700	Drainage of scrotum		T	0183	23.3500	$ 1,389.58		$ 277.92
54800	Biopsy of epididymis		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
54820	Exploration of epididymis		T	0183	23.3500	$ 1,389.58		$ 277.92
54830	Remove epididymis lesion		T	0183	23.3500	$ 1,389.58		$ 277.92
54840	Remove epididymis lesion		T	0183	23.3500	$ 1,389.58		$ 277.92
54860	Removal of epididymis		T	0183	23.3500	$ 1,389.58		$ 277.92
54861	Removal of epididymis		T	0183	23.3500	$ 1,389.58		$ 277.92
54900	Fusion of spermatic ducts		T	0183	23.3500	$ 1,389.58		$ 277.92
54901	Fusion of spermatic ducts		T	0183	23.3500	$ 1,389.58		$ 277.92
55000	Drainage of hydrocele		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
55040	Removal of hydrocele		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
55041	Removal of hydroceles		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
55060	Repair of hydrocele		T	0183	23.3500	$ 1,389.58		$ 277.92
55100	Drainage of scrotum abscess	CH	T	0008	16.2953	$ 969.75		$ 193.95
55110	Explore scrotum		T	0183	23.3500	$ 1,389.58		$ 277.92
55120	Removal of scrotum lesion		T	0183	23.3500	$ 1,389.58		$ 277.92
55150	Removal of scrotum		T	0183	23.3500	$ 1,389.58		$ 277.92
55175	Revision of scrotum		T	0183	23.3500	$ 1,389.58		$ 277.92
55180	Revision of scrotum		T	0183	23.3500	$ 1,389.58		$ 277.92
55200	Incision of sperm duct		T	0183	23.3500	$ 1,389.58		$ 277.92
55250	Removal of sperm duct(s)		T	0183	23.3500	$ 1,389.58		$ 277.92
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.3500	$ 1,389.58		$ 277.92
55450	Ligation of sperm duct		T	0183	23.3500	$ 1,389.58		$ 277.92
55500	Removal of hydrocele		T	0183	23.3500	$ 1,389.58		$ 277.92
55520	Removal of sperm cord lesion		T	0183	23.3500	$ 1,389.58		$ 277.92
55530	Revise spermatic cord veins		T	0183	23.3500	$ 1,389.58		$ 277.92
55535	Revise spermatic cord veins		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
55540	Revise hernia & sperm veins		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
55550	Laparo ligate spermatic vein		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
55559	Laparo proc, spermatic cord		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
55600	Incise sperm duct pouch	CH	T	0183	23.3500	$ 1,389.58		$ 277.92
55680	Remove sperm pouch lesion		T	0183	23.3500	$ 1,389.58		$ 277.92
55700	Biopsy of prostate		T	0184	4.4432	$ 264.42	$ 96.27	$ 52.88
55705	Biopsy of prostate		T	0184	4.4432	$ 264.42	$ 96.27	$ 52.88
55720	Drainage of prostate abscess		T	0162	23.3383	$ 1,388.89		$ 277.78

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55725	Drainage of prostate abscess		T	0162	23.3383	$ 1,388.89		$ 277.78
55859	Percut/needle insert, pros		T	0163	33.5963	$ 1,999.35		$ 399.87
55860	Surgical exposure, prostate		T	0165	16.5343	$ 983.97		$ 196.79
55870	Electroejaculation		T	0197	3.0721	$ 182.82		$ 36.56
55873	Cryoablate prostate		T	0674	111.3747	$ 6,628.02		$ 1,325.60
55899	Genital surgery procedure		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
56405	I & D of vulva/perineum	CH	T	0189	2.3805	$ 141.67		$ 28.33
56420	Drainage of gland abscess		T	0189	2.3805	$ 141.67		$ 28.33
56440	Surgery for vulva lesion		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
56441	Lysis of labial lesion(s)		T	0193	14.6385	$ 871.15		$ 174.23
56501	Destroy, vulva lesions, sim		T	0017	17.9937	$ 1,070.82	$ 227.84	$ 214.16
56515	Destroy vulva lesion/s compl		T	0695	20.2372	$ 1,204.34	$ 266.59	$ 240.87
56605	Biopsy of vulva/perineum		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
56606	Biopsy of vulva/perineum		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
56620	Partial removal of vulva		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
56625	Complete removal of vulva		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
56700	Partial removal of hymen		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
56720	Incision of hymen		T	0193	14.6385	$ 871.15		$ 174.23
56740	Remove vagina gland lesion		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
56800	Repair of vagina		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
56805	Repair clitoris	CH	T	0193	14.6385	$ 871.15		$ 174.23
56810	Repair of perineum		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
56820	Exam of vulva w/scope		T	0188	1.2615	$ 75.07		$ 15.01
56821	Exam/biopsy of vulva w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57000	Exploration of vagina	CH	T	0193	14.6385	$ 871.15		$ 174.23
57010	Drainage of pelvic abscess	CH	T	0193	14.6385	$ 871.15		$ 174.23
57020	Drainage of pelvic fluid		T	0192	4.1597	$ 247.55		$ 49.51
57022	I & d vaginal hematoma, pp		T	0007	11.6717	$ 694.59		$ 138.92
57023	I & d vag hematoma, non-ob	CH	T	0008	16.2953	$ 969.75		$ 193.95
57061	Destroy vag lesions, simple		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57065	Destroy vag lesions, complex		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57100	Biopsy of vagina		T	0192	4.1597	$ 247.55		$ 49.51
57105	Biopsy of vagina		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57106	Remove vagina wall, partial		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57107	Remove vagina tissue, part		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57109	Vaginectomy partial w/nodes		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57120	Closure of vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57130	Remove vagina lesion		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57135	Remove vagina lesion		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57150	Treat vagina infection		T	0191	0.1702	$ 10.13	$ 2.85	$ 2.03
57155	Insert uteri tandems/ovoids	CH	T	0192	4.1597	$ 247.55		$ 49.51
57160	Insert pessary/other device		T	0188	1.2615	$ 75.07		$ 15.01
57170	Fitting of diaphragm/cap		T	0191	0.1702	$ 10.13	$ 2.85	$ 2.03

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57180	Treat vaginal bleeding		T	0189	2.3805	$ 141.67		$ 28.33
57200	Repair of vagina		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57210	Repair vagina/perineum		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57220	Revision of urethra		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57230	Repair of urethral lesion		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57240	Repair bladder & vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57250	Repair rectum & vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57260	Repair of vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57265	Extensive repair of vagina		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57267	Insert mesh/pelvic flr addon		T	0154	28.6432	$ 1,704.59	$ 464.85	$ 340.92
57268	Repair of bowel bulge		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57284	Repair paravaginal defect		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57287	Revise/remove sling repair		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57288	Repair bladder defect		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57289	Repair bladder & vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57291	Construction of vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57295	Change vaginal graft	NI	T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57300	Repair rectum-vagina fistula		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57310	Repair urethrovaginal lesion		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57320	Repair bladder-vagina lesion		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57330	Repair bladder-vagina lesion		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57400	Dilation of vagina		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57410	Pelvic examination	CH	T	0193	14.6385	$ 871.15		$ 174.23
57415	Remove vaginal foreign body		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57420	Exam of vagina w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57421	Exam/biopsy of vag w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57425	Laparoscopy, surg, colpopexy		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
57452	Exam of cervix w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57454	Bx/curett of cervix w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57455	Biopsy of cervix w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57456	Endocerv curettage w/scope		T	0189	2.3805	$ 141.67		$ 28.33
57460	Bx of cervix w/scope, leep		T	0193	14.6385	$ 871.15		$ 174.23
57461	Conz of cervix w/scope, leep		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57500	Biopsy of cervix		T	0192	4.1597	$ 247.55		$ 49.51
57505	Endocervical curettage		T	0189	2.3805	$ 141.67		$ 28.33
57510	Cauterization of cervix		T	0193	14.6385	$ 871.15		$ 174.23
57511	Cryocautery of cervix		T	0189	2.3805	$ 141.67		$ 28.33
57513	Laser surgery of cervix		T	0193	14.6385	$ 871.15		$ 174.23
57520	Conization of cervix		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57522	Conization of cervix		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57530	Removal of cervix		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57550	Removal of residual cervix		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
57555	Remove cervix/repair vagina		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57556	Remove cervix, repair bowel		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
57700	Revision of cervix		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57720	Revision of cervix		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
57800	Dilation of cervical canal		T	0193	14.6385	$ 871.15		$ 174.23
57820	D & c of residual cervix		T	0196	17.0012	$ 1,011.76	$ 338.23	$ 202.35
58100	Biopsy of uterus lining		T	0188	1.2615	$ 75.07		$ 15.01
58110	Bx done w/colposcopy add-on	NI	T	0188	1.2615	$ 75.07		$ 15.01
58120	Dilation and curettage		T	0196	17.0012	$ 1,011.76	$ 338.23	$ 202.35
58145	Myomectomy vag method		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58301	Remove intrauterine device		T	0189	2.3805	$ 141.67		$ 28.33
58321	Artificial insemination		T	0197	3.0721	$ 182.82		$ 36.56
58322	Artificial insemination		T	0197	3.0721	$ 182.82		$ 36.56
58323	Sperm washing		T	0197	3.0721	$ 182.82		$ 36.56
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube	CH	T	0193	14.6385	$ 871.15		$ 174.23
58346	Insert heyman uteri capsule		T	0193	14.6385	$ 871.15		$ 174.23
58350	Reopen fallopian tube		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58353	Endometr ablate, thermal		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58356	Endometrial cryoablation		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
58545	Laparoscopic myomectomy		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
58546	Laparo-myomectomy, complex		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58550	Laparo-asst vag hysterectomy		T	0132	63.6859	$ 3,790.01	$ 1,239.22	$ 758.00
58552	Laparo-vag hyst incl t/o		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58553	Laparo-vag hyst, complex		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58554	Laparo-vag hyst w/t/o, compl		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58555	Hysteroscopy, dx, sep proc		T	0190	20.9198	$ 1,244.96	$ 424.28	$ 248.99
58558	Hysteroscopy, biopsy		T	0190	20.9198	$ 1,244.96	$ 424.28	$ 248.99
58559	Hysteroscopy, lysis		T	0190	20.9198	$ 1,244.96	$ 424.28	$ 248.99
58560	Hysteroscopy, resect septum		T	0387	32.3170	$ 1,923.22	$ 655.55	$ 384.64
58561	Hysteroscopy, remove myoma		T	0387	32.3170	$ 1,923.22	$ 655.55	$ 384.64
58562	Hysteroscopy, remove fb		T	0190	20.9198	$ 1,244.96	$ 424.28	$ 248.99
58563	Hysteroscopy, ablation		T	0387	32.3170	$ 1,923.22	$ 655.55	$ 384.64
58565	Hysteroscopy, sterilization		T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
58578	Laparo proc, uterus		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
58579	Hysteroscope procedure		T	0190	20.9198	$ 1,244.96	$ 424.28	$ 248.99
58600	Division of fallopian tube		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58615	Occlude fallopian tube(s)		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
58660	Laparoscopy, lysis		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58661	Laparoscopy, remove adnexa		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58662	Laparoscopy, excise lesions		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58670	Laparoscopy, tubal cautery		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58671	Laparoscopy, tubal block		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58672	Laparoscopy, fimbrioplasty		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58673	Laparoscopy, salpingostomy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
58679	Laparo proc, oviduct-ovary		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
58770	Create new tubal opening		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58800	Drainage of ovarian cyst(s)		T	0193	14.6385	$ 871.15		$ 174.23
58820	Drain ovary abscess, open		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58823	Drain pelvic abscess, percut		T	0193	14.6385	$ 871.15		$ 174.23
58900	Biopsy of ovary(s)		T	0193	14.6385	$ 871.15		$ 174.23
58920	Partial removal of ovary(s)		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58925	Removal of ovarian cyst(s)		T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
58970	Retrieval of oocyte	CH	T	0197	3.0721	$ 182.82		$ 36.56
58974	Transfer of embryo		T	0197	3.0721	$ 182.82		$ 36.56
58976	Transfer of embryo		T	0197	3.0721	$ 182.82		$ 36.56
58999	Genital surgery procedure		T	0191	0.1702	$ 10.13	$ 2.85	$ 2.03
59000	Amniocentesis, diagnostic		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59001	Amniocentesis, therapeutic	CH	T	0192	4.1597	$ 247.55		$ 49.51
59012	Fetal cord puncture,prenatal		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59015	Chorion biopsy		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59020	Fetal contract stress test	CH	T	0192	4.1597	$ 247.55		$ 49.51
59025	Fetal non-stress test		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59030	Fetal scalp blood sample		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59070	Transabdom amnioinfus w/us		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59072	Umbilical cord occlud w/us		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59074	Fetal fluid drainage w/us		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59076	Fetal shunt placement, w/us		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59100	Remove uterus lesion	CH	T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
59150	Treat ectopic pregnancy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
59151	Treat ectopic pregnancy		T	0131	43.0498	$ 2,561.94	$ 1,001.89	$ 512.39
59160	D & c after delivery		T	0196	17.0012	$ 1,011.76	$ 338.23	$ 202.35
59200	Insert cervical dilator		T	0189	2.3805	$ 141.67		$ 28.33
59300	Episiotomy or vaginal repair		T	0193	14.6385	$ 871.15		$ 174.23
59320	Revision of cervix		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
59409	Obstetrical care		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
59412	Antepartum manipulation		T	0700	4.1398	$ 246.36		$ 49.27
59414	Deliver placenta	CH	T	0193	14.6385	$ 871.15		$ 174.23
59612	Vbac delivery only		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87
59812	Treatment of miscarriage		T	0201	17.4749	$ 1,039.95	$ 329.65	$ 207.99
59820	Care of miscarriage		T	0201	17.4749	$ 1,039.95	$ 329.65	$ 207.99
59821	Treatment of miscarriage		T	0201	17.4749	$ 1,039.95	$ 329.65	$ 207.99
59840	Abortion		T	0200	18.9518	$ 1,127.84	$ 263.69	$ 225.57
59841	Abortion		T	0200	18.9518	$ 1,127.84	$ 263.69	$ 225.57
59866	Abortion (mpr)		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59870	Evacuate mole of uterus		T	0201	17.4749	$ 1,039.95	$ 329.65	$ 207.99
59871	Remove cerclage suture		T	0194	20.6573	$ 1,229.34	$ 397.84	$ 245.87

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59897	Fetal invas px w/us		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
59898	Laparo proc, ob care/deliver		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
59899	Maternity care procedure		T	0198	1.3622	$ 81.07	$ 32.19	$ 16.21
60000	Drain thyroid/tongue cyst		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
60001	Aspirate/inject thyriod cyst		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
60100	Biopsy of thyroid		T	0004	1.7771	$ 105.76	$ 22.36	$ 21.15
60200	Remove thyroid lesion		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60210	Partial thyroid excision		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60212	Partial thyroid excision		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60220	Partial removal of thyroid		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60225	Partial removal of thyroid		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60240	Removal of thyroid		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60252	Removal of thyroid		T	0256	37.0000	$ 2,201.91		$ 440.38
60260	Repeat thyroid surgery		T	0256	37.0000	$ 2,201.91		$ 440.38
60280	Remove thyroid duct lesion		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60281	Remove thyroid duct lesion		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
60500	Explore parathyroid glands		T	0256	37.0000	$ 2,201.91		$ 440.38
60512	Autotransplant parathyroid		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
60659	Laparo proc, endocrine		T	0130	31.8753	$ 1,896.93	$ 659.53	$ 379.39
60699	Endocrine surgery procedure		T	0114	40.4596	$ 2,407.79	$ 485.91	$ 481.56
61000	Remove cranial cavity fluid		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61001	Remove cranial cavity fluid		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61020	Remove brain cavity fluid		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61026	Injection into brain canal		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61050	Remove brain canal fluid		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61055	Injection into brain canal		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61070	Brain canal shunt procedure		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
61215	Insert brain-fluid device		T	0224	41.1421	$ 2,448.41		$ 489.68
61330	Decompress eye socket		T	0256	37.0000	$ 2,201.91		$ 440.38
61334	Explore orbit/remove object	CH	T	0256	37.0000	$ 2,201.91		$ 440.38
61623	Endovasc tempory vessel occl	CH	T	0081	42.2664	$ 2,515.32		$ 503.06
61626	Transcath occlusion, non-cns		T	0081	42.2664	$ 2,515.32		$ 503.06
61790	Treat trigeminal nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
61791	Treat trigeminal tract		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
61795	Brain surgery using computer		S	0302	4.6992	$ 279.65	$ 105.94	$ 55.93
61880	Revise/remove neuroelectrode		T	0687	19.1962	$ 1,142.39	$ 456.95	$ 228.48
61885	Insrt/redo neurostim 1 array		S	0039	194.9690	$11,602.80		$ 2,320.56
61886	Implant neurostim arrays		T	0315	312.3876	$18,590.50		$ 3,718.10
61888	Revise/remove neuroreceiver		T	0688	42.8588	$ 2,550.57	$ 1,020.22	$ 510.11
62160	Neuroendoscopy add-on	CH	T	0122	6.9179	$ 411.69	$ 84.43	$ 82.34
62194	Replace/irrigate catheter	CH	T	0427	10.0109	$ 595.76		$ 119.15
62225	Replace/irrigate catheter	CH	T	0427	10.0109	$ 595.76		$ 119.15
62230	Replace/revise brain shunt		T	0224	41.1421	$ 2,448.41		$ 489.68

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62252	Csf shunt reprogram		S	0691	2.5464	$ 151.54	$ 60.61	$ 30.31
62263	Epidural lysis mult sessions		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
62264	Epidural lysis on single day		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
62268	Drain spinal cord cyst		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
62269	Needle biopsy, spinal cord		T	0685	6.0034	$ 357.27	$ 115.47	$ 71.45
62270	Spinal fluid tap, diagnostic		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
62272	Drain cerebro spinal fluid		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
62273	Inject epidural patch		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
62280	Treat spinal cord lesion		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62281	Treat spinal cord lesion		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62282	Treat spinal canal lesion		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
62294	Injection into spinal artery		T	0212	2.7712	$ 164.92	$ 65.96	$ 32.98
62310	Inject spine c/t		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62311	Inject spine l/s (cd)		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62318	Inject spine w/cath, c/t		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62319	Inject spine w/cath l/s (cd)		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
62350	Implant spinal canal cath		T	0223	28.5636	$ 1,699.85		$ 339.97
62351	Implant spinal canal cath		T	0208	42.5200	$ 2,530.41		$ 506.08
62355	Remove spinal canal catheter		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
62360	Insert spine infusion device		T	0226	72.5804	$ 4,319.33		$ 863.87
62361	Implant spine infusion pump		T	0227	155.0431	$ 9,226.77		$ 1,845.35
62362	Implant spine infusion pump		T	0227	155.0431	$ 9,226.77		$ 1,845.35
62365	Remove spine infusion device		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
62367	Analyze spine infusion pump		S	0691	2.5464	$ 151.54	$ 60.61	$ 30.31
62368	Analyze spine infusion pump		S	0691	2.5464	$ 151.54	$ 60.61	$ 30.31
63001	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63003	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63005	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63011	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63012	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63015	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63016	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63017	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63020	Neck spine disk surgery		T	0208	42.5200	$ 2,530.41		$ 506.08
63030	Low back disk surgery		T	0208	42.5200	$ 2,530.41		$ 506.08
63035	Spinal disk surgery add-on		T	0208	42.5200	$ 2,530.41		$ 506.08
63040	Laminotomy, single cervical		T	0208	42.5200	$ 2,530.41		$ 506.08
63042	Laminotomy, single lumbar		T	0208	42.5200	$ 2,530.41		$ 506.08

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63045	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63046	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63047	Removal of spinal lamina		T	0208	42.5200	$ 2,530.41		$ 506.08
63048	Remove spinal lamina add-on		T	0208	42.5200	$ 2,530.41		$ 506.08
63055	Decompress spinal cord		T	0208	42.5200	$ 2,530.41		$ 506.08
63056	Decompress spinal cord		T	0208	42.5200	$ 2,530.41		$ 506.08
63057	Decompress spine cord add-on		T	0208	42.5200	$ 2,530.41		$ 506.08
63064	Decompress spinal cord		T	0208	42.5200	$ 2,530.41		$ 506.08
63066	Decompress spine cord add-on		T	0208	42.5200	$ 2,530.41		$ 506.08
63075	Neck spine disk surgery	CH	T	0208	42.5200	$ 2,530.41		$ 506.08
63600	Remove spinal cord lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
63610	Stimulation of spinal cord		T	0220	17.3203	$ 1,030.75		$ 206.15
63615	Remove lesion of spinal cord		T	0220	17.3203	$ 1,030.75		$ 206.15
63650	Implant neuroelectrodes		S	0040	50.8322	$ 3,025.08		$ 605.02
63655	Implant neuroelectrodes	CH	S	0061	93.4063	$ 5,558.70		$ 1,111.74
63660	Revise/remove neuroelectrode		T	0687	19.1962	$ 1,142.39	$ 456.95	$ 228.48
63685	Insrt/redo spine n generator		T	0222	192.4950	$11,455.57		$ 2,291.11
63688	Revise/remove neuroreceiver		T	0688	42.8588	$ 2,550.57	$ 1,020.22	$ 510.11
63741	Install spinal shunt		T	0228	46.4126	$ 2,762.06		$ 552.41
63744	Revision of spinal shunt		T	0228	46.4126	$ 2,762.06		$ 552.41
63746	Removal of spinal shunt		T	0109	11.1714	$ 664.82		$ 132.96
64400	N block inj, trigeminal		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64402	N block inj, facial		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64405	N block inj, occipital		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64408	N block inj, vagus		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64410	N block inj, phrenic		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64412	N block inj, spinal accessor		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64413	N block inj, cervical plexus		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64415	N block inj, brachial plexus		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64416	N block cont infuse, b plex		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64417	N block inj, axillary		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64418	N block inj, suprascapular		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64420	N block inj, intercost, sng		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64421	N block inj, intercost, mlt		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64425	N block inj, ilio-ing/hypogi		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64430	N block inj, pudendal		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64435	N block inj, paracervical		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64445	N block inj, sciatic, sng		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64446	N blk inj, sciatic, cont inf		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64447	N block inj fem, single		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64448	N block inj fem, cont inf		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64449	N block inj, lumbar plexus		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64450	N block, other peripheral		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64470	Inj paravertebral c/t		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64472	Inj paravertebral c/t add-on		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64475	Inj paravertebral l/s		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64476	Inj paravertebral l/s add-on		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64479	Inj foramen epidural c/t		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64480	Inj foramen epidural add-on		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64483	Inj foramen epidural l/s		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64484	Inj foramen epidural add-on		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64505	N block, spenopalatine gangl		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64508	N block, carotid sinus s/p		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64510	N block, stellate ganglion		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64517	N block inj, hypogas plxs		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64520	N block, lumbar/thoracic		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64530	N block inj, celiac pelus		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64553	Implant neuroelectrodes		S	0225	250.8484	$14,928.24		$ 2,985.65
64555	Implant neuroelectrodes		S	0040	50.8322	$ 3,025.08		$ 605.02
64560	Implant neuroelectrodes		S	0040	50.8322	$ 3,025.08		$ 605.02
64561	Implant neuroelectrodes		S	0040	50.8322	$ 3,025.08		$ 605.02
64565	Implant neuroelectrodes		S	0040	50.8322	$ 3,025.08		$ 605.02
64573	Implant neuroelectrodes		S	0225	250.8484	$14,928.24		$ 2,985.65
64575	Implant neuroelectrodes	CH	S	0061	93.4063	$ 5,558.70		$ 1,111.74
64577	Implant neuroelectrodes	CH	S	0061	93.4063	$ 5,558.70		$ 1,111.74
64580	Implant neuroelectrodes	CH	S	0061	93.4063	$ 5,558.70		$ 1,111.74
64581	Implant neuroelectrodes	CH	S	0061	93.4063	$ 5,558.70		$ 1,111.74
64585	Revise/remove neuroelectrode		T	0687	19.1962	$ 1,142.39	$ 456.95	$ 228.48
64590	Insrt/redo perph n generator		T	0222	192.4950	$11,455.57		$ 2,291.11
64595	Revise/remove neuroreceiver		T	0688	42.8588	$ 2,550.57	$ 1,020.22	$ 510.11
64600	Injection treatment of nerve		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64605	Injection treatment of nerve		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64610	Injection treatment of nerve		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64612	Destroy nerve, face muscle		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64613	Destroy nerve, neck muscle		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64614	Destroy nerve, extrem musc		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64620	Injection treatment of nerve		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64622	Destr paravertebrl nerve l/s		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64623	Destr paravertebral n add-on		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64626	Destr paravertebrl nerve c/t		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64627	Destr paravertebral n add-on		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58
64630	Injection treatment of nerve		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64640	Injection treatment of nerve		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
64650	Chemodenerv eccrine glands	NI	T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64653	Chemodenerv eccrine glands	NI	T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
64680	Injection treatment of nerve		T	0207	6.0140	$ 357.90	$ 86.92	$ 71.58

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64681	Injection treatment of nerve		T	0203	10.0965	$ 600.85	$ 240.33	$ 120.17
64702	Revise finger/toe nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64704	Revise hand/foot nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64708	Revise arm/leg nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64712	Revision of sciatic nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64713	Revision of arm nerve(s)		T	0220	17.3203	$ 1,030.75		$ 206.15
64714	Revise low back nerve(s)		T	0220	17.3203	$ 1,030.75		$ 206.15
64716	Revision of cranial nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64718	Revise ulnar nerve at elbow		T	0220	17.3203	$ 1,030.75		$ 206.15
64719	Revise ulnar nerve at wrist		T	0220	17.3203	$ 1,030.75		$ 206.15
64721	Carpal tunnel surgery		T	0220	17.3203	$ 1,030.75		$ 206.15
64722	Relieve pressure on nerve(s)		T	0220	17.3203	$ 1,030.75		$ 206.15
64726	Release foot/toe nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64727	Internal nerve revision		T	0220	17.3203	$ 1,030.75		$ 206.15
64732	Incision of brow nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64734	Incision of cheek nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64736	Incision of chin nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64738	Incision of jaw nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64740	Incision of tongue nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64742	Incision of facial nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64744	Incise nerve, back of head		T	0220	17.3203	$ 1,030.75		$ 206.15
64746	Incise diaphragm nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64761	Incision of pelvis nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64763	Incise hip/thigh nerve	CH	T	0220	17.3203	$ 1,030.75		$ 206.15
64766	Incise hip/thigh nerve	CH	T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64771	Sever cranial nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64772	Incision of spinal nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64774	Remove skin nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64776	Remove digit nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64778	Digit nerve surgery add-on		T	0220	17.3203	$ 1,030.75		$ 206.15
64782	Remove limb nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64783	Limb nerve surgery add-on		T	0220	17.3203	$ 1,030.75		$ 206.15
64784	Remove nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64786	Remove sciatic nerve lesion		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64787	Implant nerve end		T	0220	17.3203	$ 1,030.75		$ 206.15
64788	Remove skin nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64790	Removal of nerve lesion		T	0220	17.3203	$ 1,030.75		$ 206.15
64792	Removal of nerve lesion		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64795	Biopsy of nerve		T	0220	17.3203	$ 1,030.75		$ 206.15
64802	Remove sympathetic nerves		T	0220	17.3203	$ 1,030.75		$ 206.15
64820	Remove sympathetic nerves		T	0220	17.3203	$ 1,030.75		$ 206.15
64821	Remove sympathetic nerves		T	0054	25.1321	$ 1,495.64		$ 299.13
64822	Remove sympathetic nerves		T	0054	25.1321	$ 1,495.64		$ 299.13

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64823	Remove sympathetic nerves		T	0054	25.1321	$ 1,495.64		$ 299.13
64831	Repair of digit nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64832	Repair nerve add-on		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64834	Repair of hand or foot nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64835	Repair of hand or foot nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64836	Repair of hand or foot nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64837	Repair nerve add-on		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64840	Repair of leg nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64856	Repair/transpose nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64857	Repair arm/leg nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64858	Repair sciatic nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64859	Nerve surgery		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64861	Repair of arm nerves		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64862	Repair of low back nerves		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64864	Repair of facial nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64865	Repair of facial nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64870	Fusion of facial/other nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64872	Subsequent repair of nerve		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64874	Repair & revise nerve add-on		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64876	Repair nerve/shorten bone		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64885	Nerve graft, head or neck		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64886	Nerve graft, head or neck		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64890	Nerve graft, hand or foot		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64891	Nerve graft, hand or foot		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64892	Nerve graft, arm or leg		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64893	Nerve graft, arm or leg		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64895	Nerve graft, hand or foot		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64896	Nerve graft, hand or foot		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64897	Nerve graft, arm or leg		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64898	Nerve graft, arm or leg		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64901	Nerve graft add-on		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64902	Nerve graft add-on		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64905	Nerve pedicle transfer		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64907	Nerve pedicle transfer		T	0221	31.0536	$ 1,848.03	$ 463.62	$ 369.61
64999	Nervous system surgery		T	0204	2.2667	$ 134.89	$ 40.13	$ 26.98
65091	Revise eye		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65093	Revise eye with implant		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
65101	Removal of eye		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65103	Remove eye/insert implant		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65105	Remove eye/attach implant		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65110	Removal of eye		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65112	Remove eye/revise socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65114	Remove eye/revise socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65125	Revise ocular implant		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
65130	Insert ocular implant		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
65135	Insert ocular implant		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
65140	Attach ocular implant		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65150	Revise ocular implant		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
65155	Reinsert ocular implant		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
65175	Removal of ocular implant		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
65205	Remove foreign body from eye		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
65210	Remove foreign body from eye		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
65220	Remove foreign body from eye		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
65222	Remove foreign body from eye		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
65235	Remove foreign body from eye		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65260	Remove foreign body from eye		T	0236	16.9771	$ 1,010.32		$ 202.06
65265	Remove foreign body from eye	CH	T	0237	28.7866	$ 1,713.12		$ 342.62
65270	Repair of eye wound		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
65272	Repair of eye wound		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65275	Repair of eye wound		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65280	Repair of eye wound		T	0236	16.9771	$ 1,010.32		$ 202.06
65285	Repair of eye wound	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
65286	Repair of eye wound		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
65290	Repair of eye socket wound		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
65400	Removal of eye lesion		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65410	Biopsy of cornea		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65420	Removal of eye lesion		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65426	Removal of eye lesion		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65430	Corneal smear	CH	S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
65435	Curette/treat cornea		T	0239	7.0583	$ 420.05		$ 84.01
65436	Curette/treat cornea		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65450	Treatment of corneal lesion		S	0231	1.9167	$ 114.06		$ 22.81
65600	Revision of cornea		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
65710	Corneal transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65730	Corneal transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65750	Corneal transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65755	Corneal transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65770	Revise cornea with implant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65772	Correction of astigmatism		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65775	Correction of astigmatism		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65780	Ocular reconst, transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65781	Ocular reconst, transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65782	Ocular reconst, transplant		T	0244	38.2309	$ 2,275.16	$ 803.26	$ 455.03
65800	Drainage of eye		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65805	Drainage of eye		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65810	Drainage of eye		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65815	Drainage of eye		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65820	Relieve inner eye pressure		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
65850	Incision of eye		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65855	Laser surgery of eye		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
65860	Incise inner eye adhesions		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
65865	Incise inner eye adhesions		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65870	Incise inner eye adhesions		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65875	Incise inner eye adhesions		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65880	Incise inner eye adhesions		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65900	Remove eye lesion		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
65920	Remove implant of eye		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
65930	Remove blood clot from eye		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66020	Injection treatment of eye		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66030	Injection treatment of eye		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66130	Remove eye lesion		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66150	Glaucoma surgery		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66155	Glaucoma surgery		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66160	Glaucoma surgery		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66165	Glaucoma surgery		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66170	Glaucoma surgery		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66172	Incision of eye		T	0673	29.0835	$ 1,730.79	$ 649.56	$ 346.16
66180	Implant eye shunt		T	0673	29.0835	$ 1,730.79	$ 649.56	$ 346.16
66185	Revise eye shunt		T	0673	29.0835	$ 1,730.79	$ 649.56	$ 346.16
66220	Repair eye lesion	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
66225	Repair/graft eye lesion		T	0673	29.0835	$ 1,730.79	$ 649.56	$ 346.16
66250	Follow-up surgery of eye		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66500	Incision of iris		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66505	Incision of iris		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66600	Remove iris and lesion		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66605	Removal of iris		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66625	Removal of iris		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66630	Removal of iris		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66635	Removal of iris		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66680	Repair iris & ciliary body		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66682	Repair iris & ciliary body		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66700	Destruction, ciliary body		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66710	Ciliary transsleral therapy		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66711	Ciliary endoscopic ablation		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66720	Destruction, ciliary body		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
66740	Destruction, ciliary body		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66761	Revision of iris		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
66762	Revision of iris		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
66770	Removal of inner eye lesion		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66820	Incision, secondary cataract		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66821	After cataract laser surgery		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
66825	Reposition intraocular lens		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
66830	Removal of lens lesion		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
66840	Removal of lens material		T	0245	13.0344	$ 775.69	$ 217.05	$ 155.14
66850	Removal of lens material		T	0249	27.6388	$ 1,644.81	$ 524.67	$ 328.96
66852	Removal of lens material		T	0249	27.6388	$ 1,644.81	$ 524.67	$ 328.96
66920	Extraction of lens		T	0249	27.6388	$ 1,644.81	$ 524.67	$ 328.96
66930	Extraction of lens		T	0249	27.6388	$ 1,644.81	$ 524.67	$ 328.96
66940	Extraction of lens		T	0245	13.0344	$ 775.69	$ 217.05	$ 155.14
66982	Cataract surgery, complex		T	0246	23.3185	$ 1,387.71	$ 495.96	$ 277.54
66983	Cataract surg w/iol, 1 stage		T	0246	23.3185	$ 1,387.71	$ 495.96	$ 277.54
66984	Cataract surg w/iol, 1 stage		T	0246	23.3185	$ 1,387.71	$ 495.96	$ 277.54
66985	Insert lens prosthesis		T	0246	23.3185	$ 1,387.71	$ 495.96	$ 277.54
66986	Exchange lens prosthesis		T	0246	23.3185	$ 1,387.71	$ 495.96	$ 277.54
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
67005	Partial removal of eye fluid		T	0237	28.7866	$ 1,713.12		$ 342.62
67010	Partial removal of eye fluid		T	0237	28.7866	$ 1,713.12		$ 342.62
67015	Release of eye fluid		T	0237	28.7866	$ 1,713.12		$ 342.62
67025	Replace eye fluid	CH	T	0237	28.7866	$ 1,713.12		$ 342.62
67027	Implant eye drug system	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
67028	Injection eye drug		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67030	Incise inner eye strands		T	0236	16.9771	$ 1,010.32		$ 202.06
67031	Laser surgery, eye strands		T	0247	5.0255	$ 299.07	$ 104.31	$ 59.81
67036	Removal of inner eye fluid	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
67038	Strip retinal membrane	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
67039	Laser treatment of retina	CH	T	0672	36.8773	$ 2,194.61		$ 438.92
67040	Laser treatment of retina		T	0672	36.8773	$ 2,194.61		$ 438.92
67101	Repair detached retina	CH	T	0236	16.9771	$ 1,010.32		$ 202.06
67105	Repair detached retina		T	0248	4.7199	$ 280.89	$ 95.08	$ 56.18
67107	Repair detached retina		T	0672	36.8773	$ 2,194.61		$ 438.92
67108	Repair detached retina		T	0672	36.8773	$ 2,194.61		$ 438.92
67110	Repair detached retina		T	0236	16.9771	$ 1,010.32		$ 202.06
67112	Rerepair detached retina		T	0672	36.8773	$ 2,194.61		$ 438.92
67115	Release encircling material		T	0236	16.9771	$ 1,010.32		$ 202.06
67120	Remove eye implant material		T	0236	16.9771	$ 1,010.32		$ 202.06
67121	Remove eye implant material	CH	T	0237	28.7866	$ 1,713.12		$ 342.62
67141	Treatment of retina		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67145	Treatment of retina		T	0248	4.7199	$ 280.89	$ 95.08	$ 56.18
67208	Treatment of retinal lesion	CH	T	0236	16.9771	$ 1,010.32		$ 202.06
67210	Treatment of retinal lesion		T	0248	4.7199	$ 280.89	$ 95.08	$ 56.18
67218	Treatment of retinal lesion		T	0236	16.9771	$ 1,010.32		$ 202.06

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67220	Treatment of choroid lesion		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67221	Ocular photodynamic ther		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67225	Eye photodynamic ther add-on		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67227	Treatment of retinal lesion	CH	T	0236	16.9771	$ 1,010.32		$ 202.06
67228	Treatment of retinal lesion		T	0248	4.7199	$ 280.89	$ 95.08	$ 56.18
67250	Reinforce eye wall		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67255	Reinforce/graft eye wall		T	0237	28.7866	$ 1,713.12		$ 342.62
67299	Eye surgery procedure		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
67311	Revise eye muscle		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67312	Revise two eye muscles		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67314	Revise eye muscle		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67316	Revise two eye muscles		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67318	Revise eye muscle(s)		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67320	Revise eye muscle(s) add-on		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67331	Eye surgery follow-up add-on		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67332	Rerevise eye muscles add-on		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67334	Revise eye muscle w/suture		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67335	Eye suture during surgery		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67340	Revise eye muscle add-on		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67343	Release eye tissue		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67345	Destroy nerve of eye muscle		T	0238	2.6031	$ 154.91		$ 30.98
67350	Biopsy eye muscle		T	0699	8.9556	$ 532.96		$ 106.59
67399	Eye muscle surgery procedure		T	0243	22.0338	$ 1,311.25	$ 431.39	$ 262.25
67400	Explore/biopsy eye socket		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67405	Explore/drain eye socket		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67412	Explore/treat eye socket		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67413	Explore/treat eye socket		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67414	Explr/decompress eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67415	Aspiration, orbital contents		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67420	Explore/treat eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67430	Explore/treat eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67440	Explore/drain eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67445	Explr/decompress eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67450	Explore/biopsy eye socket		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67500	Inject/treat eye socket		S	0231	1.9167	$ 114.06		$ 22.81
67505	Inject/treat eye socket		T	0238	2.6031	$ 154.91		$ 30.98
67515	Inject/treat eye socket		T	0238	2.6031	$ 154.91		$ 30.98
67550	Insert eye socket implant		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67560	Revise eye socket implant		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67570	Decompress optic nerve		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
67599	Orbit surgery procedure		T	0238	2.6031	$ 154.91		$ 30.98
67700	Drainage of eyelid abscess		T	0238	2.6031	$ 154.91		$ 30.98
67710	Incision of eyelid		T	0239	7.0583	$ 420.05		$ 84.01

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67715	Incision of eyelid fold		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67800	Remove eyelid lesion		T	0238	2.6031	$ 154.91		$ 30.98
67801	Remove eyelid lesions		T	0239	7.0583	$ 420.05		$ 84.01
67805	Remove eyelid lesions		T	0238	2.6031	$ 154.91		$ 30.98
67808	Remove eyelid lesion(s)		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67810	Biopsy of eyelid		T	0238	2.6031	$ 154.91		$ 30.98
67820	Revise eyelashes		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
67825	Revise eyelashes		T	0238	2.6031	$ 154.91		$ 30.98
67830	Revise eyelashes		T	0239	7.0583	$ 420.05		$ 84.01
67835	Revise eyelashes		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67840	Remove eyelid lesion		T	0239	7.0583	$ 420.05		$ 84.01
67850	Treat eyelid lesion		T	0239	7.0583	$ 420.05		$ 84.01
67875	Closure of eyelid by suture		T	0239	7.0583	$ 420.05		$ 84.01
67880	Revision of eyelid		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
67882	Revision of eyelid		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67900	Repair brow defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67901	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67902	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67903	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67904	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67906	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67908	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67909	Revise eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67911	Revise eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67912	Correction eyelid w/implant		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67914	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67915	Repair eyelid defect	CH	T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67916	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67917	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67921	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67922	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67923	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67924	Repair eyelid defect		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67930	Repair eyelid wound		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67935	Repair eyelid wound		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67938	Remove eyelid foreign body		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
67950	Revision of eyelid		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67961	Revision of eyelid		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67966	Revision of eyelid		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
67971	Reconstruction of eyelid		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67973	Reconstruction of eyelid		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67974	Reconstruction of eyelid		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
67975	Reconstruction of eyelid		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67999	Revision of eyelid		T	0238	2.6031	$ 154.91		$ 30.98
68020	Incise/drain eyelid lining		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68040	Treatment of eyelid lesions		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
68100	Biopsy of eyelid lining		T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
68110	Remove eyelid lining lesion		T	0699	8.9556	$ 532.96		$ 106.59
68115	Remove eyelid lining lesion		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68130	Remove eyelid lining lesion		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
68135	Remove eyelid lining lesion		T	0239	7.0583	$ 420.05		$ 84.01
68200	Treat eyelid by injection		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
68320	Revise/graft eyelid lining		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68325	Revise/graft eyelid lining		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
68326	Revise/graft eyelid lining		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68328	Revise/graft eyelid lining		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68330	Revise eyelid lining		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
68335	Revise/graft eyelid lining		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68340	Separate eyelid adhesions		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68360	Revise eyelid lining		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
68362	Revise eyelid lining		T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
68371	Harvest eye tissue, alograft		T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
68399	Eyelid lining surgery		T	0238	2.6031	$ 154.91		$ 30.98
68400	Incise/drain tear gland		T	0238	2.6031	$ 154.91		$ 30.98
68420	Incise/drain tear sac		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68440	Incise tear duct opening		T	0238	2.6031	$ 154.91		$ 30.98
68500	Removal of tear gland		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68505	Partial removal, tear gland		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68510	Biopsy of tear gland		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68520	Removal of tear sac		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68525	Biopsy of tear sac		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68530	Clearance of tear duct		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68540	Remove tear gland lesion		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68550	Remove tear gland lesion		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
68700	Repair tear ducts		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68705	Revise tear duct opening		T	0238	2.6031	$ 154.91		$ 30.98
68720	Create tear sac drain		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
68745	Create tear duct drain		T	0241	23.1681	$ 1,378.76	$ 384.47	$ 275.75
68750	Create tear duct drain		T	0242	30.3478	$ 1,806.03	$ 597.36	$ 361.21
68760	Close tear duct opening		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
68761	Close tear duct opening		S	0231	1.9167	$ 114.06		$ 22.81
68770	Close tear system fistula		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68801	Dilate tear duct opening		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
68810	Probe nasolacrimal duct	CH	S	0231	1.9167	$ 114.06		$ 22.81
68811	Probe nasolacrimal duct		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47
68815	Probe nasolacrimal duct		T	0240	18.0194	$ 1,072.35	$ 315.31	$ 214.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68840	Explore/irrigate tear ducts		S	0231	1.9167	$ 114.06		$ 22.81
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
69000	Drain external ear lesion		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
69005	Drain external ear lesion	CH	T	0008	16.2953	$ 969.75		$ 193.95
69020	Drain outer ear canal lesion		T	0006	1.5100	$ 89.86	$ 21.76	$ 17.97
69100	Biopsy of external ear		T	0019	4.1481	$ 246.86	$ 71.87	$ 49.37
69105	Biopsy of external ear canal		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
69110	Remove external ear, partial		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
69120	Removal of external ear		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69140	Remove ear canal lesion(s)		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69145	Remove ear canal lesion(s)		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
69150	Extensive ear canal surgery		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
69200	Clear outer ear canal		X	0340	0.6137	$ 36.52		$ 7.30
69205	Clear outer ear canal		T	0022	19.5716	$ 1,164.73	$ 354.45	$ 232.95
69210	Remove impacted ear wax		X	0340	0.6137	$ 36.52		$ 7.30
69220	Clean out mastoid cavity		T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
69222	Clean out mastoid cavity		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
69300	Revise external ear		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69310	Rebuild outer ear canal		T	0256	37.0000	$ 2,201.91		$ 440.38
69320	Rebuild outer ear canal		T	0256	37.0000	$ 2,201.91		$ 440.38
69399	Outer ear surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
69400	Inflate middle ear canal		T	0251	2.0789	$ 123.72		$ 24.74
69401	Inflate middle ear canal		T	0251	2.0789	$ 123.72		$ 24.74
69405	Catheterize middle ear canal		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
69410	Inset middle ear (baffle)	CH	D					
69420	Incision of eardrum	CH	T	0251	2.0789	$ 123.72		$ 24.74
69421	Incision of eardrum		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
69424	Remove ventilating tube		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
69433	Create eardrum opening		T	0252	8.1033	$ 482.24	$ 113.41	$ 96.45
69436	Create eardrum opening		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
69440	Exploration of middle ear		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69450	Eardrum revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69501	Mastoidectomy		T	0256	37.0000	$ 2,201.91		$ 440.38
69502	Mastoidectomy		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69505	Remove mastoid structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69511	Extensive mastoid surgery		T	0256	37.0000	$ 2,201.91		$ 440.38
69530	Extensive mastoid surgery		T	0256	37.0000	$ 2,201.91		$ 440.38
69540	Remove ear lesion		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
69550	Remove ear lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
69552	Remove ear lesion		T	0256	37.0000	$ 2,201.91		$ 440.38
69601	Mastoid surgery revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69602	Mastoid surgery revision		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69603	Mastoid surgery revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69604	Mastoid surgery revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69605	Mastoid surgery revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69610	Repair of eardrum		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69620	Repair of eardrum		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69631	Repair eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69632	Rebuild eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69633	Rebuild eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69635	Repair eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69636	Rebuild eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69637	Rebuild eardrum structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69641	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69642	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69643	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69644	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69645	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69646	Revise middle ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69650	Release middle ear bone		T	0254	23.3114	$ 1,387.28	$ 321.35	$ 277.46
69660	Revise middle ear bone		T	0256	37.0000	$ 2,201.91		$ 440.38
69661	Revise middle ear bone		T	0256	37.0000	$ 2,201.91		$ 440.38
69662	Revise middle ear bone		T	0256	37.0000	$ 2,201.91		$ 440.38
69666	Repair middle ear structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69667	Repair middle ear structures		T	0256	37.0000	$ 2,201.91		$ 440.38
69670	Remove mastoid air cells		T	0256	37.0000	$ 2,201.91		$ 440.38
69676	Remove middle ear nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69700	Close mastoid fistula		T	0256	37.0000	$ 2,201.91		$ 440.38
69711	Remove/repair hearing aid		T	0256	37.0000	$ 2,201.91		$ 440.38
69714	Implant temple bone w/stimul		T	0256	37.0000	$ 2,201.91		$ 440.38
69715	Temple bne implnt w/stimulat		T	0256	37.0000	$ 2,201.91		$ 440.38
69717	Temple bone implant revision		T	0256	37.0000	$ 2,201.91		$ 440.38
69718	Revise temple bone implant		T	0256	37.0000	$ 2,201.91		$ 440.38
69720	Release facial nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69725	Release facial nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69740	Repair facial nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69745	Repair facial nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69799	Middle ear surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
69801	Incise inner ear		T	0256	37.0000	$ 2,201.91		$ 440.38
69802	Incise inner ear		T	0256	37.0000	$ 2,201.91		$ 440.38
69805	Explore inner ear		T	0256	37.0000	$ 2,201.91		$ 440.38
69806	Explore inner ear		T	0256	37.0000	$ 2,201.91		$ 440.38
69820	Establish inner ear window		T	0256	37.0000	$ 2,201.91		$ 440.38
69840	Revise inner ear window		T	0256	37.0000	$ 2,201.91		$ 440.38
69905	Remove inner ear		T	0256	37.0000	$ 2,201.91		$ 440.38

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69910	Remove inner ear & mastoid		T	0256	37.0000	$ 2,201.91		$ 440.38
69915	Incise inner ear nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69930	Implant cochlear device		T	0259	393.7337	$23,431.49	$ 8,698.43	$ 4,686.30
69949	Inner ear surgery procedure		T	0251	2.0789	$ 123.72		$ 24.74
69955	Release facial nerve		T	0256	37.0000	$ 2,201.91		$ 440.38
69960	Release inner ear canal		T	0256	37.0000	$ 2,201.91		$ 440.38
69979	Temporal bone surgery		T	0251	2.0789	$ 123.72		$ 24.74
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
70015	Contrast x-ray of brain		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
70030	X-ray eye for foreign body		X	0260	0.7296	$ 43.42		$ 8.68
70100	X-ray exam of jaw		X	0260	0.7296	$ 43.42		$ 8.68
70110	X-ray exam of jaw		X	0260	0.7296	$ 43.42		$ 8.68
70120	X-ray exam of mastoids		X	0260	0.7296	$ 43.42		$ 8.68
70130	X-ray exam of mastoids		X	0260	0.7296	$ 43.42		$ 8.68
70134	X-ray exam of middle ear		X	0261	1.2416	$ 73.89		$ 14.78
70140	X-ray exam of facial bones		X	0260	0.7296	$ 43.42		$ 8.68
70150	X-ray exam of facial bones		X	0260	0.7296	$ 43.42		$ 8.68
70160	X-ray exam of nasal bones		X	0260	0.7296	$ 43.42		$ 8.68
70170	X-ray exam of tear duct		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
70190	X-ray exam of eye sockets		X	0260	0.7296	$ 43.42		$ 8.68
70200	X-ray exam of eye sockets		X	0260	0.7296	$ 43.42		$ 8.68
70210	X-ray exam of sinuses		X	0260	0.7296	$ 43.42		$ 8.68
70220	X-ray exam of sinuses		X	0260	0.7296	$ 43.42		$ 8.68
70240	X-ray exam, pituitary saddle		X	0260	0.7296	$ 43.42		$ 8.68
70250	X-ray exam of skull		X	0260	0.7296	$ 43.42		$ 8.68
70260	X-ray exam of skull		X	0261	1.2416	$ 73.89		$ 14.78
70300	X-ray exam of teeth		X	0262	0.8019	$ 47.72		$ 9.54
70310	X-ray exam of teeth		X	0262	0.8019	$ 47.72		$ 9.54
70320	Full mouth x-ray of teeth		X	0262	0.8019	$ 47.72		$ 9.54
70328	X-ray exam of jaw joint		X	0260	0.7296	$ 43.42		$ 8.68
70330	X-ray exam of jaw joints		X	0260	0.7296	$ 43.42		$ 8.68
70332	X-ray exam of jaw joint		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
70336	Magnetic image, jaw joint		S	0335	5.0997	$ 303.49	$ 121.39	$ 60.70
70350	X-ray head for orthodontia		X	0260	0.7296	$ 43.42		$ 8.68
70355	Panoramic x-ray of jaws		X	0260	0.7296	$ 43.42		$ 8.68
70360	X-ray exam of neck		X	0260	0.7296	$ 43.42		$ 8.68
70370	Throat x-ray & fluoroscopy		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
70371	Speech evaluation, complex		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
70373	Contrast x-ray of larynx		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
70380	X-ray exam of salivary gland		X	0260	0.7296	$ 43.42		$ 8.68
70390	X-ray exam of salivary duct		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
70450	Ct head/brain w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70460	Ct head/brain w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
70470	Ct head/brain w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
70481	Ct orbit/ear/fossa w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
70486	Ct maxillofacial w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
70487	Ct maxillofacial w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
70488	Ct maxillofacial w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
70490	Ct soft tissue neck w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
70491	Ct soft tissue neck w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
70492	Ct sft tsue nck w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
70496	Ct angiography, head		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
70498	Ct angiography, neck		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
70540	Mri orbit/face/neck w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
70542	Mri orbit/face/neck w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
70543	Mri orbt/fac/nck w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
70544	Mr angiography head w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
70545	Mr angiography head w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
70546	Mr angiograph head w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
70547	Mr angiography neck w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
70548	Mr angiography neck w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
70549	Mr angiograph neck w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
70551	Mri brain w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
70552	Mri brain w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
70553	Mri brain w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
70557	Mri brain w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
70558	Mri brain w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
70559	Mri brain w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
71010	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71015	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71020	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71021	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71022	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71023	Chest x-ray and fluoroscopy		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
71030	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71034	Chest x-ray and fluoroscopy		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
71035	Chest x-ray		X	0260	0.7296	$ 43.42		$ 8.68
71040	Contrast x-ray of bronchi		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
71060	Contrast x-ray of bronchi		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
71090	X-ray & pacemaker insertion		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
71100	X-ray exam of ribs		X	0260	0.7296	$ 43.42		$ 8.68
71101	X-ray exam of ribs/chest		X	0260	0.7296	$ 43.42		$ 8.68
71110	X-ray exam of ribs		X	0260	0.7296	$ 43.42		$ 8.68

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
71111	X-ray exam of ribs/chest		X	0261	1.2416	$ 73.89		$ 14.78
71120	X-ray exam of breastbone		X	0260	0.7296	$ 43.42		$ 8.68
71130	X-ray exam of breastbone		X	0260	0.7296	$ 43.42		$ 8.68
71250	Ct thorax w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
71260	Ct thorax w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
71270	Ct thorax w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
71275	Ct angiography, chest		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
71550	Mri chest w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
71551	Mri chest w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
71552	Mri chest w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
72010	X-ray exam of spine	CH	X	0260	0.7296	$ 43.42		$ 8.68
72020	X-ray exam of spine		X	0260	0.7296	$ 43.42		$ 8.68
72040	X-ray exam of neck spine		X	0260	0.7296	$ 43.42		$ 8.68
72050	X-ray exam of neck spine		X	0261	1.2416	$ 73.89		$ 14.78
72052	X-ray exam of neck spine		X	0261	1.2416	$ 73.89		$ 14.78
72069	X-ray exam of trunk spine		X	0260	0.7296	$ 43.42		$ 8.68
72070	X-ray exam of thoracic spine		X	0260	0.7296	$ 43.42		$ 8.68
72072	X-ray exam of thoracic spine		X	0260	0.7296	$ 43.42		$ 8.68
72074	X-ray exam of thoracic spine		X	0260	0.7296	$ 43.42		$ 8.68
72080	X-ray exam of trunk spine		X	0260	0.7296	$ 43.42		$ 8.68
72090	X-ray exam of trunk spine		X	0261	1.2416	$ 73.89		$ 14.78
72100	X-ray exam of lower spine		X	0260	0.7296	$ 43.42		$ 8.68
72110	X-ray exam of lower spine		X	0261	1.2416	$ 73.89		$ 14.78
72114	X-ray exam of lower spine		X	0261	1.2416	$ 73.89		$ 14.78
72120	X-ray exam of lower spine	CH	X	0261	1.2416	$ 73.89		$ 14.78
72125	Ct neck spine w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
72126	Ct neck spine w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
72127	Ct neck spine w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
72128	Ct chest spine w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
72129	Ct chest spine w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
72130	Ct chest spine w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
72131	Ct lumbar spine w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
72132	Ct lumbar spine w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
72133	Ct lumbar spine w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
72141	Mri neck spine w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
72142	Mri neck spine w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
72146	Mri chest spine w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
72147	Mri chest spine w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
72148	Mri lumbar spine w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
72149	Mri lumbar spine w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
72156	Mri neck spine w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
72157	Mri chest spine w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
72158	Mri lumbar spine w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72170	X-ray exam of pelvis		X	0260	0.7296	$ 43.42		$ 8.68
72190	X-ray exam of pelvis		X	0260	0.7296	$ 43.42		$ 8.68
72191	Ct angiograph pelv w/o&w/dye		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
72192	Ct pelvis w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
72193	Ct pelvis w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
72194	Ct pelvis w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
72195	Mri pelvis w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
72196	Mri pelvis w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
72197	Mri pelvis w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
72200	X-ray exam sacroiliac joints		X	0260	0.7296	$ 43.42		$ 8.68
72202	X-ray exam sacroiliac joints		X	0260	0.7296	$ 43.42		$ 8.68
72220	X-ray exam of tailbone		X	0260	0.7296	$ 43.42		$ 8.68
72240	Contrast x-ray of neck spine		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
72255	Contrast x-ray, thorax spine		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
72265	Contrast x-ray, lower spine		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
72270	Contrast x-ray, spine		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
72275	Epidurography		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
72285	X-ray c/t spine disk		S	0388	12.1712	$ 724.32	$ 289.72	$ 144.86
72295	X-ray of lower spine disk		S	0388	12.1712	$ 724.32	$ 289.72	$ 144.86
73000	X-ray exam of collar bone		X	0260	0.7296	$ 43.42		$ 8.68
73010	X-ray exam of shoulder blade		X	0260	0.7296	$ 43.42		$ 8.68
73020	X-ray exam of shoulder		X	0260	0.7296	$ 43.42		$ 8.68
73030	X-ray exam of shoulder		X	0260	0.7296	$ 43.42		$ 8.68
73040	Contrast x-ray of shoulder		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73050	X-ray exam of shoulders		X	0260	0.7296	$ 43.42		$ 8.68
73060	X-ray exam of humerus		X	0260	0.7296	$ 43.42		$ 8.68
73070	X-ray exam of elbow		X	0260	0.7296	$ 43.42		$ 8.68
73080	X-ray exam of elbow		X	0260	0.7296	$ 43.42		$ 8.68
73085	Contrast x-ray of elbow		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73090	X-ray exam of forearm		X	0260	0.7296	$ 43.42		$ 8.68
73092	X-ray exam of arm, infant		X	0260	0.7296	$ 43.42		$ 8.68
73100	X-ray exam of wrist		X	0260	0.7296	$ 43.42		$ 8.68
73110	X-ray exam of wrist		X	0260	0.7296	$ 43.42		$ 8.68
73115	Contrast x-ray of wrist		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73120	X-ray exam of hand		X	0260	0.7296	$ 43.42		$ 8.68
73130	X-ray exam of hand		X	0260	0.7296	$ 43.42		$ 8.68
73140	X-ray exam of finger(s)		X	0260	0.7296	$ 43.42		$ 8.68
73200	Ct upper extremity w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
73201	Ct upper extremity w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
73202	Ct uppr extremity w/o&w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
73206	Ct angio upr extrm w/o&w/dye		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
73218	Mri upper extremity w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
73219	Mri upper extremity w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73220	Mri uppr extremity w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
73221	Mri joint upr extrem w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
73222	Mri joint upr extrem w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
73223	Mri joint upr extr w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
73500	X-ray exam of hip		X	0260	0.7296	$ 43.42		$ 8.68
73510	X-ray exam of hip		X	0260	0.7296	$ 43.42		$ 8.68
73520	X-ray exam of hips	CH	X	0261	1.2416	$ 73.89		$ 14.78
73525	Contrast x-ray of hip		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73530	X-ray exam of hip		X	0261	1.2416	$ 73.89		$ 14.78
73540	X-ray exam of pelvis & hips		X	0260	0.7296	$ 43.42		$ 8.68
73542	X-ray exam, sacroiliac joint		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73550	X-ray exam of thigh		X	0260	0.7296	$ 43.42		$ 8.68
73560	X-ray exam of knee, 1 or 2		X	0260	0.7296	$ 43.42		$ 8.68
73562	X-ray exam of knee, 3		X	0260	0.7296	$ 43.42		$ 8.68
73564	X-ray exam, knee, 4 or more		X	0260	0.7296	$ 43.42		$ 8.68
73565	X-ray exam of knees		X	0260	0.7296	$ 43.42		$ 8.68
73580	Contrast x-ray of knee joint		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73590	X-ray exam of lower leg		X	0260	0.7296	$ 43.42		$ 8.68
73592	X-ray exam of leg, infant		X	0260	0.7296	$ 43.42		$ 8.68
73600	X-ray exam of ankle		X	0260	0.7296	$ 43.42		$ 8.68
73610	X-ray exam of ankle		X	0260	0.7296	$ 43.42		$ 8.68
73615	Contrast x-ray of ankle		S	0275	3.4927	$ 207.85	$ 69.09	$ 41.57
73620	X-ray exam of foot		X	0260	0.7296	$ 43.42		$ 8.68
73630	X-ray exam of foot		X	0260	0.7296	$ 43.42		$ 8.68
73650	X-ray exam of heel		X	0260	0.7296	$ 43.42		$ 8.68
73660	X-ray exam of toe(s)		X	0260	0.7296	$ 43.42		$ 8.68
73700	Ct lower extremity w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
73701	Ct lower extremity w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
73702	Ct lwr extremity w/o&w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
73706	Ct angio lwr extr w/o&w/dye		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
73718	Mri lower extremity w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
73719	Mri lower extremity w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
73720	Mri lwr extremity w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
73721	Mri jnt of lwr extre w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
73722	Mri joint of lwr extr w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
74000	X-ray exam of abdomen		X	0260	0.7296	$ 43.42		$ 8.68
74010	X-ray exam of abdomen		X	0260	0.7296	$ 43.42		$ 8.68
74020	X-ray exam of abdomen		X	0260	0.7296	$ 43.42		$ 8.68
74022	X-ray exam series, abdomen		X	0261	1.2416	$ 73.89		$ 14.78
74150	Ct abdomen w/o dye		S	0332	3.1608	$ 188.10	$ 75.24	$ 37.62
74160	Ct abdomen w/dye		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
74170	Ct abdomen w/o & w/dye		S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74175	Ct angio abdom w/o & w/dye		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
74181	Mri abdomen w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
74182	Mri abdomen w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
74183	Mri abdomen w/o & w/dye		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
74190	X-ray exam of peritoneum		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
74210	Contrst x-ray exam of throat		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74220	Contrast x-ray, esophagus		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74230	Cine/vid x-ray, throat/esoph		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74235	Remove esophagus obstruction		S	0296	2.2684	$ 134.99	$ 53.99	$ 27.00
74240	X-ray exam, upper gi tract		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74241	X-ray exam, upper gi tract		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74245	X-ray exam, upper gi tract		S	0277	2.2951	$ 136.58	$ 54.63	$ 27.32
74246	Contrst x-ray uppr gi tract		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74247	Contrst x-ray uppr gi tract		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74249	Contrst x-ray uppr gi tract		S	0277	2.2951	$ 136.58	$ 54.63	$ 27.32
74250	X-ray exam of small bowel		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74251	X-ray exam of small bowel		S	0277	2.2951	$ 136.58	$ 54.63	$ 27.32
74260	X-ray exam of small bowel		S	0277	2.2951	$ 136.58	$ 54.63	$ 27.32
74270	Contrast x-ray exam of colon		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74280	Contrast x-ray exam of colon		S	0277	2.2951	$ 136.58	$ 54.63	$ 27.32
74283	Contrast x-ray exam of colon		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74290	Contrast x-ray, gallbladder		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74291	Contrast x-rays, gallbladder		S	0276	1.4693	$ 87.44	$ 34.97	$ 17.49
74300	X-ray bile ducts/pancreas		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74301	X-rays at surgery add-on		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74305	X-ray bile ducts/pancreas		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74320	Contrast x-ray of bile ducts		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
74327	X-ray bile stone removal		S	0296	2.2684	$ 134.99	$ 53.99	$ 27.00
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
74350	X-ray guide, stomach tube		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74355	X-ray guide, intestinal tube		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74360	X-ray guide, GI dilation		S	0296	2.2684	$ 134.99	$ 53.99	$ 27.00
74363	X-ray, bile duct dilation		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
74400	Contrst x-ray, urinary tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74410	Contrst x-ray, urinary tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74415	Contrst x-ray, urinary tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74420	Contrst x-ray, urinary tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74425	Contrst x-ray, urinary tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74430	Contrast x-ray, bladder		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74440	X-ray, male genital tract		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74445	X-ray exam of penis		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74450	X-ray, urethra/bladder		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74455	X-ray, urethra/bladder		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
74470	X-ray exam of kidney lesion		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
74475	X-ray control, cath insert		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
74480	X-ray control, cath insert		S	0296	2.2684	$ 134.99	$ 53.99	$ 27.00
74485	X-ray guide, GU dilation		S	0296	2.2684	$ 134.99	$ 53.99	$ 27.00
74710	X-ray measurement of pelvis	CH	X	0261	1.2416	$ 73.89		$ 14.78
74740	X-ray, female genital tract		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
74742	X-ray, fallopian tube		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
74775	X-ray exam of perineum		S	0278	2.5559	$ 152.10	$ 60.84	$ 30.42
75552	Heart mri for morph w/o dye		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
75553	Heart mri for morph w/dye		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
75554	Cardiac MRI/function	CH	S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
75555	Cardiac MRI/limited study	CH	S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
75600	Contrast x-ray exam of aorta		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75605	Contrast x-ray exam of aorta		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75625	Contrast x-ray exam of aorta		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75630	X-ray aorta, leg arteries		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75635	Ct angio abdominal arteries		S	0662	4.9944	$ 297.22	$ 118.88	$ 59.44
75650	Artery x-rays, head & neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75658	Artery x-rays, arm		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75660	Artery x-rays, head & neck		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75662	Artery x-rays, head & neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75665	Artery x-rays, head & neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75671	Artery x-rays, head & neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75676	Artery x-rays, neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75680	Artery x-rays, neck		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75685	Artery x-rays, spine		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75705	Artery x-rays, spine		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75710	Artery x-rays, arm/leg		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75716	Artery x-rays, arms/legs		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75722	Artery x-rays, kidney		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75724	Artery x-rays, kidneys		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75726	Artery x-rays, abdomen		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75731	Artery x-rays, adrenal gland		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75733	Artery x-rays, adrenals		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75736	Artery x-rays, pelvis		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75741	Artery x-rays, lung		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75743	Artery x-rays, lungs		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75746	Artery x-rays, lung		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75756	Artery x-rays, chest		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75774	Artery x-ray, each vessel		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75790	Visualize A-V shunt	CH	S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75801	Lymph vessel x-ray, arm/leg		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
75803	Lymph vessel x-ray,arms/legs		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
75805	Lymph vessel x-ray, trunk		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
75807	Lymph vessel x-ray, trunk		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
75809	Nonvascular shunt, x-ray		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
75810	Vein x-ray, spleen/liver		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75820	Vein x-ray, arm/leg	CH	S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75822	Vein x-ray, arms/legs	CH	S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75825	Vein x-ray, trunk		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75827	Vein x-ray, chest		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75831	Vein x-ray, kidney	CH	S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75833	Vein x-ray, kidneys		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75840	Vein x-ray, adrenal gland	CH	S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75842	Vein x-ray, adrenal glands	CH	S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75860	Vein x-ray, neck	CH	S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75870	Vein x-ray, skull	CH	S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75872	Vein x-ray, skull	CH	S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75880	Vein x-ray, eye socket	CH	S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75885	Vein x-ray, liver		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75887	Vein x-ray, liver		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75889	Vein x-ray, liver		S	0280	20.4187	$ 1,215.14	$ 353.85	$ 243.03
75891	Vein x-ray, liver		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75893	Venous sampling by catheter		N					
75894	X-rays, transcath therapy		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
75896	X-rays, transcath therapy		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
75898	Follow-up angiography		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
75901	Remove cva device obstruct		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
75902	Remove cva lumen obstruct		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
75940	X-ray placement, vein filter	CH	S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
75945	Intravascular us		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
75946	Intravascular us add-on	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
75960	Transcath iv stent rs&i		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75961	Retrieval, broken catheter		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75962	Repair arterial blockage		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75964	Repair artery blockage, each		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75966	Repair arterial blockage		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75968	Repair artery blockage, each		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75970	Vascular biopsy		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75978	Repair venous blockage		S	0668	6.3104	$ 375.54	$ 88.26	$ 75.11
75980	Contrast xray exam bile duct		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
75982	Contrast xray exam bile duct		S	0297	5.0977	$ 303.37	$ 121.34	$ 60.67
75984	Xray control catheter change		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75993	Atherectomy, x-ray exam		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75994	Atherectomy, x-ray exam		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75995	Atherectomy, x-ray exam		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75996	Atherectomy, x-ray exam		S	0279	8.6988	$ 517.67	$ 150.03	$ 103.53
75998	Fluoroguide for vein device		N					
76000	Fluoroscope examination		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
76001	Fluoroscope exam, extensive		N					
76003	Needle localization by x-ray		N					
76005	Fluoroguide for spine inject		N					
76006	X-ray stress view		X	0260	0.7296	$ 43.42		$ 8.68
76010	X-ray, nose to rectum		X	0260	0.7296	$ 43.42		$ 8.68
76012	Percut vertebroplasty fluor		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
76013	Percut vertebroplasty, ct		S	0274	2.9160	$ 173.53	$ 69.41	$ 34.71
76020	X-rays for bone age		X	0260	0.7296	$ 43.42		$ 8.68
76040	X-rays, bone evaluation	CH	X	0261	1.2416	$ 73.89		$ 14.78
76061	X-rays, bone survey		X	0261	1.2416	$ 73.89		$ 14.78
76062	X-rays, bone survey		X	0261	1.2416	$ 73.89		$ 14.78
76065	X-rays, bone evaluation		X	0261	1.2416	$ 73.89		$ 14.78
76066	Joint survey, single view		X	0260	0.7296	$ 43.42		$ 8.68
76070	Ct bone density, axial		S	0288	1.2216	$ 72.70		$ 14.54
76071	Ct bone density, peripheral		S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
76075	Dxa bone density, axial		S	0288	1.2216	$ 72.70		$ 14.54
76076	Dxa bone density/peripheral		S	0665	0.6381	$ 37.97		$ 7.59
76077	Ddxa bone density/v-fracture		X	0260	0.7296	$ 43.42		$ 8.68
76078	Radiographic absorptiometry	CH	X	0260	0.7296	$ 43.42		$ 8.68
76080	X-ray exam of fistula		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
76086	X-ray of mammary duct		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
76088	X-ray of mammary ducts		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
76095	Stereotactic breast biopsy	CH	X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
76096	X-ray of needle wire, breast	CH	X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
76098	X-ray exam, breast specimen		X	0260	0.7296	$ 43.42		$ 8.68
76100	X-ray exam of body section		X	0261	1.2416	$ 73.89		$ 14.78
76101	Complex body section x-ray		X	0263	1.6979	$ 101.04	$ 23.77	$ 20.21
76102	Complex body section x-rays		X	0264	3.4542	$ 205.56	$ 79.41	$ 41.11
76120	Cine/video x-rays		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
76125	Cine/video x-rays add-on		X	0260	0.7296	$ 43.42		$ 8.68
76150	X-ray exam, dry process		X	0260	0.7296	$ 43.42		$ 8.68
76350	Special x-ray contrast study		N					
76355	Ct scan for localization		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
76360	Ct scan for needle biopsy		S	0283	4.2921	$ 255.43	$ 102.17	$ 51.09
76362	Ct guide for tissue ablation	CH	S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76370	Ct scan for therapy guide		S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
76375	3d/holograph reconstr add-on	CH	D					
76376	3d render w/o postprocess	NI	X	0340	0.6137	$ 36.52		$ 7.30
76377	3d rendering w/postprocess	NI	S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
76380	CAT scan follow-up study		S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
76393	Mr guidance for needle place		S	0335	5.0997	$ 303.49	$ 121.39	$ 60.70
76394	Mri for tissue ablation		S	0335	5.0997	$ 303.49	$ 121.39	$ 60.70
76400	Magnetic image, bone marrow		S	0335	5.0997	$ 303.49	$ 121.39	$ 60.70
76496	Fluoroscopic procedure		X	0272	1.3291	$ 79.10	$ 31.64	$ 15.82
76497	Ct procedure		S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
76498	Mri procedure		S	0335	5.0997	$ 303.49	$ 121.39	$ 60.70
76499	Radiographic procedure		X	0260	0.7296	$ 43.42		$ 8.68
76506	Echo exam of head	CH	S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76510	Ophth us, b & quant a		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76511	Ophth us, quant a only		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76512	Ophth us, b w/non-quant a		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76513	Echo exam of eye, water bath		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76514	Echo exam of eye, thickness		X	0340	0.6137	$ 36.52		$ 7.30
76516	Echo exam of eye	CH	S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76519	Echo exam of eye		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76529	Echo exam of eye	CH	S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76536	Us exam of head and neck		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76604	Us exam, chest, b-scan		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76645	Us exam, breast(s)		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76700	Us exam, abdom, complete		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76705	Echo exam of abdomen		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76770	Us exam abdo back wall, comp		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76775	Us exam abdo back wall, lim		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76778	Us exam kidney transplant		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76800	Us exam, spinal canal		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76801	Ob us < 14 wks, single fetus		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76802	Ob us < 14 wks, add'l fetus		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76811	Ob us, detailed, sngl fetus		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
76812	Ob us, detailed, addl fetus		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76815	Ob us, limited, fetus(s)		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76816	Ob us, follow-up, per fetus		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76817	Transvaginal us, obstetric		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76818	Fetal biophys profile w/nst		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76819	Fetal biophys profil w/o nst		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76820	Umbilical artery echo		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
76821	Middle cerebral artery echo		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76825	Echo exam of fetal heart		S	0671	1.6763	$ 99.76	$ 39.90	$ 19.95
76826	Echo exam of fetal heart		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
76827	Echo exam of fetal heart		S	0671	1.6763	$ 99.76	$ 39.90	$ 19.95
76828	Echo exam of fetal heart		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
76830	Transvaginal us, non-ob		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76831	Echo exam, uterus	CH	S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
76856	Us exam, pelvic, complete		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76857	Us exam, pelvic, limited		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76870	Us exam, scrotum		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76872	Us, transrectal		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76873	Echograp trans r, pros study		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76880	Us exam, extremity		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76885	Us exam infant hips, dynamic	CH	S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76886	Us exam infant hips, static		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76930	Echo guide, cardiocentesis		S	0268	1.0460	$ 62.25		$ 12.45
76932	Echo guide for heart biopsy		S	0268	1.0460	$ 62.25		$ 12.45
76936	Echo guide for artery repair		S	0268	1.0460	$ 62.25		$ 12.45
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		S	0268	1.0460	$ 62.25		$ 12.45
76941	Echo guide for transfusion		S	0268	1.0460	$ 62.25		$ 12.45
76942	Echo guide for biopsy		S	0268	1.0460	$ 62.25		$ 12.45
76945	Echo guide, villus sampling		S	0268	1.0460	$ 62.25		$ 12.45
76946	Echo guide for amniocentesis		S	0268	1.0460	$ 62.25		$ 12.45
76948	Echo guide, ova aspiration		S	0268	1.0460	$ 62.25		$ 12.45
76950	Echo guidance radiotherapy		S	0268	1.0460	$ 62.25		$ 12.45
76965	Echo guidance radiotherapy		S	0268	1.0460	$ 62.25		$ 12.45
76970	Ultrasound exam follow-up		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
76975	GI endoscopic ultrasound		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76977	Us bone density measure		X	0340	0.6137	$ 36.52		$ 7.30
76986	Ultrasound guide intraoper		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
76999	Echo examination procedure		S	0265	0.9930	$ 59.09	$ 23.63	$ 11.82
77280	Set radiation therapy field		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77285	Set radiation therapy field		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77290	Set radiation therapy field		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77295	Set radiation therapy field		X	0310	13.8818	$ 826.12	$ 325.27	$ 165.22
77299	Radiation therapy planning	CH	X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77300	Radiation therapy dose plan		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77301	Radiotherapy dose plan, imrt		X	0310	13.8818	$ 826.12	$ 325.27	$ 165.22
77305	Teletx isodose plan simple		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77310	Teletx isodose plan intermed	CH	X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77315	Teletx isodose plan complex		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77321	Special teletx port plan		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77326	Brachytx isodose calc simp		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77327	Brachytx isodose calc interm		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77328	Brachytx isodose plan compl		X	0305	3.9335	$ 234.09	$ 91.38	$ 46.82
77331	Special radiation dosimetry		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77332	Radiation treatment aid(s)		X	0303	2.8241	$ 168.07	$ 66.95	$ 33.61
77333	Radiation treatment aid(s)		X	0303	2.8241	$ 168.07	$ 66.95	$ 33.61
77334	Radiation treatment aid(s)		X	0303	2.8241	$ 168.07	$ 66.95	$ 33.61
77336	Radiation physics consult		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77370	Radiation physics consult		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77399	External radiation dosimetry		X	0304	1.7323	$ 103.09	$ 41.23	$ 20.62
77401	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77402	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77403	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77404	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77406	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77407	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77408	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77409	Radiation treatment delivery		S	0300	1.4660	$ 87.24		$ 17.45
77411	Radiation treatment delivery	CH	S	0301	2.2056	$ 131.26		$ 26.25
77412	Radiation treatment delivery		S	0301	2.2056	$ 131.26		$ 26.25
77413	Radiation treatment delivery		S	0301	2.2056	$ 131.26		$ 26.25
77414	Radiation treatment delivery		S	0301	2.2056	$ 131.26		$ 26.25
77416	Radiation treatment delivery		S	0301	2.2056	$ 131.26		$ 26.25
77417	Radiology port film(s)		X	0260	0.7296	$ 43.42		$ 8.68
77418	Radiation tx delivery, imrt		S	0412	5.3573	$ 318.82		$ 63.76
77421	Stereoscopic x-ray guidance	NI	S	1502		$ 75.00		$ 15.00
77422	Neutron beam tx, simple	NI	S	0301	2.2056	$ 131.26		$ 26.25
77423	Neutron beam tx, complex	NI	S	0301	2.2056	$ 131.26		$ 26.25
77470	Special radiation treatment		S	0299	5.7678	$ 343.25		$ 68.65
77520	Proton trmt, simple w/o comp		S	0664	15.9286	$ 947.93		$ 189.59
77522	Proton trmt, simple w/comp		S	0664	15.9286	$ 947.93		$ 189.59
77523	Proton trmt, intermediate	CH	S	0667	19.0566	$ 1,134.08		$ 226.82
77525	Proton treatment, complex	CH	S	0667	19.0566	$ 1,134.08		$ 226.82
77600	Hyperthermia treatment		S	0314	5.5840	$ 332.31	$ 98.36	$ 66.46
77605	Hyperthermia treatment		S	0314	5.5840	$ 332.31	$ 98.36	$ 66.46
77610	Hyperthermia treatment		S	0314	5.5840	$ 332.31	$ 98.36	$ 66.46
77615	Hyperthermia treatment		S	0314	5.5840	$ 332.31	$ 98.36	$ 66.46
77620	Hyperthermia treatment		S	0314	5.5840	$ 332.31	$ 98.36	$ 66.46
77750	Infuse radioactive materials	CH	S	0301	2.2056	$ 131.26		$ 26.25
77761	Apply intrcav radiat simple		S	0312	5.5674	$ 331.32		$ 66.26
77762	Apply intrcav radiat interm		S	0312	5.5674	$ 331.32		$ 66.26
77763	Apply intrcav radiat compl		S	0312	5.5674	$ 331.32		$ 66.26
77776	Apply interstit radiat simpl		S	0312	5.5674	$ 331.32		$ 66.26
77777	Apply interstit radiat inter		S	0312	5.5674	$ 331.32		$ 66.26

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77778	Apply interstit radiat compl		S	0651	11.1948	$ 666.21		$ 133.24
77781	High intensity brachytherapy		S	0313	13.0202	$ 774.85		$ 154.97
77782	High intensity brachytherapy		S	0313	13.0202	$ 774.85		$ 154.97
77783	High intensity brachytherapy		S	0313	13.0202	$ 774.85		$ 154.97
77784	High intensity brachytherapy		S	0313	13.0202	$ 774.85		$ 154.97
77789	Apply surface radiation		S	0300	1.4660	$ 87.24		$ 17.45
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0313	13.0202	$ 774.85		$ 154.97
78000	Thyroid, single uptake		S	0389	1.4276	$ 84.96	$ 33.98	$ 16.99
78001	Thyroid, multiple uptakes		S	0389	1.4276	$ 84.96	$ 33.98	$ 16.99
78003	Thyroid suppress/stimul	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78006	Thyroid imaging with uptake		S	0390	2.4663	$ 146.77	$ 58.70	$ 29.35
78007	Thyroid image, mult uptakes		S	0391	2.7803	$ 165.46	$ 66.18	$ 33.09
78010	Thyroid imaging		S	0390	2.4663	$ 146.77	$ 58.70	$ 29.35
78011	Thyroid imaging with flow		S	0390	2.4663	$ 146.77	$ 58.70	$ 29.35
78015	Thyroid met imaging		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78016	Thyroid met imaging/studies		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78018	Thyroid met imaging, body		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78020	Thyroid met uptake		S	0399	1.5039	$ 89.50	$ 35.80	$ 17.90
78070	Parathyroid nuclear imaging		S	0391	2.7803	$ 165.46	$ 66.18	$ 33.09
78075	Adrenal nuclear imaging		S	0391	2.7803	$ 165.46	$ 66.18	$ 33.09
78099	Endocrine nuclear procedure		S	0390	2.4663	$ 146.77	$ 58.70	$ 29.35
78102	Bone marrow imaging, ltd		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78103	Bone marrow imaging, mult		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78104	Bone marrow imaging, body		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78110	Plasma volume, single		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78111	Plasma volume, multiple		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78120	Red cell mass, single		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78121	Red cell mass, multiple		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78122	Blood volume		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78130	Red cell survival study		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78135	Red cell survival kinetics		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78140	Red cell sequestration		S	0393	3.4467	$ 205.12	$ 82.04	$ 41.02
78160	Plasma iron turnover	CH	D					
78162	Radioiron absorption exam	CH	D					
78170	Red cell iron utilization	CH	D					
78172	Total body iron estimation	CH	D					
78185	Spleen imaging		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78190	Platelet survival, kinetics	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78191	Platelet survival	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78195	Lymph system imaging		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78199	Blood/lymph nuclear exam		S	0400	3.9160	$ 233.05	$ 93.22	$ 46.61
78201	Liver imaging		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78202	Liver imaging with flow		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78205	Liver imaging (3D)		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78206	Liver image (3d) with flow		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78215	Liver and spleen imaging		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78216	Liver & spleen image/flow		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78220	Liver function study		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78223	Hepatobiliary imaging		S	0394	4.3107	$ 256.53	$ 102.61	$ 51.31
78230	Salivary gland imaging		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78231	Serial salivary imaging		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78232	Salivary gland function exam		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78258	Esophageal motility study		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78261	Gastric mucosa imaging		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78262	Gastroesophageal reflux exam		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78264	Gastric emptying study		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78270	Vit B-12 absorption exam	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78271	Vit b-12 absrp exam, int fac	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78272	Vit B-12 absorp, combined	CH	S	0392	3.5231	$ 209.66	$ 83.86	$ 41.93
78278	Acute GI blood loss imaging		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78282	GI protein loss exam		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78290	Meckel's divert exam		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78291	Leveen/shunt patency exam		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78299	GI nuclear procedure		S	0395	3.7696	$ 224.33	$ 89.73	$ 44.87
78300	Bone imaging, limited area		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78305	Bone imaging, multiple areas		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78306	Bone imaging, whole body		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78315	Bone imaging, 3 phase		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78320	Bone imaging (3D)		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78350	Bone mineral, single photon		X	0260	0.7296	$ 43.42		$ 8.68
78399	Musculoskeletal nuclear exam		S	0396	3.9921	$ 237.57	$ 95.02	$ 47.51
78414	Non-imaging heart function		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78428	Cardiac shunt imaging		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78445	Vascular flow imaging		S	0397	2.0829	$ 123.96	$ 49.58	$ 24.79
78455	Venous thrombosis study	CH	D					
78456	Acute venous thrombus image		S	0397	2.0829	$ 123.96	$ 49.58	$ 24.79
78457	Venous thrombosis imaging		S	0397	2.0829	$ 123.96	$ 49.58	$ 24.79
78458	Ven thrombosis images, bilat		S	0397	2.0829	$ 123.96	$ 49.58	$ 24.79
78459	Heart muscle imaging (PET)		S	0306	13.4521	$ 800.55	$ 320.21	$ 160.11
78460	Heart muscle blood, single		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78461	Heart muscle blood, multiple		S	0377	6.6729	$ 397.11	$ 158.84	$ 79.42
78464	Heart image (3d), single		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78465	Heart image (3d), multiple		S	0377	6.6729	$ 397.11	$ 158.84	$ 79.42
78466	Heart infarct image		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78468	Heart infarct image (ef)		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03

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78469	Heart infarct image (3D)		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78472	Gated heart, planar, single		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78473	Gated heart, multiple		S	0376	5.0315	$ 299.43	$ 119.77	$ 59.89
78478	Heart wall motion add-on		S	0399	1.5039	$ 89.50	$ 35.80	$ 17.90
78480	Heart function add-on		S	0399	1.5039	$ 89.50	$ 35.80	$ 17.90
78481	Heart first pass, single		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78483	Heart first pass, multiple		S	0376	5.0315	$ 299.43	$ 119.77	$ 59.89
78491	Heart image (pet), single		S	0306	13.4521	$ 800.55	$ 320.21	$ 160.11
78492	Heart image (pet), multiple		S	0307	41.7549	$ 2,484.88	$ 993.95	$ 496.98
78494	Heart image, spect		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78496	Heart first pass add-on		S	0399	1.5039	$ 89.50	$ 35.80	$ 17.90
78499	Cardiovascular nuclear exam		S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
78580	Lung perfusion imaging		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78584	Lung V/Q image single breath		S	0378	5.4064	$ 321.74	$ 128.69	$ 64.35
78585	Lung V/Q imaging		S	0378	5.4064	$ 321.74	$ 128.69	$ 64.35
78586	Aerosol lung image, single		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78587	Aerosol lung image, multiple		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78588	Perfusion lung image		S	0378	5.4064	$ 321.74	$ 128.69	$ 64.35
78591	Vent image, 1 breath, 1 proj		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78593	Vent image, 1 proj, gas		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78594	Vent image, mult proj, gas		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78596	Lung differential function		S	0378	5.4064	$ 321.74	$ 128.69	$ 64.35
78599	Respiratory nuclear exam		S	0401	3.3166	$ 197.37	$ 78.94	$ 39.47
78600	Brain imaging, ltd static		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78601	Brain imaging, ltd w/flow		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78605	Brain imaging, complete		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78606	Brain imaging, compl w/flow		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78607	Brain imaging (3D)		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78608	Brain imaging (PET)		S	1513		$ 1,150.00		$ 230.00
78610	Brain flow imaging only		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78615	Cerebral vascular flow image		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78630	Cerebrospinal fluid scan		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78635	CSF ventriculography		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78645	CSF shunt evaluation		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78647	Cerebrospinal fluid scan		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78650	CSF leakage imaging		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78660	Nuclear exam of tear flow		S	0403	3.5015	$ 208.38	$ 83.35	$ 41.68
78699	Nervous system nuclear exam		S	0402	5.1709	$ 307.73	$ 123.09	$ 61.55
78700	Kidney imaging, static		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78701	Kidney imaging with flow		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78704	Imaging renogram		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78707	Kidney flow/function image		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78708	Kidney flow/function image		S	0405	4.1493	$ 246.93	$ 98.77	$ 49.39

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78709	Kidney flow/function image		S	0405	4.1493	$ 246.93	$ 98.77	$ 49.39
78710	Kidney imaging (3D)		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78715	Renal vascular flow exam		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78725	Kidney function study		S	0389	1.4276	$ 84.96	$ 33.98	$ 16.99
78730	Urinary bladder retention		X	0340	0.6137	$ 36.52		$ 7.30
78740	Ureteral reflux study		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78760	Testicular imaging		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78761	Testicular imaging/flow		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78799	Genitourinary nuclear exam		S	0404	3.6558	$ 217.56	$ 87.02	$ 43.51
78800	Tumor imaging, limited area		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78801	Tumor imaging, mult areas		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78802	Tumor imaging, whole body		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78803	Tumor imaging (3D)		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78804	Tumor imaging, whole body		S	1508		$ 650.00		$ 130.00
78805	Abscess imaging, ltd area		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78806	Abscess imaging, whole body		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78807	Nuclear localization/abscess		S	0406	4.1397	$ 246.36	$ 98.54	$ 49.27
78810	Tumor imaging (PET)		D					
78811	Tumor imaging (pet), limited		S	1513		$ 1,150.00		$ 230.00
78812	Tumor image (pet)/skul-thigh		S	1513		$ 1,150.00		$ 230.00
78813	Tumor image (pet) full body		S	1513		$ 1,150.00		$ 230.00
78814	Tumor image pet/ct, limited		S	1514		$ 1,250.00		$ 250.00
78815	Tumorimage pet/ct skul-thigh		S	1514		$ 1,250.00		$ 250.00
78816	Tumor image pet/ct full body		S	1514		$ 1,250.00		$ 250.00
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78990	Provide diag radionuclide(s)		D					
78999	Nuclear diagnostic exam		S	0389	1.4276	$ 84.96	$ 33.98	$ 16.99
79000	Init hyperthyroid therapy		D					
79001	Repeat hyperthyroid therapy		D					
79005	Nuclear rx, oral admin		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
79020	Thyroid ablation		D					
79030	Thyroid ablation, carcinoma		D					
79035	Thyroid metastatic therapy		D					
79100	Hematopoetic nuclear therapy		D					
79101	Nuclear rx, iv admin		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
79200	Nuclear rx, intracav admin		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
79300	Nuclr rx, interstit colloid		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
79400	Nonhemato nuclear therapy		D					
79403	Hematopoietic nuclear tx		S	1507		$ 550.00		$ 110.00
79420	Intravascular nuclear ther		D					
79440	Nuclear rx, intra-articular		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
79445	Nuclear rx, intra-arterial		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
79900	Provide ther radiopharm(s)		D					
79999	Nuclear medicine therapy		S	0407	3.8758	$ 230.65	$ 92.26	$ 46.13
80103	Drug analysis, tissue prep		N					
80500	Lab pathology consultation	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
80502	Lab pathology consultation		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73
82273	Test for blood, other source		D					
83715	Assay of blood lipoproteins		D					
83716	Assay of blood lipoproteins		D					
85097	Bone marrow interpretation		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
85396	Clotting assay, whole blood		N					
86064	B cells, total count	CH	D					
86077	Physician blood bank service	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
86078	Physician blood bank service		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
86079	Physician blood bank service	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
86379	Nk cells, total count	CH	D					
86485	Skin test, candida		X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
86490	Coccidioidomycosis skin test		X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
86510	Histoplasmosis skin test		X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
86580	TB intradermal test		X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
86585	TB tine test	CH	D					
86587	Stem cells, total count	CH	D					
86850	RBC antibody screen		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86860	RBC antibody elution		X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86870	RBC antibody identification		X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86880	Coombs test, direct		X	0409	0.1210	$ 7.20	$ 2.20	$ 1.44
86885	Coombs test, indirect, qual		X	0409	0.1210	$ 7.20	$ 2.20	$ 1.44
86886	Coombs test, indirect, titer		X	0409	0.1210	$ 7.20	$ 2.20	$ 1.44
86890	Autologous blood process		X	0347	0.8243	$ 49.05	$ 12.11	$ 9.81
86891	Autologous blood, op salvage	CH	X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86900	Blood typing, ABO		X	0409	0.1210	$ 7.20	$ 2.20	$ 1.44
86901	Blood typing, Rh (D)		X	0409	0.1210	$ 7.20	$ 2.20	$ 1.44
86903	Blood typing, antigen screen		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86904	Blood typing, patient serum	CH	X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86905	Blood typing, RBC antigens		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86906	Blood typing, Rh phenotype		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86920	Compatibility test, spin		X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86921	Compatibility test, incubate		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86922	Compatibility test, antiglob		X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86923	Compatibility test, electric	NI	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86927	Plasma, fresh frozen	CH	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86930	Frozen blood prep		X	0347	0.8243	$ 49.05	$ 12.11	$ 9.81
86931	Frozen blood thaw		X	0347	0.8243	$ 49.05	$ 12.11	$ 9.81
86932	Frozen blood freeze/thaw		X	0347	0.8243	$ 49.05	$ 12.11	$ 9.81

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86945	Blood product/irradiation	CH	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86950	Leukacyte transfusion	CH	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86960	Vol reduction of blood/prod	NI	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86965	Pooling blood platelets	CH	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86970	RBC pretreatment		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86971	RBC pretreatment		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86972	RBC pretreatment	CH	X	0346	0.3314	$ 19.72	$ 4.39	$ 3.94
86975	RBC pretreatment, serum		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86976	RBC pretreatment, serum		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86977	RBC pretreatment, serum		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86978	RBC pretreatment, serum		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86985	Split blood or products	CH	X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
86999	Transfusion procedure		X	0345	0.2170	$ 12.91	$ 2.87	$ 2.58
88104	Cytopathology, fluids	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88106	Cytopathology, fluids	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88107	Cytopathology, fluids	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88108	Cytopath, concentrate tech	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88112	Cytopath, cell enhance tech		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88125	Forensic cytopathology		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73
88141	Cytopath, c/v, interpret		N					
88160	Cytopath smear, other source	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88161	Cytopath smear, other source	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88162	Cytopath smear, other source	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88172	Cytopathology eval of fna		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88173	Cytopath eval, fna, report		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88180	Cell marker study		D					
88182	Cell marker study		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88184	Flowcytometry/ tc, 1 marker		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88185	Flowcytometry/tc, add-on		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88187	Flowcytometry/read, 2-8		X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88188	Flowcytometry/read, 9-15		X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88189	Flowcytometry/read, 16 & >		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88299	Cytogenetic study		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73
88300	Surgical path, gross	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88302	Tissue exam by pathologist	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88304	Tissue exam by pathologist		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88305	Tissue exam by pathologist		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88307	Tissue exam by pathologist		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88309	Tissue exam by pathologist		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88311	Decalcify tissue		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73
88312	Special stains	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88313	Special stains	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88314	Histochemical stain		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88318	Chemical histochemistry	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88319	Enzyme histochemistry	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88321	Microslide consultation	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88323	Microslide consultation	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88325	Comprehensive review of data		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88329	Path consult introp	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88331	Path consult intraop, 1 bloc		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88332	Path consult intraop, add'l	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88333	Intraop cyto path consult, 1	NI	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88334	Intraop cyto path consult, 2	NI	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88342	Immunohistochemistry	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88346	Immunofluorescent study	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88347	Immunofluorescent study	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88348	Electron microscopy		X	0661	3.1514	$ 187.54	$ 75.01	$ 37.51
88349	Scanning electron microscopy		X	0661	3.1514	$ 187.54	$ 75.01	$ 37.51
88355	Analysis, skeletal muscle	CH	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88356	Analysis, nerve		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88358	Analysis, tumor		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88360	Tumor immunohistochem/manual		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88361	Tumor immunohistochem/comput		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88362	Nerve teasing preparations		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88365	Insitu hybridization (fish)		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88367	Insitu hybridization, auto		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88368	Insitu hybridization, manual		X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
88380	Microdissection	CH	N					
88384	Eval molecular probes, 11-50	NI	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
88385	Eval molecul probes, 51-250	NI	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
88386	Eval molecul probes, 251-500	NI	X	0344	0.7584	$ 45.13	$ 15.66	$ 9.03
89049	Chct for mal hyperthermia	NI	X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
89100	Sample intestinal contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89105	Sample intestinal contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89130	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89132	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89135	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89136	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89140	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89141	Sample stomach contents		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
89220	Sputum specimen collection		X	0343	0.4553	$ 27.10	$ 10.84	$ 5.42
89230	Collect sweat for test	CH	X	0433	0.2493	$ 14.84	$ 5.93	$ 2.97
89250	Cultr oocyte/embryo <4 days		X	0348	0.7607	$ 45.27		$ 9.05
89251	Cultr oocyte/embryo <4 days		X	0348	0.7607	$ 45.27		$ 9.05
89253	Embryo hatching		X	0348	0.7607	$ 45.27		$ 9.05
89254	Oocyte identification		X	0348	0.7607	$ 45.27		$ 9.05

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89255	Prepare embryo for transfer		X	0348	0.7607	$ 45.27		$ 9.05
89257	Sperm identification		X	0348	0.7607	$ 45.27		$ 9.05
89258	Cryopreservation; embryo(s)		X	0348	0.7607	$ 45.27		$ 9.05
89259	Cryopreservation, sperm		X	0348	0.7607	$ 45.27		$ 9.05
89260	Sperm isolation, simple		X	0348	0.7607	$ 45.27		$ 9.05
89261	Sperm isolation, complex		X	0348	0.7607	$ 45.27		$ 9.05
89264	Identify sperm tissue		X	0348	0.7607	$ 45.27		$ 9.05
89268	Insemination of oocytes		X	0348	0.7607	$ 45.27		$ 9.05
89272	Extended culture of oocytes		X	0348	0.7607	$ 45.27		$ 9.05
89280	Assist oocyte fertilization		X	0348	0.7607	$ 45.27		$ 9.05
89281	Assist oocyte fertilization		X	0348	0.7607	$ 45.27		$ 9.05
89290	Biopsy, oocyte polar body		X	0348	0.7607	$ 45.27		$ 9.05
89291	Biopsy, oocyte polar body		X	0348	0.7607	$ 45.27		$ 9.05
89335	Cryopreserve testicular tiss		X	0348	0.7607	$ 45.27		$ 9.05
89342	Storage/year; embryo(s)		X	0348	0.7607	$ 45.27		$ 9.05
89343	Storage/year; sperm/semen		X	0348	0.7607	$ 45.27		$ 9.05
89344	Storage/year; reprod tissue		X	0348	0.7607	$ 45.27		$ 9.05
89346	Storage/year; oocyte(s)		X	0348	0.7607	$ 45.27		$ 9.05
89352	Thawing cryopresrved; embryo		X	0348	0.7607	$ 45.27		$ 9.05
89353	Thawing cryopresrved; sperm		X	0348	0.7607	$ 45.27		$ 9.05
89354	Thaw cryoprsvrd; reprod tiss		X	0348	0.7607	$ 45.27		$ 9.05
89356	Thawing cryopresrved; oocyte		X	0348	0.7607	$ 45.27		$ 9.05
90296	Diphtheria antitoxin		N					
90371	Hep b ig, im	CH	K	1630		$ 122.68		$ 24.54
90375	Rabies ig, im/sc	CH	K	9133		$ 63.14		$ 12.63
90376	Rabies ig, heat treated	CH	K	9134		$ 70.47		$ 14.09
90385	Rh ig, minidose, im		N					
90393	Vaccina ig, im	CH	N					
90396	Varicella-zoster ig, im	CH	K	9135		$ 76.19		$ 15.24
90471	Immunization admin	CH	X	0353	0.3917	$ 23.31		$ 4.66
90472	Immunization admin, each add	CH	X	0353	0.3917	$ 23.31		$ 4.66
90473	Immune admin oral/nasal	CH	S	1491		$ 5.00	$ 2.00	$ 1.00
90474	Immune admin oral/nasal addl	CH	S	1491		$ 5.00	$ 2.00	$ 1.00
90476	Adenovirus vaccine, type 4	CH	K	9136	0.8674	$ 51.62		$ 10.32
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc	CH	K	9169		$ 126.46		$ 25.29
90585	Bcg vaccine, percut	CH	K	9137		$ 116.33		$ 23.27
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im	CH	K	9138	0.9250	$ 55.05		$ 11.01
90645	Hib vaccine, hboc, im		N					
90646	Hib vaccine, prp-d, im		N					

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90647	Hib vaccine, prp-omp, im		N					
90648	Hib vaccine, prp-t, im		N					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine, 6-35 mo, im		L					
90658	Flu vaccine age 3 & over, im		L					
90660	Flu vaccine, nasal	CH	L					
90665	Lyme disease vaccine, im	CH	K	9170	0.9161	$ 54.52		$ 10.90
90675	Rabies vaccine, im	CH	K	9139		$ 137.59		$ 27.52
90676	Rabies vaccine, id	CH	K	9140	1.5048	$ 89.55		$ 17.91
90680	Rotovirus vacc 3 dose, oral		N					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		N					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc	CH	K	9141	1.0220	$ 60.82		$ 12.16
90710	Mmrv vaccine, sc	CH	N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im	NI	K	1634		$ 35.00		$ 7.00
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc	CH	K	9142		$ 67.07		$ 13.41
90717	Yellow fever vaccine, sc	CH	K	1636		$ 50.74		$ 10.15
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im		N					
90721	Dtap/hib vaccine, im		N					
90725	Cholera vaccine, injectable	CH	N					
90727	Plague vaccine, im		N					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc	CH	K	9143		$ 82.66		$ 16.53
90734	Meningococcal vaccine, im	CH	K	9145	0.9025	$ 53.71		$ 10.74
90735	Encephalitis vaccine, sc	CH	K	9144		$ 84.60		$ 16.92
90740	Hepb vacc, ill pat 3 dose im	CH	F					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90743	Hep b vacc, adol, 2 dose, im	CH	F					
90744	Hepb vacc ped/adol 3 dose im	CH	F					
90746	Hep b vaccine, adult, im	CH	F					
90747	Hepb vacc, ill pat 4 dose im	CH	F					
90749	Vaccine toxoid		N					
90772	Ther/proph/diag inj, sc/im	NI	X	0353	0.3917	$ 23.31		$ 4.66
90773	Ther/proph/diag inj, ia	NI	X	0359	0.8036	$ 47.82		$ 9.56
90779	Ther/prop/diag inj/inf proc	NI	X	0352	0.1368	$ 8.14		$ 1.63
90780	IV infusion therapy, 1 hour	CH	D					
90781	IV infusion, additional hour	CH	D					
90782	Injection, sc/im	CH	D					
90783	Injection, ia	CH	D					
90784	Injection, iv	CH	D					
90788	Injection of antibiotic	CH	D					
90799	Ther/prophylactic/dx inject	CH	D					
90801	Psy dx interview		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90802	Intac psy dx interview		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90804	Psytx, office, 20-30 min		S	0322	1.2304	$ 73.22		$ 14.64
90805	Psytx, off, 20-30 min w/e&m		S	0322	1.2304	$ 73.22		$ 14.64
90806	Psytx, off, 45-50 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90807	Psytx, off, 45-50 min w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90808	Psytx, office, 75-80 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90809	Psytx, off, 75-80, w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90810	Intac psytx, off, 20-30 min		S	0322	1.2304	$ 73.22		$ 14.64
90811	Intac psytx, 20-30, w/e&m		S	0322	1.2304	$ 73.22		$ 14.64
90812	Intac psytx, off, 45-50 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90813	Intac psytx, 45-50 min w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90814	Intac psytx, off, 75-80 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90815	Intac psytx, 75-80 w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90816	Psytx, hosp, 20-30 min		S	0322	1.2304	$ 73.22		$ 14.64
90817	Psytx, hosp, 20-30 min w/e&m		S	0322	1.2304	$ 73.22		$ 14.64
90818	Psytx, hosp, 45-50 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90819	Psytx, hosp, 45-50 min w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90821	Psytx, hosp, 75-80 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90822	Psytx, hosp, 75-80 min w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90823	Intac psytx, hosp, 20-30 min		S	0322	1.2304	$ 73.22		$ 14.64
90824	Intac psytx, hsp 20-30 w/e&m		S	0322	1.2304	$ 73.22		$ 14.64
90826	Intac psytx, hosp, 45-50 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90827	Intac psytx, hsp 45-50 w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90828	Intac psytx, hosp, 75-80 min		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90829	Intac psytx, hsp 75-80 w/e&m		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90845	Psychoanalysis		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90846	Family psytx w/o patient		S	0324	2.3119	$ 137.58		$ 27.52

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90847	Family psytx w/patient		S	0324	2.3119	$ 137.58		$ 27.52
90849	Multiple family group psytx		S	0325	1.3434	$ 79.95	$ 17.47	$ 15.99
90853	Group psychotherapy		S	0325	1.3434	$ 79.95	$ 17.47	$ 15.99
90857	Intac group psytx		S	0325	1.3434	$ 79.95	$ 17.47	$ 15.99
90862	Medication management		X	0374	1.1270	$ 67.07		$ 13.41
90865	Narcosynthesis		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90870	Electroconvulsive therapy		S	0320	5.2528	$ 312.60	$ 80.06	$ 62.52
90871	Electroconvulsive therapy		D					
90880	Hypnotherapy		S	0323	1.6398	$ 97.59	$ 20.35	$ 19.52
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		S	0322	1.2304	$ 73.22		$ 14.64
90911	Biofeedback peri/uro/rectal		S	0321	1.3651	$ 81.24	$ 21.72	$ 16.25
90935	Hemodialysis, one evaluation		S	0170	5.9448	$ 353.78		$ 70.76
90939	Hemodialysis study, transcut	CH	D					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	5.9448	$ 353.78		$ 70.76
91000	Esophageal intubation		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91010	Esophagus motility study		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91011	Esophagus motility study		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91012	Esophagus motility study		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91020	Gastric motility studies		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91022	Duodenal motility study	NI	X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91030	Acid perfusion of esophagus		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91032	Esophagus, acid reflux test		D					
91033	Prolonged acid reflux test		D					
91034	Gastroesophageal reflux test		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91035	G-esoph reflx tst w/electrod		S	1506		$ 450.00		$ 90.00
91037	Esoph imped function test		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91038	Esoph imped funct test > 1h		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91040	Esoph balloon distension tst		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91052	Gastric analysis test		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
91055	Gastric intubation for smear		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91060	Gastric saline load test		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91065	Breath hydrogen test		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91100	Pass intestine bleeding tube		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91105	Gastric intubation treatment		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91110	Gi tract capsule endoscopy		T	0142	9.0564	$ 538.96	$ 152.78	$ 107.79
91120	Rectal sensation test		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
91122	Anal pressure record		T	0156	2.6123	$ 155.46	$ 40.52	$ 31.09
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
91133	Electrogastrography w/test		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
91299	Gastroenterology procedure		X	0360	1.4235	$ 84.71	$ 33.88	$ 16.94
92002	Eye exam, new patient		V	0601	1.0125	$ 60.25		$ 12.05
92004	Eye exam, new patient	CH	V	0602	1.4731	$ 87.67		$ 17.53
92012	Eye exam established pat		V	0600	0.8800	$ 52.37		$ 10.47
92014	Eye exam & treatment	CH	V	0601	1.0125	$ 60.25		$ 12.05
92018	New eye exam & treatment		T	0699	8.9556	$ 532.96		$ 106.59
92019	Eye exam & treatment		T	0699	8.9556	$ 532.96		$ 106.59
92020	Special eye evaluation		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92060	Special eye evaluation		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92065	Orthoptic/pleoptic training	CH	S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92082	Visual field examination(s)		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92083	Visual field examination(s)		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92130	Water provocation tonography		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92135	Opthalmic dx imaging		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92136	Ophthalmic biometry	CH	S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92140	Glaucoma provocative tests		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92225	Special eye exam, initial		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92226	Special eye exam, subsequent		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92230	Eye exam with photos		T	0699	8.9556	$ 532.96		$ 106.59
92235	Eye exam with photos		S	0231	1.9167	$ 114.06		$ 22.81
92240	Icg angiography		S	0231	1.9167	$ 114.06		$ 22.81
92250	Eye exam with photos		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92260	Ophthalmoscopy/dynamometry	CH	S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92265	Eye muscle evaluation		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92270	Electro-oculography		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92275	Electroretinography		S	0231	1.9167	$ 114.06		$ 22.81
92283	Color vision examination		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92284	Dark adaptation eye exam		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92285	Eye photography		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92286	Internal eye photography		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92287	Internal eye photography		S	0698	1.2378	$ 73.66	$ 16.52	$ 14.73
92311	Contact lens fitting		X	0362	2.2654	$ 134.82		$ 26.96
92312	Contact lens fitting		X	0362	2.2654	$ 134.82		$ 26.96
92313	Contact lens fitting		X	0362	2.2654	$ 134.82		$ 26.96
92315	Prescription of contact lens		X	0362	2.2654	$ 134.82		$ 26.96
92316	Prescription of contact lens		X	0362	2.2654	$ 134.82		$ 26.96
92317	Prescription of contact lens		X	0362	2.2654	$ 134.82		$ 26.96
92325	Modification of contact lens		X	0362	2.2654	$ 134.82		$ 26.96

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92326	Replacement of contact lens		X	0362	2.2654	$ 134.82		$ 26.96
92330	Fitting of artificial eye	CH	D					
92335	Fitting of artificial eye	CH	D					
92352	Special spectacles fitting		X	0362	2.2654	$ 134.82		$ 26.96
92353	Special spectacles fitting		X	0362	2.2654	$ 134.82		$ 26.96
92354	Special spectacles fitting		X	0362	2.2654	$ 134.82		$ 26.96
92355	Special spectacles fitting		X	0362	2.2654	$ 134.82		$ 26.96
92358	Eye prosthesis service		X	0362	2.2654	$ 134.82		$ 26.96
92371	Repair & adjust spectacles		X	0362	2.2654	$ 134.82		$ 26.96
92390	Supply of spectacles		D					
92391	Supply of contact lenses		D					
92392	Supply of low vision aids		D					
92393	Supply of artificial eye		D					
92395	Supply of spectacles		D					
92396	Supply of contact lenses		D					
92499	Eye service or procedure		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
92502	Ear and throat examination		T	0251	2.0789	$ 123.72		$ 24.74
92504	Ear microscopy examination		N					
92510	Rehab for ear implant		D					
92511	Nasopharyngoscopy		T	0071	0.8034	$ 47.81	$ 11.31	$ 9.56
92512	Nasal function studies		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92516	Facial nerve function test		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92520	Laryngeal function studies		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92541	Spontaneous nystagmus test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92542	Positional nystagmus test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92543	Caloric vestibular test		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92544	Optokinetic nystagmus test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92545	Oscillating tracking test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92546	Sinusoidal rotational test		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92547	Supplemental electrical test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92548	Posturography		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92552	Pure tone audiometry, air		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92553	Audiometry, air & bone	CH	X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92555	Speech threshold audiometry		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92556	Speech audiometry, complete		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92557	Comprehensive hearing test		X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92561	Bekesy audiometry, diagnosis	CH	X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92562	Loudness balance test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92563	Tone decay hearing test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92564	Sisi hearing test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92565	Stenger test, pure tone		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92567	Tympanometry		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92568	Acoustic refl threshold tst		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92569	Acoustic reflex decay test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92571	Filtered speech hearing test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92572	Staggered spondaic word test	CH	X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92573	Lombard test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92575	Sensorineural acuity test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92576	Synthetic sentence test		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92577	Stenger test, speech	CH	X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92579	Visual audiometry (vra)		X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92582	Conditioning play audiometry		X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92583	Select picture audiometry		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92584	Electrocochleography		X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92585	Auditor evoke potent, compre		S	0216	2.5976	$ 154.59		$ 30.92
92586	Auditor evoke potent, limit		S	0218	1.1138	$ 66.28		$ 13.26
92587	Evoked auditory test		X	0363	0.8707	$ 51.82	$ 17.44	$ 10.36
92588	Evoked auditory test	CH	X	0660	1.5488	$ 92.17	$ 29.07	$ 18.43
92589	Auditory function test(s)		D					
92596	Ear protector evaluation		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92601	Cochlear implt f/up exam < 7		X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92602	Reprogram cochlear implt < 7		X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92603	Cochlear implt f/up exam 7 >		X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92604	Reprogram cochlear implt 7 >		X	0366	1.6829	$ 100.15	$ 26.14	$ 20.03
92620	Auditory function, 60 min	CH	X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment	CH	X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92626	Eval aud rehab status	NI	X	0365	1.1928	$ 70.98	$ 18.52	$ 14.20
92627	Eval aud status rehab add-on	NI	N					
92700	Ent procedure/service		X	0364	0.4548	$ 27.07	$ 7.06	$ 5.41
92950	Heart/lung resuscitation cpr		S	0094	2.4582	$ 146.29	$ 46.29	$ 29.26
92953	Temporary external pacing		S	0094	2.4582	$ 146.29	$ 46.29	$ 29.26
92960	Cardioversion electric, ext		S	0679	5.4992	$ 327.26	$ 95.30	$ 65.45
92961	Cardioversion, electric, int		S	0679	5.4992	$ 327.26	$ 95.30	$ 65.45
92973	Percut coronary thrombectomy	CH	T	0088	36.5126	$ 2,172.90	$ 655.22	$ 434.58
92974	Cath place, cardio brachytx	CH	T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
92977	Dissolve clot, heart vessel	CH	T	0676	2.2742	$ 135.34		$ 27.07
92978	Intravasc us, heart add-on		S	0670	28.7546	$ 1,711.22	$ 536.10	$ 342.24
92979	Intravasc us, heart add-on		S	0416	16.4464	$ 978.74		$ 195.75
92980	Insert intracoronary stent		T	0104	80.7852	$ 4,807.61		$ 961.52
92981	Insert intracoronary stent		T	0104	80.7852	$ 4,807.61		$ 961.52
92982	Coronary artery dilation		T	0083	55.2741	$ 3,289.42		$ 657.88

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92984	Coronary artery dilation		T	0083	55.2741	$ 3,289.42		$ 657.88
92986	Revision of aortic valve		T	0083	55.2741	$ 3,289.42		$ 657.88
92987	Revision of mitral valve		T	0083	55.2741	$ 3,289.42		$ 657.88
92990	Revision of pulmonary valve		T	0083	55.2741	$ 3,289.42		$ 657.88
92995	Coronary atherectomy		T	0082	91.3717	$ 5,437.62	$ 1,169.67	$ 1,087.52
92996	Coronary atherectomy add-on		T	0082	91.3717	$ 5,437.62	$ 1,169.67	$ 1,087.52
92997	Pul art balloon repr, percut		T	0081	42.2664	$ 2,515.32		$ 503.06
92998	Pul art balloon repr, percut		T	0081	42.2664	$ 2,515.32		$ 503.06
93005	Electrocardiogram, tracing		S	0099	0.3769	$ 22.43		$ 4.49
93012	Transmission of ecg		N					
93017	Cardiovascular stress test		X	0100	2.4833	$ 147.78	$ 41.44	$ 29.56
93024	Cardiac drug stress test		X	0100	2.4833	$ 147.78	$ 41.44	$ 29.56
93025	Microvolt t-wave assess		X	0100	2.4833	$ 147.78	$ 41.44	$ 29.56
93041	Rhythm ECG, tracing		S	0099	0.3769	$ 22.43		$ 4.49
93225	ECG monitor/record, 24 hrs		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93226	ECG monitor/report, 24 hrs		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93231	Ecg monitor/record, 24 hrs		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93232	ECG monitor/report, 24 hrs		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93236	ECG monitor/report, 24 hrs		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93270	ECG recording		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93271	Ecg/monitoring and analysis		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93278	ECG/signal-averaged		S	0099	0.3769	$ 22.43		$ 4.49
93303	Echo transthoracic		S	0269	3.1761	$ 189.01	$ 75.60	$ 37.80
93304	Echo transthoracic		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
93307	Echo exam of heart		S	0269	3.1761	$ 189.01	$ 75.60	$ 37.80
93308	Echo exam of heart		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
93312	Echo transesophageal		S	0270	5.9369	$ 353.31	$ 141.32	$ 70.66
93313	Echo transesophageal		S	0270	5.9369	$ 353.31	$ 141.32	$ 70.66
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	5.9369	$ 353.31	$ 141.32	$ 70.66
93316	Echo transesophageal		S	0270	5.9369	$ 353.31	$ 141.32	$ 70.66
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	5.9369	$ 353.31	$ 141.32	$ 70.66
93320	Doppler echo exam, heart		S	0671	1.6763	$ 99.76	$ 39.90	$ 19.95
93321	Doppler echo exam, heart		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
93325	Doppler color flow add-on		S	0697	1.5121	$ 89.99	$ 35.99	$ 18.00
93350	Echo transthoracic		S	0269	3.1761	$ 189.01	$ 75.60	$ 37.80
93501	Right heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93503	Insert/place heart catheter		T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
93505	Biopsy of heart lining		T	0103	15.0428	$ 895.21	$ 223.63	$ 179.04
93508	Cath placement, angiography		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93510	Left heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93511	Left heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93514	Left heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93524	Left heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93526	Rt & Lt heart catheters		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93527	Rt & Lt heart catheters		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93528	Rt & Lt heart catheters		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93529	Rt, lt heart catheterization		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93530	Rt heart cath, congenital		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93531	R & l heart cath, congenital		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93532	R & l heart cath, congenital		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93533	R & l heart cath, congenital		T	0080	36.3392	$ 2,162.58	$ 838.92	$ 432.52
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure		S	0670	28.7546	$ 1,711.22	$ 536.10	$ 342.24
93572	Heart flow reserve measure		S	0416	16.4464	$ 978.74		$ 195.75
93580	Transcath closure of asd	CH	T	0434	86.4834	$ 5,146.71		$ 1,029.34
93581	Transcath closure of vsd	CH	T	0434	86.4834	$ 5,146.71		$ 1,029.34
93600	Bundle of His recording		T	0087	33.0075	$ 1,964.31		$ 392.86
93602	Intra-atrial recording		T	0087	33.0075	$ 1,964.31		$ 392.86
93603	Right ventricular recording		T	0087	33.0075	$ 1,964.31		$ 392.86
93609	Map tachycardia, add-on		T	0087	33.0075	$ 1,964.31		$ 392.86
93610	Intra-atrial pacing		T	0087	33.0075	$ 1,964.31		$ 392.86
93612	Intraventricular pacing		T	0087	33.0075	$ 1,964.31		$ 392.86
93613	Electrophys map 3d, add-on		T	0087	33.0075	$ 1,964.31		$ 392.86
93615	Esophageal recording		T	0087	33.0075	$ 1,964.31		$ 392.86
93616	Esophageal recording		T	0087	33.0075	$ 1,964.31		$ 392.86
93618	Heart rhythm pacing		T	0087	33.0075	$ 1,964.31		$ 392.86
93619	Electrophysiology evaluation		T	0085	34.2055	$ 2,035.60	$ 426.25	$ 407.12
93620	Electrophysiology evaluation		T	0085	34.2055	$ 2,035.60	$ 426.25	$ 407.12
93621	Electrophysiology evaluation		T	0085	34.2055	$ 2,035.60	$ 426.25	$ 407.12
93622	Electrophysiology evaluation		T	0085	34.2055	$ 2,035.60	$ 426.25	$ 407.12
93623	Stimulation, pacing heart		T	0087	33.0075	$ 1,964.31		$ 392.86
93624	Electrophysiologic study	CH	T	0085	34.2055	$ 2,035.60	$ 426.25	$ 407.12
93631	Heart pacing, mapping		T	0087	33.0075	$ 1,964.31		$ 392.86
93640	Evaluation heart device		S	0084	9.6108	$ 571.95		$ 114.39

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93641	Electrophysiology evaluation		S	0084	9.6108	$ 571.95		$ 114.39
93642	Electrophysiology evaluation		S	0084	9.6108	$ 571.95		$ 114.39
93650	Ablate heart dysrhythm focus		T	0086	42.0498	$ 2,502.43	$ 812.36	$ 500.49
93651	Ablate heart dysrhythm focus		T	0086	42.0498	$ 2,502.43	$ 812.36	$ 500.49
93652	Ablate heart dysrhythm focus		T	0086	42.0498	$ 2,502.43	$ 812.36	$ 500.49
93660	Tilt table evaluation		S	0101	4.2112	$ 250.61	$ 100.24	$ 50.12
93662	Intracardiac ecg (ice)		S	0670	28.7546	$ 1,711.22	$ 536.10	$ 342.24
93701	Bioimpedance, thoracic		S	0099	0.3769	$ 22.43		$ 4.49
93721	Plethysmography tracing		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
93724	Analyze pacemaker system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93727	Analyze ilr system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93731	Analyze pacemaker system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93732	Analyze pacemaker system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93733	Telephone analy, pacemaker		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93734	Analyze pacemaker system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93735	Analyze pacemaker system		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93736	Telephonic analy, pacemaker		S	0690	0.3645	$ 21.69	$ 8.67	$ 4.34
93740	Temperature gradient studies		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
93741	Analyze ht pace device sngl		S	0689	0.5608	$ 33.37		$ 6.67
93742	Analyze ht pace device sngl		S	0689	0.5608	$ 33.37		$ 6.67
93743	Analyze ht pace device dual		S	0689	0.5608	$ 33.37		$ 6.67
93744	Analyze ht pace device dual		S	0689	0.5608	$ 33.37		$ 6.67
93745	Set-up cardiovert-defibrill		S	0689	0.5608	$ 33.37		$ 6.67
93770	Measure venous pressure		N					
93786	Ambulatory BP recording		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93788	Ambulatory BP analysis		X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
93797	Cardiac rehab		S	0095	0.5822	$ 34.65	$ 13.86	$ 6.93
93798	Cardiac rehab/monitor		S	0095	0.5822	$ 34.65	$ 13.86	$ 6.93
93799	Cardiovascular procedure		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93875	Extracranial study		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93880	Extracranial study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93882	Extracranial study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93886	Intracranial study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93888	Intracranial study		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93890	Tcd, vasoreactivity study		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93892	Tcd, emboli detect w/o inj		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93893	Tcd, emboli detect w/inj		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93922	Extremity study		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93923	Extremity study		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93924	Extremity study		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93925	Lower extremity study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93926	Lower extremity study	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93930	Upper extremity study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93931	Upper extremity study		S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93965	Extremity study		S	0096	1.6020	$ 95.34	$ 38.13	$ 19.07
93970	Extremity study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93971	Extremity study	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93975	Vascular study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93976	Vascular study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93978	Vascular study	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93979	Vascular study	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93980	Penile vascular study		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
93981	Penile vascular study	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
93990	Doppler flow testing	CH	S	0266	1.5883	$ 94.52	$ 37.80	$ 18.90
94010	Breathing capacity test		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94014	Patient recorded spirometry	CH	X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94015	Patient recorded spirometry		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94060	Evaluation of wheezing		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94070	Evaluation of wheezing		X	0369	2.7046	$ 160.95	$ 44.18	$ 32.19
94150	Vital capacity test		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94200	Lung function test (MBC/MVV)		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94240	Residual lung capacity		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94250	Expired gas collection		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94260	Thoracic gas volume	CH	X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94350	Lung nitrogen washout curve	CH	X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94360	Measure airflow resistance		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94370	Breath airway closing volume		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94375	Respiratory flow volume loop	CH	X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94400	CO2 breathing response curve		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94450	Hypoxia response curve		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94452	Hast w/report		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94453	Hast w/oxygen titrate		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94620	Pulmonary stress test/simple		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94621	Pulm stress test/complex		X	0369	2.7046	$ 160.95	$ 44.18	$ 32.19
94640	Airway inhalation treatment		S	0077	0.3428	$ 20.40	$ 7.74	$ 4.08
94642	Aerosol inhalation treatment		S	0078	1.0229	$ 60.87	$ 14.55	$ 12.17
94656	Initial ventilator mgmt		S	0079	2.2410	$ 133.36		$ 26.67
94657	Continued ventilator mgmt		S	0079	2.2410	$ 133.36		$ 26.67
94660	Pos airway pressure, CPAP		S	0068	1.2435	$ 74.00	$ 29.48	$ 14.80
94662	Neg press ventilation, cnp		S	0079	2.2410	$ 133.36		$ 26.67
94664	Evaluate pt use of inhaler		S	0077	0.3428	$ 20.40	$ 7.74	$ 4.08
94667	Chest wall manipulation		S	0077	0.3428	$ 20.40	$ 7.74	$ 4.08
94668	Chest wall manipulation		S	0077	0.3428	$ 20.40	$ 7.74	$ 4.08
94680	Exhaled air analysis, o2		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94681	Exhaled air analysis, o2/co2		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94690	Exhaled air analysis		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94720	Monoxide diffusing capacity		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94725	Membrane diffusion capacity		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94750	Pulmonary compliance study		X	0368	0.9568	$ 56.94	$ 22.77	$ 11.39
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level		N					
94770	Exhaled carbon dioxide test		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
94772	Breath recording, infant		X	0369	2.7046	$ 160.95	$ 44.18	$ 32.19
94799	Pulmonary service/procedure		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
95004	Percut allergy skin tests	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95010	Percut allergy titrate test	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95015	Id allergy titrate-drug/bug	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95024	Id allergy test, drug/bug	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95027	Id allergy titrate-airborne	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95028	Id allergy test-delayed type	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95044	Allergy patch tests	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95052	Photo patch test	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95056	Photosensitivity tests		X	0370	2.8133	$ 167.42		$ 33.48
95060	Eye allergy tests		X	0370	2.8133	$ 167.42		$ 33.48
95065	Nose allergy test	CH	X	0381	0.1925	$ 11.46	$ 2.41	$ 2.29
95070	Bronchial allergy tests		X	0369	2.7046	$ 160.95	$ 44.18	$ 32.19
95071	Bronchial allergy tests		X	0369	2.7046	$ 160.95	$ 44.18	$ 32.19
95075	Ingestion challenge test		X	0361	3.5671	$ 212.28	$ 83.23	$ 42.46
95078	Provocative testing		X	0370	2.8133	$ 167.42		$ 33.48
95115	Immunotherapy, one injection		X	0352	0.1368	$ 8.14		$ 1.63
95117	Immunotherapy injections		X	0353	0.3917	$ 23.31		$ 4.66
95144	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95145	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95146	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95147	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95148	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95149	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95165	Antigen therapy services	CH	X	0353	0.3917	$ 23.31		$ 4.66
95170	Antigen therapy services	CH	X	0352	0.1368	$ 8.14		$ 1.63
95180	Rapid desensitization		X	0370	2.8133	$ 167.42		$ 33.48
95199	Allergy immunology services		X	0370	2.8133	$ 167.42		$ 33.48
95250	Glucose monitoring, cont		X	0421	1.6026	$ 95.37		$ 19.07
95805	Multiple sleep latency test		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95806	Sleep study, unattended		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95807	Sleep study, attended		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95808	Polysomnography, 1-3		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95810	Polysomnography, 4 or more		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95811	Polysomnography w/cpap		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95812	Eeg, 41-60 minutes		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95813	Eeg, over 1 hour		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95816	Eeg, awake and drowsy	CH	S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95819	Eeg, awake and asleep	CH	S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95822	Eeg, coma or sleep only	CH	S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95824	Eeg, cerebral death only		S	0214	1.1863	$ 70.60	$ 28.24	$ 14.12
95827	Eeg, all night recording		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95829	Surgery electrocorticogram		S	0214	1.1863	$ 70.60	$ 28.24	$ 14.12
95857	Tensilon test		S	0218	1.1138	$ 66.28		$ 13.26
95858	Tensilon test & myogram	CH	D					
95860	Muscle test, one limb		S	0218	1.1138	$ 66.28		$ 13.26
95861	Muscle test, 2 limbs		S	0218	1.1138	$ 66.28		$ 13.26
95863	Muscle test, 3 limbs		S	0218	1.1138	$ 66.28		$ 13.26
95864	Muscle test, 4 limbs		S	0218	1.1138	$ 66.28		$ 13.26
95865	Muscle test, larynx	NI	S	0218	1.1138	$ 66.28		$ 13.26
95866	Muscle test, hemidiaphragm	NI	S	0218	1.1138	$ 66.28		$ 13.26
95867	Muscle test cran nerv unilat		S	0218	1.1138	$ 66.28		$ 13.26
95868	Muscle test cran nerve bilat		S	0218	1.1138	$ 66.28		$ 13.26
95869	Muscle test, thor paraspinal		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95870	Muscle test, nonparaspinal		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95872	Muscle test, one fiber		S	0218	1.1138	$ 66.28		$ 13.26
95873	Guide nerv destr, elec stim	NI	S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95874	Guide nerv destr, needle emg	NI	S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95875	Limb exercise test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95900	Motor nerve conduction test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95903	Motor nerve conduction test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95904	Sense nerve conduction test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95920	Intraop nerve test add-on		S	0216	2.5976	$ 154.59		$ 30.92
95921	Autonomic nerv function test		S	0218	1.1138	$ 66.28		$ 13.26
95922	Autonomic nerv function test		S	0218	1.1138	$ 66.28		$ 13.26
95923	Autonomic nerv function test		S	0218	1.1138	$ 66.28		$ 13.26
95925	Somatosensory testing		S	0216	2.5976	$ 154.59		$ 30.92
95926	Somatosensory testing		S	0216	2.5976	$ 154.59		$ 30.92
95927	Somatosensory testing		S	0216	2.5976	$ 154.59		$ 30.92
95928	C motor evoked, uppr limbs		S	0218	1.1138	$ 66.28		$ 13.26
95929	C motor evoked, lwr limbs		S	0218	1.1138	$ 66.28		$ 13.26
95930	Visual evoked potential test		S	0216	2.5976	$ 154.59		$ 30.92
95933	Blink reflex test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95934	H-reflex test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95936	H-reflex test		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
95937	Neuromuscular junction test		S	0218	1.1138	$ 66.28		$ 13.26
95950	Ambulatory eeg monitoring		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95951	EEG monitoring/videorecord		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95953	EEG monitoring/computer		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95954	EEG monitoring/giving drugs		S	0214	1.1863	$ 70.60	$ 28.24	$ 14.12
95955	EEG during surgery		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95956	Eeg monitoring, cable/radio		S	0209	11.2895	$ 671.85	$ 268.73	$ 134.37
95957	EEG digital analysis		S	0214	1.1863	$ 70.60	$ 28.24	$ 14.12
95958	EEG monitoring/function test		S	0213	2.2509	$ 133.95	$ 53.58	$ 26.79
95961	Electrode stimulation, brain		S	0216	2.5976	$ 154.59		$ 30.92
95962	Electrode stim, brain add-on		S	0216	2.5976	$ 154.59		$ 30.92
95965	Meg, spontaneous	CH	T	0430	10.8452	$ 645.41		$ 129.08
95966	Meg, evoked, single	CH	T	0430	10.8452	$ 645.41		$ 129.08
95967	Meg, evoked, each add'l	CH	T	0430	10.8452	$ 645.41		$ 129.08
95970	Analyze neurostim, no prog		S	0218	1.1138	$ 66.28		$ 13.26
95971	Analyze neurostim, simple		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95972	Analyze neurostim, complex		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95973	Analyze neurostim, complex		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95974	Cranial neurostim, complex		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95975	Cranial neurostim, complex		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95978	Analyze neurostim brain/1h		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95979	Analyz neurostim brain addon		S	0692	1.9774	$ 117.68	$ 30.16	$ 23.54
95990	Spin/brain pump refil & main		T	0125	1.9021	$ 113.20		$ 22.64
95991	Spin/brain pump refil & main		T	0125	1.9021	$ 113.20		$ 22.64
95999	Neurological procedure		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
96000	Motion analysis, video/3d		S	0216	2.5976	$ 154.59		$ 30.92
96001	Motion test w/ft press meas		S	0216	2.5976	$ 154.59		$ 30.92
96002	Dynamic surface emg		S	0218	1.1138	$ 66.28		$ 13.26
96003	Dynamic fine wire emg		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
96100	Psychological testing	CH	D					
96101	Psycho testing by psych/phys	NI	X	0373	1.2514	$ 74.47		$ 14.89
96102	Psycho testing by technician	NI	X	0382	3.4127	$ 203.09	$ 81.23	$ 40.62
96103	Psycho testing admin by comp	NI	X	0373	1.2514	$ 74.47		$ 14.89
96110	Developmental test, lim		X	0373	1.2514	$ 74.47		$ 14.89
96111	Developmental test, extend		X	0373	1.2514	$ 74.47		$ 14.89
96115	Neurobehavior status exam	CH	D					
96116	Neurobehavioral status exam	NI	X	0373	1.2514	$ 74.47		$ 14.89
96117	Neuropsych test battery	CH	D					
96118	Neuropsych tst by psych/phys	NI	X	0373	1.2514	$ 74.47		$ 14.89
96119	Neuropsych testing by tech	NI	X	0382	3.4127	$ 203.09	$ 81.23	$ 40.62
96120	Neuropsych tst admin w/comp	NI	X	0373	1.2514	$ 74.47		$ 14.89
96150	Assess hlth/behave, init	CH	S	0432	0.6396	$ 38.06		$ 7.61
96151	Assess hlth/behave, subseq	CH	S	0432	0.6396	$ 38.06		$ 7.61
96152	Intervene hlth/behave, indiv	CH	S	0432	0.6396	$ 38.06		$ 7.61
96153	Intervene hlth/behave, group	CH	S	0432	0.6396	$ 38.06		$ 7.61
96154	Interv hlth/behav, fam w/pt	CH	S	0432	0.6396	$ 38.06		$ 7.61

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96400	Chemotherapy, sc/im	CH	D					
96401	Chemo, anti-neopl, sq/im	NI	S	0116	1.1488	$ 68.37		$ 13.67
96402	Chemo hormon antineopl sq/im	NI	S	0116	1.1488	$ 68.37		$ 13.67
96405	Chemo intralesional, up to 7		S	0116	1.1488	$ 68.37		$ 13.67
96406	Chemo intralesional over 7		S	0116	1.1488	$ 68.37		$ 13.67
96408	Chemotherapy, push technique	CH	D					
96410	Chemotherapy,infusion method	CH	D					
96412	Chemo, infuse method add-on	CH	D					
96414	Chemo, infuse method add-on	CH	D					
96416	Chemo prolong infuse w/pump	NI	S	0117	3.1766	$ 189.04	$ 42.54	$ 37.81
96420	Chemo, ia, push tecnique		S	0116	1.1488	$ 68.37		$ 13.67
96422	Chemo ia infusion up to 1 hr		S	0117	3.1766	$ 189.04	$ 42.54	$ 37.81
96423	Chemo ia infuse each addl hr		N					
96425	Chemotherapy,infusion method		S	0117	3.1766	$ 189.04	$ 42.54	$ 37.81
96440	Chemotherapy, intracavitary		S	0116	1.1488	$ 68.37		$ 13.67
96445	Chemotherapy, intracavitary		S	0116	1.1488	$ 68.37		$ 13.67
96450	Chemotherapy, into CNS		S	0116	1.1488	$ 68.37		$ 13.67
96520	Port pump refill & main	CH	D					
96521	Refill/maint, portable pump	NI	T	0125	1.9021	$ 113.20		$ 22.64
96522	Refill/maint pump/resvr syst	NI	T	0125	1.9021	$ 113.20		$ 22.64
96523	Irrig drug delivery device	NI	N					
96530	Syst pump refill & main	CH	D					
96542	Chemotherapy injection		S	0116	1.1488	$ 68.37		$ 13.67
96545	Provide chemotherapy agent	CH	D					
96549	Chemotherapy, unspecified		S	0116	1.1488	$ 68.37		$ 13.67
96567	Photodynamic tx, skin	CH	T	0016	2.5080	$ 149.25	$ 32.68	$ 29.85
96570	Photodynamic tx, 30 min		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
96571	Photodynamic tx, addl 15 min		T	0015	1.6338	$ 97.23	$ 20.13	$ 19.45
96900	Ultraviolet light therapy		S	0001	0.3998	$ 23.79	$ 7.00	$ 4.76
96902	Trichogram		N					
96910	Photochemotherapy with UV-B		S	0001	0.3998	$ 23.79	$ 7.00	$ 4.76
96912	Photochemotherapy with UV-A		S	0001	0.3998	$ 23.79	$ 7.00	$ 4.76
96913	Photochemotherapy, UV-A or B		S	0683	1.9289	$ 114.79	$ 25.79	$ 22.96
96920	Laser tx, skin < 250 sq cm		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
96921	Laser tx, skin 250-500 sq cm		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
96922	Laser tx, skin > 500 sq cm		T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
96999	Dermatological procedure		T	0010	0.5923	$ 35.25	$ 9.65	$ 7.05
97020	Microwave therapy		D					
97504	Orthotic training		D					
97520	Prosthetic training		D					
97597	Active wound care/20 cm or <	CH	T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
97598	Active wound care > 20 cm	CH	T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
97601	Wound(s) care, selective		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97602	Wound(s) care non-selective	CH	X	0340	0.6137	$ 36.52		$ 7.30
97605	Neg press wound tx, < 50 cm	CH	T	0012	0.8477	$ 50.45	$ 11.18	$ 10.09
97606	Neg press wound tx, > 50 cm	CH	T	0013	1.0603	$ 63.10	$ 13.07	$ 12.62
97703	Prosthetic checkout		D					
97780	Acupuncture w/o stimul		D					
97781	Acupuncture w/stimul		D					
98925	Osteopathic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98926	Osteopathic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98927	Osteopathic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98928	Osteopathic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98929	Osteopathic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98940	Chiropractic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98941	Chiropractic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
98942	Chiropractic manipulation		S	0060	0.5011	$ 29.82		$ 5.96
99052	Medical services at night	CH	D					
99054	Medical servcs, unusual hrs		D					
99078	Group health education		N					
99091	Collect/review data from pt	CH	N					
99141	Sedation, iv/im or inhalant	CH	D					
99142	Sedation, oral/rectal/nasal	CH	D					
99143	Mod cs by same phys, < 5 yrs	NI	N					
99144	Mod cs by same phys, 5 yrs +	NI	N					
99145	Mod cs by same phys add-on	NI	N					
99148	Mod cs diff phys < 5 yrs	NI	N					
99149	Mod cs diff phys 5 yrs +	NI	N					
99150	Mod cs diff phys add-on	NI	N					
99170	Anogenital exam, child		T	0191	0.1702	$ 10.13	$ 2.85	$ 2.03
99175	Induction of vomiting		N					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					
99195	Phlebotomy		X	0372	0.5580	$ 33.21	$ 10.09	$ 6.64
99201	Office/outpatient visit, new		V	0600	0.8800	$ 52.37		$ 10.47
99202	Office/outpatient visit, new		V	0600	0.8800	$ 52.37		$ 10.47
99203	Office/outpatient visit, new		V	0601	1.0125	$ 60.25		$ 12.05
99204	Office/outpatient visit, new		V	0602	1.4731	$ 87.67		$ 17.53
99205	Office/outpatient visit, new		V	0602	1.4731	$ 87.67		$ 17.53
99211	Office/outpatient visit, est		V	0600	0.8800	$ 52.37		$ 10.47
99212	Office/outpatient visit, est		V	0600	0.8800	$ 52.37		$ 10.47
99213	Office/outpatient visit, est		V	0601	1.0125	$ 60.25		$ 12.05
99214	Office/outpatient visit, est		V	0602	1.4731	$ 87.67		$ 17.53
99215	Office/outpatient visit, est		V	0602	1.4731	$ 87.67		$ 17.53
99241	Office consultation		V	0600	0.8800	$ 52.37		$ 10.47
99242	Office consultation		V	0600	0.8800	$ 52.37		$ 10.47

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99243	Office consultation		V	0601	1.0125	$ 60.25		$ 12.05
99244	Office consultation		V	0602	1.4731	$ 87.67		$ 17.53
99245	Office consultation		V	0602	1.4731	$ 87.67		$ 17.53
99261	Follow-up inpatient consult	CH	D					
99262	Follow-up inpatient consult	CH	D					
99263	Follow-up inpatient consult	CH	D					
99271	Confirmatory consultation	CH	D					
99272	Confirmatory consultation	CH	D					
99273	Confirmatory consultation	CH	D					
99274	Confirmatory consultation	CH	D					
99275	Confirmatory consultation	CH	D					
99281	Emergency dept visit		V	0610	1.2399	$ 73.79	$ 18.71	$ 14.76
99282	Emergency dept visit		V	0610	1.2399	$ 73.79	$ 18.71	$ 14.76
99283	Emergency dept visit		V	0611	2.1707	$ 129.18	$ 34.26	$ 25.84
99284	Emergency dept visit		V	0612	3.7772	$ 224.78	$ 51.89	$ 44.96
99285	Emergency dept visit		V	0612	3.7772	$ 224.78	$ 51.89	$ 44.96
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour		S	0620	8.0276	$ 477.73	$ 131.61	$ 95.55
99292	Critical care, add'l 30 min		N					
99300	Ic, infant pbw 2501-5000 gm	NI	N					
99301	Nursing facility care		D					
99302	Nursing facility care		D					
99303	Nursing facility care		D					
99311	Nursing fac care, subseq		D					
99312	Nursing fac care, subseq		D					
99313	Nursing fac care, subseq		D					
99321	Rest home visit, new patient		D					
99322	Rest home visit, new patient		D					
99323	Rest home visit, new patient		D					
99331	Rest home visit, est pat		D					
99332	Rest home visit, est pat		D					
99333	Rest home visit, est pat		D					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99358	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					
99361	Physician/team conference	CH	N					
99362	Physician/team conference	CH	N					
99431	Initial care, normal newborn		V	0600	0.8800	$ 52.37		$ 10.47
99432	Newborn care, not in hosp		N					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.4582	$ 146.29	$ 46.29	$ 29.26

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001F	Heart failure composite		D					
0001T	Endovas repr abdo ao aneurys		D					
0002F	Tobacco use, smoking, assess		D					
0003F	Tobacco use, non-smoking		D					
0003T	Cervicography	CH	S	1492		$ 15.00		$ 3.00
0004F	Tobacco use txmnt counseling		D					
0005F	Osteoarthritis composite		D					
0005T	Perc cath stent/brain cv art		D					
0006F	Statin therapy, prescribed		D					
0006T	Perc cath stent/brain cv art		D					
0007F	Beta-blocker thx prescribed		D					
0007T	Perc cath stent/brain cv art		D					
0008F	Ace inhibitor thx prescribed		D					
0008T	Upper gi endoscopy w/suture		T	0422	24.0525	$ 1,431.39	$ 448.81	$ 286.28
0009F	Assess anginal symptom/level		D					
0009T	Endometrial cryoablation		D					
0010F	Assess anginal symptom/level		D					
0010T	Tb test, gamma interferon		D					
0011F	Oral antiplat thx prescribed		D					
0012T	Osteochondral knee autograft		D					
0013T	Osteochondral knee allograft		D					
0014T	Meniscal transplant, knee		D					
0016T	Thermotx choroid vasc lesion		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
0017T	Photocoagulat macular drusen		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
0018T	Transcranial magnetic stimul		S	0215	0.6025	$ 35.86	$ 14.34	$ 7.17
0020T	Extracorp shock wave tx, ft		D					
0023T	Phenotype drug test, hiv 1		D					
0027T	Endoscopic epidural lysis	CH	T	0220	17.3203	$ 1,030.75		$ 206.15
0028T	Dexa body composition study		N					
0031T	Speculoscopy		N					
0032T	Speculoscopy w/direct sample		N					
0033T	Endovasc taa repr incl subcl	CH	D					
0034T	Endovasc taa repr w/o subcl	CH	D					
0035T	Insert endovasc prosth, taa	CH	D					
0036T	Endovasc prosth, taa, add-on	CH	D					
0037T	Artery transpose/endovas taa	CH	D					
0038T	Rad endovasc taa rpr w/cover	CH	D					
0039T	Rad s/i, endovasc taa repair	CH	D					
0040T	Rad s/i, endovasc taa prosth	CH	D					
0042T	Ct perfusion w/contrast, cbf		N					
0044T	Whole body photography		N					
0045T	Whole body photography		N					
0046T	Cath lavage, mammary duct(s		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0047T	Cath lavage, mammary duct(s)		T	0021	14.9984	$ 892.57	$ 219.48	$ 178.51
0054T	Bone surgery using computer	CH	S	0302	4.6992	$ 279.65	$ 105.94	$ 55.93
0055T	Bone surgery using computer	CH	S	0302	4.6992	$ 279.65	$ 105.94	$ 55.93
0056T	Bone surgery using computer	CH	S	0302	4.6992	$ 279.65	$ 105.94	$ 55.93
0057T	Uppr gi scope w/ thrml txmnt		D					
0058T	Cryopreservation, ovary tiss		X	0348	0.7607	$ 45.27		$ 9.05
0059T	Cryopreservation, oocyte		X	0348	0.7607	$ 45.27		$ 9.05
0062T	Rep intradisc annulus;1 lev	CH	T	0050	23.9367	$ 1,424.50		$ 284.90
0063T	Rep intradisc annulus;>1lev	CH	T	0050	23.9367	$ 1,424.50		$ 284.90
0064T	Spectroscop eval expired gas		X	0367	0.6539	$ 38.91	$ 14.80	$ 7.78
0067T	Ct colonography;dx	CH	S	0333	5.1053	$ 303.82	$ 121.52	$ 60.76
0069T	Analysis only heart sound		N					
0070T	Interp only heart sound		N					
0071T	U/s leiomyomata ablate <200	CH	T	0195	26.7972	$ 1,594.73	$ 483.80	$ 318.95
0072T	U/s leiomyomata ablate >200	CH	T	0202	41.2319	$ 2,453.75	$ 981.50	$ 490.75
0073T	Delivery, comp imrt		S	0412	5.3573	$ 318.82		$ 63.76
0083T	Stereotactic rad tx mngmt		N					
0084T	Temp prostate urethral stent		T	0164	1.1600	$ 69.03	$ 16.96	$ 13.81
0085T	Breath test heart reject		X	0340	0.6137	$ 36.52		$ 7.30
0086T	L ventricle fill pressure		N					
0087T	Sperm eval hyaluronan		X	0348	0.7607	$ 45.27		$ 9.05
0088T	Rf tongue base vol reduxn		T	0253	16.0740	$ 956.58	$ 282.29	$ 191.32
0089T	Actigraphy testing, 3-day	NI	S	0218	1.1138	$ 66.28		$ 13.26
0099T	Implant corneal ring	NI	T	0233	14.6645	$ 872.70	$ 266.33	$ 174.54
0100T	Prosth retina receive&gen	NI	T	0672	36.8773	$ 2,194.61		$ 438.92
0101T	Extracorp shockwv tx,hi enrg	NI	T	1547		$ 850.00		$ 170.00
0102T	Extracorp shockwv tx,anesth	NI	T	1547		$ 850.00		$ 170.00
0106T	Touch quant sensory test	NI	X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
0107T	Vibrate quant sensory test	NI	X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
0108T	Cool quant sensory test	NI	X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
0109T	Heat quant sensory test	NI	X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
0110T	Nos quant sensory test	NI	X	0341	0.1035	$ 6.16	$ 2.46	$ 1.23
0120T	Fibroadenoma cryoablate, ea	NI	T	0029	31.4826	$ 1,873.56	$ 632.64	$ 374.71
0123T	Scleral fistulization	NI	T	0234	22.0521	$ 1,312.34	$ 511.31	$ 262.47
0124T	Conjunctival drug placement	NI	T	0232	6.9204	$ 411.84	$ 103.17	$ 82.37
0126T	Chd risk imt study	NI	N					
0133T	Esophageal Implant Injexn	NI	T	1556		$ 1,750.00		$ 350.00
0135T	Perq cryoablate renal tumor	NI	T	0163	33.5963	$ 1,999.35		$ 399.87
0137T	Prostate Saturation Sampling	NI	T	0184	4.4432	$ 264.42	$ 96.27	$ 52.88
0144T	Ct Heart Wo Dye; Qual Calc	NI	S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
0145T	Ct Heart W/Wo Dye Funct	NI	S	0376	5.0315	$ 299.43	$ 119.77	$ 59.89
0146T	Ccta W/Wo Dye	NI	S	0376	5.0315	$ 299.43	$ 119.77	$ 59.89
0147T	Ccta W/Wo, Quan Calcium	NI	S	0376	5.0315	$ 299.43	$ 119.77	$ 59.89

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0148T	Ccta W/Wo, Strxr	NI	S	0377	6.6729	$ 397.11	$ 158.84	$ 79.42
0149T	Ccta W/Wo, Strxr Quan Calc	NI	S	0377	6.6729	$ 397.11	$ 158.84	$ 79.42
0150T	Ccta W/Wo, Disease Strxr	NI	S	0398	4.2038	$ 250.17	$ 100.06	$ 50.03
0151T	Ct Heart Funct Add-On	NI	S	0282	1.5934	$ 94.82	$ 37.92	$ 18.96
0152T	Computer Chest Add-On	NI	N					
0154T	Implant Aneur Sensor Study	NI	X	0097	1.0211	$ 60.77	$ 23.79	$ 12.15
A4220	Infusion pump refill kit		N					
A4248	Chlorhexidine antisept		N					
A4254	Battery for glucose monitor		D					
A4260	Levonorgestrel implant		D					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4270	Disposable endoscope sheath	CH	N					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4324	Male ext cath w/adh coating		D					
A4325	Male ext cath w/adh strip		D					
A4347	Male external catheter		D					
A4521	Adult size diaper sm each		D					
A4522	Adult size diaper med each		D					
A4523	Adult size diaper lg each		D					
A4524	Adult size diaper xl each		D					
A4525	Adult size brief sm each		D					
A4526	Adult size brief med each		D					
A4527	Adult size brief lg each		D					
A4528	Adult size brief xl each		D					
A4529	Child size diaper sm/med ea		D					
A4530	Child size diaper lg each		D					
A4531	Child size brief sm/med each		D					
A4532	Child size brief lg each		D					
A4533	Youth size diaper each		D					
A4535	Disp incont liner/shield ea		D					
A4536	Prot underwr wshbl any sz ea		D					
A4537	Under pad reusable any sz ea		D					
A4538	Reusable diaper from dpr svc		D					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4609	Trach suction cath clsed sys		D					
A4610	Trach sctn cath 72h clsedsys		D					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab	CH	H	0704				
A4643	High dose contrast MRI	CH	D					
A4644	Contrast 100-199 MGs iodine	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4645	Contrast 200-299 MGs iodine	CH	D					
A4646	Contrast 300-399 MGs iodine	CH	D					
A4647	Supp- paramagnetic contr mat	CH	D					
A4656	Needle any size		D					
A5119	Skin barrier wipes box pr 50		D					
A5509	Direct heat form shoe insert		D					
A5511	Custom fab molded shoe inser		D					
A6551	Neg press wound ther canistr		D					
A9500	Tc99m sestamibi	CH	H	1600				
A9502	Tc99m tetrofosmin	CH	H	0705				
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide	CH	H	1602				
A9505	TL201 thallium	CH	H	1603				
A9507	In111 capromab	CH	H	1604				
A9508	I131 iodobenguate, dx	CH	H	1045				
A9510	Tc99m disofenin	CH	H	9146				
A9511	Technetium TC 99m depreotide	CH	D					
A9512	Tc99m pertechnetate		N					
A9513	Technetium tc-99m mebrofenin	CH	D					
A9514	Technetiumtc99mpyrophosphate	CH	D					
A9515	Technetium tc-99m pentetate	CH	D					
A9516	I123 iodide cap, dx	CH	H	9148				
A9517	I131 iodide cap, rx	CH	H	1064				
A9519	Technetiumtc-99mmacroag albu	CH	D					
A9520	Technetiumtc-99m sulfur clld	CH	D					
A9521	Tc99m exametazime	CH	H	1096				
A9522	Indium111ibritumomabtiuxetan	CH	D					
A9523	Yttrium90ibritumomabtiuxetan	CH	D					
A9524	I131 serum albumin, dx	CH	H	9100				
A9525	Low/iso-osmolar contrast mat		D					
A9526	Nitrogen N-13 ammonia	CH	H	0737				
A9528	Iodine I-131 iodide cap, dx	CH	H	1088				
A9529	I131 iodide sol, dx	CH	H	1065				
A9530	I131 iodide sol, rx	CH	H	1150				
A9531	I131 max 100uCi	CH	H	9149				
A9532	I125 serum albumin, dx	CH	H	9150				
A9533	I-131 tositumomab diagnostic		D					
A9534	I-131 tositumomab therapeut		D					
A9535	Injection, methylene blue	NI	K	1640		$ 3.05		$ 0.61
A9536	Tc99m depreotide	NI	H	1641				
A9537	Tc99m mebrofenin	NI	N					
A9538	Tc99m pyrophosphate	NI	N					
A9539	Tc99m pentetate	NI	N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9540	Tc99m MAA	NI	N					
A9541	Tc99m sulfur colloid	NI	N					
A9542	In111 ibritumomab, dx	NI	H	1642				
A9543	Y90 ibritumomab, rx	NI	H	1643				
A9544	I131 tositumomab, dx	NI	H	1644				
A9545	I131 tositumomab, rx	NI	H	1645				
A9546	Co57/58	NI	N					
A9547	In111 oxyquinoline	NI	H	1646				
A9548	In111 pentetate	NI	H	1647				
A9549	Tc99m arcitumomab	NI	H	1648				
A9550	Tc99m gluceptate	NI	H	1649				
A9551	Tc99m succimer	NI	H	1650				
A9552	F18 fdg	NI	H	1651				
A9553	Cr51 chromate	NI	H	1652				
A9554	I125 iothalamate, dx	NI	H	1653				
A9555	Rb82 rubidium	NI	H	1654				
A9556	Ga67 gallium	NI	H	1671				
A9557	Tc99m bicisate	NI	H	1672				
A9558	Xe133 xenon 10mci	NI	N					
A9559	Co57 cyano	NI	N					
A9560	Tc99m labeled rbc	NI	H	1673				
A9561	Tc99m oxidronate	NI	N					
A9562	Tc99m mertiatide	NI	H	1674				
A9563	P32 Na phosphate	NI	H	1675				
A9564	P32 chromic phosphate	NI	H	1676				
A9565	In111 pentetreotide	NI	H	1677				
A9566	Tc99m fanolesomab	NI	H	1678				
A9567	Technetium TC-99m aerosol	NI	H	1679				
A9600	Sr89 strontium	CH	H	0701				
A9605	Sm 153 lexidronm	CH	H	0702				
A9698	Non-rad contrast materialNOC	NI	N					
A9699	Radiopharm rx agent noc		N					
B4151	Enteral formulae cat1natural		D					
B4156	Enteral formulae category vi		D					
B4184	Parenteral sol lipids 10%		D					
B4186	Parenteral sol lipids 20%		D					
C1079	CO 57/58 per 0.5 uCi	CH	D					
C1080	I-131 tositumomab, dx	CH	D					
C1081	I-131 tositumomab, tx	CH	D					
C1082	In-111 ibritumomab tiuxetan	CH	D					
C1083	Yttrium 90 ibritumomab tiuxe	CH	D					
C1091	IN111 oxyquinoline,per0.5mCi	CH	D					
C1092	IN 111 pentetate per 0.5 mCi	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1093	TC99M fanolesomab	CH	D					
C1122	Tc 99M ARCITUMOMAB PER VIAL	CH	D					
C1178	BUSULFAN IV, 6 Mg		K	1178	0.1795	$ 10.68		$ 2.14
C1200	TC 99M Sodium Glucoheptonat	CH	D					
C1201	TC 99M SUCCIMER, PER Vial	CH	D					
C1300	HYPERBARIC Oxygen		S	0659	1.5155	$ 90.19		$ 18.04
C1305	Apligraf, 44cm2	CH	D					
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx source, Gold 198		H	1716				
C1717	Brachytx source, HDR Ir-192		H	1717				
C1718	Brachytx source, Iodine 125		H	1718				
C1719	Brachytx sour,Non-HDR Ir-192		H	1719				
C1720	Brachytx sour, Palladium 103		H	1720				
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1767	Generator, neurostim, imp		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1775	FDG, per dose (4-40 mCi/ml)	CH	D					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil	CH	N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis	CH	N					
C1819	Tissue local excision	CH	N					
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx source, Yttrium-90		H	2616				
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2632	Brachytx sol, I-125, per mCi		H	2632				
C2633	Brachytx source, Cesium-131		H	2633				
C2634	Brachytx source, HA, I-125		H	2634				
C2635	Brachytx source, HA, P-103		H	2635				
C2636	Brachytx linear source, P-10		H	2636				
C2637	Brachytx, Ytterbium-169	NF	H	2637				
C8900	MRA w/cont, abd		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8901	MRA w/o cont, abd		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
C8902	MRA w/o fol w/cont, abd		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8903	MRI w/cont, breast, uni		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8904	MRI w/o cont, breast, uni		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8906	MRI w/cont, breast, bi		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8907	MRI w/o cont, breast, bi		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
C8908	MRI w/o fol w/cont, breast,		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8909	MRA w/cont, chest		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8910	MRA w/o cont, chest		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8911	MRA w/o fol w/cont, chest		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8912	MRA w/cont, lwr ext		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8913	MRA w/o cont, lwr ext		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8918	MRA w/cont, pelvis		S	0284	6.2342	$ 371.00	$ 148.40	$ 74.20
C8919	MRA w/o cont, pelvis		S	0336	5.8678	$ 349.20	$ 139.68	$ 69.84
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.5070	$ 506.26	$ 202.50	$ 101.25
C8950	IV inf, tx/dx, up to 1 hr	NI	S	0120	2.0293	$ 120.77	$ 28.21	$ 24.15
C8951	IV inf, tx/dx, each addl hr	NI	N					
C8952	Tx, prophy, dx IV push	NI	X	0359	0.8036	$ 47.82		$ 9.56
C8953	Chemotx adm, IV push	NI	S	0116	1.1488	$ 68.37		$ 13.67
C8954	Chemotx adm, IV inf up to 1h	NI	S	0117	3.1766	$ 189.04	$ 42.54	$ 37.81
C8955	Chemotx adm, IV inf, addl hr	NI	N					
C8956	Refill/maint port/impl pump	NI	T	0125	1.9021	$ 113.20		$ 22.64
C8957	Prolonged IV inf, req pump	NI	S	0120	2.0293	$ 120.77	$ 28.21	$ 24.15
C9000	Na chromateCr51, per 0.25mCi	CH	D					
C9003	Palivizumab, per 50 mg		K	9003	4.3120	$ 256.61		$ 51.32
C9007	Baclofen Intrathecal kit-1am	CH	D					
C9008	Baclofen Refill Kit-500mcg	CH	D					
C9009	Baclofen Refill Kit-2000mcg	CH	D					
C9013	Co 57 cobaltous chloride	CH	D					
C9102	51 Na Chromate, 50mCi	CH	D					
C9103	Na lothalamate I-125, 10 uCi	CH	D					
C9105	Hep B imm glob, per 1 ml	CH	D					
C9109	Tirofiban hcl, 6.25 mg		D					
C9112	Perflutren lipid micro, 2ml	CH	D					
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121	0.2176	$ 12.95		$ 2.59
C9123	Transcyte, 247cm2	CH	D					
C9124	Injection, daptomycin		D					
C9125	Injection, risperidone		D					
C9127	Paclitaxel protein pr	CH	D					
C9128	Inj pegaptanib sodium	CH	D					
C9129	Inj clofarabine	CH	D					
C9200	Orcel, 36 cm2	CH	D					
C9201	Dermagraft, 37.5cm2	CH	D					
C9202	Octafluoropropane	CH	D					
C9203	Perflexane lipid micro	CH	D					
C9205	Oxaliplatin	CH	D					
C9206	Integra, per cm2	CH	D					
C9207	Injection, bortezomib		D					
C9208	Injection, agalsidase beta		D					
C9209	Injection, laronidase		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9210	Injection, palonosetron HCL		D					
C9211	Inj, alefacept, IV	CH	D					
C9212	Inj, alefacept, IM	CH	D					
C9213	Injection, Pemetrexed		D					
C9214	Injection, Bevacizumab		D					
C9215	Injection, Cetuximab		D					
C9216	Abarelix, Inject Suspension		D					
C9217	Injection, Omalizumab		D					
C9218	Injection, Azacitidine	CH	D					
C9219	Mycophenolic Acid, Oral		D					
C9220	Sodium hyaluronate		G	9220		$ 193.59		$ 38.72
C9221	Graftjacket Reg Matrix		G	9221		$ 1,307.48		$ 261.50
C9222	Graftjacket SftTis		G	9222		$ 883.21		$ 176.64
C9223	Inj adenosine, tx dx	CH	D					
C9224	Injection, galsulfase	NF	K	9224		$ 1,522.15		$ 304.43
C9225	Fluocinolone acetonide	NF	G	9225		$19,345.00		$ 3,869.00
C9226	Ziconotide intrathecal inf	CH	D					
C9400	Thallous chloride, brand	CH	D					
C9401	Strontium-89 chloride, brand	CH	D					
C9402	Th I131 so iodide cap, brand	CH	D					
C9403	Dx I131 so iodide cap, brand	CH	D					
C9404	Dx I131 so iodide sol, brand	CH	D					
C9405	Th I131 so iodide sol, brand	CH	D					
C9410	Dexrazoxane HCl inj, brand	CH	D					
C9411	Pamidronate disodium, brand	CH	D					
C9413	Na hyaluronate bran	CH	D					
C9414	Etoposide oral, brand	CH	D					
C9415	Doxorubic hcl chemo, brand	CH	D					
C9417	Bleomycin sulfate inj, brand	CH	D					
C9418	Cisplatin inj, brand	CH	D					
C9419	Inj cladribine, brand	CH	D					
C9420	Cyclophosphamide inj, brand	CH	D					
C9421	Cyclophosphamide lyo, brand	CH	D					
C9422	Cytarabine hcl inj, brand	CH	D					
C9423	Dacarbazine inj, brand	CH	D					
C9424	Daunorubicin, brand	CH	D					
C9425	Etoposide inj, brand	CH	D					
C9426	Floxuridine inj, brand	CH	D					
C9427	Ifosfomide inj, brand	CH	D					
C9428	Mesna injection, brand	CH	D					
C9429	Idarubicin hcl inj, brand	CH	D					
C9430	Leuprolide acetate bran	CH	D					
C9431	Paclitaxel inj, brand	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9432	Mitomycin inj, brand	CH	D					
C9433	Thiotepa inj, brand	CH	D					
C9435	Gonadorelin hydroch, brand	CH	D					
C9436	Azathioprine parenteral,brnd	CH	D					
C9437	Carmus bischl nitro inj	CH	D					
C9438	Cyclosporine oral, brand	CH	D					
C9439	Diethylstilbestrol injection	CH	D					
C9440	Vinorelbine tar,brand	CH	D					
C9701	Stretta System		D					
C9703	Bard Endoscopic Suturing Sys		D					
C9704	Inj inert subs upper GI	CH	D					
C9712	Insert pH capsule, GERD		D					
C9713	Non-contact laser vap prosta	CH	D					
C9714	Breast inters rad tx, immed		D					
C9715	Breast inters rad tx, delay		D					
C9716	RF Energy to Anus		S	1519		$ 1,750.00		$ 350.00
C9717	Stapled Hemorrhoidopexy		D					
C9718	Kyphoplasty, first vertebra	CH	D					
C9719	Kyphoplasty, each addl	CH	D					
C9720	HE ESW tx, tennis elbow	CH	D					
C9721	HE ESW tx, plantar fasciitis	CH	D					
C9722	KV imaging w/IR tracking	CH	D					
C9723	Dyn IR Perf Img	NF	S	1502		$ 75.00		$ 15.00
C9724	EPS gast cardia plic	NF	T	0422	24.0525	$ 1,431.39	$ 448.81	$ 286.28
C9725	Place endorectal app	NF	S	1507		$ 550.00		$ 110.00
D0150	Comprehensve oral evaluation		S	0330	9.3925	$ 558.96		$ 111.79
D0240	Intraoral occlusal film		S	0330	9.3925	$ 558.96		$ 111.79
D0250	Extraoral first film		S	0330	9.3925	$ 558.96		$ 111.79
D0260	Extraoral ea additional film		S	0330	9.3925	$ 558.96		$ 111.79
D0270	Dental bitewing single film		S	0330	9.3925	$ 558.96		$ 111.79
D0272	Dental bitewings two films		S	0330	9.3925	$ 558.96		$ 111.79
D0274	Dental bitewings four films		S	0330	9.3925	$ 558.96		$ 111.79
D0277	Vert bitewings-sev to eight		S	0330	9.3925	$ 558.96		$ 111.79
D0460	Pulp vitality test		S	0330	9.3925	$ 558.96		$ 111.79
D1510	Space maintainer fxd unilat		S	0330	9.3925	$ 558.96		$ 111.79
D1515	Fixed bilat space maintainer		S	0330	9.3925	$ 558.96		$ 111.79
D1520	Remove unilat space maintain		S	0330	9.3925	$ 558.96		$ 111.79
D1525	Remove bilat space maintain		S	0330	9.3925	$ 558.96		$ 111.79
D1550	Recement space maintainer		S	0330	9.3925	$ 558.96		$ 111.79
D2999	Dental unspec restorative pr		S	0330	9.3925	$ 558.96		$ 111.79
D3460	Endodontic endosseous implan		S	0330	9.3925	$ 558.96		$ 111.79
D3999	Endodontic procedure		S	0330	9.3925	$ 558.96		$ 111.79
D4260	Osseous surgery per quadrant		S	0330	9.3925	$ 558.96		$ 111.79

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4263	Bone replce graft first site		S	0330	9.3925	$ 558.96		$ 111.79
D4264	Bone replce graft each add		S	0330	9.3925	$ 558.96		$ 111.79
D4268	Surgical revision procedure		S	0330	9.3925	$ 558.96		$ 111.79
D4270	Pedicle soft tissue graft pr		S	0330	9.3925	$ 558.96		$ 111.79
D4271	Free soft tissue graft proc		S	0330	9.3925	$ 558.96		$ 111.79
D4273	Subepithelial tissue graft		S	0330	9.3925	$ 558.96		$ 111.79
D4355	Full mouth debridement		S	0330	9.3925	$ 558.96		$ 111.79
D4381	Localized delivery antimicro		S	0330	9.3925	$ 558.96		$ 111.79
D5911	Facial moulage sectional		S	0330	9.3925	$ 558.96		$ 111.79
D5912	Facial moulage complete		S	0330	9.3925	$ 558.96		$ 111.79
D5983	Radiation applicator		S	0330	9.3925	$ 558.96		$ 111.79
D5984	Radiation shield		S	0330	9.3925	$ 558.96		$ 111.79
D5985	Radiation cone locator		S	0330	9.3925	$ 558.96		$ 111.79
D5987	Commissure splint		S	0330	9.3925	$ 558.96		$ 111.79
D6920	Dental connector bar		S	0330	9.3925	$ 558.96		$ 111.79
D7111	Extraction coronal remnants		S	0330	9.3925	$ 558.96		$ 111.79
D7140	Extraction erupted tooth/exr		S	0330	9.3925	$ 558.96		$ 111.79
D7210	Rem imp tooth w mucoper flp		S	0330	9.3925	$ 558.96		$ 111.79
D7220	Impact tooth remov soft tiss		S	0330	9.3925	$ 558.96		$ 111.79
D7230	Impact tooth remov part bony		S	0330	9.3925	$ 558.96		$ 111.79
D7240	Impact tooth remov comp bony		S	0330	9.3925	$ 558.96		$ 111.79
D7241	Impact tooth rem bony w/comp		S	0330	9.3925	$ 558.96		$ 111.79
D7250	Tooth root removal		S	0330	9.3925	$ 558.96		$ 111.79
D7260	Oral antral fistula closure		S	0330	9.3925	$ 558.96		$ 111.79
D7261	Primary closure sinus perf		S	0330	9.3925	$ 558.96		$ 111.79
D7291	Transseptal fiberotomy		S	0330	9.3925	$ 558.96		$ 111.79
D7940	Reshaping bone orthognathic		S	0330	9.3925	$ 558.96		$ 111.79
D9110	Tx dental pain minor proc		N					
D9230	Analgesia		N					
D9248	Sedation (non-iv)		N					
D9630	Other drugs/medicaments		S	0330	9.3925	$ 558.96		$ 111.79
D9930	Treatment of complications		S	0330	9.3925	$ 558.96		$ 111.79
D9940	Dental occlusal guard		S	0330	9.3925	$ 558.96		$ 111.79
D9950	Occlusion analysis		S	0330	9.3925	$ 558.96		$ 111.79
D9951	Limited occlusal adjustment		S	0330	9.3925	$ 558.96		$ 111.79
D9952	Complete occlusal adjustment		S	0330	9.3925	$ 558.96		$ 111.79
E0169	Seatlift incorp commodechair		D					
E0176	Air pressre pad/cushion nonp		D					
E0177	Water press pad/cushion nonp		D					
E0178	Gel pressre pad/cushion nonp		D					
E0179	Dry pressre pad/cushion nonp		D					
E0192	Pad wheelchr low press/posit		D					
E0454	Pressure ventilator		D					

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E0616	Cardiac event recorder		N					
E0749	Elec osteogen stim implanted		N					
E0752	Neurostimulator electrode		D					
E0754	Pulsegenerator pt programmer		D					
E0756	Implantable pulse generator		D					
E0757	Implantable RF receiver		D					
E0758	External RF transmitter		D					
E0759	Replace rdfrquncy transmittr		D					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0830	Ambulatory traction device		N					
E0953	Pneumatic tire		D					
E0954	Wheelchair semi-pneumatic ca		D					
E0962	Wheelchair 1 inch cushion		D					
E0963	Wheelchair 2 inch cushion		D					
E0964	Wheelchair 3 inch cushion		D					
E0965	Wheelchair 4 inch cushion		D					
E0972	Transfer board or device		D					
E0996	Wheelchair tire solid		D					
E1000	Wheelchair tire pneumatic ca		D					
E1001	Wheelchair wheel		D					
E1012	Int seat sys planar ped w/c		D					
E1013	Int seat sys contour ped w/c		D					
E1019	HD feature power seat		D					
E1021	Ex hd feature power seat		D					
E1025	Pedwc lat/thor sup nocontour		D					
E1026	Pedwc contoured lat/thor sup		D					
E1027	Ped wc lat/ant support		D					
E1210	Whlchr moto ful arm leg rest		D					
E1211	Wheelchair motorized w/ det		D					
E1212	Wheelchair motorized w full		D					
E1213	Wheelchair motorized w/ det		D					
E1239	Ped power wheelchair NOS		D					
E1399	Durable medical equipment mi		N					
G0001	Drawing blood for specimen		D					
G0008	Admin influenza virus vac	CH	X	0350	0.3917	$ 23.31		
G0009	Admin pneumococcal vaccine	CH	X	0350	0.3917	$ 23.31		
G0030	PET imaging prev PET single		D					
G0031	PET imaging prev PET multple		D					
G0032	PET follow SPECT 78464 singl		D					
G0033	PET follow SPECT 78464 mult		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0034	PET follow SPECT 76865 singl		D					
G0035	PET follow SPECT 78465 mult		D					
G0036	PET follow cornry angio sing		D					
G0037	PET follow cornry angio mult		D					
G0038	PET follow myocard perf sing		D					
G0039	PET follow myocard perf mult		D					
G0040	PET follow stress echo singl		D					
G0041	PET follow stress echo mult		D					
G0042	PET follow ventriculogm sing		D					
G0043	PET follow ventriculogm mult		D					
G0044	PET following rest ECG singl		D					
G0045	PET following rest ECG mult		D					
G0046	PET follow stress ECG singl		D					
G0047	PET follow stress ECG mult		D					
G0101	CA screen;pelvic/breast exam		V	0600	0.8800	$ 52.37		$ 10.47
G0102	Prostate ca screening; dre		N					
G0104	CA screen;flexi sigmoidscope		S	0159	3.6322	$ 216.16		$ 54.04
G0105	Colorectal scrn; hi risk ind		T	0158	7.5542	$ 449.56		$ 112.39
G0106	Colon CA screen;barium enema		S	0157	2.1344	$ 127.02		$ 25.40
G0110	Nett pulm-rehab educ; ind		D					
G0111	Nett pulm-rehab educ; group		D					
G0112	Nett;nutrition guid, initial		D					
G0113	Nett;nutrition guid,subseqnt		D					
G0114	Nett; psychosocial consult		D					
G0115	Nett; psychological testing		D					
G0116	Nett; psychosocial counsel		D					
G0117	Glaucoma scrn hgh risk direc		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
G0118	Glaucoma scrn hgh risk direc		S	0230	0.7902	$ 47.03	$ 14.97	$ 9.41
G0120	Colon ca scrn; barium enema		S	0157	2.1344	$ 127.02		$ 25.40
G0121	Colon ca scrn not hi rsk ind		T	0158	7.5542	$ 449.56		$ 112.39
G0125	PET img WhBD sgl pulm ring		D					
G0127	Trim nail(s)		T	0009	0.7513	$ 44.71		$ 8.94
G0129	Partial hosp prog service		P	0033	4.1322	$ 245.91		$ 49.18
G0130	Single energy x-ray study		X	0260	0.7296	$ 43.42		$ 8.68
G0166	Extrnl counterpulse, per tx		T	0678	1.7600	$ 104.74		$ 20.95
G0173	Linear acc stereo radsur com		S	1528		$ 5,250.00		$ 1,050.00
G0175	OPPS Service,sched team conf		V	0602	1.4731	$ 87.67		$ 17.53
G0176	OPPS/PHP;activity therapy		P	0033	4.1322	$ 245.91		$ 49.18
G0177	OPPS/PHP train & educ serv		P	0033	4.1322	$ 245.91		$ 49.18
G0186	Dstry eye lesn,fdr vssl tech		T	0235	4.7925	$ 285.21	$ 69.52	$ 57.04
G0210	PET img wholebody dxlung		D					
G0211	PET img wholbody init lung		D					
G0212	PET img wholebod restag lung		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0213	PET img wholbody dx		D					
G0214	PET img wholebod init		D					
G0215	PETimg wholebod restag		D					
G0216	PET img wholebod dx melanoma		D					
G0217	PET img wholebod init melan		D					
G0218	PET img wholebod restag mela		D					
G0237	Therapeutic procd strg endur		S	0411	0.3922	$ 23.34		$ 4.67
G0238	Oth resp proc, indiv		S	0411	0.3922	$ 23.34		$ 4.67
G0239	Oth resp proc, group		S	0411	0.3922	$ 23.34		$ 4.67
G0242	Multisource photon ster plan		D					
G0243	Multisour photon stero treat	CH	S	0127	122.7483	$ 7,304.87		$ 1,460.97
G0244	Observ care by facility topt	CH	D					
G0245	Initial foot exam pt lops		V	0600	0.8800	$ 52.37		$ 10.47
G0246	Followup eval of foot pt lop		V	0600	0.8800	$ 52.37		$ 10.47
G0247	Routine footcare pt w lops		T	0009	0.7513	$ 44.71		$ 8.94
G0248	Demonstrate use home inr mon		S	1503		$ 150.00		$ 30.00
G0249	Provide test material,equipm		S	1503		$ 150.00		$ 30.00
G0251	Linear acc based stero radio		S	1513		$ 1,150.00		$ 230.00
G0252	PET imaging initial dx		D					
G0253	PET image brst dection recur		D					
G0257	Unsched dialysis ESRD pt hos		S	0170	5.9448	$ 353.78		$ 70.76
G0258	IV infusion during obs stay		D					
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0206	5.4011	$ 321.42	$ 75.55	$ 64.28
G0263	Adm with CHF, CP, asthma	CH	D					
G0264	Assmt otr CHF, CP, asthma	CH	D					
G0267	Bone marrow or psc harvest		S	0110	3.6419	$ 216.73		$ 43.35
G0268	Removal of impacted wax md		X	0340	0.6137	$ 36.52		$ 7.30
G0269	Occlusive device in vein art		N					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0279	Excorp shock tx, elbow epi		D					
G0280	Excorp shock tx other than		D					
G0288	Recon, CTA for surg plan		S	0417	3.9600	$ 235.66		$ 47.13
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	108.1459	$ 6,435.87		$ 1,287.17
G0291	Drug-eluting stents,each add		T	0656	108.1459	$ 6,435.87		$ 1,287.17
G0292	Adm exp drugs,clinical trial		D					
G0293	Non-cov surg proc,clin trial		S	1505		$ 350.00		$ 70.00
G0294	Non-cov proc, clinical trial		S	1502		$ 75.00		$ 15.00
G0297	Insert single chamber/cd		T	0107	279.4800	$16,632.13	$ 3,344.78	$ 3,326.43
G0298	Insert dual chamber/cd		T	0107	279.4800	$16,632.13	$ 3,344.78	$ 3,326.43
G0299	Inser/repos single icd+leads		T	0108	375.2863	$22,333.66		$ 4,466.73

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0300	Insert reposit lead dual+gen		T	0108	375.2863	$22,333.66		$ 4,466.73
G0302	Pre-op service LVRS complete		S	1509		$ 750.00		$ 150.00
G0303	Pre-op service LVRS 10-15dos		S	1507		$ 550.00		$ 110.00
G0304	Pre-op service LVRS 1-9 dos		S	1504		$ 250.00		$ 50.00
G0305	Post op service LVRS min 6		S	1504		$ 250.00		$ 50.00
G0332	Preadmin IV immunoglobulin	NI	S	1502		$ 75.00		$ 15.00
G0338	Linear accelerator stero pln		D					
G0339	Robot lin-radsurg com, first		S	1528		$ 5,250.00		$ 1,050.00
G0340	Robt lin-radsurg fractx 2-5		S	1525		$ 3,750.00		$ 750.00
G0344	Initial preventive exam		V	0601	1.0125	$ 60.25		$ 12.05
G0345	IV infuse hydration, initial		D					
G0346	Each additional infuse hour		D					
G0347	IV infusion therapy/diagnost		D					
G0348	Each additional hr up to 8hr		D					
G0349	Additional sequential infuse		D					
G0350	Concurrent infusion		D					
G0351	Therapeutic/diagnostic injec		D					
G0353	IV push,single orinitial dru		D					
G0354	Each addition sequential IV		D					
G0355	Chemo adminisrate subcut/IM		D					
G0356	Hormonal anti-neoplastic		D					
G0357	IV push single/initial subst		D					
G0358	IV push each additional drug		D					
G0359	Chemotherapy IV one hr initi		D					
G0360	Each additional hr 1-8 hrs		D					
G0361	Prolong chemo infuse>8hrs pu		D					
G0362	Each add sequential infusion		D					
G0363	Irrigate implanted venous de		D					
G0364	Bone marrow aspirate & biops		X	0342	0.1450	$ 8.63	$ 3.45	$ 1.73
G0365	Vessel mapping hemo access		S	0267	2.5543	$ 152.01	$ 60.80	$ 30.40
G0367	EKG tracing for initial prev		S	0099	0.3769	$ 22.43		$ 4.49
G0369	Pharm fee 1st month transpla		D					
G0370	Pharmacy fee oral cancer etc		D					
G0371	Pharm dispense inhalation 30		D					
G0374	Pharm dispense inhalation 90		D					
G0375	Smoke/tobacco counselng 3-10	NF	S	1491		$ 5.00	$ 2.00	$ 1.00
G0376	Smoke/tobacco counseling >10	NF	S	1491		$ 5.00	$ 2.00	$ 1.00
G0378	Hospital observation per hr	NI	Q	0339	7.1429	$ 425.08		$ 85.02
G0379	Direct admit hospital observ	NI	Q	0600	0.8800	$ 52.37		$ 10.47
G3001	Admin + supply, tositumomab		S	1522		$ 2,250.00		$ 450.00
J0120	Tetracyclin injection	CH	N					
J0128	Abarelix injection		G	9216		$ 67.78		$ 13.56
J0130	Abciximab injection		K	1605		$ 486.98		$ 97.40

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0132	Acetylcysteine injection	NI	K	1680		$ 52.00		$ 10.40
J0133	Acyclovir injection	NI	N					
J0135	Adalimumab injection		K	1083		$ 293.98		$ 58.80
J0150	Injection adenosine 6 MG	CH	K	0379		$ 32.63		$ 6.53
J0152	Adenosine injection	CH	K	0917		$ 70.27		$ 14.05
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection	CH	K	9208		$ 127.17		$ 25.43
J0190	Inj biperiden lactate/5 mg		N					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$ 39.22		$ 7.84
J0207	Amifostine		K	7000		$ 439.31		$ 87.86
J0210	Methyldopate hcl injection	CH	K	2210		$ 9.79		$ 1.96
J0215	Alefacept	CH	K	1633		$ 26.56		$ 5.31
J0256	Alpha 1 proteinase inhibitor		K	0901		$ 3.28		$ 0.66
J0278	Amikacin sulfate injection	NI	K	1681		$ 12.50		$ 2.50
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl	CH	N					
J0285	Amphotericin B		K	9030		$ 22.94		$ 4.59
J0287	Amphotericin b lipid complex		K	9024		$ 11.24		$ 2.25
J0288	Ampho b cholesteryl sulfate		K	0735		$ 12.00		$ 2.40
J0289	Amphotericin b liposome inj		K	0736		$ 18.18		$ 3.64
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0350	Injection anistreplase 30 u	CH	K	1606		$ 2,268.46		$ 453.69
J0360	Hydralazine hcl injection		N					
J0365	Aprotonin, 10,000 kiu	NI	K	1682		$ 2.31		$ 0.46
J0380	Inj metaraminol bitartrate		N					
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection		K	9031		$ 160.00		$ 32.00
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	K	1638		$ 21.85		$ 4.37
J0475	Baclofen 10 MG injection		K	9032		$ 190.29		$ 38.06
J0476	Baclofen intrathecal trial	CH	K	1631		$ 70.74		$ 14.15
J0480	Basiliximab	NI	K	1683		$ 1,420.76		$ 284.15
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject		N					
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj		N					

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J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj	CH	N					
J0583	Bivalirudin	CH	N					
J0585	Botulinum toxin a per unit		K	0902		$ 4.91		$ 0.98
J0587	Botulinum toxin type B		K	9018		$ 7.80		$ 1.56
J0592	Buprenorphine hydrochloride		N					
J0595	Butorphanol tartrate 1 mg	CH	N					
J0600	Edetate calcium disodium inj	CH	K	0892		$ 40.38		$ 8.08
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection	CH	K	0893		$ 37.81		$ 7.56
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$ 32.52		$ 6.50
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection	CH	K	0876		$ 3.37		$ 0.67
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride	CH	K	0935		$ 63.34		$ 12.67
J0740	Cidofovir injection		K	9033		$ 768.71		$ 153.74
J0743	Cilastatin sodium injection	CH	N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal	NI	K	1684		$ 3.76		$ 0.75
J0800	Corticotropin injection	CH	K	1280		$ 107.18		$ 21.44
J0835	Inj cosyntropin per 0.25 MG	CH	K	0835		$ 67.82		$ 13.56
J0850	Cytomegalovirus imm IV /vial		K	0903		$ 722.68		$ 144.54
J0878	Daptomycin injection		G	9124		$ 0.29		$ 0.06

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0880	Darbepoetin alfa injection		D					
J0881	Darbepoetin alfa, non-esrd	NI	K	1685		$ 3.01		$ 0.60
J0885	Epoetin alfa, non-esrd	NI	K	1686		$ 9.22		$ 1.84
J0895	Deferoxamine mesylate inj	CH	K	0895		$ 15.38		$ 3.08
J0900	Testosterone enanthate inj	CH	N					
J0945	Brompheniramine maleate inj	CH	N					
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj	CH	N					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt	CH	K	1210		$ 27.28		$ 5.46
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)	NI	K	1687		$ 546.93		$ 109.39
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection	CH	K	9166		$ 8.05		$ 1.61
J1190	Dexrazoxane HCl injection		K	0726		$ 200.08		$ 40.02
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		N					
J1212	Dimethyl sulfoxide 50% 50 ML	CH	N					
J1230	Methadone injection	CH	N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection	CH	N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		$ 6.52		$ 1.30
J1265	Dopamine injection	NI	N					
J1270	Injection, doxercalciferol		N					
J1320	Amitriptyline injection		N					
J1325	Epoprostenol injection	CH	N					
J1327	Eptifibatide injection		K	1607		$ 13.13		$ 2.63
J1330	Ergonovine maleate injection	CH	K	1330	0.5564	$ 33.11		$ 6.62
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1410	Inj estrogen conjugate 25 MG		K	9038		$ 56.71		$ 11.34
J1430	Ethanolamine oleate 100 mg	NI	K	1688		$ 79.35		$ 15.87
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj	CH	K	1436		$ 71.69		$ 14.34
J1438	Etanercept injection		K	1608		$ 149.62		$ 29.92
J1440	Filgrastim 300 mcg injection		K	0728		$ 177.81		$ 35.56
J1441	Filgrastim 480 mcg injection		K	7049		$ 279.57		$ 55.91
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg	NI	K	1689		$ 11.88		$ 2.38
J1452	Intraocular Fomivirsen na		K	9040		$ 212.00		$ 42.40
J1455	Foscarnet sodium injection	CH	N					
J1457	Gallium nitrate injection		K	1085		$ 1.25		$ 0.25
J1460	Gamma globulin 1 CC inj	CH	N					
J1563	IV immune globulin	CH	D					
J1564	Immune globulin 10 mg	CH	D					
J1565	RSV-ivig		K	0906		$ 16.18		$ 3.24
J1566	Immune globulin, powder	NI	K	2731		$ 21.28		$ 4.26
J1567	Immune globulin, liquid	NI	K	2732		$ 28.15		$ 5.63
J1570	Ganciclovir sodium injection		N					
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$ 64.92		$ 12.98
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		$ 180.30		$ 36.06
J1626	Granisetron HCl injection		K	0764		$ 7.14		$ 1.43
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg	NI	K	1690	0.0670	$ 3.99		$ 0.80
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium		N					
J1655	Tinzaparin sodium injection	CH	K	1655		$ 2.31		$ 0.46
J1670	Tetanus immune globulin inj	CH	K	1670		$ 85.67		$ 17.13
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection	CH	K	1740		$ 111.70		$ 22.34
J1742	Ibutilide fumarate injection		K	9044		$ 249.56		$ 49.91
J1745	Infliximab injection		K	7043		$ 53.43		$ 10.69
J1750	Iron dextran	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1751	Iron dextran 165 injection	NI	K	1691		$ 11.80		$ 2.36
J1752	Iron dextran 267 injection	NI	K	1692		$ 10.20		$ 2.04
J1756	Iron sucrose injection		K	9046		$ 0.36		$ 0.07
J1785	Injection imiglucerase /unit		K	0916		$ 3.91		$ 0.78
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					
J1830	Interferon beta-1b / .25 MG		K	0910		$ 85.95		$ 17.19
J1835	Itraconazole injection		K	9047		$ 36.30		$ 7.26
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1931	Laronidase injection	CH	K	9209		$ 23.87		$ 4.77
J1940	Furosemide injection		N					
J1945	Lepiridin	NI	K	1693		$ 146.92		$ 29.38
J1950	Leuprolide acetate /3.75 MG		K	0800		$ 434.89		$ 86.98
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		$ 23.72		$ 4.74
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	N					
J2210	Methylergonovin maleate inj		N					
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate / 5 MG	CH	N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection	NI	G	1694		$ 6.45		$ 1.29
J2280	Inj, moxifloxacin 100 mg	CH	N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2324	Nesiritide	CH	D					
J2325	Nesiritide injection	NI	K	1695		$ 29.89		$ 5.98
J2353	Octreotide injection, depot		K	1207		$ 87.31		$ 17.46
J2354	Octreotide inj, non-depot	CH	N					
J2355	Oprelvekin injection		K	7011		$ 247.77		$ 49.55
J2357	Omalizumab injection		G	9300		$ 15.88		$ 3.18
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		$ 3.85		$ 0.77
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection	NI	K	1696		$ 11.00		$ 2.20
J2430	Pamidronate disodium /30 MG		K	0730		$ 40.63		$ 8.13
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl	CH	K	9210		$ 17.99		$ 3.60
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection	NI	G	1697		$ 1,054.70		$ 210.94
J2504	Pegademase bovine, 25 iu	NI	K	1739		$ 166.07		$ 33.21
J2505	Pentastarch 10% solution		K	9119		$ 2,078.07		$ 415.61
J2510	Sincalide injection		N					
J2513	Pentastarch 10% solution	NI	K	1698		$ 12.72		$ 2.54
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate	CH	N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton	CH	K	1635		$ 1.70		$ 0.34
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2725	Inj protirelin per 250 mcg	CH	N					
J2730	Pralidoxime chloride inj	CH	K	2730		$ 91.90		$ 18.38
J2760	Phentolaine mesylate inj	CH	N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin	CH	K	2770		$ 103.11		$ 20.62
J2780	Ranitidine hydrochloride inj		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2783	Rasburicase		G	0738		$ 111.34		$ 22.27
J2788	Rho d immune globulin 50 mcg		K	9023		$ 24.51		$ 4.90
J2790	Rho d immune globulin inj	CH	K	0884		$ 84.99		$ 17.00
J2792	Rho(D) immune globulin h, sd		K	1609		$ 13.73		$ 2.75
J2794	Risperidone, long acting		G	9125		$ 4.69		$ 0.94
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection	NI	K	1699		$ 27.58		$ 5.52
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$ 21.87		$ 4.37
J2850	Inj secretin synthetic human	NI	K	1700		$ 20.31		$ 4.06
J2910	Aurothioglucose injeciton	CH	K	1639		$ 24.50		$ 4.90
J2912	Sodium chloride injection		N					
J2916	Na ferric gluconate complex	CH	N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection	CH	K	2940	0.5982	$ 35.60		$ 7.12
J2941	Somatropin injection		K	7034		$ 43.87		$ 8.77
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$ 1,278.84		$ 255.77
J2995	Inj streptokinase /250000 IU		K	0911		$ 79.50		$ 15.90
J2997	Alteplase recombinant		K	7048		$ 31.44		$ 6.29
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG	CH	K	3030		$ 50.99		$ 10.20
J3070	Pentazocine hcl injection		N					
J3100	Tenecteplase injection		K	9002		$ 2,064.24		$ 412.85
J3105	Terbutaline sulfate inj		N					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		$ 699.27		$ 139.85
J3245	Tirofiban hydrochloride		D					
J3246	Tirofiban HCl		K	7041		$ 7.86		$ 1.57
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection	NI	K	1701		$ 54.02		$ 10.80
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		$ 146.85		$ 29.37
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		$ 372.86		$ 74.57
J3320	Spectinomycn di-hcl inj		N					
J3350	Urea injection		K	9051	0.6353	$ 37.81		$ 7.56
J3355	Urofollitropin, 75 iu	NI	K	1741		$ 48.45		$ 9.69
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		$ 457.73		$ 91.55
J3370	Vancomycin hcl injection		N					
J3395	Verteporfin injection		D					
J3396	Verteporfin injection		K	1203		$ 8.96		$ 1.79
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg	CH	N					
J3415	Pyridoxine hcl 100 mg	CH	N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$ 4.57		$ 0.91
J3470	Hyaluronidase injection	CH	K	1637		$ 50.15		$ 10.03
J3471	Ovine, up to 999 USP units	NI	K	1702		$ 129.87		$ 25.97
J3472	Ovine, 1000 USP units	NI	K	1703		$ 108.33		$ 21.67
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate	CH	N					
J3487	Zoledronic acid		K	9115		$ 200.03		$ 40.01
J3490	Drugs unclassified injection		N					
J3530	Nasal vaccine inhalation	CH	N					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7051	Sterile saline/water	CH	D					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7188	Inj Vonwillebrand factor iu	NI	K	1704		$ 0.87		$ 0.17

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7189	Factor viia	NI	K	1705		$ 1.02		$ 0.20
J7190	Factor viii		K	0925		$ 0.65		$ 0.13
J7191	Factor VIII (porcine)		K	0926		$ 1.86		$ 0.37
J7192	Factor viii recombinant		K	0927		$ 1.05		$ 0.21
J7193	Factor IX non-recombinant		K	0931		$ 0.87		$ 0.17
J7194	Factor ix complex		K	0928		$ 0.66		$ 0.13
J7195	Factor IX recombinant		K	0932		$ 0.98		$ 0.20
J7197	Antithrombin iii injection	CH	K	0930		$ 1.64		$ 0.33
J7198	Anti-inhibitor		K	0929		$ 1.30		$ 0.26
J7308	Aminolevulinic acid hcl top		K	7308		$ 101.87		$ 20.37
J7310	Ganciclovir long act implant		K	0913		$ 4,240.00		$ 848.00
J7317	Sodium hyaluronate injection	CH	D					
J7318	Hyaluron/deriv intra-art inj	NI	K	1706		$ 7.20		$ 1.44
J7320	Hylan G-F 20 injection	CH	D					
J7340	Metabolic active D/E tissue	CH	K	1632		$ 26.91		$ 5.38
J7341	Non-human, metabolic tissue	NI	K	1707		$ 1.01		$ 0.20
J7342	Metabolically active tissue		K	9054		$ 15.51		$ 3.10
J7343	Nonmetabolic act d/e tissue	CH	K	1629		$ 10.69		$ 2.14
J7344	Nonmetabolic active tissue		K	9156		$ 63.37		$ 12.67
J7350	Injectable human tissue		K	9055		$ 5.35		$ 1.07
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$ 49.96		$ 9.99
J7502	Cyclosporine oral 100 mg		K	0888		$ 3.48		$ 0.70
J7504	Lymphocyte immune globulin		K	0890		$ 295.72		$ 59.14
J7505	Monoclonal antibodies		K	7038		$ 864.56		$ 172.91
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		$ 3.45		$ 0.69
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$ 312.17		$ 62.43
J7513	Daclizumab, parenteral		K	1612		$ 367.61		$ 73.52
J7515	Cyclosporine oral 25 mg	CH	K	7515		$ 0.91		$ 0.18
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		$ 2.54		$ 0.51
J7518	Mycophenolic acid		G	9219		$ 2.16		$ 0.43
J7520	Sirolimus, oral		K	9020		$ 6.83		$ 1.37
J7525	Tacrolimus injection	CH	K	9006		$ 136.86		$ 27.37
J7599	Immunosuppressive drug noc		N					
J7616	Albuterol compound solution		D					
J7617	Levalbuterol compounded sol		D					
J7674	Methacholine chloride, neb	CH	N					
J7799	Non-inhalation drug for DME	CH	N					
J8501	Oral aprepitant		G	0868		$ 4.64		$ 0.93

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J8510	Oral busulfan		K	7015		$ 1.96		$ 0.39
J8520	Capecitabine, oral, 150 mg		K	7042		$ 3.51		$ 0.70
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone	NI	K	1708		$ 0.22		$ 0.04
J8560	Etoposide oral 50 MG		K	0802		$ 37.17		$ 7.43
J8597	Antiemetic drug oral NOS	NI	N					
J8600	Melphalan oral 2 MG		N					
J8610	Methotrexate oral 2.5 MG		N					
J8700	Temozolomide		K	1086		$ 7.22		$ 1.44
J9000	Doxorubic hcl 10 MG vl chemo	CH	N					
J9001	Doxorubicin hcl liposome inj		K	7046		$ 364.53		$ 72.91
J9010	Alemtuzumab injection		K	9110		$ 511.52		$ 102.30
J9015	Aldesleukin/single use vial		K	0807		$ 724.63		$ 144.93
J9017	Arsenic trioxide		K	9012		$ 33.25		$ 6.65
J9020	Asparaginase injection		K	0814		$ 54.17		$ 10.83
J9025	Azacitidine injection	NI	K	1709		$ 4.04		$ 0.81
J9027	Clofarabine injection	NI	G	1710		$ 116.87		$ 23.37
J9031	Bcg live intravesical vac		K	0809		$ 115.78		$ 23.16
J9035	Bevacizumab injection		G	9214		$ 57.11		$ 11.42
J9040	Bleomycin sulfate injection		K	0857		$ 48.71		$ 9.74
J9041	Bortezomib injection	CH	K	9207		$ 29.02		$ 5.80
J9045	Carboplatin injection		K	0811		$ 35.25		$ 7.05
J9050	Carmus bischl nitro inj		K	0812		$ 139.14		$ 27.83
J9055	Cetuximab injection		G	9215		$ 49.76		$ 9.95
J9060	Cisplatin 10 MG injection	CH	N					
J9065	Inj cladribine per 1 MG		K	0858		$ 37.94		$ 7.59
J9070	Cyclophosphamide 100 MG inj	CH	N					
J9093	Cyclophosphamide lyophilized	CH	N					
J9098	Cytarabine liposome	CH	K	1166		$ 382.72		$ 76.54
J9100	Cytarabine hcl 100 MG inj	CH	N					
J9120	Dactinomycin actinomycin d		N					
J9130	Dacarbazine 100 mg inj		K	0819		$ 5.20		$ 1.04
J9150	Daunorubicin		K	0820		$ 23.90		$ 4.78
J9151	Daunorubicin citrate liposom		K	0821		$ 56.51		$ 11.30
J9160	Denileukin diftitox, 300 mcg		K	1084		$ 1,252.93		$ 250.59
J9165	Diethylstilbestrol injection	CH	N					
J9170	Docetaxel		K	0823		$ 293.64		$ 58.73
J9175	Elliotts b solution per ml	NI	N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$ 24.76		$ 4.95
J9181	Etoposide 10 MG inj	CH	N					
J9185	Fludarabine phosphate inj		K	0842		$ 262.87		$ 52.57
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		$ 60.41		$ 12.08

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9201	Gemcitabine HCl		K	0828		$ 115.89		$ 23.18
J9202	Goserelin acetate implant		K	0810		$ 175.04		$ 35.01
J9206	Irinotecan injection		K	0830		$ 126.92		$ 25.38
J9208	Ifosfomide injection		K	0831		$ 34.68		$ 6.94
J9209	Mesna injection		K	0732		$ 10.55		$ 2.11
J9211	Idarubicin hcl injection		K	0832		$ 286.84		$ 57.37
J9212	Interferon alfacon-1	CH	K	0912		$ 3.92		$ 0.78
J9213	Interferon alfa-2a inj		K	0834		$ 32.87		$ 6.57
J9214	Interferon alfa-2b inj		K	0836		$ 13.30		$ 2.66
J9215	Interferon alfa-n3 inj		K	0865		$ 8.60		$ 1.72
J9216	Interferon gamma 1-b inj		K	0838		$ 272.44		$ 54.49
J9217	Leuprolide acetate suspnsion		K	9217		$ 224.42		$ 44.88
J9218	Leuprolide acetate injeciton		K	0861		$ 10.00		$ 2.00
J9219	Leuprolide acetate implant		K	7051		$ 2,371.75		$ 474.35
J9225	Histrelin implant	NI	K	1711		$ 5,000.00		$ 1,000.00
J9230	Mechlorethamine hcl inj		N					
J9245	Inj melphalan hydrochl 50 MG		K	0840		$ 753.64		$ 150.73
J9250	Methotrexate sodium inj		N					
J9263	Oxaliplatin	CH	K	1738		$ 8.53		$ 1.71
J9264	Paclitaxel injection	NI	G	1712		$ 8.32		$ 1.66
J9265	Paclitaxel injection		K	0863		$ 13.33		$ 2.67
J9266	Pegaspargase/singl dose vial		K	0843		$ 1,611.20		$ 322.24
J9268	Pentostatin injection		K	0844		$ 1,900.52		$ 380.10
J9270	Plicamycin (mithramycin) inj		K	0860	1.0311	$ 61.36		$ 12.27
J9280	Mitomycin 5 MG inj		K	0862		$ 22.29		$ 4.46
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$ 323.80		$ 64.76
J9300	Gemtuzumab ozogamicin		K	9004		$ 2,248.15		$ 449.63
J9305	Pemetrexed injection		G	9213		$ 40.67		$ 8.13
J9310	Rituximab cancer treatment		K	0849		$ 455.92		$ 91.18
J9320	Streptozocin injection	CH	K	0850		$ 154.68		$ 30.94
J9340	Thiotepa injection		K	0851		$ 47.96		$ 9.59
J9350	Topotecan		K	0852		$ 763.80		$ 152.76
J9355	Trastuzumab		K	1613		$ 54.39		$ 10.88
J9357	Valrubicin, 200 mg	CH	K	9167		$ 369.60		$ 73.92
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9390	Vinorelbine tartrate/10 mg		K	0855		$ 42.83		$ 8.57
J9395	Injection, Fulvestrant		K	9120		$ 81.33		$ 16.27
J9600	Porfimer sodium		K	0856		$ 2,464.57		$ 492.91
J9999	Chemotherapy drug		N					
K0064	Zero pressure tube flat free		D					
K0066	Solid tire any size each		D					
K0067	Pneumatic tire any size each		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0068	Pneumatic tire tube each		D					
K0074	Pneumatic caster tire each		D					
K0075	Semi-pneumatic caster tire		D					
K0076	Solid caster tire each		D					
K0078	Pneumatic caster tire tube		D					
K0102	Crutch and cane holder		D					
K0104	Cylinder tank carrier		D					
K0105	Iv hanger		D					
K0106	Arm trough each		D					
K0415	RX antiemetic drg, oral NOS		D					
K0416	Rx antiemetic drg,rectal NOS		D					
K0452	Wheelchair bearings		D					
K0600	Functional neuromuscularstim		D					
K0618	TLSO 2 piece rigid shell		D					
K0619	TLSO 3 piece rigid shell		D					
K0620	Tubular elastic dressing		D					
K0627	Cervical pneum trac equip		D					
K0628	Multi den insert direct form		D					
K0629	Multi den insert custom mold		D					
K0630	SIO flex pelvisacral prefab		D					
K0631	SIO flex pelvisacral custom		D					
K0632	SIO panel prefab		D					
K0633	SIO panel custom		D					
K0634	LO flexibl L1-below L5 pre		D					
K0635	LO sag stays/panels pre-fab		D					
K0636	LO sagitt rigid panel prefab		D					
K0637	LO flex w/o rigid stays pre		D					
K0638	LSO flex w/rigid stays cust		D					
K0639	LSO post rigid panel pre		D					
K0640	LSO sag-coro rigid frame pre		D					
K0641	LSO sag-cor rigid frame cust		D					
K0642	LSO flexion control prefab		D					
K0643	LSO flexion control custom		D					
K0644	LSO sagit rigid panel prefab		D					
K0645	LSO sagittal rigid panel cus		D					
K0646	LSO sag-coronal panel prefab		D					
K0647	LSO sag-coronal panel custom		D					
K0648	LSO s/c shell/panel prefab		D					
K0649	LSO s/c shell/panel custom		D					
K0650	Gen w/c cushion width < 22"		D					
K0651	Gen w/c cushion width > 22"		D					
K0652	Skin pro w/c cus wd < 22"		D					
K0653	Skin protect w/c cus wd>=22"		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0654	Position w/c cush width <22"		D					
K0655	Position w/c cush width >22"		D					
K0656	Skin pro/pos w/c cus wd <22"		D					
K0657	Skin pro/pos w/c cus wd>=22"		D					
K0658	Custom fabricate w/c cushion		D					
K0659	Powered w/c cushion		D					
K0660	Gen use back cush width <22"		D					
K0661	Gen use back cush width >22"		D					
K0662	Position back cush wdth <22"		D					
K0663	Position back cush wdth >22"		D					
K0664	Pos back post/lat width <22"		D					
K0665	Pos back post/lat width >22"		D					
K0666	Custom fab w/c back cushion		D					
K0667	Mt hardwre man/light pwr w/c		D					
K0668	Replace cover w/c seat cush		D					
K0670	Stance phase only		D					
K0671	Portable oxygen concentrator		D					
K0731	Lith ion bat CID non-ear lvl		D					
K0732	Lith ion batt CID ear level		D					
L0476	TLSO flexion compres jac pre		D					
L0478	TLSO flexion compres jac cus		D					
L0500	Lso flex surgical support		D					
L0510	Lso flexible custom fabricat		D					
L0515	Lso flex elas w/ rig post pa		D					
L0520	Lso a-p-l control with apron		D					
L0530	Lso ant-pos control w apron		D					
L0540	Lso lumbar flexion a-p-l		D					
L0550	Lso a-p-l control molded		D					
L0560	Lso a-p-l w interface		D					
L0561	Prefab lso		D					
L0565	Lso a-p-l control custom		D					
L0600	Sacroiliac flex surg support		D					
L0610	Sacroiliac flexible custm fa		D					
L0620	Sacroiliac semi-rig w apron		D					
L0860	Magnetic resonanc image comp		D					
L1750	Legg perthes sling		D					
L2034	KAFO pla sin up w/wo k/a cus	NI						
L2039	KAFO,plstic,medlat rotat con		D					
L2387	Add LE poly knee custom KAFO	NI						
L2435	Knee joint polycentric joint		D					
L3963	Molded w/ articulating elbow		D					
L5674	Bk suspension sleeve		D					
L5675	Bk heavy duty susp sleeve		D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5846	Knee-shin sys microprocessor		D					
L5847	Microprocessor cntrl feature		D					
L5989	Pylon w elctrnc force sensor		D					
L8100	Compression stocking BK18-30		D					
L8110	Compression stocking BK30-40		D					
L8120	Compression stocking BK40-50		D					
L8130	Gc stocking thighlngth 18-30		D					
L8140	Gc stocking thighlngth 30-40		D					
L8150	Gc stocking thighlngth 40-50		D					
L8160	Gc stocking full lngth 18-30		D					
L8170	Gc stocking full lngth 30-40		D					
L8180	Gc stocking full lngth 40-50		D					
L8190	Gc stocking waistlngth 18-30		D					
L8195	Gc stocking waistlngth 30-40		D					
L8200	Gc stocking waistlngth 40-50		D					
L8210	Gc stocking custom made		D					
L8220	Gc stocking lymphedema		D					
L8230	Gc stocking garter belt		D					
L8239	G compression stocking NOS		D					
L8490	Air seal suction reten systm		D					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea	NI	N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device/system		N					
L8620	Repl lithium ion battery		D					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8682	Implt neurostim radiofq rec	NI	N					
L8699	Prosthetic implant NOS		N					
M0064	Visit for drug monitoring		X	0374	1.1270	$ 67.07		$ 13.41
P9010	Whole blood for transfusion		K	0950	1.9835	$ 118.04		$ 23.61
P9011	Blood split unit		K	0967	1.3878	$ 82.59		$ 16.52
P9012	Cryoprecipitate each unit		K	0952	0.7923	$ 47.15		$ 9.43
P9016	RBC leukocytes reduced		K	0954	2.7446	$ 163.33		$ 32.67

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.1842	$ 70.47		$ 14.09
P9019	Platelets, each unit		K	0957	0.8663	$ 51.55		$ 10.31
P9020	Plaelet rich plasma unit		K	0958	4.6668	$ 277.73		$ 55.55
P9021	Red blood cells unit		K	0959	2.0435	$ 121.61		$ 24.32
P9022	Washed red blood cells unit		K	0960	3.1830	$ 189.42		$ 37.88
P9023	Frozen plasma, pooled, sd		K	0949	1.2810	$ 76.23		$ 15.25
P9031	Platelets leukocytes reduced		K	1013	1.6536	$ 98.41		$ 19.68
P9032	Platelets, irradiated		K	9500	1.4559	$ 86.64		$ 17.33
P9033	Platelets leukoreduced irrad		K	0968	2.5330	$ 150.74		$ 30.15
P9034	Platelets, pheresis		K	9507	7.3009	$ 434.48		$ 86.90
P9035	Platelet pheres leukoreduced		K	9501	8.2952	$ 493.66		$ 98.73
P9036	Platelet pheresis irradiated		K	9502	5.4817	$ 326.22		$ 65.24
P9037	Plate pheres leukoredu irrad		K	1019	9.7736	$ 581.64		$ 116.33
P9038	RBC irradiated		K	9505	2.4807	$ 147.63		$ 29.53
P9039	RBC deglycerolized		K	9504	5.7773	$ 343.81		$ 68.76
P9040	RBC leukoreduced irradiated		K	0969	3.6678	$ 218.27		$ 43.65
P9041	Albumin (human),5%, 50ml		K	0961	0.4987	$ 29.68		$ 5.94
P9043	Plasma protein fract,5%,50ml		K	0956	1.1429	$ 68.02		$ 13.60
P9044	Cryoprecipitatereducedplasma		K	1009	1.2536	$ 74.60		$ 14.92
P9045	Albumin (human), 5%, 250 ml		K	0963	1.2907	$ 76.81		$ 15.36
P9046	Albumin (human), 25%, 20 ml		K	0964	0.4839	$ 28.80		$ 5.76
P9047	Albumin (human), 25%, 50ml		K	0965	1.0966	$ 65.26		$ 13.05
P9048	Plasmaprotein fract,5%,250ml		K	0966	5.3107	$ 316.05		$ 63.21
P9050	Granulocytes, pheresis unit		K	9506	16.7317	$ 995.72		$ 199.14
P9051	Blood, l/r, cmv-neg		K	1010	3.4943	$ 207.95		$ 41.59
P9052	Platelets, hla-m, l/r, unit		K	1011	10.2526	$ 610.14		$ 122.03
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	11.0037	$ 654.84		$ 130.97
P9054	Blood, l/r, froz/degly/wash		K	1016	4.4061	$ 262.21		$ 52.44
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	8.8483	$ 526.57		$ 105.31
P9056	Blood, l/r, irradiated		K	1018	3.0005	$ 178.56		$ 35.71
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	5.8125	$ 345.91		$ 69.18
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.4896	$ 267.18		$ 53.44
P9059	Plasma, frz between 8-24hour		K	0955	1.2566	$ 74.78		$ 14.96
P9060	Fr frz plasma donor retested		K	9503	1.5934	$ 94.82		$ 18.96
P9612	Catheterize for urine spec		N					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.4833	$ 147.78	$ 41.44	$ 29.56
Q0091	Obtaining screen pap smear		T	0191	0.1702	$ 10.13	$ 2.85	$ 2.03
Q0092	Set up port xray equipment		N					
Q0136	Non esrd epoetin alpha inj	CH	D					
Q0137	Darbepoetin alfa, non esrd	CH	D					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0166	Granisetron HCl 1 mg oral		K	0765		$ 35.13		$ 7.03
Q0167	Dronabinol 2.5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0179	Ondansetron HCl 8mg oral		K	0769		$ 32.77		$ 6.55
Q0180	Dolasetron mesylate oral		K	0763		$ 48.24		$ 9.65
Q0182	Nonmetabolic act d/e tissue		D					
Q0183	Nonmetabolic active tissue		D					
Q0187	Factor viia recombinant	CH	D					
Q0515	Sermorelin acetate injection	NI	N					
Q1001	Ntiol category 1	CH	D					
Q1002	Ntiol category 2	CH	D					
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		N					
Q1005	Ntiol category 5		N					
Q2001	Oral cabergoline 0.5 mg		D					
Q2002	Elliotts b solution per ml	CH	D					
Q2003	Aprotinin, 10,000 kiu	CH	D					
Q2004	Bladder calculi irrig sol		N					
Q2005	Corticorelin ovine triflutat	CH	D					
Q2006	Digoxin immune fab (ovine)	CH	D					
Q2007	Ethanolamine oleate 100 mg	CH	D					
Q2008	Fomepizole, 15 mg	CH	D					
Q2009	Fosphenytoin, 50 mg		K	7028		$ 5.32		$ 1.06
Q2011	Hemin, per 1 mg	CH	D					
Q2012	Pegademase bovine, 25 iu	CH	D					
Q2013	Pentastarch 10% solution	CH	D					
Q2014	Sermorelin acetate, 0.5 mg	CH	D					
Q2017	Teniposide, 50 mg		K	7035		$ 264.05		$ 52.81
Q2018	Urofollitropin, 75 iu	CH	D					
Q2019	Basiliximab	CH	D					
Q2020	Histrelin acetate	CH	D					
Q2021	Lepirudin	CH	D					
Q2022	VonWillebrandFactrCmplxperIU	CH	D					
Q3000	Rubidium-Rb-82	CH	D					
Q3002	Gallium ga 67	CH	D					
Q3003	Technetium tc99m bicisate	CH	D					
Q3004	Xenon xe 133	CH	D					
Q3005	Technetium tc99m mertiatide	CH	D					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3006	Technetium tc99m glucepatate	CH	D					
Q3007	Sodium phosphate p32	CH	D					
Q3008	Indium 111-in pentetreotide	CH	D					
Q3009	Technetium tc99m oxidronate	CH	D					
Q3010	Technetium tc99mlabeledrbcs	CH	D					
Q3011	Chromic phosphate p32	CH	D					
Q3012	Cyanocobalamin cobalt co57	CH	D					
Q3025	IM inj interferon beta 1-a		K	9022		$ 93.07		$ 18.61
Q3031	Collagen skin test		N					
Q4054	Darbepoetin alfa, esrd use		D					
Q4055	Epoetin alfa, esrd use		D					
Q4075	Acyclovir, 5 mg	CH	D					
Q4076	Dopamine hcl, 40 mg	CH	D					
Q4077	Treprostinil, 1 mg	CH	D					
Q4079	Injection, Natalizumab, 1 MG	NF	G	9126		$ 6.39		$ 1.28
Q9941	IVIG lyophil 1g	CH	D					
Q9942	IVIG lyophil 10 mg	CH	D					
Q9943	IVIG non-lyophil 1g	CH	D					
Q9944	IVIG non-lyophil 10 mg	CH	D					
Q9945	LOCM <=149 mg/ml iodine, 1ml	CH	K	9157		$ 0.24		$ 0.05
Q9946	LOCM <=149 mg/ml iodine, 1ml	CH	K	9158		$ 1.79		$ 0.36
Q9947	LOCM 200-249mg/ml iodine,1ml	CH	K	9159		$ 1.30		$ 0.26
Q9948	LOCM 250-299mg/ml iodine,1ml	CH	K	9160		$ 0.30		$ 0.06
Q9949	LOCM 300-349mg/ml iodine,1ml	CH	K	9161		$ 0.34		$ 0.07
Q9950	LOCM 350-399mg/ml iodine,1ml	CH	K	9162		$ 0.23		$ 0.05
Q9951	LOCM >= 400 mg/ml iodine,1ml	CH	K	9163		$ 0.19		$ 0.04
Q9952	Inj Gad-base MR contrast, ml	CH	K	9164		$ 2.93		$ 0.59
Q9953	Inj Fe-based MR contrast, ml	CH	K	1713		$ 30.41		$ 6.08
Q9954	Oral MR contrast, 100 ml	CH	K	9165		$ 8.97		$ 1.79
Q9955	Inj perflexane lip micros,ml	CH	K	9203		$ 13.25		$ 2.65
Q9956	Inj octafluoropropane mic,ml	CH	K	9202		$ 41.43		$ 8.29
Q9957	Inj perflutren lip micros,ml	CH	K	9112		$ 61.88		$ 12.38
Q9958	HOCM <=149 mg/ml iodine, 1ml	CH	K	1714		$ 0.06		$ 0.01
Q9959	HOCM 150-199mg/ml iodine,1ml	CH	N					
Q9960	HOCM 200-249mg/ml iodine,1ml	CH	K	1715		$ 0.09		$ 0.02
Q9961	HOCM 250-299mg/ml iodine,1ml	CH	K	1734		$ 0.15		$ 0.03
Q9962	HOCM 300-349mg/ml iodine,1ml	CH	K	1735		$ 0.14		$ 0.03
Q9963	HOCM 350-399mg/ml iodine,1ml	CH	K	1736		$ 0.38		$ 0.08
Q9964	HOCM >= 400 mg/ml iodine,1ml	CH	K	1737		$ 0.20		$ 0.04
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2785	Corneal tissue processing		F					

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2790	Amniotic membrane		N					

Addendum D1.—Payment Status Indicators for the Hospital Outpatient Prospective Payment System

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
	• Ambulance Services	
	• Clinical Diagnostic Laboratory Services	
	• Non-Implantable Prosthetic and Orthotic Devices	
	• EPO for ESRD Patients	
	• Physical, Occupational, and Speech Therapy	
	• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital	
	• Diagnostic Mammography	
	• Screening Mammography	
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x,13x, and 14x).	Not paid under OPPS.
		• May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
		• An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available.

Indicator	Item/Code/Service	OPPS Payment Status
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS.
E	Items, Codes, and Services:	Not paid under OPPS.
	• That are not covered by Medicare based on statutory exclusion.	
	• That are not covered by Medicare for reasons other than statutory exclusion.	
	• That are not recognized by Medicare but for which an alternate code for the same item or service may be available.	
	• For which separate payment is not provided by Medicare.	
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass-through amount.
H	(1) Pass-Through Device Categories	(1) Separate cost-based pass-through payment; Not subject to coinsurance.
	(2) Brachytherapy Sources	(2) Separate cost-based non-pass-through payment.
	(3) Radiopharmaceutical Agents	(3) Separate cost-based non-pass-through payment.
K	Non-Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.

Indicator	Item/Code/Service	OPPS Payment Status
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		(1) Separate APC payment based on OPPS payment criteria.
		(2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

Addendum D2.--Comment Indicators

Comment Indicator	Descriptor
NF	New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
NI	New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS codes in current year and next calendar year; status indicator and/or APC assignment have changed.

Addendum E.—CPT Codes That Are Paid Only As Inpatient Procedures

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
00524	C	Anesth, chest drainage
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, heart surg w/o pump
00561	C	Anesth, heart surg < age 1
00562	C	Anesth, heart surg w/pump
00580	C	Anesth, heart/lung transplant
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
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
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
11004	C	Debride genitalia & perineum
11005	C	Debride abdom wall
11006	C	Debride genit/per/abdom wall
11008	C	Remove mesh from abd wall
15756	C	Free myo/skin flap microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Escharotomy; add'l incision
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
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
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
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
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
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
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw 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
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
21510	C	Drainage of bone lesion
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22010	C	I&d, p-spine, c/t/cerv-thor
22015	C	I&d, p-spine, l/s/ls
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck 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
22532	C	Lat thorax spine fusion
22533	C	Lat lumbar spine fusion
22534	C	Lat thor/lumb, add'l seg
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1-2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32503	C	Resect apical lung tumor

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
32504	C	Resect apical lung tum/chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32855	C	Prepare donor lung, single
32856	C	Prepare donor lung, double
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33507	C	Repair art, intramural
33510	C	CABG, vein, single

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
33548	C	Restore/remodel, ventricle
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
33768	C	Cavopulmonary Shunting
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
33880	C	Endovasc taa repr incl subcl
33881	C	Endovasc taa repr w/o subcl
33883	C	Insert endovasc prosth, taa
33884	C	Endovasc prosth, taa, add-on
33886	C	Endovasc prosth, delayed
33889	C	Artery transpose/endovas taa
33891	C	Car-car bp grft/endovas taa
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33925	C	Rpr pul art unifocal w/o cpb
33926	C	Repr pul art, unifocal w/cpb
33930	C	Removal of donor heart/lung
33933	C	Prepare donor heart/lung

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33944	C	Prepare 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	Endovas aaa repr w/sm tube
34802	C	Endovas aaa repr w/2-p part
34803	C	Endovas aaa repr w/3-p part
34804	C	Endovas aaa repr w/1-p part
34805	C	Endovas aaa repr w/long tube
34808	C	Endovas iliac a device addon
34812	C	Xpose for endoprosth, femorl
34813	C	Femoral endovas graft add-on
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, add'l
34830	C	Open aortic tube prosth repr

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
35510	C	Artery bypass graft
35511	C	Artery bypass graft
35512	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
35522	C	Artery bypass graft
35525	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35697	C	Reimplant artery each
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
37182	C	Insert hepatic shunt (tips)
37215	C	Transcath stent, cca w/eps
37216	C	Transcath stent, cca w/o eps
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
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
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43644	C	Lap gastric bypass/roux-en-y
43645	C	Lap gastr bypass incl smll i
43770	C	Lap, place gastr adjust band
43771	C	Lap, revise adjust gast band
43772	C	Lap, remove adjust gast band
43773	C	Lap, change adjust gast band
43774	C	Lap remov adj gast band/port
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	V-band gastroplasty
43843	C	Gastroplasty w/o v-band
43845	C	Gastroplasty duodenal switch
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass incl small i
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/o taper, cong
44127	C	Enterectomy w/taper, cong
44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44137	C	Remove intestinal allograft
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
44187	C	Lap, ileo/jejuno-stomy
44188	C	Lap, colostomy
44202	C	Lap, enterectomy
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
44227	C	Lap, close enterostomy
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
44715	C	Prepare donor intestine
44720	C	Prep donor intestine/venous
44721	C	Prep donor intestine/artery
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
44950	C	Appendectomy
44955	C	Appendectomy add-on

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservior
45395	C	Lap, removal of rectum
45397	C	Lap, remove rectum w/pouch
45400	C	Laparoscopic proctopexy
45402	C	Lap proctopexy w/sig resect
45540	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
46710	C	Repr per/vag pouch sngl proc
46712	C	Repr per/vag pouch dbl proc
46715	C	Rep perf anoper fistu
46716	C	Rep perf anoper/vestib fistu
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47140	C	Partial removal, donor liver
47141	C	Partial removal, donor liver
47142	C	Partial removal, donor liver
47143	C	Prep donor liver, whole
47144	C	Prep donor liver, 3-segment
47145	C	Prep donor liver, lobe split
47146	C	Prep donor liver/venous
47147	C	Prep donor liver/arterial
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
48551	C	Prep donor pancreas
48552	C	Prep donor pancreas/venous
48554	C	Transpl allograft pancreas
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
49040	C	Drain, open, abdom abscess
49060	C	Drain, open, retrop abscess
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, intra-abdom
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50250	C	Cryoablate renal mass open
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Remove cadaver donor kidney
50320	C	Remove kidney, living donor
50323	C	Prep cadaver renal allograft
50325	C	Prep donor renal graft
50327	C	Prep renal graft/venous
50328	C	Prep renal graft/arterial
50329	C	Prep renal graft/ureteral
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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 w/ureter
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
53415	C	Reconstruction of urethra

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
54650	C	Orchiopexy (Fowler-Stephens)
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Colpopexy, extraperitoneal
57283	C	Colpopexy, intraperitoneal
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	Myomectomy abdom method
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58956	C	Bso, omentectomy w/tah
58960	C	Exploration of abdomen
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61316	C	Implt cran bone flap to abdo

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
61340	C	Subtemporal decompression
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61517	C	Implt brain chemotx add-on
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
61537	C	Removal of brain tissue
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61540	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61566	C	Removal of brain tissue
61567	C	Incision of brain tissue
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Transcath occlusion, cns
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61863	C	Implant neuroelectrode
61864	C	Implant neuroelectrde, addl
61867	C	Implant neuroelectrode
61868	C	Implant neuroelectrde, add'l
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62148	C	Retr bone flap to fix skull
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Brain cavity shunt w/scope
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, add'l cervical
63044	C	Laminotomy, add'l lumbar
63050	C	Cervical laminoplasty
63051	C	C-laminoplasty w/graft/plate
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63101	C	Removal of vertebral body
63102	C	Removal of vertebral body
63103	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
63295	C	Repair of laminectomy defect
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
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	Intravascular cath exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
75956	C	Xray, endovasc thor ao repr
75957	C	Xray, endovasc thor ao repr
75958	C	Xray, place prox ext thor ao
75959	C	Xray, place dist ext thor ao
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

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
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
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonate crit care, initial
99296	C	Neonate critical care subseq
99298	C	Ic for lbw infant < 1500 gm
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
0048T	C	Implant ventricular device
0049T	C	External circulation assist
0050T	C	Removal circulation assist
0051T	C	Implant total heart system
0052T	C	Replace component heart syst
0053T	C	Replace component heart syst
0075T	C	Perq stent/chest vert art
0076T	C	S&i stent/chest vert art
0077T	C	Cereb therm perfusion probe
0078T	C	Endovasc aort repr w/device
0079T	C	Endovasc visc extnsn repr
0080T	C	Endovasc aort repr rad s&i
0081T	C	Endovasc visc extnsn s&i
0090T	C	Cervical artific disc
0091T	C	Lumbar artific disc
0092T	C	Artific disc addl
0093T	C	Cervical artific diskectomy

CPT/ HCPCS	CY 2006 Final Status Indicator	Description
0094T	C	Lumbar artific diskectomy
0095T	C	Artific diskectomy addl
0096T	C	Rev cervical artific disc
0097T	C	Rev lumbar artific disc
0098T	C	Rev artific disc addl
0153T	C	Implant Aneur Sensor Add-On
G0341	C	Percutaneous islet celltrans
G0342	C	Laparoscopy islet cell trans
G0343	C	Laparotomy islet cell transp

Addendum L.—Out-Migration Wage Adjustment[1] CY 2006

Provider Number		Out-Migration Adjustment	Qualifying County Name
010005		0.0259	MARSHALL
010008	*	0.0212	CRENSHAW
010009		0.0092	MORGAN
010010		0.0259	MARSHALL
010012	*	0.0205	DE KALB
010022	*	0.0714	CHEROKEE
010025	*	0.0235	CHAMBERS
010029	*	0.0107	LEE
010035	*	0.0375	CULLMAN
010038		0.0062	CALHOUN
010045	*	0.0160	FAYETTE
010047		0.0155	BUTLER
010054		0.0092	MORGAN
010061		0.0506	JACKSON
010072	*	0.0310	TALLADEGA
010078		0.0062	CALHOUN
010083	*	0.0121	BALDWIN
010085		0.0092	MORGAN
010100	*	0.0121	BALDWIN
010101	*	0.0310	TALLADEGA
010109		0.0451	PICKENS
010115		0.0093	FRANKLIN
010129		0.0121	BALDWIN

Provider Number		Out-Migration Adjustment	Qualifying County Name
010143	*	0.0375	CULLMAN
010146		0.0062	CALHOUN
010150	*	0.0155	BUTLER
010158	*	0.0093	FRANKLIN
010164	*	0.0310	TALLADEGA
013027		0.0121	BALDWIN
040014	*	0.0159	WHITE
040019	*	0.0697	ST. FRANCIS
040047	*	0.0090	RANDOLPH
040069	*	0.0140	MISSISSIPPI
040071		0.0026	JEFFERSON
040076	*	0.1075	HOT SPRING
040100	*	0.0159	WHITE
050008		0.0026	SAN FRANCISCO
050009	*	0.0478	NAPA
050013	*	0.0478	NAPA
050014	*	0.0131	AMADOR
050016		0.0103	SAN LUIS OBISPO
050042	*	0.0219	TEHAMA
050046		0.0156	VENTURA
050047		0.0026	SAN FRANCISCO
050055		0.0026	SAN FRANCISCO
050065	*	0.0029	ORANGE
050069	*	0.0029	ORANGE
050073	*	0.0269	SOLANO
050076	*	0.0026	SAN FRANCISCO
050082		0.0156	VENTURA
050084		0.0555	SAN JOAQUIN
050089	*	0.0152	SAN BERNARDINO
050090	*	0.0308	SONOMA
050099	*	0.0152	SAN BERNARDINO
050101		0.0269	SOLANO
050117		0.0463	MERCED
050118	*	0.0555	SAN JOAQUIN
050122		0.0555	SAN JOAQUIN
050129	*	0.0152	SAN BERNARDINO
050133		0.0170	YUBA
050136	*	0.0308	SONOMA
050140	*	0.0152	SAN BERNARDINO
050150	*	0.0316	NEVADA

Provider Number		Out-Migration Adjustment	Qualifying County Name
050152		0.0026	SAN FRANCISCO
050159		0.0156	VENTURA
050167		0.0555	SAN JOAQUIN
050168	*	0.0029	ORANGE
050173	*	0.0029	ORANGE
050174	*	0.0308	SONOMA
050177		0.0156	VENTURA
050193	*	0.0029	ORANGE
050224	*	0.0029	ORANGE
050226	*	0.0029	ORANGE
050228	*	0.0026	SAN FRANCISCO
050230	*	0.0029	ORANGE
050232		0.0103	SAN LUIS OBISPO
050236		0.0156	VENTURA
050245	*	0.0152	SAN BERNARDINO
050272	*	0.0152	SAN BERNARDINO
050279	*	0.0152	SAN BERNARDINO
050291	*	0.0308	SONOMA
050298	*	0.0152	SAN BERNARDINO
050300	*	0.0152	SAN BERNARDINO
050313		0.0555	SAN JOAQUIN
050325		0.0176	TUOLUMNE
050327	*	0.0152	SAN BERNARDINO
050331	*	0.0308	SONOMA
050335		0.0176	TUOLUMNE
050336		0.0555	SAN JOAQUIN
050348	*	0.0029	ORANGE
050367		0.0269	SOLANO
050377		0.0062	MADERA
050385	*	0.0308	SONOMA
050394		0.0156	VENTURA
050407		0.0026	SAN FRANCISCO
050426	*	0.0029	ORANGE
050444		0.0463	MERCED
050454		0.0026	SAN FRANCISCO
050457		0.0026	SAN FRANCISCO
050469	*	0.0152	SAN BERNARDINO

Provider Number		Out-Migration Adjustment	Qualifying County Name
050476		0.0257	LAKE
050494	*	0.0316	NEVADA
050506		0.0103	SAN LUIS OBISPO
050517	*	0.0152	SAN BERNARDINO
050526	*	0.0029	ORANGE
050528	*	0.0463	MERCED
050535	*	0.0029	ORANGE
050539		0.0257	LAKE
050539		0.0257	LAKE
050543	*	0.0029	ORANGE
050547	*	0.0308	SONOMA
050548	*	0.0029	ORANGE
050549	*	0.0156	VENTURA
050550	*	0.0029	ORANGE
050551	*	0.0029	ORANGE
050567	*	0.0029	ORANGE
050568		0.0062	MADERA
050570	*	0.0029	ORANGE
050580	*	0.0029	ORANGE
050584	*	0.0152	SAN BERNARDINO
050585	*	0.0029	ORANGE
050586	*	0.0152	SAN BERNARDINO
050589	*	0.0029	ORANGE
050592	*	0.0029	ORANGE
050594	*	0.0029	ORANGE
050603	*	0.0029	ORANGE
050609	*	0.0029	ORANGE
050616		0.0156	VENTURA
050618	*	0.0152	SAN BERNARDINO
050633		0.0103	SAN LUIS OBISPO
050667	*	0.0478	NAPA
050668	*	0.0026	SAN FRANCISCO
050678	*	0.0029	ORANGE
050680		0.0269	SOLANO
050690	*	0.0308	SONOMA
050693	*	0.0029	ORANGE
050695		0.0555	SAN JOAQUIN
050720	*	0.0029	ORANGE
050728	*	0.0308	SONOMA

Provider Number		Out-Migration Adjustment	Qualifying County Name
050731		0.0152	SAN BERNARDINO
052035		0.0029	ORANGE
052037		0.0152	SAN BERNARDINO
052039		0.0029	ORANGE
053034		0.0029	ORANGE
053037		0.0152	SAN BERNARDINO
053304		0.0029	ORANGE
054074		0.0269	SOLANO
054077		0.0156	VENTURA
054093		0.0152	SAN BERNARDINO
054111		0.0152	SAN BERNARDINO
054122		0.0478	NAPA
054141		0.0269	SOLANO
060001	*	0.0294	WELD
060003	*	0.0203	BOULDER
060027	*	0.0203	BOULDER
060103	*	0.0203	BOULDER
064007		0.0203	BOULDER
070003	*	0.0009	WINDHAM
070006	*	0.0047	FAIRFIELD
070010	*	0.0047	FAIRFIELD
070018	*	0.0047	FAIRFIELD
070020		0.0073	MIDDLESEX
070021	*	0.0009	WINDHAM
070028	*	0.0047	FAIRFIELD
070033	*	0.0047	FAIRFIELD
070034	*	0.0047	FAIRFIELD
074000		0.0047	FAIRFIELD
074008		0.0009	WINDHAM
074014		0.0047	FAIRFIELD
080001		0.0063	NEW CASTLE
080003		0.0063	NEW CASTLE
082000		0.0063	NEW CASTLE
083300		0.0063	NEW CASTLE
084002		0.0063	NEW CASTLE
100014		0.0118	VOLUSIA
100017		0.0118	VOLUSIA
100045	*	0.0118	VOLUSIA
100047		0.0021	CHARLOTTE
100062		0.0060	MARION

Provider Number		Out-Migration Adjustment	Qualifying County Name
100068		0.0118	VOLUSIA
100072		0.0118	VOLUSIA
100077		0.0021	CHARLOTTE
100102		0.0125	COLUMBIA
100118	*	0.0398	FLAGLER
100156		0.0125	COLUMBIA
100175		0.0231	DE SOTO
100212		0.0060	MARION
100232		0.0347	PUTNAM
100236		0.0021	CHARLOTTE
100252	*	0.0233	OKEECHOBEE
100290		0.0582	SUMTER
110023	*	0.0500	GORDON
110027		0.0387	FRANKLIN
110029	*	0.0063	HALL
110041	*	0.0777	HABERSHAM
110069	*	0.0474	HOUSTON
110124		0.0428	WAYNE
110136		0.0261	BALDWIN
110150	*	0.0261	BALDWIN
110153	*	0.0474	HOUSTON
110187	*	0.1172	LUMPKIN
110189	*	0.0031	FANNIN
110190		0.0182	MACON
110205	*	0.0779	GILMER
130003	*	0.0095	NEZ PERCE
130024		0.0275	BONNER
130049	*	0.0349	KOOTENAI
130066		0.0349	KOOTENAI
140012	*	0.0220	LEE
140026		0.0346	LA SALLE
140033		0.0147	LAKE
140043	*	0.0046	WHITESIDE
140058	*	0.0081	MORGAN
140084		0.0147	LAKE
140100		0.0147	LAKE
140110	*	0.0346	LA SALLE
140130		0.0147	LAKE
140155		0.0027	KANKAKEE
140160	*	0.0286	STEPHENSON
140161	*	0.0138	LIVINGSTON
140186		0.0027	KANKAKEE
140202		0.0147	LAKE

Provider Number		Out-Migration Adjustment	Qualifying County Name
140205		0.0163	BOONE
140234	*	0.0346	LA SALLE
140291	*	0.0147	LAKE
150022		0.0249	MONTGOMERY
150030	*	0.0201	HENRY
150035		0.0083	PORTER
150045		0.0416	DE KALB
150060		0.0051	VERMILLION
150060		0.0051	VERMILLION
150062		0.0153	DECATUR
150065	*	0.0139	JACKSON
150076	*	0.0189	MARSHALL
150088	*	0.0196	MADISON
150091		0.0573	HUNTINGTON
150102	*	0.0160	STARKE
150113	*	0.0196	MADISON
150122		0.0199	RIPLEY
154047		0.0189	MARSHALL
160013		0.0218	MUSCATINE
160026	*	0.0496	BOONE
160030		0.0040	STORY
160032		0.0272	JASPER
160080	*	0.0049	CLINTON
160140		0.0364	PLYMOUTH
170137	*	0.0336	DOUGLAS
180012	*	0.0083	HARDIN
180066	*	0.0567	LOGAN
180127	*	0.0352	FRANKLIN
180128		0.0282	LAWRENCE
183028		0.0083	HARDIN
190001	*	0.0645	WASHINGTON
190003	*	0.0107	IBERIA
190010		0.0401	TANGIPAHOA
190015	*	0.0401	TANGIPAHOA
190017		0.0235	ST. LANDRY
190054		0.0107	IBERIA
190078		0.0235	ST. LANDRY
190088		0.0705	WEBSTER
190099	*	0.0390	AVOYELLES
190106	*	0.0238	ALLEN
190133		0.0238	ALLEN
190144		0.0705	WEBSTER
190184		0.0161	CALDWELL

Provider Number		Out-Migration Adjustment	Qualifying County Name
190190		0.0161	CALDWELL
190191	*	0.0235	ST. LANDRY
190246		0.0161	CALDWELL
192040		0.0401	TANGIPAHOA
193044		0.0401	TANGIPAHOA
200002	*	0.0129	LINCOLN
200013		0.0186	WALDO
200024	*	0.0071	ANDROSCOGGIN
200032		0.0466	OXFORD
200034	*	0.0071	ANDROSCOGGIN
200050	*	0.0140	HANCOCK
210001		0.0129	WASHINGTON
210004		0.0040	MONTGOMERY
210016		0.0040	MONTGOMERY
210018		0.0040	MONTGOMERY
210022		0.0040	MONTGOMERY
210023		0.0209	ANNE ARUNDEL
210043		0.0209	ANNE ARUNDEL
210048		0.0287	HOWARD
210057		0.0040	MONTGOMERY
220001	*	0.0056	WORCESTER
220002		0.0249	MIDDLESEX
220003	*	0.0056	WORCESTER
220006		0.0306	ESSEX
220010	*	0.0306	ESSEX
220011		0.0249	MIDDLESEX
220019	*	0.0056	WORCESTER
220025	*	0.0056	WORCESTER
220028	*	0.0056	WORCESTER
220029	*	0.0306	ESSEX
220033	*	0.0306	ESSEX
220035	*	0.0306	ESSEX
220049		0.0249	MIDDLESEX
220058	*	0.0056	WORCESTER
220062	*	0.0056	WORCESTER
220063		0.0249	MIDDLESEX
220070		0.0249	MIDDLESEX
220080	*	0.0306	ESSEX
220082		0.0249	MIDDLESEX
220084		0.0249	MIDDLESEX
220089		0.0249	MIDDLESEX
220090	*	0.0056	WORCESTER
220095	*	0.0056	WORCESTER

Provider Number		Out-Migration Adjustment	Qualifying County Name
220098		0.0249	MIDDLESEX
220101		0.0249	MIDDLESEX
220105		0.0249	MIDDLESEX
220163	*	0.0056	WORCESTER
220171		0.0249	MIDDLESEX
220174	*	0.0306	ESSEX
222000		0.0249	MIDDLESEX
222026		0.0306	ESSEX
222044		0.0306	ESSEX
223026		0.0249	MIDDLESEX
223028		0.0306	ESSEX
223029		0.0056	WORCESTER
223033		0.0056	WORCESTER
224007		0.0249	MIDDLESEX
224022		0.0249	MIDDLESEX
230003	*	0.0035	OTTAWA
230013	*	0.0091	OAKLAND
230015		0.0359	ST. JOSEPH
230019	*	0.0091	OAKLAND
230021		0.0136	BERRIEN
230022	*	0.0113	BRANCH
230029	*	0.0091	OAKLAND
230037	*	0.0178	HILLSDALE
230041		0.0099	BAY
230042	*	0.0685	ALLEGAN
230047	*	0.0082	MACOMB
230069	*	0.0487	LIVINGSTON
230071	*	0.0091	OAKLAND
230072	*	0.0035	OTTAWA
230075		0.0145	CALHOUN
230078	*	0.0136	BERRIEN
230092		0.0389	JACKSON
230093	*	0.0079	MECOSTA
230096	*	0.0359	ST. JOSEPH
230099	*	0.0339	MONROE
230106	*	0.0030	NEWAYGO
230121	*	0.0691	SHIAWASSEE
230130	*	0.0091	OAKLAND
230151	*	0.0091	OAKLAND
230174	*	0.0035	OTTAWA
230184		0.0389	JACKSON
230195	*	0.0082	MACOMB
230204	*	0.0082	MACOMB

Provider Number		Out-Migration Adjustment	Qualifying County Name
230207	*	0.0091	OAKLAND
230217	*	0.0145	CALHOUN
230222		0.0228	MIDLAND
230223	*	0.0091	OAKLAND
230227	*	0.0082	MACOMB
230254	*	0.0091	OAKLAND
230257	*	0.0082	MACOMB
230264	*	0.0082	MACOMB
230269	*	0.0091	OAKLAND
230277	*	0.0091	OAKLAND
230279	*	0.0487	LIVINGSTON
232023		0.0082	MACOMB
232025		0.0136	BERRIEN
232028		0.0145	CALHOUN
232034		0.0685	ALLEGAN
233025		0.0145	CALHOUN
233028		0.0091	OAKLAND
234011		0.0091	OAKLAND
234021		0.0082	MACOMB
234023		0.0091	OAKLAND
240013	*	0.0226	MORRISON
240018	*	0.1196	GOODHUE
240021		0.0920	LE SUEUR
240044		0.0868	WINONA
240064	*	0.0138	ITASCA
240069	*	0.0419	STEELE
240071	*	0.0454	RICE
240133		0.0319	MEEKER
240152	*	0.0735	KANABEC
240152		0.0735	KANABEC
240154		0.0138	ITASCA
240187	*	0.0506	MC LEOD
240211	*	0.0705	PINE
250040	*	0.0294	JACKSON
250045		0.0042	HANCOCK
260011		0.0007	COLE
260025	*	0.0078	MARION
260047	*	0.0007	COLE
260074	*	0.0158	RANDOLPH
260097		0.0425	JOHNSON
260127		0.0158	PIKE
280054		0.0137	GAGE
280077	*	0.0089	DODGE

Provider Number		Out-Migration Adjustment	Qualifying County Name
280123		0.0137	GAGE
290019	*	0.0026	CARSON CITY
290049		0.0026	CARSON CITY
293029		0.0026	CARSON CITY
300011	*	0.0069	HILLSBOROUGH
300012	*	0.0069	HILLSBOROUGH
300017		0.0361	ROCKINGHAM
300020	*	0.0069	HILLSBOROUGH
300023		0.0361	ROCKINGHAM
300029		0.0361	ROCKINGHAM
300034	*	0.0069	HILLSBOROUGH
303026		0.0361	ROCKINGHAM
304001		0.0361	ROCKINGHAM
310002	*	0.0351	ESSEX
310009	*	0.0351	ESSEX
310010		0.0092	MERCER
310011		0.0115	CAPE MAY
310013	*	0.0351	ESSEX
310018	*	0.0351	ESSEX
310021	*	0.0092	MERCER
310038	*	0.0350	MIDDLESEX
310039		0.0350	MIDDLESEX
310044		0.0092	MERCER
310054	*	0.0351	ESSEX
310070	*	0.0350	MIDDLESEX
310076	*	0.0351	ESSEX
310078	*	0.0351	ESSEX
310083	*	0.0351	ESSEX
310092		0.0092	MERCER
310093	*	0.0351	ESSEX
310096	*	0.0351	ESSEX
310108		0.0350	MIDDLESEX
310110		0.0092	MERCER
310119	*	0.0351	ESSEX
310123		0.0351	ESSEX
310124		0.0350	MIDDLESEX
313025		0.0351	ESSEX
313027		0.0092	MERCER
314011		0.0350	MIDDLESEX
320003		0.0629	SAN MIGUEL
320011		0.0442	RIO ARRIBA
320018		0.0063	DONA ANA
320085		0.0063	DONA ANA

Provider Number		Out-Migration Adjustment	Qualifying County Name
330004	*	0.0959	ULSTER
330008	*	0.0470	WYOMING
330027	*	0.0137	NASSAU
330094	*	0.0778	COLUMBIA
330106	*	0.0137	NASSAU
330126	*	0.0560	ORANGE
330135	*	0.0560	ORANGE
330167		0.0137	NASSAU
330181	*	0.0137	NASSAU
330182	*	0.0137	NASSAU
330191	*	0.0026	WARREN
330198		0.0137	NASSAU
330205	*	0.0560	ORANGE
330209	*	0.0560	ORANGE
330224		0.0959	ULSTER
330225		0.0137	NASSAU
330235	*	0.0270	CAYUGA
330259		0.0137	NASSAU
330264	*	0.0560	ORANGE
330276		0.0063	FULTON
330331		0.0137	NASSAU
330332		0.0137	NASSAU
330372		0.0137	NASSAU
330386	*	0.1139	SULLIVAN
340015		0.0267	ROWAN
340020		0.0207	LEE
340021	*	0.0216	CLEVELAND
340037		0.0216	CLEVELAND
340039	*	0.0144	IREDELL
340069	*	0.0053	WAKE
340070		0.0448	ALAMANCE
340073	*	0.0053	WAKE
340085		0.0377	DAVIDSON
340096		0.0377	DAVIDSON
340104		0.0216	CLEVELAND
340114	*	0.0053	WAKE
340126	*	0.0161	WILSON
340127	*	0.0961	GRANVILLE
340129	*	0.0144	IREDELL
340133		0.0308	MARTIN
340138	*	0.0053	WAKE
340144	*	0.0144	IREDELL
340145	*	0.0563	LINCOLN

Provider Number		Out-Migration Adjustment	Qualifying County Name
340173	*	0.0053	WAKE
344014		0.0053	WAKE
360013	*	0.0166	SHELBY
360025	*	0.0087	ERIE
360036	*	0.0263	WAYNE
360065	*	0.0141	HURON
360070		0.0028	STARK
360078	*	0.0159	PORTAGE
360084		0.0028	STARK
360086	*	0.0168	CLARK
360093		0.0120	DEFIANCE
360095	*	0.0087	HANCOCK
360100		0.0028	STARK
360107	*	0.0213	SANDUSKY
360131		0.0028	STARK
360151		0.0028	STARK
360156		0.0213	SANDUSKY
360175	*	0.0159	CLINTON
360187	*	0.0168	CLARK
360197	*	0.0092	LOGAN
360267		0.0028	STARK
362007		0.0213	SANDUSKY
370004	*	0.0193	OTTAWA
370014	*	0.0831	BRYAN
370015	*	0.0463	MAYES
370023		0.0084	STEPHENS
370065		0.0121	CRAIG
370113	*	0.0205	DELAWARE
370149		0.0356	POTTAWATOMIE
370179	*	0.0314	OKFUSKEE
380002		0.0130	JOSEPHINE
380008	*	0.0201	LINN
380022		0.0201	LINN
380029		0.0075	MARION
380051		0.0075	MARION
380056		0.0075	MARION
390011		0.0012	CAMBRIA
390044		0.0200	BERKS
390046		0.0098	YORK
390056		0.0042	HUNTINGDON
390065	*	0.0501	ADAMS
390066	*	0.0259	LEBANON
390096		0.0200	BERKS

Provider Number		Out-Migration Adjustment	Qualifying County Name
390101		0.0098	YORK
390110	*	0.0012	CAMBRIA
390130		0.0012	CAMBRIA
390138	*	0.0325	FRANKLIN
390146		0.0053	WARREN
390150	*	0.0206	GREENE
390151	*	0.0325	FRANKLIN
390162		0.0200	NORTHAMPTON
390201		0.1127	MONROE
390233		0.0098	YORK
392030		0.0501	ADAMS
392034		0.0200	NORTHAMPTON
393026		0.0200	BERKS
393037		0.0098	YORK
393050		0.0200	NORTHAMPTON
394020		0.0259	LEBANON
420007		0.0001	SPARTANBURG
420020	*	0.0035	GEORGETOWN
420027		0.0210	ANDERSON
420030	*	0.0103	COLLETON
420039	*	0.0153	UNION
420043		0.0177	CHEROKEE
420068	*	0.0097	ORANGEBURG
420070	*	0.0101	SUMTER
420083		0.0001	SPARTANBURG
420093		0.0001	SPARTANBURG
420098		0.0035	GEORGETOWN
423029		0.0210	ANDERSON
440008	*	0.0663	HENDERSON
440024		0.0387	BRADLEY
440030		0.0056	HAMBLEN
440035	*	0.0441	MONTGOMERY
440047		0.0499	GIBSON
440056		0.0321	JEFFERSON
440060	*	0.0499	GIBSON
440063		0.0011	WASHINGTON
440067	*	0.0056	HAMBLEN
440073	*	0.0513	MAURY
440105		0.0011	WASHINGTON
440114		0.0523	LAUDERDALE
440115		0.0499	GIBSON
440143		0.0448	MARSHALL
440148	*	0.0568	DE KALB

Provider Number		Out-Migration Adjustment	Qualifying County Name
440153		0.0007	COCKE
440174		0.0372	HAYWOOD
440181		0.0407	HARDEMAN
440184		0.0011	WASHINGTON
440185	*	0.0387	BRADLEY
444006		0.0011	WASHINGTON
450032	*	0.0416	HARRISON
450039	*	0.0097	TARRANT
450050		0.0750	WARD
450059	*	0.0073	COMAL
450064	*	0.0097	TARRANT
450087	*	0.0097	TARRANT
450099	*	0.0180	GRAY
450121	*	0.0097	TARRANT
450135	*	0.0097	TARRANT
450137	*	0.0097	TARRANT
450144	*	0.0573	ANDREWS
450163		0.0134	KLEBERG
450187	*	0.0264	WASHINGTON
450194	*	0.0328	CHEROKEE
450214	*	0.0368	WHARTON
450224	*	0.0411	WOOD
450347	*	0.0427	WALKER
450362		0.0486	BURNET
450370		0.0258	COLORADO
450389	*	0.0881	HENDERSON
450395		0.0484	POLK
450419	*	0.0097	TARRANT
450438	*	0.0258	COLORADO
450447	*	0.0358	NAVARRO
450451	*	0.0551	SOMERVELL
450465		0.0435	MATAGORDA
450547	*	0.0411	WOOD
450563	*	0.0097	TARRANT
450565		0.0486	PALO PINTO
450596		0.0808	HOOD
450597		0.0077	DE WITT
450623	*	0.0492	FANNIN
450626		0.0294	JACKSON
450626		0.0294	JACKSON
450639	*	0.0097	TARRANT
450672	*	0.0097	TARRANT
450675	*	0.0097	TARRANT

Provider Number		Out-Migration Adjustment	Qualifying County Name
450677	*	0.0097	TARRANT
450694	*	0.0368	WHARTON
450747	*	0.0195	ANDERSON
450755	*	0.0484	HOCKLEY
450763		0.0236	HUTCHINSON
450779	*	0.0097	TARRANT
450813		0.0195	ANDERSON
450858	*	0.0097	TARRANT
450872	*	0.0097	TARRANT
450880	*	0.0097	TARRANT
452019		0.0097	TARRANT
452028		0.0097	TARRANT
453040		0.0097	TARRANT
453041		0.0097	TARRANT
453042		0.0097	TARRANT
453089		0.0195	ANDERSON
453300		0.0097	TARRANT
454012		0.0097	TARRANT
460017		0.0392	BOX ELDER
460036	*	0.0700	WASATCH
460039	*	0.0392	BOX ELDER
470018		0.0287	WINDSOR
490019		0.1240	CULPEPER
490038		0.0022	SMYTH
490047	*	0.0198	PAGE
490084		0.0167	ESSEX
490105	*	0.0022	SMYTH
490110		0.0082	MONTGOMERY
500003	*	0.0208	SKAGIT
500007		0.0208	SKAGIT
500019		0.0213	LEWIS
500021		0.0055	PIERCE
500024		0.0023	THURSTON
500039	*	0.0174	KITSAP
500041	*	0.0118	COWLITZ
500079		0.0055	PIERCE
500108		0.0055	PIERCE
500118		0.0548	MASON
500122	*	0.0459	ISLAND
500129		0.0055	PIERCE
500139		0.0023	THURSTON
500143		0.0023	THURSTON
503301		0.0055	PIERCE

Provider Number		Out-Migration Adjustment	Qualifying County Name
504010		0.0055	PIERCE
510018	*	0.0209	JACKSON
510028	*	0.0141	FAYETTE
510028		0.0141	FAYETTE
510039		0.0112	OHIO
510047	*	0.0275	MARION
510050		0.0112	OHIO
510077	*	0.0021	MINGO
520028	*	0.0157	GREEN
520035		0.0077	SHEBOYGAN
520042		0.0118	SAUK
520044		0.0077	SHEBOYGAN
520057		0.0118	SAUK
520059	*	0.0200	RACINE
520071	*	0.0239	JEFFERSON
520095	*	0.0118	SAUK
520096	*	0.0200	RACINE
520102	*	0.0298	WALWORTH
520116	*	0.0239	JEFFERSON
520132		0.0077	SHEBOYGAN
522005		0.0200	RACINE

[1] Addendum L lists all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. This list includes hospitals designated in Table 4J of the FY 2006 hospital IPPS final rule (August 12, 2005). Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. For purposes of wage index adjustments under the OPPS, we have adopted any changes in eligibility for the out-migration adjustment resulting from requests to waive reclassification. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk. This list also includes TEFRA hospitals falling in a designated out-migration county.

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