DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 410, 413, 414, 415, 424, and 485

[HCFA–1006–P]

RIN 0938–AI52

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1999

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would make several policy changes affecting Medicare Part B payment. The changes that relate to physician services include: resource-based practice expense relative value units, medical direction rules for anesthesia services, and payment for abnormal Pap smears. Also, we would rebase the Medicare Economic Index from a 1989 base year to a 1996 base year. Under the law, we are required to develop a resource-based system for determining practice expense relative value units. The Balanced Budget Act of 1997 (BBA 1997) delayed, for 1 year, implementation of the resource-based practice expense relative value units until January 1, 1999. Also, BBA 1997 revised our payment policy for nonphysician practitioners, for outpatient rehabilitation services, and for drugs and biologicals not paid on a cost or prospective payment basis. In addition, BBA 1997 permits certain physicians and practitioners to opt out of Medicare and furnish covered services to Medicare beneficiaries through private contracts. In addition, since we established the physician fee schedule on January 1, 1992, our experience indicates that some of our Part B payment policies need to be reconsidered. This proposed rule is intended to correct inequities in physician payment and solicits public comments on specific proposed policy changes.

DATES: Comments on the proposed resource-based practice expense policy will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 3, 1998. Comments on all other issues will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 4, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1006–P, P.O. Box 26688, Baltimore, MD 21207–0488.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1006–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT: Roberta Epps, (410) 786–4503 (for issues related to outpatient rehabilitation services, nurse practitioners, clinical nurse specialists, and certified nurse-midwives).

Stephen Heffler, (410) 786–1211 (for issues related to the Medicare Economic Index).

Anita Heygster, (410) 786–4486 (for issues related to private contracts).

Jim Menas, (410) 786–4507 (for issues related to Pap smears and medical direction for anesthesia services).

Robert Niemann, (410) 786–4569 (for issues related to the drugs and biologicals policy).

Regina Walker-Wren, (410) 786–9160 (for issues related to physician assistants).

Stanley Weintraub, (410) 786–4498 (for issues related to practice expense relative value units and all other issues).

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations. Information on the regulation's impact appears throughout the preamble and not exclusively in part V.

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In addition, because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AANA—American Association of Nurse Anesthetists
ABC—Activity based costing
ABN—Advance Beneficiary Notice
AHE—Average Hourly Earnings
AMA—American Medical Association
ASA—American Society of Anesthesiologists
AWP—Average Wholesale Price
BBA—Balanced Budget Act of 1997
BLS—Bureau of Labor Statistics
CF—Conversion factor
CFR—Code of Federal Regulations
CMSAs—Consolidated Metropolitan Statistical Areas
CORF—Comprehensive outpatient rehabilitation facility
CPEPs—Clinical Practice Expert Panels
CPI—Consumer Price Index
CPI–U—Consumer Price Index for All Urban Consumers
CPS—Current Population Survey
CPT—[Physicians'] Current Procedural Terminology [4th Edition, 1997, copyrighted by the American Medical Association]
CRNA—Certified Registered Nurse Anesthetist
DME—Durable medical equipment
DMEPOS—Durable medical equipment, prosthetics, orthotics, and supplies
DRG—Diagnosis-related group
EAC—Estimated Acquisition Cost
ECI—Employment Cost Index
ES–202—Data—Bureau of Labor Statistics from State unemployment insurance agencies
ESRD—End-stage renal disease
FDA—Food and Drug Administration
FMR—Fair market rental
GAAP—Generally accepted accounting principles
GAF—Geographic adjustment factor
GPCI—Geographic practice cost index
HCFA—Health Care Financing Administration
HCPCS—HCFA Common Procedure Coding System
HHS—[Department of] Health and Human Services
HMO—Health maintenance organization
HUD—[Department of] Housing and Urban Development
MEDPAC—Medicare Payment Advisory Commission
MEI—Medicare Economic Index
MGMA—Medical Group Management Association
MSA—Metropolitan Statistical Area
NAIC—National Association of Insurance Commissioners
NPI—National provider identifier
OBRA—Omnibus Budget Reconciliation Act
OTIP—Occupational therapist in independent practice
PC—Professional component
PMSA—Primary Metropolitan Statistical Area
PPI—Producer Price Index
PPS—Prospective payment system
PTIP—Physical therapist in independent practice
RUC—[AMA's Specialty Society] Relative [Value] Update Committee

RVU—Relative value unit
SMS—Socioeconomic Monitoring System
SNF—Skilled nursing facility
TC—Technical component
TEFRA—Tax Equity and Fiscal Responsibility Act
UPIN—Uniform provider identifier number

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physician services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' This section contains three major elements: (1) A fee schedule for the payment of physician services; (2) a sustainable growth rate for the rates of increase in Medicare expenditures for physician services; and (3) limits on the amounts that nonparticipating physicians can charge beneficiaries. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense.

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs because of changes resulting from a review of those RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If this tolerance is exceeded, we must make adjustments to the conversion factors (CFs) to preserve budget neutrality.

B. Published Changes to the Fee Schedule

We published a final rule on November 25, 1991 (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physician services furnished on or after January 1, 1992. In the November 1991 final rule (56 FR 59511), we stated our intention to update RVUs for new and revised codes in the American Medical Association's (AMA's) Physicians' Current Procedural Terminology (CPT) through an ''interim RVU'' process every year. The updates to the RVUs and fee schedule policies follow:

- November 25, 1992, as a final notice with comment period on new and revised RVUs only (57 FR 55914).
- December 2, 1993, as a final rule with comment period (58 FR 63626) to revise the refinement process used to establish physician work RVUs and to revise payment policies for specific physician services and supplies. (We solicited comments on new and revised RVUs only.)
- December 8, 1994, as a final rule with comment period (59 FR 63410) to revise the geographic adjustment factor (GAF) values, fee schedule payment areas, and payment policies for specific physician services. The final rule also discussed the process for periodic review and adjustment of RVUs not less frequently than every 5 years as required by section 1848(c)(2)(B)(i) of the Act.
- December 8, 1995, as a final rule with comment period (60 FR 63124) to revise various policies affecting payment for physician services including Medicare payment for physician services in teaching settings, the RVUs for certain existing procedure codes, and to establish interim RVUs for new and revised procedure codes. The rule also included the final revised 1996 geographic practice cost indices (GPCIs).
- November 22, 1996, as a final rule with comment period (61 FR 59490) to revise the policy for payment for diagnostic services, transportation in connection with furnishing diagnostic tests, changes in geographic payment areas (localities), and changes in the procedure status codes for a variety of services.
- October 31, 1997, as a final rule with comment period (62 FR 59048) to revise the geographic practice cost index (GPCI), physician supervision of diagnostic tests, establishment of independent diagnostic testing facilities, the methodology used to develop reasonable compensation equivalent limits, payment to participating and nonparticipating suppliers, global surgical services, caloric vestibular testing, and clinical consultations. The final rule also implemented certain provisions of the Balanced Budget Act of 1997 (BBA 1997) (Public Law 105–33), enacted on August 5, 1997, and implemented the RVUs for certain existing procedure codes and established interim RVUs for new and revised procedure codes.

This proposed rule would affect the regulations set forth at 42 CFR part 405, which consists of regulations on Federal health insurance for the aged and disabled; part 410, which consists of regulations on supplementary medical insurance benefits; part 414, which consists of regulations on the payment for Part B medical and other health services; part 415, which pertains to services furnished by physicians in providers, supervising physicians in teaching settings, and residents in certain settings; part 424, which pertains to the conditions for Medicare payment; and part 485, which pertains to conditions of participation: specialized providers.

II. Specific Proposals for Calendar Year 1999

A. Resource-Based Practice Expense Relative Value Units

1. Current Practice Expense Relative Value Unit System

The Act details the types of services that are paid under the physician fee schedule. These include physician services, services and supplies incident to a physician service, diagnostic x-ray tests, diagnostic laboratory tests (excluding clinical laboratory tests), and x-ray, radium, and radioactive isotope therapy. BBA 1997 added other services such as certain preventive services. While some of these services do not have work RVUs, all of the services have practice expense and malpractice expense RVUs. (Physician anesthesia services are included under the physician fee schedule but are paid under a different payment methodology that uses a separate CF and allowable base and time units. Physician anesthesia services do not have practice expense and malpractice expense RVUs.) Payments for practice expense RVUs account for approximately 41 percent of total physician fee schedule payments.

In most cases, the current practice expense RVUs are calculated based on a statutory formula. They are derived from the product of ''base allowed charges'' and service-specific practice expense percentages. The base allowed charge is the national allowed charge for the service furnished during 1991. The service-specific practice expense percentage is a weighted average of the practice expense percentages of the specialties performing the service.

For services furnished beginning with calendar year 1994 and whose practice expense RVUs exceed 1994 work RVUs and are performed in the office setting less than 75 percent of the time, practice expense RVUs in each of 1994, 1995, and 1996 were reduced by 25 percent of the amount they exceed the 1994 work RVUs. (Before 1998, practice expense RVUs were not reduced to less than 128 percent of 1994 work RVUs.)

For services furnished beginning with calendar year 1998 whose practice expense RVUs (determined for 1998) exceeded 110 percent of the work RVUs and which were provided less than 75 percent of the time in an office setting, the 1998 practice expense RVUs were reduced to a number equal to 110 percent of the work RVUs. This limitation did not apply to services that had a proposed resource-based practice expense RVU in the June 18, 1997 proposed rule (62 FR 33158), which was

an increase from its 1997 practice expense RVU. For office visit procedure codes performed beginning calendar year 1998, the practice expense RVUs were increased by a uniform percentage to equal the aggregate decrease in the practice expense RVUs for other services.

2. Criticism of Current Practice Expense Relative Value Unit System

A common criticism of the current practice expense RVU system is that for many services the RVUs, which are based on charges under the reasonable charge system, are not based directly on the resources involved with furnishing the service. Rather, the charge-based nature of the current fee schedule practice expense retains historical charge patterns that existed before the implementation of the physician fee schedule on January 1, 1992. Those charge patterns favor procedures and tests performed in hospitals rather than evaluation and management services and other office-based services.

For example, a primary care physician would have to bill CPT code 99213 (level 3 office visit, established patient) approximately 80 times to collect the same amount of practice expense payments as a cardiac surgeon would for performing one coronary artery bypass graft with three coronary venous grafts (CPT code 33512), although the practice expenses the surgeon typically incurs for the cardiac surgery are primarily related to the pre- and postoperative services furnished in the office, administrative costs, and overhead. The costs for clinical staff, medical supplies, and medical equipment furnished to hospital patients are included in the diagnosis-related group (DRG) payment made to the hospital as required by section 1862(a)(14).

In their 1993 annual report to the Congress, the Physician Payment Review Commission recommended that the Congress revise the practice expense component of the physician fee schedule so that it is resource-based. They further recommended that we collect data regarding the direct cost incurred in delivering each service and that a formula-based approach be used to allocate indirect costs. This recommendation was instrumental in the Congress' legislating the resource-based practice expense component.

3. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Public Law 103–432), enacted on October 31, 1994, requires us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician service. In developing the methodology, we must consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation required the new payment methodology to be effective for services furnished in 1998.

The legislation specifically requires that, in implementing the new system of practice expense RVUs, we must apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Before publication of the final rule in October 1997, section 4505 of the BBA 1997 delayed initial implementation of resource-based practice expense RVUs until 1999. It also required that we do the following:

- Use, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures.
- Consult with organizations representing physicians regarding methodology and data to be used.
- Develop a refinement method to be used during the transition.
- Consider impact projections that compare new proposed payment amounts to data on actual physician practice expenses.

4. Originally Proposed Methodology for Developing Resource-Based Practice Expense Relative Value Units

To implement the October 1994 legislation, we published a proposed rule on June 18, 1997 (62 FR 33158). In the proposed rule, we established a framework in which practice expenses were divided into direct and indirect costs. Direct costs are those costs that can be directly attributed to providing a service, such as the cost of a nurse's time (salary), medical supplies and equipment, administrative costs of billing, record maintenance, and the scheduling of office patients. Direct costs also include the physician's costs of office staff time for scheduling appointments and billing and collection activities associated with a medical procedure furnished in a hospital. Indirect costs cannot be directly attributed to a specific service, and include costs such as rent, utilities, office equipment and supplies, and accounting and legal fees. The allocation of indirect costs to specific products or services is a classic accounting problem. The indirect costs are difficult to relate directly to a specific service because they are incurred by the practice as a whole.

The June 1997 proposed rule (62 FR 33172) described the following methodology for calculating the proposed direct practice expense RVUs.

- We calculated the total pool of practice expense RVUs for 1995 and divided it into direct and indirect practice expense pools using the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) survey data and our 1995 national claims history data. The national distribution of direct and indirect practice expense RVUs was 55 percent direct practice expense RVUs and 45 percent indirect practice expense RVUs.
- The underpinning for the proposed direct components of the practice expense RVUs was the data reported by the Clinical Practice Expert Panels (CPEPs) for clinical and administrative labor, medical supplies, and medical equipment inputs. There were 15 CPEPs, corresponding to the major medical specialties, which were made up of nominees from all major specialty societies. (A description of the CPEPs is contained in the June 1997 proposed rule (62 FR 33161).) (See Addendum A for a detailed description of the CPEP process.)
- These data were edited to apply Medicare payment policy rules to ensure that the reported data were consistent with our national hospital and physician payment policies. The primary adjustment was the removal of direct inputs recorded for clinical labor staff, medical equipment, and medical supplies furnished to hospital patients. Other adjustments were made for the professional component of a service, the technical component of a service, and the combined service, for codes that have an indicator of ZZZ under the physician fee schedule, and for certain allergy and immunotherapy codes performed on a per-test, per-dose, or per-vial basis.
- We believed that the relative relationships of the staff time estimates within the individual CPEPs were generally correct but that the absolute time estimates needed normalization. We placed the codes from the different CPEPs on the same scale using a normalization process that we call ''linking.'' Specifically, linking shifted an entire CPEP's data relative to other CPEPs' data, based on the relationship of the values assigned across panels for codes that had been assigned to multiple CPEPs. We separately linked clinical and administrative labor costs. Statistically, the linking was done using regression methods.

• After the data were edited and linked, our physicians and clinical staff analyzed the direct practice expense RVUs to determine if there were unexplainable variations in the underlying CPEP data. This review resulted in the application of two general reasonableness rules. First, a decision was made to cap the administrative time of several categories of service (services without a global period and procedures subject to global periods with zero follow-up days) at the administrative time assigned to CPT code 99213 (midlevel office visits). Second, we decided to cap the nonphysician clinical staff time at 1.5 times the physician time, in minutes, for performing the procedure. Additional more specific rules were applied to certain supplies and supply costs and for certain codes, such as psychotherapy, physical therapy, chemotherapy, and nerve block codes.

• The aggregate percentage shares across all specialties of labor and medical supplies and equipment from the CPEP data were scaled to the percentage shares of these categories from the AMA's SMS survey data. The CPEP expenses for labor, medical supplies, and medical equipment were adjusted by scaling factors of 1.21, 1.06, and 0.39 respectively.

• The direct practice expense dollar amounts were converted into direct practice expense RVUs. An adjustment factor of 0.65 was used to convert the aggregate direct practice expense dollars to the available Medicare direct practice expense dollars.

• Aggregate indirect practice expense RVUs were allocated to individual codes based on the code-specific sum of the direct practice expense, the malpractice expense, and the physician work RVU.

• The direct and the indirect practice expense RVUs per code were combined to produce a single practice expense RVU per code.

Other practice expense proposals in the June 1997 proposed rule (62 FR 33160) included:

• Replacement of the current site-of-service differential policy that systematically reduces the practice expense RVUs by 50 percent for certain procedures with a policy that would generally identify two different levels (office or nonoffice) of practice expense RVUs for each procedure code depending on the site of service.

• Elimination of the current policy that allows additional practice expense RVUs for supplies that are used incident to a physician service but were not the type of routine supplies included in the current practice expense RVUs for specific services. These supplies were included in the CPEP data for the specific procedure code.

• Reduction of the practice expenses for multiple nonsurgical services performed at the same time as an evaluation and management service.

The June 1997 proposed rule provided for a 60-day comment period ending on August 18, 1997.

5. Balanced Budget Act of 1997 Provisions Pertaining to Resource-Based Practice Expense Relative Value Units

On August 5, 1997, the President signed into law the Balanced Budget Act of 1997 (BBA 1997). Section 4505(a) of BBA 1997 delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, BBA 1997 provided for the following revisions in the requirements to change from a charge-based practice expense RVU system to a resource-based method.

Instead of paying for all services entirely under a resource-based system in 1999, section 4505(b) of BBA 1997 provided for a 4-year transition period. The practice expense RVUs for the year 1999 will be the product of 75 percent of the previous year's RVUs (1998) and 25 percent of the resource-based RVUs. For the year 2000, the percentages will be 50 percent charge-based and 50 percent resource-based. For the year 2001, the percentages will be 25 percent charge-based and 75 percent resource-based. For subsequent years, the RVUs will be totally resource-based.

Section 4505(c) of BBA 1997 required the Comptroller General to review and evaluate our proposed rule and report to the Congress by February 1998. The review was required to include an analysis of (1) the adequacy of the data used in preparing the rule, (2) categories of allowable costs, (3) methods for allocating direct and indirect expenses, (4) the potential impact of the rule on beneficiary access to services, and (5) any other matters related to the appropriateness of resource-based methodology for practice expenses. The Comptroller General was also to consult with representatives of physician organizations with respect to matters of both data and methodology.

Section 4505(e) of BBA 1997 provided that, for 1998, the practice expense RVUs be adjusted for certain services in anticipation of the implementation of resource-based practice expenses beginning in 1999. Practice expense RVUs for office visits were increased. For other services whose practice expense RVUs (determined for 1998) exceeded 110 percent of the work RVUs and which were provided less than 75 percent of the time in an office setting, the 1998 practice expense RVUs were reduced to a number equal to 110 percent of the work RVUs. This limitation did not apply to services that had a proposed resource-based practice expense RVU in the June 1997 proposed rule that was an increase from its 1997 practice expense RVU. The total of the reductions was less than the statutory maximum of $390 million. The procedure codes affected and the final RVUs for 1998 were published in the October 31, 1997 final rule (62 FR 59103).

Section 4505(d)(2) of BBA 1997 required that the Secretary transmit a report to the Congress by March 1, 1998, including a presentation of data to be used in developing the practice expense RVUs and an explanation of the methodology. A report was submitted to the Congress in early March 1998. Section 4505(d)(3) requires that a proposed rule be published by May 1, 1998, with a 90-day comment period. For the transition to begin on January 1, 1999, a final rule must be published by October 31, 1998.

BBA 1997 also required that we develop new resource-based practice expense RVUs. In developing these new practice expense RVUs, section 4505(d)(1) required us to: (1) Utilize, to the maximum extent practicable, generally accepted accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be tied to specific procedures, and use actual data on equipment utilization and other key assumptions; (2) consult with organizations representing physicians regarding the methodology and data to be used; and (3) develop a refinement process to be used during each of the 4 years of the transition period.

6. HCFA Response to BBA 1997 Requirements

BBA 1997 required us to develop new resource-based RVUs and to consult with physician organizations regarding methodology and data. To meet the BBA 1997 requirements and to promote input as we developed new RVUs, we have sought and will continue to encourage maximum input from those affected by this initiative. The following is a summary of activities we have undertaken.

• Validation Panel Meetings.

We hosted 17 medical specialty panels that were charged with validating the CPEP direct cost data for the high-volume CPT codes for each specialty. All the major medical specialty societies were represented, including nonphysician organizations.

Each panel, consisting of about 12 to 15 members, was made up of the appropriate specialists, two general surgeons, two primary care physicians, and two Medicare carrier medical directors. The panel members reviewed and, if they believed necessary, revised the clinical and administrative times and the supplies and equipment involved for each code. Consensus within panels was reached on about 200 codes.

• Cross Specialty Panel.

Although the October validation panels were able to reach consensus on many high-volume procedures within specific specialties, we were concerned that there was not a uniform or consistent scale applied to labor inputs across specialties. Therefore, in December, we convened a multiple specialty panel of 37 panelists, including physicians, nonphysicians, and administrators nominated by the specialty societies.

We expected the panel to help us achieve consistency across panels on resource inputs, such as insurance billing and transcription times, and to standardize the clinical staff types for similar classes of services, whether they be registered nurses, medical assistants, licensed practical nurses, or a mix of these staff types. The results of the cross specialty panel were generally unsuccessful. While the panel did provide the arena for panelists to furnish explanations of times for activities that we believed to be excessive, the panelists were generally reluctant to make any major modifications in the times or staff they had assigned to their own services. The panelists could not agree to any rules that would aid us in standardizing the data.

The panelists did recommend that we explore an option that treats billing and insurance activities as indirect costs. Many panelists also suggested that we proceed cautiously and try to minimize the magnitude of redistribution.

• Indirect Cost Symposium.

We convened a meeting on November 21, 1997 on indirect practice expenses to provide a forum for participants to discuss their preferred methodology for allocating indirect costs. We asked those organizations that commented on our proposed indirect cost methodology to make a formal presentation of their views. All major medical specialty groups were invited to attend and join in the discussion.

Some groups endorsed the methodology we proposed in the June 1997 proposed rule (62 FR 33172) with some modifications. One modification recommended was to eliminate malpractice RVUs as a factor in allocating indirect costs. It was noted, even by some advocates for other allocation methods, that our proposed methodology embodied traditional accounting methods for allocating indirect costs.

Only two major alternatives to our proposed methodology were presented. The first, the Activity Based Costing (ABC) method, was described as a cutting edge approach to determining the cost of individual products (CPT codes). Under the ABC method, the total costs of a practice are collected and assigned to discrete processes or activities. These costs are then assigned to products to which they are related.

The ABC method was developed for industries in which direct labor (the traditional cost accounting method for allocating indirect costs) is not the dominant factor in the production of the good or service. This method is in the early developmental stages in medical practice use.

The second alternative methodology presented was the physician work RVU method of allocating indirect practice expenses. This method would allocate indirect costs using only the physician work RVUs. However, there did not appear to be much support for this methodology at the meeting. It would, for example, penalize physician practices that have proportionately higher equipment costs.

• October 31, 1997 Notice with Comment Period

• To inform all interested parties of our plans to issue a new proposed rule and to request additional data from the medical community to assist us in meeting BBA 1997 requirements, on October 31, 1997, we published a notice (62 FR 59267).

In that notice, we requested that physicians, physician organizations, or others provide us with the following information:

• Generally accepted cost accounting principles—We specifically requested information on the following: (1) Aspects of the cost accounting methodology used in the June 1997 proposed rule that were not consistent with the statutory guidance; and (2) complete copies of studies of resource-based practice expense RVUs, including any underlying surveys supporting these studies, performed by physicians or physician groups or their contractors or consultants, including pertinent details about the survey.

• Equipment utilization—We specifically requested complete copies of any studies or other data showing the actual utilization of equipment by physician practices, including pertinent details about the survey, such as response rates, sampling design, methodology, directions, and definitions.

• Other assumptions—We specifically requested information regarding the useful life of equipment, the amount and percentage of direct practice costs versus the amount and percentage of indirect costs by specialty, and practice expense values for sites for which values were not proposed in the June 1997 proposed rule (62 FR 33158).

• Use of physician-employed staff in hospitals and other facility settings—We specifically requested comments and information about the extent to which a physician employee, such as a registered nurse, accompanies the physician to the hospital, ambulatory surgical center, or other facilities to provide services, such as acting as an assistant at surgery or serving as a scrub nurse. We asked for names of specific facilities so that we might contact them in order to more fully understand the nature of the relationships.

• Refinement process—We requested comments on how this refinement process would operate including assigning practice expense RVUs to new codes, who would be involved in the refinement process, and how all of the users of the physician fee schedule would have access to the process.

• Review of New Methodology by KPMG Peat Marwick LLP—Under contract #500–97–0402, we requested that KPMG Peat Marwick LLP review the practice expense per hour methodology. They concluded that the methodology follows reasonable cost accounting principles. They made this determination based on an examination of the available data sources and a consideration of the cost and feasibility of acquiring additional nationally representative data. As a future consideration, they recommended sample validation of our cost allocation bases.

7. Summary of General Input From the Medical Community and Comments From the October 1997 Notice With Comment Period

Some physicians, such as primary care physicians, expressed satisfaction that the proposed methodology was generally sound. In addition, the AMA was supportive of our panel process for direct expenses and offered many helpful comments. However, many surgeons and medical specialties argued that we should discard our current practice expense data, and develop payments that reflect their ''actual costs.''

Both in written comments and in our meetings with the medical community, we received much feedback on our methodology for indirect practice expense. However, there was no consensus regarding methods for allocating indirect costs to individual procedure codes.

In addition, we received 56 specific comments from individuals, major organizations, and physician specialty groups on our October 1997 notice. The comments are summarized by the following categories:

• Generally Accepted Accounting Principles.

Some of the groups expected to experience an increase in payment under the June 1997 proposed rule thought our approach satisfied the current statutory mandate that we utilize generally accepted accounting principles (GAAP). Those physician groups that expected to experience a decrease in payments based on the methodology described in the June 1997 proposed rule said the approach in the proposed rule was inconsistent with GAAP. They argued that GAAP requires us to use actual practice expense data and said the data from the CPEPs and validation panels were based on erroneous assumptions, or were unverified approximations. At least five commenters supported using the activity-based accounting approach.

• Equipment utilization.

Some groups furnished equipment-specific utilization levels for a few services. Generally, the equipment and utilization levels were not based on representative surveys of physicians performing the service. Some suggestions were as follows:

	Percent
Electroencephalography equipment.	26
Electromyography	36.5
Nerve Conduction Velocity	36.5
Cystoscope	5
Loop electrode excision procedure.	1
Colposcope	1.6
YAG laser	12
ARGON laser	5 to 6.4
Fundus camera	31.3
Spirometry and Ancillary Equipment.	10 to 17
Bronchoscopy	5 to 10

• Useful Life.

We did not receive specific comments on suggested useful lives for specific medical equipment, which is an important factor in estimating equipment costs.

• Direct and Indirect Costs.

Some commenters pointed out that not all clinical labor can be classified as direct costs. Tasks such as ordering supplies and attending meetings or continuing education classes should be captured as indirect costs. Some groups, including one primary care group, said that billing costs should be an indirect expense, while others supported maintaining them as direct costs. Many groups supported an allocation process in which indirect costs are assigned based on a specialty's specific indirect cost percentage. Only one group specifically objected to this approach. Some physician groups provided specific direct and indirect cost ratios based on limited surveys of their membership.

• Employed Staff.

According to an American Hospital Association survey, 63 percent of respondents (from 573 hospitals) believed that a physician brought staff to the hospital during the last 6 months of 1996. Of these respondents, 82 percent said this was not a regular practice. Therefore, the American Hospital Association commented it is not a typical practice in the United States for physicians to bring their own staff to a hospital.

Five surgical specialties and subspecialties—neurosurgery, ophthalmology, general thoracic surgery, congenital thoracic surgery, and adult cardiac surgery—indicated that at least 50 percent of practices use employed clinical staff in nonoffice settings. General surgery indicated that 31 percent of general surgery practices pay for clinical staff working in nonoffice settings. The Society of Thoracic Surgeons stated that they do not have data on the number of clinical nurses who work with thoracic surgeons in hospitals. However, they stated that a survey of physician assistants shows that 72 percent of physician assistants employed in cardiovascular surgery were employed by solo or group physician practices.

According to the American Academy of Ophthalmology, 51 percent of ophthalmologists bring equipment, such as keratomes, diamond knives, cataract trays, and muscle trays to furnish services to hospital patients.

• Refinement.

Most commenters support using the AMA's Specialty Society Relative Value Update Committee's (RUC's) process to refine the practice expense RVUs. (Currently the RUC recommends refinement of the physician work RVUs.) Of these commenters, many recommended that the process include nurses and practice managers, that there be established rules and procedures for data collection, survey design, and response rates, and that the process allows participation by subspecialties, such as transplant surgeons and pediatric surgeons. One commenter suggested a process using the AMA, Medical Group Management Association (MGMA), and HCFA. Some commenters suggested using a RUC process only for new codes.

• Transition.

Several commenters stated that the base year for the transition should be the 1997 practice expense RVUs and not the 1998 practice expense RVUs. They suggested that the 1998 adjustment required by BBA 1997 is not intended to be included in the base for purposes of the practice expense transition. Some commenters recommended that we explore using ceilings and floors during the transition period or use caution so as to limit the amount of the redistribution.

• Site-of-Service Differential.

Commenters from the American Academy of Orthopaedic Surgeons stated that we need office practice expense RVUs for musculoskeletal system surgery codes 25000, 25031, 26040, 26060, 26608, 29815 through 29848, and 29870 through 29898. Some commenters believe we should develop practice expense RVUs for all procedures at all sites and permit office endoscopy only under very limited and clearly defined standards.

• Data Quality.

The American College of Surgeons stated that the CPEP data are based on erroneous assumptions, educated guesses, and unverified approximations. They stated that the data from panels are unreliable for the administrative times for chiropractic manipulation, level 3 office visits, inpatient consultations, balloon angioplasty, and clinical times for allergy skin testing.

• Validation.

The AMA stated that we should use AMA and MGMA data on full time equivalent staff for each physician to assess how well various methodological options account for total labor costs. The American College of Physicians suggested we complete an impact analysis that compares proposed practice expense payments to actual practice expenses on a specialty by specialty basis, as well as sponsoring a study requiring on-site visits to practices.

8. Issues Considered in Developing New Practice Expense RVUs

We faced the following major issues as we decided whether and how to modify our original proposal for physician practice expense RVUs. These issues arose from many sources: from concerns about the CPEP data and our

original proposed methodology, from the requirements of BBA 1997, from the findings and recommendations in the General Accounting Office's Report to the Congress on physician practice expense, and from input we received from the medical community.

• Purpose.

Our original practice expense proposal was based on the 1994 legislation, which stated that the new practice expense methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings. We interpreted this to mean that Medicare payments for each service should be based on the relative resources typically and reasonably involved with performing the service. We believed we could best calculate these resources by achieving clinical consensus on the actual inputs it would typically take to perform a given service. However, surgeons and some other specialties contended that the purpose of a resource-based practice expense system should be to reimburse them based on their total current expenditures for practice costs. Because the higher paid specialties have more to spend on their practices as a result of historic charging practices and insurance coverage, there is a concern that adopting such a methodology would not achieve the desired equity. The argument made by some outside groups is that physicians have been increasingly forced to be more efficient and, as a result, differences in practice expenses among specialties reflect ''real'' costs that should then be reflected in the new practice expense RVUs.

With the passage of BBA in August 1997, the statute now requires us to ''utilize, to the maximum extent practicable, generally accepted cost accounting principles which recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures. * * *'' Therefore, in developing and analyzing any new alternative methods for computing practice expense RVUs, we have evaluated how well each option recognizes all practice expense costs.

• ''Bottom-up'' versus ''Top-down'' Methodology.

In line with our original stated purpose and the 1994 legislation, our practice expense methodology published in the June 1997 proposed rule (62 FR 33172) used a ''bottom-up'' approach, which obtained expert panel estimates of actual inputs—staff times, supplies, and equipment—for each procedure and then used these estimates to build up to the direct practice expense RVUs. Some groups complained that some of the published relative values were too low and favored using studies that actually measured the inputs onsite. Unfortunately, if any reliable data exist at all, they are only for a few scattered specialties, and it certainly is not practical for us to undertake such a task (Medicare pays physicians for over 7,000 services). We understand that even the few specialties that have attempted surveys have had limited success obtaining complete practice expense data from even limited selected practices.

Many of the specialty societies favored a ''top-down'' methodology, which would start our calculations with their total current expenditures and then allocate these costs down to the procedure level by some method. Several groups supported using an Activity Based Costing (ABC) methodology for calculating practice expenses. The proponents of ABC maintain that it produces more accurate costs because it measures the costs of processes (for example, servicing patients, scheduling, and billing) as opposed to traditional costing systems, which measure resources (for example, salaries and rent). However, ABC is only in the experimental stages in medical practice use, and many difficult questions about its utility in medical practices have not been resolved, for example, its assumption that all medical practices operate in the same manner. ABC still requires subjective estimations, or some other algorithm, to allocate costs from ''processes'' to individual CPT codes.

• Available Data Sources.

Much of the debate about what would constitute the most accurate practice expense methodology cannot be resolved in the short run. There is no consensus about the best way to determine the most accurate practice expense methodology. Furthermore, there are only limited data sources available. CPEP data, along with the modifications made by our subsequent panels, are the only source of estimates at the CPT code level of resource inputs needed to provide each service. AMA's SMS survey data are from a national survey of randomly selected self-employed physicians that collects information on practice expense on an aggregate level, and can be used to determine overall differences in expenditures among specialties.

The only other relevant data sources of which we are presently aware are a few other surveys of practice expense, such as those performed by the MGMA, *Medical Economics*, and the American College of Surgeons. Because of selective sampling and low response rates of these three surveys, these data are not representative of the population of physicians and cannot be used to derive code-specific RVUs, though the data might prove useful in validating general impacts.

• Specialty-Specific Differences.

Our June 1997 proposed rule did not explicitly recognize specialty-specific differences. Differences across specialties were only reflected implicitly to the extent that more indirect RVUs would be allocated to those procedures with the greatest physician work and direct costs. Under our June 1997 proposed approach, we allocated indirect relative values based on the typical use of resources, that is, the direct practice expense RVUs, the physician work RVUs, and the malpractice RVUs per code.

The specialty groups, along with the AMA and even some primary care groups, were almost unanimous in their view that we should use an approach that explicitly recognizes specialty-specific differences in the indirect cost of practice. It was pointed out, as an example, that some specialties such as radiology or ophthalmology would have much higher indirect equipment costs than other specialties. The specialty groups believed that not recognizing such specialty differences would be inherently unfair to some specialties. The AMA staff suggested that we use their survey data to calculate the specialty-specific indirect costs.

In developing our options for a new practice expense methodology, we, therefore, needed to decide whether we would maintain specialty-neutral methods, use specialty differentials to help allocate only indirect RVUs, or use specialty-specific data to establish the total redistributive pools for each specialty.

• Administrative Costs.

Another decision we had to make as we developed new practice expense RVUs was how a new proposal would treat administrative costs. The June 1997 proposed rule (62 FR 33167) methodology treated administrative labor cost as a direct expense, and the administrative cost RVUs were derived from the CPEP data. On first reviewing the raw CPEP inputs for administrative staff times, it appeared that there were some problems with the data. First, some of the suggested administrative staff times appeared excessively high, particularly for the billing staff. Second, there was variation in staff times for the same CPT code between the different panels. In the June 1997 proposed rule (62 FR 33166), we dealt with these problems through our linking

methodology and by capping administrative times. Both of these methods were strongly opposed by many specialty groups, largely because our adjustments had dramatic effects on the raw data. For example, the linking coefficient for thoracic surgery reduced their administrative inputs by 76 percent. There were also comments claiming that many administrative duties are of a general nature that cannot be fully captured on a code-specific basis.

As a result of these concerns, many outside groups have suggested that we treat administrative cost as an indirect practice expense. The advantages of adopting this suggestion would be that we could get around the mentioned data discrepancies, avoid the controversial use of linking for administrative labor, and be more certain that we had captured all administrative costs. The main disadvantage would be that it would greatly increase the percentage of RVUs that would have to be allocated by a formula.

• Clinical Costs.

Although the problems were on a lesser scale, we observed many of the same difficulties with the raw CPEP inputs for clinical costs as there were for the administrative costs discussed above. There was some lack of standardization of clinical staff types between the CPEP panels, and some staff times appeared excessive. In the June 1997 proposed rule, these problems were addressed by linking and by capping the clinical times; both of these methods caused considerable controversy in the medical community. We had hoped that the validation and cross-specialty panels would have resolved the inconsistencies across specialties, but they were unable to accomplish this task. It was clear, therefore, that any new proposal would still have to address a method of standardizing the data between the various specialty panels.

• The General Accounting Office (GAO) Report to Congress on Physician Practice Expense.

As already mentioned, BBA 1997 required the GAO to review and evaluate our June 1997 proposed rule on a resource-based methodology for practice expenses. This report was issued in February 1998 and concluded that both our use of expert panels to develop direct cost estimates and our original allocation methodology for indirect costs were acceptable options. However, the GAO raised questions about the validity of some specifics of the linking regression model and about the appropriateness of capping administrative and clinical labor time estimates. In addition, the report suggested that using specialty-specific indirect expense ratios, based on the SMS survey data, would be more clearly consistent with BBA 1997. Also, the report recommended that we consider classifying administrative labor costs as indirect expenses. (See section 18 for a more detailed discussion of the report's recommendations.)

9. Alternative Practice Expense Methodologies Considered

We carefully considered two alternative approaches to developing new practice expense RVUs: the first maintained the ''bottom-up'' methodology of our original proposal, while the second adopted a ''top-down'' methodology.

• ''Bottom-up'' Option.

We regard our original ''bottom-up'' proposal as a viable method of developing practice expense RVUs. It clearly fulfilled the requirement of the Social Security Amendments of 1994, which states that practice expense relative values should be based on the relative practice expense resources involved in furnishing the service. Both the GAO and the Physician Payment Review Commission, as well as many researchers in the field, supported our use of expert panels to estimate direct practice expenses. Therefore, we developed a method that was similar to our original proposal.

Like our proposal in the June 1997 proposed rule, this option based its calculation for all direct inputs on the data reported by the CPEPs. As before, both clinical and administrative labor were linked, and all direct cost estimates were scaled as in the original proposed rule. However, in a significant departure from our original proposal, the caps on clinical and administrative staff times were eliminated. For indirect costs, this option continued not to recognize a specialty-specific method of cost allocation to specific procedures. It did, however, have a different indirect allocation formula from our original proposal; under this option, 50 percent would be allocated on the basis of direct costs and 50 percent on the basis of physician time. Of the latter 50 percent, physician time in the office would get a weight 50 percent higher than physician time out of the office. If there was no physician involvement, as is the case with technical component services, the maximum clinical staff time would be used.

• The ''Top-Down'' Option.

This option is a departure from our original proposal and is an effort to balance the requirements of the 1994 Social Security Amendments with the 1997 BBA requirements. It uses the two significant sources of actual practice expense data we have available: the CPEP data and the AMA's SMS survey data. It allocates current aggregate specialty practice costs to specific procedures and, thus, can be seen as a ''top-down'' approach.

This option is based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physician services across specialties. The specialty practice cost data are derived from the AMA's SMS survey data on actual practice expenses. The survey data are used to calculate the practice expenses generated for every hour worked by a physician. The average practice expense per hour for the physicians in a given specialty is then multiplied by the total number of physician hours worked by that specialty as reflected in the Medicare claims data. This determines the total pool of practice expense payments for that specialty. We then allocated this pool to the procedures performed by that specialty using the CPEP data (excluding the administrative staff time associated with specific procedures) and the physician work RVUs. We calculated a weighted average of the practice expense payments for procedures performed by more than one specialty.

After much analysis and discussion, we have decided to propose the ''top-down'' methodology. We believe the ''top-down'' methodology is more responsive than the ''bottom-up'' approach to both BBA 1997 requirements and to many of the concerns of the medical community. By using aggregate specialty practice costs as the basis for establishing the practice expense pools, we are recognizing all of a specialty's costs, not just those linked with a specific procedure. By basing the redistributions of the practice expense system on physician-reported actual practice expense data, by using a specialty-specific allocation method, and by treating administrative costs as an indirect expense, we avoid many of the criticisms leveled at our original proposal.

We also believe this option is responsive to the short-term recommendations in the GAO Report to Congress on physician practice expense payments relating to the June 1997 proposed rule's limits on clinical and administrative staff time and possible changes in the linking algorithm. Our recommended methodology would make these recommendations moot by eliminating the limits and linking algorithm that were part of our previous

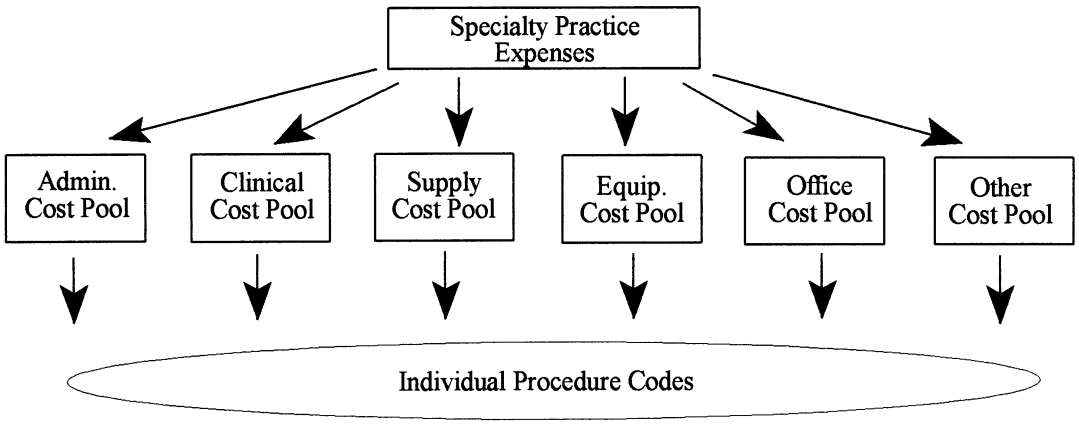
proposal. Finally, based on our experiences with the validation panels we held in October and December 1997, we believe the ''top-down'' approach will be less difficult to refine.

10. Description of the Proposed Methodology for Developing Practice Expense Relative Value Units

(See Addendum B for a detailed technical description of the proposed methodology.)

a. Overview. We used actual practice expense data by specialty to create six cost pools (administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other). We then allocated these cost pools to individual procedure codes. An overview of this approach is presented in Exhibit 1.

Exhibit 1. Overall Allocation Approach



b. Data Sources. We used the 1995 through 1997 AMA's SMS survey data to develop the cost pools and the CPEP data to allocate these cost pools to procedure codes.

The AMA originally developed the SMS in 1981. It covers a broad range of economic and practice characteristics. The annual SMS survey is designed to provide representative information on the population of all non-federal physicians who spend the greatest proportion of their time in patient care activities. The survey is sent to both office and hospital-based physicians, but excludes residents. The recipients of the survey are randomly selected from the AMA's physician master file, which contains current and historical information on every physician in the United States, including nonmembers of the AMA.

The SMS survey consists of three distinct sections:

- Screening questions to verify the physician's self-designated practice specialty and eligibility for the survey.
- A main questionnaire to collect information on practice characteristics, hours worked, volume of services, fees for selected procedures, income, and expenses.
- Special topic questions to provide information on key socioeconomic issues.

The SMS survey is a computer-assisted telephone survey that checks the consistency of responses during the survey and automatically skips questions that are not relevant to the physician. To prepare the physician, the AMA mails a practice expense summary in advance. The physician may designate a proxy such as a practice manager or an accountant to answer the practice expense questions. The AMA makes vigorous efforts to achieve a high response rate despite the short field period of surveys. Each interviewer's work is monitored by supervisory staff for both production and quality. AMA staff also monitors interviews to ensure that a high level of quality is maintained throughout the survey.

The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians. The CPEPs identified the direct inputs involved in each physician service for procedure codes in an office setting and out-of-office setting. (See Addendum A for a detailed description of the CPEP process.)

c. Practice Expense Cost Pools. We created practice expense cost pools by physician specialty for clinical labor, administrative labor, medical supplies, medical equipment, office supplies, and all other expenses. There are three steps in the creation of the cost pools.

Step 1: Use the AMA's SMS survey data of actual cost data, by physician specialty, for 1995 through 1997 to determine practice expenses per hour by cost category.

Step 2: Determine the total number of physician hours, by specialty, spent treating Medicare patients as reflected in the Medicare claims data.

Step 3: Calculate the practice expense pools by specialty and by cost category using the results from step 1 and step 2.

A short description of each step follows.

Step 1: Determine practice expenses per hour by cost category.

Based on the AMA's SMS survey data for each physician respondent, we calculated practice expenses per hour spent in patient care activities by cost pool. We made the following assumptions in this calculation:

- The physician respondent shares practice expense equally with all other physician owners in the practice.
- The physician respondent works the same number of hours as all other physician owners in the practice.
- For any employee physician in the practice, the hours spent in patient care activities are the average hours spent in patient care activities for employee physicians in the specialty of the physician respondent.

Using the above assumptions, the practice expenses per hour for each physician respondent's practice was calculated as the practice expenses for the practice divided by the total number

of hours spent in patient care activities by the physicians in the practice. The practice expenses per hour for the specialty are an average of the practice expenses per hour for the respondent physicians in that specialty.

Step 2: Determine the number of physician hours spent treating Medicare patients.

For each specialty, the total number of physician hours spent treating Medicare patients was calculated from physician time data for each procedure code and the Medicare claims data. The primary sources for the physician time data are surveys submitted to the AMA's RUC and surveys done by Harvard for the initial establishment of the work RVUs.

Step 3: Determine the practice expense pools by specialty and by cost category.

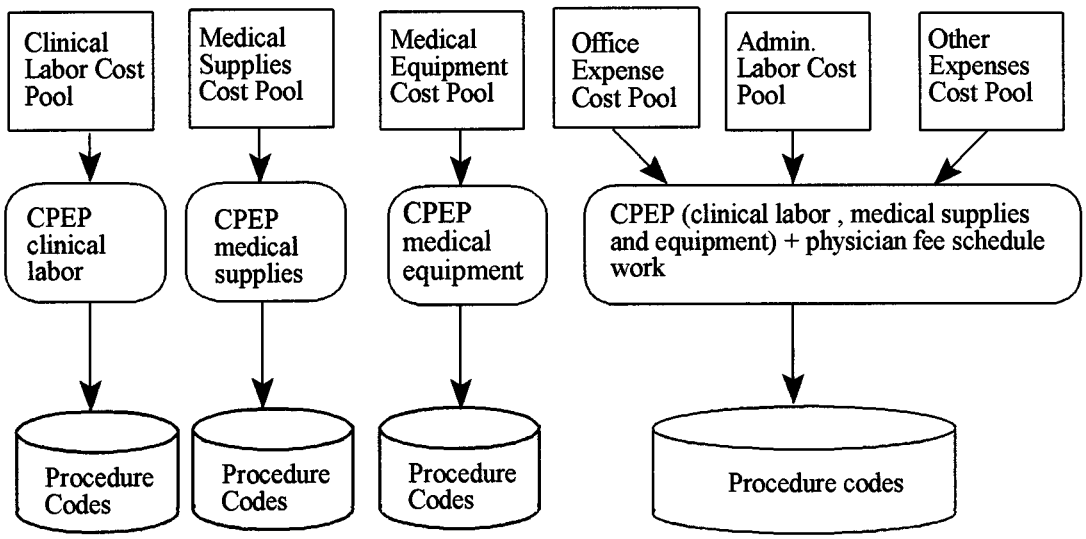
The practice expense cost pools for clinical labor, administrative labor, medical supplies, medical equipment, office expenses, and all other expenses are determined by multiplying the practice expenses per hour for these categories (calculated in step 1) by the total physician hours (calculated in step 2).

d. Cost Allocation Methodology

We allocated by specialty each practice expense cost pool to individual procedure codes either using the CPEP data for clinical labor, medical supplies, and medical equipment, or using a combination of the CPEP data for clinical labor, medical supplies, and medical equipment and the physician fee schedule work RVUs.

Exhibit 2 depicts our cost allocation methodology. For each specialty, the six cost pools and their respective cost allocation bases are used to determine costs for each procedure code.

Exhibit 2. Cost Allocation Methodology



Step 4: Allocate the practice expense pools by specialty to individual procedures.

For each specialty, we separated the six practice expense pools (clinical labor, administrative labor, medical supplies, medical equipment, office expenses, and all other expenses) created in Step 3 into two groups and used a different allocation basis for each group. Group one includes clinical labor, medical supplies, and medical equipment, and group two includes administrative labor, office expenses, and all other expenses.

Group one: clinical labor, medical supplies, and medical equipment.

We used the CPEP data as the allocation basis for the group one pools (clinical labor, medical supplies, and medical equipment). The CPEP data for clinical labor were used to allocate the clinical labor cost pool, the CPEP data for medical supplies were used to allocate the medical supplies cost pool, and the CPEP data for medical equipment were used to allocate the medical equipment cost pool.

Group two: administrative, labor, office expenses, and other expenses.

For the allocation of administrative labor, office expenses, and other expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs was used to allocate the cost pools.

Step 5: Weight average allocations for procedures performed by more than one specialty.

For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients.

11. Comments of the American Medical Association Regarding the Use of the Socioeconomic Monitoring System Survey Data to Construct Practice Expense Relative Value Units

At our request, the AMA sent two tables summarizing practice expense information by physician specialty. Additionally, the AMA supplied us with SMS background information and comments regarding its use to construct resource-based practice expense RVUs.

The following are the AMA's comments as well as two tables derived from the SMS data:

The SMS survey is an annual nationally representative survey of physicians drawn randomly from the AMA's Physician Masterfile (a listing of all member and nonmember physicians in the United States). The survey was conducted by an external contractor—the Rand Corporation was the survey contractor for the 1995 through 1997 SMS surveys. Unit response rates to SMS have been roughly 60 percent in recent years, which is as high or higher than comparable physician surveys. It is a computer-assisted telephone survey which allows checks to be made for the consistency of responses during the survey and to automatically skip questions that are not relevant to particular physicians. On the practice expense questions, special effort is made to obtain accurate information. A practice expense summary is mailed to all physicians that are to be surveyed to allow them to obtain the information before being contacted. The physician may designate a proxy such as a

practice manager or accountant to answer the practice expense questions if they do not have the information.

However, it is important to stress that the SMS data were never collected for the purpose of developing relative values. We feel that there are several potential problems with using SMS data to construct practice expense RVUs. These concerns were first raised in a letter from the AMA to HCFA in November 1996. In particular, we are concerned that:

—Sample sizes for some specialties will be too small to permit separate calculation of expense data from SMS. Even among the larger specialties, the inherent variability of the expense data will mean that the average expense figures provided will be subject to significant sampling error.

—Response rates for the expense items tend to be low relative to other questions on the survey leading to potential non-response bias.

—SMS is a physician-level survey, and physicians in groups are asked for their share of expenses rather than the practice's expenses. Practice-level data may provide a better basis for constructing practice expense RVUs.

Despite these problems, we recognize your need to use the best available information. The tables that you requested show the means and standard errors of practice expenses per direct patient care hour from the 1995 through 1997 SMS surveys. Since SMS collects practice expense data for the prior year, these tables summarize SMS respondents' hourly expenses for the years 1994 through 1996. Only non-federal, non-resident, patient care physicians are surveyed on SMS. In addition, only physicians who are full or part-owners of their practices are asked the practice expense questions. The following records were excluded prior to tabulating the data as you requested:

—Physicians practicing fewer than 26 weeks the prior year (including cases where weeks worked the previous year were missing);

—Cases with a missing response to the question on typical hours in direct patient care per week (3 cases where the response to this question was 168 hours were also excluded);

—Cases where any of the individual expense items (total non-physician personnel expense; clerical non-physician personnel expense; office expenses; medical supplies expenses; medical equipment expenses; and other or miscellaneous practice expenses) were missing; and

—Cases where total expenses (excluding professional liability insurance premiums and employee physician payroll expense) were zero.

Expenses per hour were calculated as you requested (and as described in the notes to the tables). All results were weighted for unit non-response. It will not be possible to replicate these figures exactly from the AMA's Physician Marketplace Statistics or Socioeconomic Characteristics of Medical Practice publications due, in part, to the exclusions mentioned above.

TABLE 1.—MEAN PRACTICE EXPENSES PER HOUR SPENT IN PATIENT CARE ACTIVITIES, HOURS AND EXPENSES ADJUSTED FOR PRACTICE SIZE

[In dollars]

Specialty	Number of cases	Non-phys payroll per hour	Clerical payroll per hour*	Office expense per hour	Supplies expense per hour	Equipment expense per hour	Other expense per hour	Total expense per hour**
ALL PHYSICIANS	3910	27.0	15.0	19.1	7.2	3.2	11.0	67.5
GENERAL/FAMILY PRACTICE	409	30.2	15.1	18.2	8.1	3.6	8.6	68.6
GENERAL INTERNAL MEDICINE	430	22.4	13.3	17.0	6.4	2.1	6.2	54.2
CARDIOVASCULAR DISEASE	94	30.2	14.9	19.9	5.8	6.4	20.7	82.9
GASTROENTEROLOGY	84	23.2	15.4	17.9	2.7	1.8	11.0	56.6
ALLERGY/IMMUNOLOGY	31	66.2	27.0	33.3	17.5	3.3	16.4	136.6
PULMONARY DISEASE	49	20.0	12.2	15.0	2.8	1.6	6.4	45.8
ONCOLOGY	27	44.7	22.7	25.7	87.2	5.5	10.3	173.4
GENERAL SURGERY	257	22.5	15.7	17.2	3.1	2.0	9.4	54.1
OTOLARYNGOLOGY	103	44.8	27.3	33.4	7.7	5.8	18.3	110.1
ORTHOPEDIC SURGERY	203	42.9	26.0	30.8	10.3	3.6	18.1	105.6
OPHTHALMOLOGY	210	52.9	27.8	35.9	11.3	9.0	22.7	131.8
UROLOGICAL SURGERY	118	29.6	18.6	22.8	24.5	6.0	11.6	94.6
PLASTIC SURGERY	85	28.6	18.3	30.2	16.3	4.6	23.3	103.0
NEUROLOGICAL SURGERY	42	33.5	24.3	31.7	1.8	1.1	15.7	83.9
CARD/THOR/VASC SURGERY	44	30.1	16.2	18.3	1.4	3.1	11.0	63.8
PEDIATRICS	249	26.1	13.3	20.0	10.8	1.6	8.4	66.9
OBSTETRICS/GYNECOLOGY	266	32.3	16.9	21.2	7.3	3.4	11.7	75.9
RADIOLOGY	214	19.0	9.6	12.5	4.8	8.3	13.6	58.2
PSYCHIATRY	351	7.3	5.3	10.1	0.4	0.3	7.5	25.6
ANESTHESIOLOGY	232	14.4	3.7	5.9	0.3	0.4	5.7	26.7
PATHOLOGY	82	16.7	8.4	6.7	4.0	1.6	17.7	46.7
DERMATOLOGY	96	49.5	26.7	33.1	12.5	4.8	15.2	115.0
EMERGENCY MEDICINE	61	5.3	1.9	1.6	0.5	0.1	5.5	13.0
NEUROLOGY	61	26.2	21.6	15.8	5.0	4.2	7.7	58.8
PHYS MED/RHEUMATOLOGY	75	38.6	23.2	28.5	4.9	3.9	12.0	88.0
OTHER SPECIALTY	37	21.1	12.4	19.7	3.6	1.3	9.7	55.4

Source: American Medical Association, 1995–1997 Socioeconomic Monitoring System (SMS) surveys.

* Clerical payroll is included in total non-physician payroll.

** Total expenses exclude professional liability insurance premiums and employee physician payroll.

Notes:

(1) Only self-employed non-federal non-resident patient care physicians who responded to all relevant expense questions are included. Self-employed physician respondents with no practice expenses for the year are excluded.

(2) Physicians whose typical number of hours worked in patient care activities per week is missing, less than 20, or equal to 168 (3 cases) are excluded. Physicians whose number of weeks worked the previous year is missing or less than 26 are excluded.

(3) For each respondent, total practice expense and expense components per hour are calculated as (4)/(5) below.

(4) Expenses adjusted for practice size = self-employed respondent expenses* # physician owners.

(5) Hours adjusted for practice size = (respondent hours* # physician owners) + (employee physician hours (see (6) below)* # employee physicians).

6) The typical number of hours worked in patient care activities for the employee physician(s) of a self-employed physician's practice is not known. Mean hours worked in patient care activities for employee physicians of each specialty are used as an estimate of employee physician hours.

TABLE 2.—STANDARD ERRORS OF MEAN PRACTICE EXPENSES PER HOUR SPENT IN PATIENT CARE ACTIVITIES, HOURS AND EXPENSES ADJUSTED FOR PRACTICE SIZE

[In dollars]

Specialty	Number of cases	Non-phys payroll per hour	Clerical payroll per hour	Office expense per hour	Supplies expense per hour	Equipment expense per hour	Other expense per hour	Total expenses per hour**
ALL PHYSICIANS	3910	0.5	0.3	0.4	0.3	0.2	0.3	1.1
GENERAL/FAMILY PRACTICE	409	1.3	0.6	1.2	0.5	0.7	0.6	3.0
GENERAL INTERNAL MEDICINE	430	1.2	0.6	1.0	0.6	0.3	0.6	2.6
CARDIOVASCULAR DISEASE	94	2.9	1.4	1.9	0.8	1.3	5.2	8.0
GASTROENTEROLOGY	84	1.6	1.1	1.9	0.3	0.3	2.2	4.1
ALLERGY/IMMUNOLOGY	31	7.9	3.8	3.8	4.2	1.5	2.9	11.2
PULMONARY DISEASE	49	1.6	1.4	2.2	0.6	0.5	0.9	3.5
ONCOLOGY	27	7.5	3.8	5.7	16.4	1.4	3.8	23.2
GENERAL SURGERY	257	1.4	0.9	0.9	0.3	0.3	0.8	2.5
OTOLARYNGOLOGY	103	3.0	2.3	3.5	0.9	1.1	2.1	6.8
ORTHOPEDIC SURGERY	203	1.7	1.2	2.1	0.8	0.4	2.0	4.7
OPHTHALMOLOGY	210	2.9	1.4	2.6	1.3	1.1	2.1	6.3
UROLOGICAL SURGERY	118	1.4	1.0	2.1	1.8	1.0	1.4	4.4
PLASTIC SURGERY	85	2.3	1.4	3.5	2.8	1.0	3.4	8.1
NEUROLOGICAL SURGERY	42	4.0	2.5	5.7	0.7	0.4	2.1	9.4
CARD/THOR/VASC SURGERY	44	4.2	2.0	2.9	0.3	1.7	2.2	8.0
PEDIATRICS	249	1.6	0.7	1.7	1.0	0.3	1.2	3.8
OBSTETRICS/GYNECOLOGY	266	1.7	0.9	1.3	0.7	0.3	1.0	3.3
RADIOLOGY	214	2.0	0.9	2.0	0.8	1.9	1.3	5.7
PSYCHIATRY	351	0.7	0.5	0.6	0.2	0.1	0.6	1.5
ANESTHESIOLOGY	232	1.8	0.6	0.8	0.1	0.1	0.7	2.4
PATHOLOGY	82	2.7	1.8	1.7	0.8	0.5	2.9	6.4
DERMATOLOGY	96	4.8	2.0	5.2	2.0	1.2	1.8	10.4
EMERGENCY MEDICINE	61	1.4	0.6	0.5	0.3	0.1	0.9	2.1
NEUROLOGY	61	3.1	3.1	1.4	1.5	1.1	2.2	6.4
PHYS MED/RHEUMATOLOGY	75	5.1	2.5	6.1	0.7	1.4	2.9	12.1
OTHER SPECIALTY	37	4.4	2.4	5.1	1.1	0.6	2.1	9.5

Source: American Medical Association, 1995–1997 Socioeconomic Monitoring System (SMS) surveys.

* Clerical payroll is included in total non-physician payroll.

** Total expenses exclude professional liability insurance premiums and employee physician payroll.

Notes:

(1) Only self-employed non-federal non-resident patient care physicians who responded to all relevant expense questions are included. Self-employed physician respondents with no practice expenses for the year are excluded.

(2) Physicians whose typical number of hours worked in patient care activities per week is missing, less than 20, or equal to 168 (3 cases) are excluded. Physicians whose number of weeks worked the previous year is missing or less than 26 are excluded.

(3) For each respondent, total practice expense and expense components per hour are calculated as (4)/(5) below.

(4) Expenses adjusted for practice size = self-employed respondent expenses * # physician owners.

(5) Hours adjusted for practice size = (respondent hours * # physician owners) + (employee physician hours (see (6) below) * # employee physicians).

(6) The typical number of hours worked in patient care activities for the employee physician(s) of a self-employed physician's practice is not known. Mean hours worked in patient care activities for employee physicians of each specialty are used as an estimate of employee physician hours.

12. Other Methodological Issues

a. Professional and Technical Component Services. Using the methodology described above, the professional and technical components of the resource-based practice expense relative value units do not necessarily sum to the global resource-based practice expense relative value units since specialties with different practice expenses per hour provide the components of these services in different proportions. For example, emergency medicine physicians have proportionately more professional component chest x-ray billings than global billings relative to radiologists. We used the following methodologies so that the professional and technical component resource-based practice expense relative value units for a service sum to the global resource-based relative value units.

For codes with professional and technical components excluding HCPCS codes 70010 through 79440, G0030 through G0047, G0050, G0062, G0063, G0106, G0120, G0122, G0125, and G0126, we used the following methodology:

After we determined the practice expense RVUs using the practice expense per hour methodology, we budget neutrally distributed the total (global, professional, and technical) practice expense payments for each code between the global, professional, and technical components as follows:

Step 1: Calculate a weighted average resource-based practice expense RVU across the facility and nonfacility settings using the allowed utilization from the Medicare claims data.

Step 2: Using the RVUs calculated in Step 1 for the global, professional, and

technical components of each code and the Medicare utilization data, calculate the total new resource-based practice expense payments for each code.

Step 3: Set the global resource-based practice expense RVUs for each code equal to the sum of the resource-based practice expense RVUs for the professional and technical components calculated in Step 2.

Step 4: Using the global RVUs calculated in Step 3, the professional and technical component RVUs calculated in Step 1, and the Medicare utilization data, calculate practice expense payments for each code.

Step 5: Multiply the global relative value units calculated in Step 3 and the professional and technical component RVUs calculated in Step 1 by the ratio of the practice expense payments for each code calculated in Step 2 to the practice expense payments for each code calculated in Step 4.

For HCPCS codes 70010 through 79440, G0030 through G0047, G0050, G0062, G0063, G0106, G0120, G0122, G0125, and G0126, we used the following methodology:

We used the current 1998 practice expense RVUs for this set of codes, which are based primarily on the original radiology fee schedule, to determine the relatives between the new resource-based practice expense relative value units as follows:

Step 1: Using the current 1998 practice expense RVUs, calculate the current aggregate practice expense payments for this set of codes.

Step 2: Using the resource-based practice expense RVUs determined from the methodology described above, calculate the aggregate practice expense payments for this set of codes.

Step 3: Uniformly multiply the current practice expense RVUs by the ratio of the aggregate resource-based practice expense payments calculated in Step 2 to the aggregate practice expense payments calculated in Step 1.

For HCPCS codes Q0092, R0070, and R0075, we used the following methodology:

The practice expense RVUs for HCPCS code Q0092 was determined by applying the ratio described in Step 3 above to the existing practice expense RVUs. The practice expense RVUs for HCPCS codes R0070 and R0075 were determined by applying the ratio described above to practice expense RVUs for these codes calculated from the average allowed charge in the Medicare claims data.

b. Practice Expenses per Hour Adjustments and Specialty Crosswalks. We have one general comment on our use of the SMS practice expense per hour data. Some practices employ midlevel providers such as nurse practitioners and optometrists. The practice expenses per hour from the SMS survey are calculated in terms of hours spent in patient care activities by physicians in a practice. These practice expenses per hour are greater than practice expenses per hour spent in patient care activities by the physicians and midlevel providers in a practice. As a result, the practice expense per hour methodology is potentially biased in favor of specialties who use more, relative to other specialties, midlevel providers as physician extenders to create billable services under the Medicare fee schedule. Although we made no adjustment to the practice expenses per hour for this due to a lack of data, we believe the issue should be examined as part of the refinement of the resource-based practice expense RVUs.

Below are the adjustments we made to the practice expense per hour data and the crosswalks we used to assign the specialties reflected in our claims data to those found in the practice expense tables from the SMS survey data.

- We set the medical materials and supplies practice expenses per hour for the specialties of ''Oncology'' and ''Allergy and Immunology'' equal to the medical materials and supplies practice expenses per hour for ''All Physicians'' since we make separate payment for the drugs furnished by these specialties.

With regard to oncology, while Medicare does not have an expansive outpatient drug benefit, it does cover outpatient drugs that are furnished by a physician, oral cancer drugs, and certain other specific drugs. In addition to paying for the costs of these drugs (outside the physician fee schedule), Medicare also makes a separate payment to physicians for the ''administration'' of cancer drugs (under the physician fee schedule). This separate payment for chemotherapy administration recognizes the expenses involved with ordering, storing and handling, and performing other tasks associated with administering such drugs. These expenses are practice expenses and are treated as part of resource-based practice expenses; they are not part of the costs of the drug and are not included in Medicare payments for chemotherapy drugs.

We believe that physicians' expenses for the administration of cancer drugs, as well as the costs of the drugs themselves, are included in their responses to the AMA survey. Therefore, to avoid a duplicate payment (that is, paying for the drug separately and also including the costs of the drug in practice expenses), we need to separate the costs of the drug from the practice expenses for the administration of the chemotherapy drugs.

We are proposing to use the ''All Physician'' practice expenses per hour for medical materials and supplies to reflect, in a relative sense, all the practice expenses for administration of chemotherapy. The difference between the practice expense per hour for medical material and supplies for oncologists and for all physicians would be the costs of the drugs themselves. We invite comments about our approach or alternative ways to separate the costs of the drugs from the costs of their administration.

- We based the administrative payroll, office, and other practice expenses per hour for the specialties of ''Physical Therapy'' and ''Occupational Therapy'' on data used to develop the salary equivalency guidelines for these specialties. (Since speech and language pathologists are not identified as Medicare specialties in our claims data, we could not explicitly use their salary equivalency guideline data.) The data used to calculate the salary equivalency practice expenses per hour for these categories of expenses includes an allowance for 250 square feet of space per therapist, and the utilities and other overhead to run the practice, including administrative costs. We set the remaining practice expense per hour categories equal to the ''All Physicians'' practice expenses per hour from the SMS survey data. We used the clinical payroll expenses for ''All Physicians'' instead of the salary equivalency data for physical therapy assistants and aides since we are concerned that there may be an overlap between the cost of therapy assistants and aides reflected in the practice expenses and the amount of work allocated to services provided by occupational and physical therapists.

- The following are the crosswalks we used to assign the specialties reflected in our claims data to those found in the practice expense tables from the SMS survey data. Note that we refer to the difference between the nonphysician payroll expenses per hour and the clerical payroll expenses per hour as the clinical payroll expenses per hour.

TABLE 3.—PRACTICE EXPENSE PER HOUR CROSSWALKS

HCFA specialty code and description	AMA specialty	Clinical labor PE/Hr	Medical supplies PE/Hr	Medical equipment PE/Hr	Cler., office, and other PE/Hr
01—General Practice	General/Family Practice	$15.10	$8.10	$3.60	$41.90
02—General Surgery	General Surgery	6.80	3.10	2.00	42.30
03—Allergy/Immunology	Allergy And Immunology*	39.20	7.20	3.30	76.70
04—Otology, Laryn., Rhino	Otolaryngology	17.50	7.70	5.80	79.00
05—Anesthesiology	Anesthesiology	10.70	0.30	0.40	15.30
06—Cardiology	Cardiovascular Disease	15.30	5.80	6.40	55.50
07—Dermatology	Dermatology	22.80	12.50	4.80	75.00
08—Family Practice	General/Family Practice	15.10	8.10	3.60	41.90
10—Gastroenterology	Gastroenterology	7.80	2.70	1.80	44.30
11—Internal Medicine	General Internal Medicine	9.10	6.40	2.10	36.50
12—Manip. Therapy	All Physicians	12.00	7.20	3.20	45.10
13—Neurology	Neurology	4.60	5.00	4.20	45.10
14—Neurosurgery	Neurological Surgery	9.20	1.80	1.10	71.70
16—OB–GYN	Obstetrics/Gynecology	15.40	7.30	3.40	49.80
18—Ophthalmology	Ophthalmology	25.10	11.30	9.00	86.40
19—Oral Surgery	All Physicians	12.00	7.20	3.20	45.10
20—Orthopedic Surgery	Orthopedic Surgery	16.90	10.30	3.60	74.90
22—Pathology	Pathology	8.30	4.00	1.60	32.80
24—Plastic Surgery	Plastic Surgery	10.30	16.30	4.60	71.80
25—Physical Medicine	Physical Medicine/Rheumatology	15.40	4.90	3.90	63.70
26—Psychiatry	Psychiatry	2.00	0.40	0.30	22.90
28—Colorectal Surgery	General Surgery	6.80	3.10	2.00	42.30
29—Pulmonary Disease	Pulmonary Disease	7.80	2.80	1.60	33.60
30—Radiology	Radiology	9.40	4.80	8.30	35.70
33—Thoracic Surgery	Cardiac/Thoracic/Vascular Surgery	13.90	1.40	3.10	45.50
34—Urology	Urological Surgery	11.00	24.50	6.00	53.00
35—Chiropractor, Licensed	General Internal Medicine	9.10	6.40	2.10	36.50
36—Nuclear Medicine	Radiology	9.40	4.80	8.30	35.70
37—Pediatrics	Pediatrics	12.80	10.80	1.60	41.70
38—Geriatrics	General Internal Medicine	9.10	6.40	2.10	36.50
39—Nephrology	General Internal Medicine	9.10	6.40	2.10	36.50
40—Hand Surgery	Orthopedic Surgery	16.90	10.30	3.60	74.90
41—Optometrist	All Physicians	12.00	7.20	3.20	45.10
43—CRNA/AA	Anesthesiology	10.70	0.30	0.40	15.30
44—Infectious Disease	General Internal Medicine	9.10	6.40	2.10	36.50
46—Endocrinology	General Internal Medicine	9.10	6.40	2.10	36.50
48—Podiatry	General Surgery	6.80	3.10	2.00	42.30
50—Nurse Practitioners	General Internal Medicine	9.10	6.40	2.10	36.50
62—Psychologist (Billing Independently)	Psychiatry	2.00	0.40	0.30	22.90
65—Physical Therapist (Indep. Practice)	All Physicians*	12.00	7.20	3.20	10.90
66—Rheumatology	Physical Medicine/Rheumatology	15.40	4.90	3.90	63.70
67—Occupational Therapist	All Physicians*	12.00	7.20	3.20	10.90
68—Clinical Psychologist	Psychiatry	2.00	0.40	0.30	22.90
69—Independent Laboratory	All Physicians	12.00	7.20	3.20	45.10
70—Clinic Or Other Group	All Physicians	12.00	7.20	3.20	45.10
76—Periperal Vascular Disease	All Physicians	12.00	7.20	3.20	45.10
77—Vascular Surgery	Cardiac/Thoracic/Vascular Surgery	13.90	1.40	3.10	45.50
78—Cardiac Surgery	Cardiac/Thoracic/Vascular Surgery	13.90	1.40	3.10	45.50
79—Addiction Medicine	Psychiatry	2.00	0.40	0.30	22.90
80—Clinical Social Worker	Psychiatry	2.00	0.40	0.30	22.90
81—Critical Care (Intensivists)	All Physicians	12.00	7.20	3.20	45.10
82—Hematology	General Internal Medicine	9.10	6.40	2.10	36.50
83—Hematology/Oncology	Oncology*	22.00	7.20	5.50	58.70
84—Preventive Medicine	General Internal Medicine	9.10	6.40	2.10	36.50
85—Maxillofacial Surgery	All Physicians	12.00	7.20	3.20	45.10
86—Neuropsychiatry	Psychiatry	2.00	0.40	0.30	22.90
89—Clinical Nurse Practitioner	General Internal Medicine	9.10	6.40	2.10	36.50
90—Medical Oncology	Oncology	22.00	7.20	5.50	58.70
91—Surgical Oncology	All Physicians	12.00	7.20	3.20	45.10
92—Radiation Oncology	Radiology	9.40	4.80	8.30	35.70
93—Emergency Medicine	Emergency Medicine	3.40	0.50	0.10	9.00
94—Interventional Radiology	Radiology	9.40	4.80	8.30	35.70
95—Indep. Physiological Lab	All Physicians	12.00	7.20	3.20	45.10
97—Physician Assistants	General/Family Practice	15.10	8.10	3.60	41.90
98—Gynecology/Oncology	Obstetrics/Gynecology	15.40	7.30	3.40	49.80

*Practice expense per hour were adjusted as follows:
(1) Allergy & Immunology and Oncology use supplies for All Physicians.
(2) Physical Therapy and Occupational Therapy use salary equivalency data for clerical, office and other practice expenses per hour.

• Due to uncertainty concerning the appropriate crosswalk and time data for the nonphysician specialty ''Audiologist'' and the fact that the relatively few codes performed by audiologists are also performed by other specialties, we did not crosswalk this specialty. Until we can obtain more data, we derived the resource-based practice expense RVUs for codes performed by audiologists from the practice expenses per hour of the other specialties which perform these codes.

• Because we have no reason to assume that the distribution of radiologists by equipment ownership reflected in the SMS survey data differs from the distribution found in our claims data, we did not attempt to differentiate the practice expenses per hour for radiologists by equipment ownership. The use of the average practice expenses per hour should create the appropriate practice expense pool for radiology. We invite comments on this issue. We realize that practice expenses vary by equipment ownership; however, the appropriate recognition of this is through the differential allocation of the practice expense pool to the professional, technical, and global services performed by radiologists.

c. Time Associated with the Work Relative Value Units. As a general comment on the time data, we are concerned that any imprecision in the time estimates for high volume services which have relatively little time associated with them may potentially bias the practice expense methodology in favor of the specialties which perform these services. For example, if a high volume procedure which typically takes four minutes to perform has a surveyed time of 5 minutes, this procedure's contribution to the practice expense pool for that specialty is inflated by 25 percent. In contrast, if a procedure which typically takes 100 minutes to perform has a surveyed time of 101 minutes, its contribution is only inflated by 1 percent. We believe this issue should be examined as part of the refinement of the resource-based practice expense RVUs.

• The time data from the Harvard study performed for the initial establishment of the work relative value units were collected over a number of years using primarily surveys of practicing physicians. The time data submitted to the RUC for the refinement of the work relative value units were also collected over a number of years using primarily physician surveys. The time data resulting from the refinement of the work relative value units have been systematically greater than the time data obtained by the Harvard study for the same services. On average, this difference is approximately 25 percent. We increased the Harvard time data in order to ensure consistency between these data sources.

• We calculated the total physician time for CPT codes 70010 through 79440 using the work RVUs and the work per unit time for CPT 99213, except for codes in the range of CPT codes 78000 through 78891 for which we had Harvard survey data and codes for which we had data from surveys done for the AMA RUC.

• Based on the judgment of our clinical staff, we calculated the total physician time for CPT codes 90918 through 90921 using the work RVUs and the work per unit time for CPT code 99213.

• Based on the judgment of our clinical staff, we set the total time associated with the work RVUs for CPT 97001 through 97770 as follows:

HCPCS	Time (min)
97001	30
97002	20
97003	45
97004	30
97010	5
97012	15
97014	13
97016	18
97018	13
97020	14
97022	15
97024	15
97026	10
97028	9
97032	18
97033	14
97034	16
97035	12
97036	15
97039	10
97110	15
97112	15
97113	15
97116	15
97122	15
97124	15
97139	15
97150	15
97250	15
97260	15
97261	15
97265	15
97504	15
97520	15
97530	15
97535	15
97537	15
97542	15
97703	15
97750	15
97770	15

• A high percentage of codes performed by the nonphysician specialties of Independent Physiological Lab, Clinical Psychologist, and Psychologist (Independent Billing) do not have work RVUs and, therefore, time data. Because the practice expenses per hour for these specialties were crosswalked from SMS specialties, when calculating their practice expense pools we used the maximum clinical staff time from the CPEP data for the codes that lack work RVUs.

• We calculated the time for CPT codes 00100 through 01996 using the base and time units from the anesthesia fee schedule and the Medicare allowed claims data.

13. Other Practice Expense Policies

a. Site-of-Service Payment Differential. Under the physician fee schedule, if a physician service of the type routinely furnished in physician offices is furnished in facility settings, our current policy is that the fee schedule amount for the service is determined by reducing the practice expense RVUs for the service by 50 percent. Certain services are excluded from the regulation including rural health clinic services, surgical services not on the ambulatory surgical center covered list that are furnished in an ambulatory surgical center, anesthesia services, and diagnostic and therapeutic radiology services (see § 414.32 (Determining payments for certain physician services furnished in facility settings)).

The site-of-service payment differential is a long established policy to avoid duplicate payments for practice costs while, at the same time, recognizing that some office practice cost is incurred when physicians perform procedures outside the office setting. The site-of-service policy applies to both inpatient and outpatient hospital settings.

Since the implementation of the physician fee schedule, we have compiled a list of services furnished outside physician offices that are subject to the site-of-service payment differential. The current list includes approximately 700 services.

As part of the resource-based practice expense initiative, we are proposing to replace the current policy that systematically reduces the practice expense RVU by 50 percent for certain procedures with a policy that would generally identify two different levels (facility and nonfacility) of practice expense RVUs for each procedure code depending on the site-of-service. In general, we would furnish two levels of practice expense RVUs per code; one when the procedure is performed in the office or other site (or nonfacility) if no additional facility fee is paid and

another when the procedure is performed out of the office (for example, in a hospital or an ambulatory surgical center in which the costs of resources, such as labor, medical supplies, and medical equipment are paid outside the physician fee schedule and only to the hospital or ambulatory surgical center).

Some services, by the nature of their codes, are performed only in certain settings and would have only one level of practice expense RVU per code. Many of these are evaluation and management codes with code descriptions specific as to the site of service. Examples of these codes are the following:

- Inpatient hospital care for new or established patients (CPT codes 99221 through 99223).
- Subsequent hospital care (CPT codes 99231 through 99239).
- Emergency department services for new or established patients (CPT codes 99281 through 99285).
- Critical care services (CPT codes 99291 through 99297).
- Nursing facility services (CPT codes 99301 through 99303).
- Subsequent nursing facility care (CPT codes 99311 through 99313).
- Domiciliary, rest home (CPT codes 99321 through 99333).
- Home services (CPT codes 99341 through 99350.

We note that office or outpatient evaluation and management services (CPT codes 99201 through 99215) are used to report services furnished in the physician office or in a hospital outpatient department; therefore, these procedure codes will have different levels of practice expense RVUs. Other services, such as most major surgical services with a 90-day global period, are performed entirely or almost entirely in the hospital, and we are generally providing a practice expense RVU only for the out-of-office or facility setting.

In the majority of cases, however, we would provide both facility and nonfacility practice expense RVUs. The higher nonfacility practice expense RVUs are generally used to calculate payments for services performed in a physician office and for services furnished to a patient in the patient's home, or facility or institution other than a hospital, skilled nursing facility, or ambulatory surgical center. For these services, the physician typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the physician service.

The lower facility practice expense RVUs generally are used to calculate payments for services furnished to hospital, SNF, and ambulatory surgical center patients. The costs for nonphysician services and other items, including medical equipment and supplies, are typically borne by the hospital, by the SNF, or the ambulatory surgical center.

b. Additional Relative Value Units for Additional Office-Based Expenses for Certain Procedure Codes. Usually office medical supplies or surgical services in the physician office are included in the practice expense portion of the payment for the medical or surgical service to which they are incidental. The November 1991 final rule (56 FR 59522) included a policy that allowed a practice expense RVU of 1.0 to pay for the supplies that are used incident to a physician service but generally are not the type of routine supplies included in the practice expense RVUs for specific services. For example, if the physician performed a cystourethroscopy with a biopsy (CPT code 52204) in the office and billed for a surgical tray (HCFA Common Procedure Coding System (HCPCS) code A4550) in addition to the procedure, the physician would receive approximately $34.86 (an RVU of .95) for the surgical tray in addition to the payment for the cystourethroscopy with biopsy. The November 1991 final rule (56 FR 59811) listed 44 procedure codes that qualified for additional RVUs if furnished in the physician office. This list was expanded in the December 1993 final rule (58 FR 63854) to include several cystoscopy codes. Included in this list of procedures for which an additional amount for supplies may be paid if performed in a physician office are closing a tear duct (CPT code 68671) and billing for a permanent lacrimal duct implant (HCPCS A4263) and inserting an access port (CPT code 36533) and billing for an implantable vascular access portal/catheter (A4300). These supplies were given the same RVU as HCPCS code A4550.

We are proposing to revise this policy under the resource-based practice expense system. We believe the supply costs that this policy is designed to cover were included in the supply inputs identified by the CPEPs and the AMA's SMS survey. Thus, they were included in the practice expense RVUs for each related procedure code. Therefore, we are proposing to discontinue separate payment for supply codes A4263, A4300 and A4550.

c. Anesthesia Services. Although physician anesthesia services are paid under the physician fee schedule, these services do not have practice expense RVUs. Rather, payment for physician anesthesia services is determined based on the sum of allowable base and time units multiplied by a locality-specific anesthesia CF.

Since the beginning of the physician fee schedule, overall budget neutrality and work adjustments have been made to the anesthesia CF and not to the base and time units. We are proposing to follow the same process and make an adjustment to the anesthesia CF to move anesthesia services under the resource-based practice expense system. The adjustment to the anesthesia CF is 3.5 percent.

14. Refinement

Section 4505(d)(1)(C) of the BBA requires the Secretary to develop a refinement process to be used during each of the 4 years of the transition period. In this section, we will describe those aspects of this proposed rule that we believe are subject to refinement as well as our proposed process for refinement during the coming year. In light of the complexity of the issues associated with establishing the initial proposed practice expense RVUs, we believe it is premature to propose, in this proposed rule, the refinement process for subsequent years of the transition period. We also believe it would be premature to finalize the practice expense RVUs before the fall of 1999. Therefore, we will keep the practice expense RVUs as interim RVUs until at least the fall of 1999. We also are open to extending the period during which the practice expense RVUs are interim beyond 1999 if we believe that more time is needed to identify and correct errors.

We are particularly interested in receiving comments on our proposed refinement process for this year, and we are soliciting recommendations for the process in subsequent years. Based on our analysis of comments we receive, we hope to describe our plans for the entire refinement process in the final rule.

a. Issues Involved in Refinement. We believe the refinement process for practice expense RVUs will enable us to:

- Review and refine practice expense/hour data.
- Obtain and review practice expense/hour data for specialties or practitioners not included in the SMS survey.
- Address anomalies, if any, in the code-specific Harvard/RUC physician time data.
- Address anomalies, if any, in the code-specific CPEP data on clinical staff types and times, quantity and cost of medical supplies, and quantity and cost of medical equipment.
- Refine, as needed, our process of developing practice expense RVUs for codes that were not addressed by the

CPEP process, for example, codes that were new in 1996, 1997, and 1998.

• Develop practice expense RVUs for codes that will be new in 1999 and beyond.

Our plans for each of these six points are as follows:

• Refinement of the practice expense/hour data. The practice expense/hour data are based on the SMS survey. (These data can be found in Table 1). Although the SMS survey was not designed to support the development of practice expense RVUs, we believe it is the best available source of data on actual practice costs that allows us to recognize all staff, equipment, supplies, and expenses, not just those that can be tied to specific procedures. In fact, we believe one advantage of the SMS data is that they were collected before this proposed rule.

The SMS survey data used in this proposed rule do not include the practice expense information on all specialties recognized by Medicare. However, for certain larger specialties, for example, family practice and general surgery, the sample of physicians surveyed is of sufficient size to serve as the basis of the practice expense/hour calculation in the short term. For those larger specialties, we are unlikely to make any changes in the practice expense/hour calculation in the final rule to be published this fall. In the long term, specifically, 1999 and beyond, we are prepared to refine the practice expense/hour data of the larger specialties if we receive compelling evidence that the SMS data are incorrect. Any arguments that the practice expense/hour for a given specialty should be changed would be strengthened by the submission of survey data comparable to the SMS that include data for a range of specialties expected to gain and lose Medicare revenue.

We are concerned that the validity of future SMS surveys could be affected if we decided to explicitly link the data collected to future revisions of the Medicare fee schedule. Also, SMS is a physician level survey, and physicians in groups are asked for their share of expenses rather than the practices' expenses. Practice level data may provide a better basis for constructing practice expense RVUs. We invite comments on potential revisions to the SMS survey or alternative sources of data that could be used for long term refinement. Finally, because the calculation of the practice expense/hour is so critical to our methodology, we also invite comment on the need to confirm, through audit or other means, the survey data that would be used for long term refinement.

• Refinement of the crosswalk for the practice expense/hour data. The SMS data we used for this proposed rule do not include data for all specialties that are recognized by Medicare, and they do not include data on nonphysician practitioners who are paid under the physician fee schedule. To develop this proposal, it was necessary to crosswalk certain specialties and nonphysician practitioners to the practice expense/hour data we developed for the specialties included in the SMS. We invite comments on the appropriateness of our crosswalks. Any arguments that the practice expense/hour data should be changed would be strengthened by the submission of survey data comparable to the SMS data.

• Refinement of the physician time data. The number of practice expense RVUs assigned to the services performed by a given specialty is determined by the practice expense/hour data from the SMS and the physician time data for each of the codes. The physician time data are based on the Harvard resource-based RVS study and RUC survey data that were developed as part of the refinement of the work RVUs. We are confident that these data are accurate although there may be some codes for which the final work RVUs we have assigned may be inconsistent with the time data. We will accept comments on the code-specific physician time data but must point out that any proposed revisions to the time data have implications for the work RVUs assigned to those codes. We do not intend to revisit work RVU issues that have been already addressed as part of the 5-year review. (Total physician time data can be found in the ''Total Physician Time'' file located on the HCFA Homepage. Specific instructions for accessing this and other Internet files referred to in this proposed rule can be found at the end of this refinement section.)

• Refinement of the CPEP data. The identification and correction of errors, if any, in the code-specific CPEP data on clinical staff types and times, quantity and cost of medical supplies, and quantity and cost of medical equipment has its principal effect on the relative relationship of the practice expense RVUs assigned to services performed by a given specialty.

It is important to understand that the allocation of practice expense RVUs at the code level is based on CPEP data that have not been revised or edited in any fashion. We have not made any revisions or edits for two main reasons. First, we received many comments in response to last year's proposed rule that objected to the data reasonableness edits and caps that were part of our proposal. Second, we received many comments in response to June 1997 proposed rule that objected to our decision to exclude from the CPEP data the direct inputs for medical equipment, medical supplies, and clinical staff recorded for hospital patients. In addition, we found this decision to be quite controversial in subsequent meetings with representatives of various specialty societies. Under our proposed methodology that begins with the total practice expense costs, the question as to the appropriateness of including the direct inputs for medical equipment, medical supplies, and clinical staff in the inputs for hospital patients is much less important because the inclusion of the data impacts the distribution of practice expense RVUs across the entire fee schedule only to the extent codes are performed by more than one specialty.

For example, if a given specialty performs cardiovascular procedures, including time for nursing staff in the hospital for these procedures allocates more of the fixed practice expense pool of dollars for that specialty to these procedures, leaving fewer dollars for the other codes performed by that specialty. We believe the most appropriate method for determining the relative relationship of the RVUs assigned to cardiovascular procedures in this proposed rule is to rely on the CPEP that developed the inputs for those procedures. Therefore, the direct inputs for medical equipment, medical supplies, and clinical staff recorded for hospital patients have not been removed from the CPEP data.

In deciding not to modify the CPEP data, we recognize the possibility that the RVUs assigned to some codes will appear to be incorrect or anomalous. Any apparent errors will be identified and corrected in response to the comments we receive on this proposed rule and through our refinement process. We received comments in response to last year's proposed rule that pointed out apparent errors in the RVUs, and many of the CPEP inputs were revised during the validation panels we conducted in October 1997. We have not incorporated any of those revisions to the data primarily because our methodology for developing RVUs has been revised, and we were not convinced that all the revisions that occurred during the validation panels were correct. To the extent that commenters believe that previously submitted comments are still valid or that data revisions that occurred during the validation panels are still

appropriate, we request that they again be brought to our attention in response to this proposed rule.

While we will accept comments on any code-specific data, we recommend that commenters focus their attention during this comment period on high-volume services with large aggregate expenditures under Medicare. We will review the comments with the assistance of our carrier medical directors. Time constraints preclude convening multiple specialty panels to assist us in our review of the comments. However, as noted above, the practice expense RVUs would be interim values for at least 1999, including those we change as a result of our review of the comments.

Because all of the practice expense RVUs will be interim during 1999, commenters will have another opportunity to identify errors in the code-specific CPEP data during the comment period of the final rule with comment period to be published in the fall of 1998. We believe that the codes identified as possible errors during the comment periods of the proposed rule and the final rule will constitute the universe of codes whose code-specific CPEP data should be reviewed. In other words, although we may keep all the practice expense RVUs interim beyond 1999 as we refine other aspects of the physician fee schedule, it is not our intention to continually review the inputs for all the codes on the fee schedule on an annual basis.

We do believe it is important to have the advice of practicing physicians on the appropriateness of recommended changes to the CPEP inputs. We have two principal options for obtaining that advice. The first option would be for us to convene multiple specialty panels to review the recommended changes. The second option would be to ask the RUC, or a new organization like the RUC that includes broad representation across all specialties and includes nonphysician practitioners, to do this. We believe that under either option, the panel or panels should include individuals other than physicians, for example, practice managers or nurses, who could bring additional experience and expertise to the discussion. The panels would need to meet no later than the summer of 1999 to consider the comments we received on both the proposed rule and the final rule. We invite comments on these options and would welcome any other recommendations.

- Refinement of the crosswalk for 1996, 1997, and 1998 codes. Because the CPEP process was based on 1995 CPT codes, it was necessary for us to develop practice expense RVUs for new codes that were developed for the 1996, 1997, and 1998 CPT books. The process we used was based on comparing the new codes to other comparable codes for which we had actual CPEP data. Files containing information about the crosswalks used for codes that were new in 1996, 1997, and 1998 are available on the HCFA homepage under the heading ''CPEP Data Crosswalked to 1998 CPT Codes.'' Since this crosswalk was based on our judgment rather than actual data, we invite comments on the appropriateness of our crosswalks. Also, we will accept new code specific-data on clinical staff types and times, quantity and cost of medical supplies, and quantity and cost of medical equipment. Any comments we receive on these codes will be reviewed as part of the process of review described above.
- Development of practice expense RVUs for codes that will be new in 1999 and beyond. There will be new codes included in CPT 1999 for which we will not have practice expense data in time for publication in the 1998 final rule. We plan to develop interim practice expense RVUs for these codes by preparing a crosswalk of CPEP data from existing codes. The crosswalk we use will be available with the final rule, and the practice expense values for the codes will be subject to comment. However, the interim values will serve as the basis of payment during 1999.

We do not believe that preparing a crosswalk of new codes is the most appropriate method of developing practice expense RVUs for new codes. However, for 1999, time constraints do not permit any other approach. Beyond 1999, we would like to develop a process whereby we receive recommended practice expense RVUs or recommended inputs for clinical staff types and times, quantity and cost of medical supplies, and quantity and cost of medical equipment.

For the assignment of work RVUs to new and revised codes, we first look to the RUC for recommended RVUs. Under that process, codes that will be new or revised in the next year's CPT are referred from the CPT editorial panel to the RUC. Specialty societies are informed of these codes and furnished an opportunity to survey a sample of physicians in their specialty for the development of recommended RVUs. The entire RUC then reviews the survey results and forwards the recommended work RVUs to us.

We then review the RUC's recommended work RVUs with the assistance of our Medicare carrier medical directors and publish our decisions as interim RVUs in the final rule for the upcoming year. For example, work RVUs for codes that were new or revised in CPT 1998 were published as interim RVUs in the October 1997 final rule.

Publishing RVUs as interim allows the public the opportunity to furnish comments on the appropriateness of our interim work RVUs. During the following year, we review any comments we have received with the assistance of multiple-specialty panels we have convened. We consider our analysis of any comments on the interim work RVUs and the advice we receive from the multiple specialty panels in the assignment of the final work RVUs that are announced in the final rule for the next year's physician fee schedule.

For practice expense RVUs, we believe there are two principal options. First, we could continue to crosswalk new codes to existing codes, publish the results of that crosswalk as interim practice expense RVUs in the final rule, and review comments we receive with the assistance of our multiple specialty panels. Second, we could request the RUC or a RUC-like organization to provide recommended practice expense RVUs or recommended inputs before publication of the proposed rule as we do with work RVUs. This approach would allow us to publish interim RVUs based on the advice of practicing physicians. As with the work RVUs, any comments we received on the interim RVUs could then be reviewed with the assistance of HCFA multiple specialty panels. We invite comments on these options and would welcome any other recommendations.

b. Example of the Process for Reviewing and Commenting on Practice Expense Relative Value Units. To facilitate the development of responses to this proposed rule, to illustrate the issues involved in refining the RVUs for practice expense, and to furnish further guidance on the use of the data files that are available on the Internet, we are furnishing the following analysis of an apparent anomaly in a family of codes. This analysis is intended to serve as an example of the process for reviewing and commenting on the practice expense RVUs. We have not concluded that revisions to the RVUs proposed for this family of codes are warranted. In the event that no comments are received on the RVUs for these codes, it is unlikely that we will make any revisions.

In the ophthalmology section of the CPT, there are four codes for the reporting of eye exams. The codes, brief descriptors, and the proposed practice expense RVUs follow:

Code	Descriptor	Practice expense RVUs
92002	Eye exam, new patient, intermediate	0.96
92004	Eye exam, new patient, comprehensive	1.58
92012	Eye exam, established patient, intermediate	1.26
92014	Eye exam, established patient, comprehensive	1.25

We believe there is a rank order anomaly in this family. We expected that the practice expense RVUs for new patients would be higher than the practice expense RVUs for established patients and that the practice expense RVUs for comprehensive visits would be higher than practice expense RVUs for intermediate visits. For example, we expected that CPT code 92014 would have higher practice expenses than CPT code 92012, which is not the case.

To analyze this apparent anomaly, we first reviewed the data on which specialties furnish the services. These data are located on the HCFA Homepage under the file name ''Procedure Code Utilization by Specialty.'' This analysis is important because one potential cause of an anomaly is that codes in a given family of codes are performed by physicians in different specialties whose practice expenses per hour are different. In this case, the dominant specialty performing the codes is ophthalmology. Optometrists also perform these services but with less frequency than ophthalmologists. In Table 2, the sum of the practice expenses per hour for ophthalmology is $131.80, and the sum of the practice expenses per hour for optometry is $67.50. Although the practice expense per hour differs for ophthalmology and optometry because ophthalmology is by far the dominant specialty, this anomaly cannot be attributed to differences in practice expense per hour.

We next reviewed the code-specific data for in-office services on clinical labor, equipment, and supplies that are included in the file ''CPEP Data Converted Into 1998 Dollar Amounts,'' located on the HCFA Homepage. This file is based on the raw CPEP data that have been converted to monetary amounts. It is considerably easier to review than the raw CPEP data because it includes fewer data points per code. (The file containing raw CPEP data, ''Raw CPEP Data'', can also be found in the HCFA Homepage. Both of these files also contain CPEP data for supplies and equipment.)

Code	Descriptor	Clin	Eqp	Sup	Total services	% Ophthalmology	% Optometry
92002	Eye exam, new patient, intermediate.	15.44	11.76	3.41	354,000	48	50
92004	Eye exam, new patient, comprehensive.	16.87	12.85	3.41	1,866,000	72	27
92012	Eye exam, est. patient, intermediate.	11.15	8.49	27.60	6,022,000	85	13
92014	Eye exam, est. patient, comprehensive.	14.01	10.67	3.41	6,980,000	79	20

These data show that the relative relationship within the family of codes appears to be appropriate for clinical staff and equipment. However, for supplies there is a large discrepancy in that the supply costs for code 92012 are eight times greater than the supply costs for the other three codes. To determine whether the supply costs for code 92012 are too high or the supply costs for the other three codes are too low, it is necessary to review the actual supply inputs assigned to the codes by the CPEP. These data may be found as a subdirectory of the file, ''CPEP Data Converted to 1998 Dollars.'' We reviewed the inputs but have made no judgments about them. We believe the inputs should be reviewed by the specialties providing the service.

As can be seen in the table, 85 percent of the code 92012 services are furnished by ophthalmologists, and 13 percent are furnished by optometrists. The table also shows that this is a high volume family of codes and that errors in the CPEP data could cause distortions in the relative relationships of the RVUs assigned to services furnished by ophthalmologists and optometrists. Under our proposed methodology for developing RVUs, any revisions to the CPEP data will primarily impact only those specialties that furnish the service. Thus, if we determine that the supply inputs for code 92012 include items that are not typically furnished and are recommended for removal, that will ''free up'' RVUs that can be redistributed across the other services furnished by the two specialties.

Conversely, if it is determined that the supply inputs for the other three codes are missing items that are typically furnished and are recommended for inclusion, that will require RVUs to be taken from the other services furnished by the two specialties, not from other services on the physician fee schedule. We view this as a significant advantage of our proposed methodology in that the highly contentious atmosphere of refinement under our earlier methodology is greatly reduced because, except when multiple specialties perform the same service, agreement or disagreement with the CPEP inputs of one specialty does not directly impact the RVUs assigned to services furnished by other specialties.

c. Information on Accessing Data Files on HCFA's Homepage. The aforementioned files can be obtained on the HCFA Homepage at ''www.hcfa.gov.'' Following is the step by step process by which the data files can be accessed.

Step 1: After accessing the HCFA Homepage go to Stats and Data.

Step 2: Go to 1999 Resource-Based Practice Expense.

Step 3: Under Resource-Based Practice Expense, you will have the option of accessing one of six files related to resource-based practice expense:

Raw CPEP Data

This file includes the original CPEP data. There are four subgroups within this file:

Clinical Work
Medical Supplies
Procedure Specific Medical Equipment

Overhead Medical Equipment

1998 Code Crosswalks

Since the CPEP data were based upon 1995 data, we performed crosswalks for codes which were new codes in 1996, 1997, and 1998. This file shows the crosswalks that were used for all codes that were new after 1995. In addition, this file also contains those codes gap-filled based on analogous procedures due to an absence of data from the CPEP process.

CPEP Data Crosswalked to 1998 Codes

This file crosswalks all CPEP data to 1998 codes.

CPEP Data Converted to 1998 Codes Converted Into Dollars

This file converts the CPEP data, crosswalked to 1998 codes, into dollars.

Procedure Code Utilization by Specialty

This file shows the Medicare allowed services for each procedure code performed by each specialty.

Time Associated With the Work Relative Value Units

This file contains the time associated with the work RVUs for each procedure.

15. Reductions in Practice Expense Relative Value Units for Multiple Procedures

In the June 1997 proposed rule (62 FR 33171), we had recommended reducing the practice expense RVUs for multiple nonsurgical services performed at the same time as an evaluation and management service. We had proposed this as a way to reflect the lower practice costs that would result when more than one service is performed during a single patient encounter. Many commenters, as well as the Medicare Payment Advisory Commission (MEDPAC), recommended that we not implement a multiple procedure reduction, at least until this issue has been further studied.

We have decided not to propose this reduction at this time but will consider it in the future. We invite comments on this specific issue. The current multiple surgical procedure reduction policy with regard to physician work is not affected by the practice expense proposal.

16. Transition

Under the transition enacted under BBA 1997, practice expense RVUs in 1999 are to be based 75 percent on the old method and 25 percent on the resource-based method. In 2000, the shares are 50 percent old method and 50 percent resource-based. In 2001, the shares are 25 percent old method and 75 percent resource-based. Beginning in 2002, practice expense RVUs are entirely resource-based.

In our October 1997 final rule (62 FR 59052), we indicated that the old method to be used in the formula constitutes the 1998 practice expense RVUs actually used for payment. We received a comment that suggested that we consider an alternative interpretation of the law for purposes of the transition starting point that would eliminate the 1998 changes in practice expenses enacted by BBA 1997. This comment was based on the theory that the 1998 changes were for 1 year only and not intended to be included in the base practice expense used for the transition. This alternative would result in higher payments for certain specialty procedures and lower payments for medical visits during 1999, 2000, and 2001. Beginning in 2002, the starting point for the transition does not matter as practice expenses are entirely resource-based.

We have considered this suggestion. We do not believe that we can, as suggested by the commenter, utilize 1997 practice expense RVUs actually used for payment because we do not believe that we could treat the reductions enacted in BBA 1997 for 1998 differently from the similar reductions enacted in OBRA 1993 on practice expenses for 1994, 1995, and 1996. That is, the effects of both amendments should be included in the base or excluded. We believe that the appropriate option, other than using 1998 practice expense RVUs, is to exclude the effects of both the OBRA 1993 and BBA 1997 provisions and revert to practice expense RVUs as they existed before any amendments. We do not believe that this is the better alternative. In addition to creating practical problems of requiring imputation of practice expense RVUs for the many new codes that have been established between 1991 and 1998, it would seem contrary to the statute's plain intent of moving toward a resource-based payment system. This alternative could also potentially result in a ''yo-yoing'' of practice expense RVUs between 1998 and future years. Practice expense RVUs for certain procedures explicitly increased by the Congress in 1998 could be reduced in 1999 only to be increased again when the practice expense is fully resource-based. If we were to use 1997 RVUs as the base for the transitions, payments for office visit procedure codes, for example, would likely decrease noticeably during 1999, reversing the clear policy the Congress enacted in BBA 1997 by raising them. To adopt such a construction of the law would not gradually ''transition'' payments to the new resource-based system, but instead would represent an abrupt change in direction, a result at odds with the purpose of having a transition period and with transitions previously established for payment changes in Medicare. We find nothing in the legislative history to suggest that the Congress intended such an atypical transition. Therefore, we propose to use the 1998 practice expense RVUs for purposes of the blend during the transition years of 1999, 2000, and 2001.

17. Proposed Regulation Revisions

We are proposing to revise § 414.22 (Relative value units (RVUs)), paragraph (b), (Practice expense RVUs), to state that for services beginning January 1, 1999, the practice expense RVUs would be based on a blend of 75 percent of the 1998 code-specific practice expense RVUs and 25 percent of the relative practice expense resources involved in furnishing the service. For services beginning January 1, 2000, the practice expense RVUs would be based on a blend of 50 percent of the 1998 code-specific practice expense RVUs and 50 percent of the relative practice expense resources involved in furnishing the service. For services beginning January 1, 2001, the practice expense RVUs would be based on a blend of 25 percent of the 1998 code-specific practice expense RVUs and 75 percent of the relative practice expense resources involved in furnishing the service. For services beginning January 1, 2002, the practice expense RVUs would be based on 100 percent of the relative practice expense resources involved in furnishing the service.

There would be only one level of practice expense RVUs per code for the following categories of services: those that have only the technical component of the practice expense RVUs; only the professional component practice expense RVUs; certain evaluation and management services, such as hospital or nursing facility visits that are furnished exclusively in one setting; and major surgical services. For other services, there would be two different levels of practice expense RVUs per code. The lower practice expense RVUs would apply to services furnished to hospital or ambulatory surgical center patients. The higher practice expense RVUs would apply to services furnished in a physician office or services other than visits but performed in a patient's home and services furnished to patients in a nursing facility, skilled nursing

facility, or an institution other than a hospital or ambulatory surgical center.

18. Response to GAO Recommendations

As previously discussed, the GAO report to Congress on practice expense made five recommendations for further action; two of these are short term recommendations that are addressed by this proposed rule and three are longer term recommendations that will be addressed during the refinement process. The GAO recommendations are as follows:

• Short Term Recommendations.

+ Use sensitivity analyses to test the effects of the limits we placed on the panels' estimates of clinical and administrative labor and our assumptions about equipment utilization.

We believe that our proposed methodology answers the concerns that prompted this recommendation. Our current proposal has eliminated the limits previously placed on the CPEP panels' estimates of clinical and administrative staff times. In addition, because the proposed methodology is based on specialty-specific RVU pools, changes in assumptions about equipment utilization rates would impact redistributions between specialties only to the extent that codes are performed by more than one specialty.

+ Evaluate the classification of the administrative labor associated with billing and other administrative expenses as indirect expenses, alternative methods for assigning indirect expenses, and alternative specifications of the regression model used to link the panels' estimates.

We again believe that our proposed methodology is responsive to this recommendation. Under our proposal, administrative expenses are treated as indirect costs, and we have developed a method of assigning indirect expenses that we believe most closely reflects the various specialties' actual costs. The third part of the recommendation is now moot as the current proposed methodology no longer utilizes the linking algorithm.

• Longer Term Recommendations.

+ Determine whether changes in hospital staffing patterns and physicians' use of their clinical staff in hospital settings warrant adjustments between Medicare reimbursements to hospitals and physicians. Similarly, we should determine whether physicians have shifted tasks to nonphysician clinical staff in a way that warrants reexamining the physician work RVUs.

+ Work with physician groups and the AMA to develop a process for collecting data from physician practices as a cross-check on the calculated practice expense RVUs and periodically refine and update the RVUs.

+ Monitor indicators of beneficiary access to care, focusing on those services with the greatest cumulative reductions in physician fee schedule allowances, and consider any access problems when making refinements to the practice expense RVUs.

We agree with all of these recommendations. One of the major tasks of any proposed refinement process will be determining when any additional data are need, whether it be on physician practice patterns or actual practice expenses. We welcome comments and suggestions on how best to carry out these recommendations to aid us in developing a strategy for data gathering in our final rule. We plan to monitor access to care.

B. Medical Direction for Anesthesia Services

The conditions for payment of medical direction were discussed in the March 2, 1983 final rule (48 FR 8902) that implemented section 108 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, effective October 1, 1983.

TEFRA added section 1887 to the Act and required that we distinguish between services furnished by physicians to patients that are now payable under the physician fee schedule and services furnished by physicians to hospitals that are reimbursed to the hospital on a prospective payment basis for inpatients or on a reasonable cost basis for outpatients.

Section 1887 of the Act did not, however, include a reference to ''medical direction.'' This is a term we adopted from the medical profession that refers to the necessary level of direct involvement of the anesthesiologist in each of two to four concurrent anesthesia procedures so that the service meets the definition of physician services as required by section 1887 of the Act.

Our definition of medical direction closely followed the standards of anesthesia care team practice promulgated by the American Society of Anesthesiologists (ASA).

The conditions for payment of medical direction are included in § 415.110 (Conditions for payment: Medically directed anesthesia services). For each patient, the physician must furnish seven kinds of services, and the physician may not perform any other services while he or she is directing the concurrent procedures unless they meet the exception as noted. The medical direction activities in § 415.110(a) (Services furnished directly or concurrently) are as follows:

• Performs a pre-anesthesia examination and evaluation.

• Prescribes the anesthesia plan.

• Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence.

• Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions.

• Monitors the course of anesthesia at frequent intervals.

• Remains physically present and available for immediate diagnosis and treatment of emergencies.

• Provides indicated post-anesthesia care.

The regulations currently refer to these conditions as applying to services furnished directly or concurrently. The reference to services furnished directly is not correct. It suggests that the physician personally performing the anesthesia services only has to provide the same kind of services as the physician medically directing the anesthesia service. In fact, the physician personally performing the anesthesia service must perform the entire anesthesia service alone. This policy is included in § 414.46(c)(1)(i) (Additional rules for payment of anesthesia services, Physician personally performs the anesthesia procedure). Therefore, we are proposing to delete the reference in the regulations to services furnished directly.

The December 1995 final rule (60 FR 63152) included the policy to allow the physician's medical direction of a certified registered nurse anesthetist (CRNA) performing a single anesthesia service. However, this provision did not take effect until January 1, 1998. This policy was incorporated in § 414.46(d)(iii) (Additional rules for payment of anesthesia services, Anesthesia services medically directed by a physician). A program memorandum explaining this policy was issued to the Medicare carriers in January 1998.

We are revising § 415.110 (Conditions for payment: Medically directed anesthesia services) so that it is consistent with § 414.46(d)(iii) by stating that medical direction can apply to the single anesthesia service furnished by a CRNA.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) added section 1848(a)(4)(Special Rule For Medical Direction) to the Act. This section of the

Act specified the calculation of the payment allowances for medical direction services on or after January 1, 1994. Thus, the specific payment policy is specified in the law. The law provides that the medical direction of the performance of an anesthesia service furnished on or after January 1, 1998, is 50 percent of the fee schedule amount that would have been paid if the anesthesia service was furnished by the physician alone.

Both the ASA and the American Association of Nurse Anesthetists (AANA) have pointed out that the current requirements are outdated and too restrictive. The current requirements are oriented to the administration of a general anesthetic, which was the predominate mode of practice when the regulations were originally implemented. There are other types of anesthesia, such as regional, spinal or epidural anesthesia, and monitored anesthesia care, which are becoming more common and for which the current requirements are not completely appropriate. For example, in monitored anesthesia care, there is no definable emergence as there is for general anesthesia.

Also, the AANA has advised us that requiring the presence of the anesthesiologist for induction for all cases may not be appropriate and may delay the start of surgery and result in the inefficient use of operating room time. In addition, the ASA has advised us that neither the regulations nor the operating instructions explain the level of documentation required by the anesthesiologist to support the payment for the medical direction service. The ASA believes that the lack of instructions for medical documentation and the concerns about payment audits have reportedly prompted anesthesiologists to overly document anesthesia records.

The ASA and the AANA have reached consensus on a revised recommended set of medical direction requirements. We have reviewed their recommendations and are proposing to revise our regulations in § 415.110 (Conditions for payment: Anesthesia services) to reflect current anesthesia practice arrangements. Namely, we would:

- Provide that the physician either perform the pre-anesthesia examination and evaluation or review one performed by another qualified individual.
- No longer require the physician to be present during induction and emergence.
- Require that the physician monitor the course of anesthesia at intervals medically indicated by the nature of the procedure and the patient's condition.

C. Separate Payment for Physician Interpretation of an Abnormal Papanicolaou Smear

With the exception of hospital inpatients, we currently do not allow separate payment for the physician's interpretation of an abnormal Papanicolaou (Pap) smear.

About 10 percent of Pap smears are abnormal and are interpreted by a physician, usually a pathologist. If a physician interprets an abnormal Pap smear for a patient, other than a hospital inpatient, payment for the physician interpretation (and the underlying test) is made under the clinical laboratory fee schedule payment for the Pap smear test. The physician negotiates with the laboratory for payment for the physician service.

The clinical laboratory fee schedule allowances were initially derived from the 1984 prevailing charges made by independent laboratories for the Pap smear test. Historically, independent laboratories did not bill separately for the physician interpretation of the abnormal Pap smear; thus, no separate allowance was established. Therefore, the initial clinical laboratory fee schedule allowances reflect payment for both the test and any associated interpretation.

The 1998 clinical fee schedule national allowance for the Pap smear test is $7.15. The 1998 physician fee schedule national allowance for the physician interpretation of the abnormal Pap smear for a hospital inpatient is $28.62.

The College of American Pathologists requested we recognize separate payment for the physician interpretation of the abnormal Pap smear in all settings. We believe this proposal would establish an understandable and uniform definition of physician services across sites. Therefore, we are proposing to recognize, under the physician fee schedule, separate payment for the physician interpretation of an abnormal Pap smear in all settings.

The Pap smear test may be furnished by a hospital or an independent laboratory. The independent laboratory could bill for the complete service: the technical component (the performance of the test) and the professional component (the interpretation of the test) furnished by the independent laboratory's pathologist. For services to hospital patients, the Pap smear interpretation usually is furnished by the hospital pathologist who can bill for the professional component of the service.

D. Rebasing and Revising the Medicare Economic Index

1. Background

a. History. In the 1972 Amendments to the Act (Public Law 92–603) enacted on October 30, 1972, the Congress mandated the use of an economic index in determining payment for physician services under Medicare Part B. Although the 1972 Amendments did not specify the particular type of index to be used, we established the Medicare Economic Index (MEI). The MEI follows the recommendations outlined by the Senate Finance Committee in its report accompanying the legislation in that it attempts to present an equitable measure for changes in the costs of physician time and operating expenses.

The current MEI represents a weighted sum of annual price changes for various inputs needed to produce physician services. Since its inception, the MEI has consisted of two principal components or expense categories—physician net income and physician practice expenses. Physician net income is further delineated into wages and salaries and benefits. The physician practice expense portion is delineated into six major categories: (1) Nonphysician employee compensation, which includes the wages and salaries and benefits of nonphysician employees in physician offices; (2) office expenses; (3) medical materials and supplies; (4) professional liability insurance; (5) medical equipment; and (6) other professional expenses. These broad expense categories are still the major expense shares in the proposed MEI and are discussed in greater detail in the following sections.

b. Use of Current Data. The MEI was last rebased and revised in the November 25, 1992 final rule (57 FR 55896). The current base year for the MEI is 1989. We believe that it is desirable to rebase and revise the index periodically so that the expense shares and proxies will reflect current conditions. For this reason, we are proposing to rebase the MEI to reflect 1996 physician expenses and review the proxies we currently use to ensure using the most appropriate proxy for each expense category. We will continue to adjust the physician and nonphysician employee compensation for economy-wide labor productivity to avoid accounting for both physician productivity and economy-wide productivity in the physician update framework.

The proposed MEI expense categories were derived primarily from the 1997 AMA SMS, which measured physician earnings and practice expenses for 1996.

The AMA data were used to set expenditure weights for physician earnings and the six major physician practice expense categories. To further disaggregate into subcategories reflecting more specific physician expenses, we used data from the 1992 Asset and Expenditure Survey, the 1996 Bureau of the Census Current Population Survey, the 1997 Bureau of Labor Statistics Employment Cost Index, and the *Medical Economics* Continuing Survey data for 1996.

2. Rebasing and Revising Expense Categories

Developing a rebased and revised MEI requires selecting a base year and determining the number and composition of expense categories. As mentioned earlier, we are proposing to rebase the MEI to 1996. We chose 1996 as the base year for two main reasons: (1) The 1996 data were the most recent available data for most of the data sources we are proposing to use; and (2) the 1996 data were representative of the changing distribution of physician earnings and practice expenses over time.

We determined the number and composition of expense categories based on the criteria used to develop the current MEI expenditure weights and our other input price index expenditure weights (for more information on these criteria see the November 25, 1992, proposed rule (57 FR 55900)). Using these criteria of mutually exclusiveness and exhaustiveness, we developed the rebased and revised MEI presented in Table 4.

TABLE 4.—REVISED MEDICARE ECONOMIC INDEX EXPENDITURE CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense category	Weights 1989 (1)	Weights 1996 (1 2)	Proposed price proxies
Total	100.000	100.000	
Physician Earnings (4)	54.155	54.460	
Wages and Salaries	45.342	44.197	AHE—Private (3).
Benefits (5)	8.813	10.263	ECI—Ben: Private (3).
Physician Practice Expenses	45.845	45.540	
Non-Physician Employee Compensation	16.296	16.812	
Employee Wages and Salaries	13.786	12.424	
Prof/Tech Wages	3.790	5.662	ECI—W/S: Private P&T (3).
Managers Wages	2.620	2.410	ECI—W/S: Private Admin (3).
Clerical Wages	5.074	3.830	ECI—W/S: Private Clerical (3).
Services Wages	2.233	0.522	ECI—W/S: Private Service (3).
Craft Wages	0.069		
Employee Benefits (5)	2.510	4.388	ECI—Ben: Priv. White Collar (3).
Office Expenses	10.280	11.581	CPI(U)—Housing.
Medical Materials and Supplies	5.251	4.516	PPI Drugs/PPI Surg. Appl/CPI(U) Med Sup.
Professional Liability Insurance	4.780	3.152	HCFA—Prof. Liab. Phys. Prem. Survey.
Medical Equipment	2.348	1.878	PPI—Medical Instruments and Equip.
Other Professional Expense	6.890	7.601	
Automobile	1.400	1.300	CPI(U)—Private Transportation.
All Other	5.490	6.301	CPI(U)—All Items less Food and Energy.

Footnotes:
(1) Due to rounding, weights may not sum to 100.000%.
(2) Sources: Socioeconomic Monitoring System 1997 Survey of Physicians, Center for Health Policy Research, American Medical Association; Anne L. Finger, ''What it costs to run a practice,'' Medical Economics, October 27, 1997; U.S. Department of Labor, Bureau of Labor Statistics; and U.S. Department of Commerce, Bureau of the Census, 1992 Asset and Expenditure Survey, and 1997 Current Population Survey.
(3) Net of change in the 10-year moving average of output per man-hour for the non-farm business sector.
(4) Includes employee physician payroll.
(5) Includes paid leave.

To determine the expenditure weights, we used currently available and statistically valid data sources on physician earnings and practice expenses. While we consulted numerous data sources, we used five sources to determine the rebased and revised MEI expenditure weights: (1) The 1997 AMA SMS survey (1996 data); (2) the March 1997 Bureau of Labor Statistics (BLS) Employment Cost Index; (3) the 1992 Bureau of the Census Asset and Expenditure Survey (the latest available); (4) the 1996 Bureau of the Census Current Population Survey; and (5) the *Medical Economics* continuing survey published October 1997 (1996 data). No one data source provided all of the information needed to determine expenditure weights according to our criteria. The use of each of these data sources is described in detail below.

a. American Medical Association Socioeconomic Monitoring System Survey. Like the current MEI, the proposed MEI will use AMA data on mean physician net income (physician earnings) and professional expenses for self-employed physicians for the major expenditure categories. The seven major expenditure categories taken from the AMA data, as shown in Table 1, are physician earnings, nonphysician employee compensation, office expenses, medical materials and supplies, professional liability insurance, medical equipment, and other professional expenses. The weights represent each expenditure category's proportion of total expenses in 1996. While many of the category weights have changed since 1989, the effect on the percent change in the MEI has been minimal, as explained later.

The physician earnings expenditure category in the rebased MEI is defined differently from the one in the current MEI as it includes employee physician compensation. Until recently, employee physician compensation was not available through the AMA survey and was not included in any AMA expenditure categories. AMA reported these data separately in 1996. We believe it is appropriate, for our purposes, to include employee physician compensation in the MEI category of physician earnings. The physician income (earnings) and overhead expenses generated by employee physicians are currently included in the AMA expenditure

categories. We propose including employee physician payroll in physician earnings to be consistent with the current methodologies used in payment under the physician fee schedule. Under the physician fee schedule, the work RVU is paid based on the service provided and not on who provides the service. Since employee physicians do the same services as self-employed physicians, employee physician time would be included in the work RVU. By including employee physician compensation in the physician earnings category for the MEI, we have achieved two goals: (1) Appropriately categorizing these expenses to be consistent with the physician fee schedule; and (2) adjusting these expenses by the appropriate price proxies for a physician's own time. A detailed discussion of the price proxies is presented below.

b. Employment Cost Index Survey. The Employment Cost Index (ECI) survey has shares of total compensation for wages and salaries and benefits by private industry health services occupational category that can be used to allocate the wage and fringe benefit shares for nonphysician employees. The data on these shares are produced for March of every year. We determined that March 1997 would be most representative of the shares in 1996 because the March 1996 data would miss any changes that occurred during the last three quarters of that year. The shares are determined from employer costs per hour worked. Paid leave is defined as a benefit under this survey. Unfortunately, this survey does not have data for offices of physicians. However, data are available on wage and fringe benefit shares for total health services that include hospitals, nursing homes, offices of physicians, and offices of dentists. While not a direct measure of employee wage and fringe benefit shares in offices of physicians, the shares for health services from the ECI survey do provide a normative estimate of the split between wages and fringes.

In the ECI survey for total health services, the wage and fringe benefit split of compensation was 73.9 percent and 26.1 percent, respectively. For comparison purposes, when we included paid leave as part of wages, these shares were very similar to nonphysician employee wage and fringe benefit share data from two physician group practice studies. Based on this analysis, we are proposing to use the wage and fringe benefit shares for total health services from the ECI survey, with paid leave as a benefit, in the rebased and revised MEI for nonphysician employee compensation. The wage and fringe benefit shares for physicians and nonphysician compensation in the current MEI were developed from a special study conducted by our Office of the Actuary. These current and revised shares are presented in Table 1.

c. Asset and Expenditure Survey. We are proposing to use the 1992 Bureau of the Census Asset and Expenditure survey to derive an estimate of the wage and fringe benefit share for physicians under the MEI. The wage and fringe benefit share for all persons employed in physician offices is available from the 1992 Asset and Expenditure survey. This share includes both physicians and nonphysician employees in the physician office. By aging this share to 1996 using the ECI for wages and fringe benefits for total health services and moving paid leave from wages to fringe benefits based on analysis of ECI data on health services, we were able to develop a wage and fringe benefit share for physician offices for 1996. The wage share for physician offices was 79.4 percent, and the fringe benefit share 20.6 percent. Using this wage and fringe benefit share, the wage and fringe benefit share for nonphysician employees developed from the ECI survey, and the share for physician and nonphysician compensation developed from the AMA survey, we were able to impute a wage and fringe benefit share for physicians. The wage share was 81.2 percent, and the benefit share 18.8 percent for physicians. We compared these shares to physician group data on physician wage and fringe benefit shares and found them to be very consistent. Therefore, we are proposing to use these wage and fringe benefit shares for physicians in the rebased and revised MEI, as shown in Table 1.

d. Current Population Survey. We are proposing to use the 1996 Current Population Survey (CPS) from the Bureau of the Census to determine the distribution of nonphysician employee wages in the rebased and revised MEI. The 1989 CPS was used to determine the distribution for the current MEI. The new distribution is presented in Table 5. Craft and kindred workers are no longer included in the distribution because their share is not significant.

TABLE 5.—PERCENT DISTRIBUTION OF NON-PHYSICIAN PAYROLL EXPENSE BY OCCUPATIONAL GROUP: 1996

BLS occupational group	Expenditure shares (1)
Total	100.000
Professional and Technical Workers	45.570
Managers	19.399
Clerical Workers	30.831
Service Workers	4.199

(1) These weights were derived from the 1996 Current Population Survey, U.S. Bureau of the Census.

e. Medical Economics Continuing Survey. Consistent with the current MEI, we are proposing to use the *Medical Economics* Continuing Survey to determine the weight for automobile (professional car) expenses. We used the 1996 Continuing Survey published in the October 27, 1997, *Medical Economics* (Finger, 1997) to determine a weight of 1.3 percent in the proposed MEI for automobile expenses, which is nearly identical to the 1.4 percent share in the current MEI.

3. Selection of Price Proxies

a. Background. After the 1996 cost weights for the revised MEI were developed, we reviewed the current set of price proxies to determine whether they were still the most appropriate to monitor the rate of price change for each expenditure category. As was the case in 1992 (57 FR 55901), most of the indicators we considered are based on BLS data and are grouped into one of the following five categories:

- Producer Price Indices (PPIs). PPIs measure price changes for goods sold in other than retail markets. They are the preferred proxies for physician purchases at the wholesale level. These fixed-weight indexes are a measure of price change at the producer or at the intermediate stage of production.
- Consumer Price Indices (CPIs). CPIs measure change in the prices of final goods and services bought by consumers. Similar to the PPIs, they are fixed-weight. CPIs may not represent the price changes faced by producers. For this reason, CPIs were used absent an appropriate PPI or if the expenditure was similar to that of retail consumers in general, rather than to a purchase at the wholesale level.
- Average Hourly Earnings (AHEs). AHEs permit the measurement of changes in hourly earnings for production and nonsupervisory workers for specific industries as well as the nonfarm business economy. AHEs are calculated by dividing gross payrolls for wages and salaries by total hours. The

series reflects shifts in employment mix and, thus, is representative of actual changes in hourly earnings for industries or for the nonfarm business economy.

- ECIs for wages and salaries. These ECIs measure the rate of change in employee wage rates per hour worked. These fixed-weight indices are not affected by shifts in industry or occupation employment levels.
- ECIs for employee benefits. These ECIs measure the rate of change in employer costs of employee benefits such as the employer's share of Social Security taxes, pension and other retirement plans, insurance benefits (life, health, disability, and accident), and paid leave. Like ECIs for wages and salaries, they are not affected by changes in industry output or occupational shifts.

As with choosing the expenditure categories, choosing appropriate wage and price proxies for each expense category necessarily involves making tradeoffs and using judgment. The strengths and weaknesses of each proxy variable need to be evaluated using several criteria that can potentially conflict.

The first criterion is relevance. The price variable should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass judgments about relative efficiency of the market generating the price and wage increases and may include normative factors relating to fairness.

The second criterion is reliability or low sampling variability. If the proxy wage-price variable has a high sampling variability or inexplicable erratic patterns over time, its value is greatly diminished since it is unlikely to reflect accurately price changes in its associated expenditure category. Low sampling variability can conflict with relevance since the more specifically a price variable is defined in terms of service, commodity, or geographic area the higher the sampling variability in some cases.

Timeliness of actual published data is the third criterion. For this reason, monthly and quarterly data take priority over annual data.

The fourth criterion is the length of time the time-series data has been in use. A well-established time series is needed to assess the reasonableness of the series and to provide a solid base from which to forecast future price changes in the series. Forecasting the MEI is required to make Federal budget and Trustee's report estimates.

The BLS price proxy categories previously described meet the criteria of relevance, reliability, timeliness, and time-series length. The price-wage proxies for the rebased and revised MEI (shown in Table 1) are the same as those chosen for the current MEI.

b. Expense Categories. (1) Physician Time

Because the revenue associated with physician time is the single largest cost component in the MEI (54.5 percent), the selection of the price proxy for wages and salaries cost category is a major determinant of the rate of change in the MEI. For that reason, we are furnishing an extensive discussion of the selection of the price proxy for the wages and salaries component as we did in the November 1992 final rule (57 FR 55903). We have found no compelling reason to change the wage proxy for this expense category and offer the same rationale that we used in the November 1992 final rule.

The legislative history of the MEI reveals Congressional concern that increases in physician charges are a cause, rather than a result, of inflation. The following language from the Senate Finance Committee report accompanying the 1972 Social Security Amendments makes that point clearly:

> The committee * * * believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be *fair to all concerned* (emphasis added) and follow rather than lead inflationary trends. * * * Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels. * * * S. Rep. No. 1230, 92d Cong., 2d Sess. 190–191 (1972).

There is obvious circularity if increases in prevailing charges are linked to increases in physician charges, which are then tied to increases in physician income. The committee's expectation that the rate of price inflation assigned to the physician time portion of the MEI be permitted to increase by an amount consistent with increases in general earnings levels seems to reflect the Congress' preference for an equitable external price proxy; that is, a compensation proxy based on compensation outside or external to the physician services industry. We examined the following three principal alternatives for the wages and salary component of the physician time cost category:

- The use of AHEs for production and nonsupervisory workers in the private nonfarm economy.

This option suggests a standard of payment that implies that price increases for the physician labor component should be the same as for workers in the overall economy, that is, general earnings. This option presumes that the price increase for the physician time category (excluding fringe benefits) should reflect the changing mix of industry output and employment. This alternative appears to reflect most closely the Senate Finance Committee's reference to general earnings levels. Since earnings are per hour, a constant quantity of labor input per unit of time is reflected. In addition, the use of the AHEs data is consistent with the BLS labor productivity measures. The revised MEI as well as the current MEI incorporates an adjustment for economy-wide labor productivity to preclude a double-counting of productivity. Economy-wide wage increases reflect economy-wide productivity increases. In addition, physician practice productivity increases associated with the fee-for-service Medicare payment system automatically result in revenue increases for the individual physician practices. Economy-wide productivity increases are adjusted out of the compensation portion of the MEI so that individual physician practices get all of their own productivity increases, but not economy-wide productivity increases as well. The adjustment will continue to be for the 10-year moving average change in productivity.

- The use of ECIs for wages and salaries of the total private nonfarm economy.

This option suggests a standard of payment that implies that price increases for the physician labor component should be the same as that for workers in a hypothetical, overall economy in which there are no shifts in the employment patterns of workers. The overall ECI weighs nine broad occupational categories and permits measurement of the change in the hourly straight time wage rate for private industry workers (Nathan, 1987 and Schwenk, 1985). ECIs are unaffected by changes in occupational employment shifts or industry output shifts. Therefore, this alternative would not recognize changes in the composition of the work force over time as intended by the Senate Finance Committee.

- The use of an ECI for wages and salaries for private professional and technical workers.

This proxy implies that price changes in the physician time component, excluding fringe benefits, should correspond to those for private sector professional and technical workers. The professional and technical workers category is one of the nine categories that comprise the overall ECI. Physicians are a tiny subset of this occupational group. The supply, demand, and opportunity cost characteristics of this broad category, however, may be different from the supply, demand, and opportunity cost characteristics of an efficient market for physician services. Most professional and technical workers are in labor markets where firms compete for employees. Most office-based physicians are self-employed. Some occupations within the professional and technical group are in short supply leading to upward pressure on compensation levels. Use of this price series would take the MEI away from the general earnings specified in the enacting legislation.

Each of the above options implies a different standard of equity. In Table 6, we compare the annual rates of change in the MEI using three different price variables for physician earnings suggested as options.

TABLE 6.—COMPARISON OF ANNUAL PERCENT CHANGES IN THE MEI WITH ALTERNATIVE PHYSICIAN WAGE PRICE PROXIES

Year ending June 30	Revised MEI with alternative proxies for physicians' own time		
	AHE: total private nonfarm	ECI: wages/salaries for total private	ECI: wages/salaries for professional and technical
1992	2.8	3.1	3.4
1993	2.2	2.3	2.7
1994	2.1	2.3	2.3
1995	2.0	2.1	2.0
1996	1.9	1.9	1.8
1997	2.3	2.2	2.0
Average: 1992–1997	2.2	2.3	2.4

The proposed MEI uses AHEs for the private nonfarm economy as the proxy of choice for the physician wages and salaries component of the input price index and is the same price measure used in the 1989-based MEI. In our judgment, this alternative remains the one that most closely comports with Congressional intent as expressed in the Senate Finance Committee's 1972 report referenced above. AHEs change in accordance with market forces associated with changes in the type and mix of workers. This is not the case with ECIs, since ECIs reflect a fixed composition of the work force at a given time. Therefore, the rate of change in an ECI may differ substantially from an actual AHE measure.

The current MEI uses the ECI for fringe benefits for total private industry as the price proxy for fringe benefits. We propose using the same proxy for the 1996-based MEI. This means that both the wage and fringe benefit proxies for physician time are derived from the nonfarm private sector and are both computed on a per-hour basis.

(2) Nonphysician Employee Compensation. As in the 1989-based MEI, we are proposing to use the 1996 Current Population Survey data on earnings and employment by occupation to develop labor cost shares for the nonphysician occupational groups shown in Table 5. BLS maintains an ECI for each of these occupational groups and we are proposing to use these as price proxies for nonphysician employee wages in the same manner they are used in the current MEI. We multiplied each of the occupational cost shares by the changes in the occupational ECI for that category. These values were summed to yield an overall rate of price change.

The skill mix shift in physician offices has been substantial in the last few years as work formerly done in the hospital increasingly is done in ambulatory settings. These skill mix shifts appropriately are held constant in this Laspeyres index of nonphysician employees' wages and salaries. Skill mix shifts that reflect rising intensity of outputs in physician offices are automatically paid for by higher charge structures for the more complex mix of service inputs. Physicians performing more complex services may hire more skilled employees, and, thus, may tend to charge more for their services.

The current MEI uses the ECI for fringe benefits for white collar employees in the private sector. Most nonphysician employees in physician offices are white collar employees. We are proposing to use the ECI for benefits for white collar employees in the rebased and revised MEI. Note that we will continue to adjust the nonphysician employee compensation portion of the MEI by the 10-year moving average change in economy-wide productivity since physician practice productivity is being recognized.

(3) Office Expense. Office expenses include rent or mortgage for office space, furnishings, insurance, utilities, and telephone. We are proposing the continued use of the CPI–U for housing because it is a comprehensive measure of the cost of housing including rent, owner's equivalent rent, insurance, maintenance and repair services, fuels, utilities, telephones, furnishings, and housekeeping services. This proxy covers about 80 percent of the population.

(4) Medical Materials and Supplies. This cost category includes drugs, outside laboratory work, x-ray films, and other related services. There is no price proxy that includes this mix of materials and supplies. In the absence of one index, in the 1989-based MEI we equally weighted the following three price proxies associated with the medical materials and supplies listed above:

- The PPI for ethical drugs.
- The PPI for surgical appliances and supplies.
- The CPI–U for medical equipment and supplies.

We propose using the same blended proxy for the 1996-based MEI.

(5) Professional Liability Insurance. This cost category includes costs for professional medical liability or malpractice insurance premiums including costs associated with self-insurance. Changes in the cost of medical liability insurance premiums currently are measured based on our survey of the rate of change in average liability premiums for $100,000/$300,000 coverage (that is, $100,000 for per-case limitation and $300,000 for total coverage or the minimum furnished) among major insurers. We measured change with historical data each January 1 and interpolated quarterly changes for March, June, and September.

We improved the professional medical liability index in two major ways. First, we used actual rates for $1 million/$3 million premiums in the index for the most current historical period and estimated them for earlier years. Starting with 1996 levels and 1997 percentage changes, rates for $1 million/$3 million premiums will be computed; in future periods we will use premiums for $1 million/$3 million of coverage.

Second, the revised index uses data on a quarterly basis that is calculated into a four-quarter moving average percent change like all our other price proxies. We achieve this by tracking the premium changes that occur during each quarter. We gathered historical premium data back to 1992 and established average premium levels based on the mix of physicians by specialty in 1996. We calculated four-

quarter moving averages and percent changes from 1992 through 1997 to more accurately forecast changes in premium levels for future budget and Trustees' report estimates. The previous method obtained the premium change only for January 1 of each year.

We are proposing the changes described above because we believe they will improve the quality of measuring change in physician professional medical liability premiums. Far more physicians have $1 million/$3 million coverage rather than $100,000/$300,000 coverage. Taking quarterly measurements and computing a four-quarter moving average percent change is the same methodology used for all the other price proxies. The resulting series better captures the changes through the year.

(6) Medical Equipment. Medical equipment includes depreciation, leases, and rent on medical equipment. We propose to use the PPI for medical instruments and equipment as the price proxy for this category, consistent with the price proxy used in the 1989-based MEI.

(7) Other Professional Expenses. This category has two subcomponents: professional car and ''other.'' The professional car category includes depreciation and upkeep for the practice-related use of a professional car. We are proposing the continued use of the CPI–U for private transportation for this cost category, consistent with the price proxy used in the 1989-based MEI. This excludes airline fares, inter-city bus and train transportation, and intra-city bus and train transportation.

This category also includes the residual subcategory of other expenses. This residual category includes professional expenses such as accounting services, legal services, office management services, continuing education, professional association memberships, journals, and other professional expenses. In the absence of one price proxy or even a group of price proxies that might reflect this heterogeneous mix of goods and services, we use the CPI-U for all items less food and energy, consistent with the price proxy used in the 1989-based MEI.

4. Summary of Changes

Updating the MEI to the 1996 base year resulted in small changes in expense category weights. Physician earnings increased slightly from 54.2 percent of the index in 1989 to 54.5 percent in 1996. Physician practice expenses dropped slightly due to declines in the expense shares for medical materials and supplies, professional liability insurance, and medical equipment. These declines were mostly offset by increases in the expense shares for nonphysician employee compensation, office expenses, and other professional expenses.

TABLE 7.—ANNUAL PERCENT CHANGE IN THE CURRENT AND REVISED MEDICARE ECONOMIC INDEX

Years ending June 30	Current MEI 89-base % change	Revised MEI 96-base % change	Difference
1985	3.3	3.2	−0.1
1986	3.3	3.0	−0.3
1987	3.0	2.7	−0.3
1988	3.6	3.4	−0.2
1989	3.4	3.5	0.1
1990	3.0	3.4	0.4
1991	3.2	3.4	0.2
1992	2.8	2.8	0.0
1993	2.1	2.2	0.1
1994	2.1	2.1	0.0
1995	2.0	2.0	0.0
1996	2.1	1.9	−0.2
1997	2.2	2.3	0.1
Average 1985—1997	2.8	2.8	0.0

The rebased and revised MEI is very similar to the current MEI. Using the new expense category weights and new proxy for professional medical liability premiums, the difference in the annual percent change in the index is within two-tenths of one percent in most years from 1985 through 1997. The average annual percent change from 1985 to 1997 was identical. Thus, this revision and rebasing, while making the expense shares more timely, has little impact on the percent changes in the MEI as a whole.

III. Implementation of the Balanced Budget Act of 1997 (BBA 1997)

In addition to the resource-based practice expense relative value units, BBA 1997 provides for revisions to the payment policy for drugs and biologicals, a provision allowing private contracting with Medicare beneficiaries, payment for outpatient rehabilitation services based on the physician fee schedule, and revisions to our policy for nonphysician practitioners.

A. Payment for Drugs and Biologicals

Before January 1, 1998, drugs and biologicals not paid on a cost or prospective payment basis were paid based on the lower of the estimated acquisition cost (EAC) or the national average wholesale price (AWP) as reflected in sources such as the *Red Book, Blue Book,* or *Medispan.* For purposes of this discussion, we will use the term ''drugs'' to refer to drugs and biologicals. Examples of drugs that are paid on this basis are drugs furnished incident to a physician service, drugs furnished by pharmacies under the durable medical equipment (DME) benefit, and drugs furnished by independent dialysis facilities that are not included in the end-stage renal disease (ESRD) composite rate payment.

Section 4556 of BBA 1997 established payment for drugs not paid on a cost or prospective payment basis at the lower of the actual billed amount or 95 percent of the AWP, effective January 1, 1998. In this proposed rule, we are revising the current regulations at § 405.517 to conform to this statutory change. This regulation would remove the EAC and provide for payment at the lower of the actual charge on the Medicare claim or 95 percent of the AWP.

Also, we are proposing to revise the method of calculating the AWP. Our current regulations provide that, for multiple-source drugs, the AWP equals the median AWP of the generic forms of the drug. The AWP of the brand name products is ignored on the presumption the brand AWP is always higher than the generic AWPs. While this may have been true when the policy was first promulgated, it is not always true now. Therefore, we are proposing that the AWP for multiple-source drugs would equal the lower of the median price of the generic AWPs or the lowest brand name AWP.

B. Private Contracting With Medicare Beneficiaries

Section 4507 of BBA 1997 amended section 1802 of the Act to permit certain physicians and practitioners to opt-out of Medicare and to provide through private contracts services that would otherwise be covered by Medicare. Under such contracts the mandatory claims submission and limiting charge rules of section 1848(g) of the Act would not apply. This section, which was effective on January 1, 1998, and was implemented through operating instructions, counters the effect of certain provisions of Medicare law that, absent section 4507 of BBA 1997, preclude physicians and practitioners from contracting privately with Medicare beneficiaries to pay without regard to Medicare limits.

Specifically, section 1848(g) of the Act restricts the amounts that can be collected from beneficiaries by nonparticipating physicians who do not take assignment on the Medicare claim (physicians who take assignment

voluntarily agree to accept the Medicare payment amount as payment in full and collect only deductible and coinsurance amounts from the beneficiary). Moreover, section 1842(b)(18) requires certain practitioners to take assignment when they furnish covered services to Medicare beneficiaries and restricts what they can collect from beneficiaries to deductible and coinsurance amounts. The statute not only imposes these rules (without an exception before passage of section 4507 of BBA 1997), but it also provides strong sanctions for violation of them. Hence, Medicare law absent section 4507 effectively precludes a physician or practitioner from privately contracting with a Medicare beneficiary for the delivery of Medicare-covered items and services, except in compliance with these rules (for example, to pay more than the limits set by law). Section 4507 of BBA 1997 permits such private contracting, provided the requirements of BBA 1997 are met.

The private contracting provision was effective for private contracts entered into, on, or after January 1, 1998. We implemented it through a series of operating instructions for Medicare carriers and information that carriers were instructed to provide to physicians and practitioners. Specifically, in November 1998, we issued Program Memorandum No. B–97–9 (change request number 294) that transmitted the Medicare fee schedule for physician services and contained the fact sheet that carriers were instructed to send to physicians and practitioners with the 1998 fee schedule information. This document, which is commonly called the ''Dear Doctor letter,'' advised physicians and practitioners of the fee schedule amounts for 1998, the changes to regulations, and also the important changes that BBA 1997 made to coverage and payment for physician services, including the private contracting changes.

Due to the private contracting provisions, we extended the participating enrollment period to February 2, 1998, to give physicians sufficient time to consider the changes made by BBA 1997 before making a participation decision. In January 1998, we issued Program Memorandum No. B 97–17 (change request number 193), that was devoted in its entirety to private contracting and not only laid out the processes that would apply but also answered the most frequently asked questions about private contracting. Carriers were instructed to share this information with physicians and practitioners through carrier bulletins.

Lastly, in April 1998, we issued Program Memorandum No. B 98–12 (change request number 468), which amended the process to be followed when the carriers receive a claim from a physician or practitioner who has opted-out of Medicare under the private contracting provision and thus should not bill Medicare.

We are using this proposed rule to place in regulations the requirements that section 4507 of BBA 1997 added to sections 1802(b) and 1862(a)(19) of the Act. In addition to placing the statutory requirements in regulations, this proposed rule also proposes ancillary policies that we believe are necessary to clarify what it means when a physician or practitioner exercises his or her ability to ''opt out'' of Medicare.

There has been a lot of confusion and misinformation about when private contracts are needed. Before we discuss our proposed rules governing private contracting, we want to address some of the most common questions about Medicare claims submission rules and private contracting.

• Do the private contracting rules apply to Part A?

No. The Medicare claims submission and private contracting rules apply only when a physician or practitioner furnishes Medicare-covered services to a beneficiary who is enrolled in Medicare Part B. They do not apply to individuals who have only Medicare Part A or to individuals who are age 65 or over but who do not have Medicare. Therefore, if the patient is not enrolled in Medicare Part B, a private contract is not needed for the physician or practitioner to continue to bill the patient and to charge without regard to the Medicare mandatory claims submission and limiting charge rules.

The private contracting provision of the statute defines ''beneficiary'' (for purposes of that section only) as a person who is eligible for Part A or who is enrolled in Part B. However, the private contracting provisions of the law set aside the mandatory claims and limiting charge rules that apply only to Part B. Therefore, notwithstanding the statutory definition of the term ''beneficiary'' to mean, in part, an individual who is eligible for Part A, as a practical matter section 4507 applies only to services furnished to an individual who is enrolled in Part B.

• Must a physician or practitioner who provides services that are not covered by Medicare sign a private contract with the beneficiary and opt-out of Medicare to be paid for noncovered services?

No. Since Medicare rules do not apply to services that Medicare does not cover, a section 4507 private contract is not needed to bill for them, and neither the Medicare claims submission nor the Medicare limiting charges rules apply to these services. A private contract is needed only for Medicare-covered services and then only if the physician or practitioner is opting-out or has opted-out.

A physician or practitioner may furnish a service that Medicare covers under some or many circumstances but that would likely be deemed as not reasonable and necessary by Medicare in a particular case (for example, multiple nursing home visits, some concurrent care services). In that particular case, the physician or practitioner should give the beneficiary an advance beneficiary notice (ABN) that states the service may not be covered by Medicare and that the beneficiary will be liable to pay for the service if it is denied. If the claim is denied by Medicare, a private contract is not necessary to permit the physician or practitioner to bill the beneficiary for the service.

• What are the rules governing claims submission to Medicare?

There are situations where a physician or practitioner who has not opted-out of Medicare is not authorized to submit a claim for a covered item or service provided to a Medicare beneficiary. A beneficiary, for reasons of his or her own, may decline to authorize the physician or practitioner to submit a claim or to furnish confidential medical information that is needed to submit a proper claim to Medicare. For example, the beneficiary may not want information about the beneficiary's mental illness or HIV/AIDS status to be disclosed to anyone. If the beneficiary does not sign the claim or otherwise authorize the claim submission, the physician or practitioner should not submit the claim to Medicare. However, the limiting charge would apply to the service. Moreover, if the beneficiary or his or her legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

Where the beneficiary authorizes the claim submission, physicians and practitioners must submit claims for services furnished to an individual enrolled in Medicare Part B unless they have opted-out of Medicare under the private contracting provisions of the law.

Physicians and practitioners who furnish services to a Medicare beneficiary need not submit claims to Medicare in the following cases:

- The beneficiary is not enrolled in Medicare Part B; Medicare limiting charge does not apply.
- The beneficiary refuses to authorize the physician or practitioner to submit a claim for a covered service to Medicare; Medicare limiting charge does apply.
- The service is categorically noncovered (for example, hearing aids and meals on wheels for diabetics); Medicare limiting charge does not apply.
- The service is not covered because the beneficiary is enrolled in a Medicare risk HMO and the HMO will not pay for the service because the physician or practitioner is outside of the HMO's network; Medicare limiting charge does not apply.

Provisions of the proposed rule relating to private contracting.

Definitions

In § 405.400, we define certain terms. We are proposing to define ''beneficiary'' to mean an individual who is enrolled in Part B of Medicare. As we discussed above, the statute's definition of the term has created considerable confusion about whether physicians must opt-out of Medicare to charge individuals who are over age 65 and eligible for Part A of Medicare but who are not enrolled in Part B of Medicare. We believe it is necessary to define the term ''beneficiary'' as being limited to an individual who is enrolled in Part B of Medicare in order to avoid continued confusion on this issue. We believe that having a definition that differs from the statute's definition is justified because the context in which the definition is used is that of Part B claims submission rules, Part B limiting charges, and coverage of Part B services. None of these policies is applicable to individuals who are not enrolled in Part B of Medicare.

We propose to define ''emergency care services'' as being services furnished to an individual who has an ''emergency medical condition'' as that term is defined in § 489.24. Reliance on the longstanding definition of emergency medical condition is, we believe, an appropriate and useful way to define emergency care services.

We are proposing to define ''legal representative'' to mean an individual who has been appointed as the Medicare beneficiary's legal guardian under State law, or who has been granted a power of attorney from the beneficiary, which power of attorney is sufficient to permit the individual to enter into private contracts on the Medicare beneficiary's behalf. This is necessary to clarify that, if a beneficiary has a legal representative, that party can act on the beneficiary's behalf when signing a private contract. We recognize that this is a strict standard and we invite comments on it. However, our concern is that we ensure that only parties who were authorized to make legal and financial commitments on behalf of the beneficiary be permitted to sign private contracts on a beneficiary's behalf since signing such a contract may incur a significant debt for a beneficiary.

We are defining the term ''opt-out'' to mean the status of meeting the conditions specified in § 405.410. When the physician or practitioner meets these conditions, he or she ceases to be bound by Medicare's mandatory claims submission rule and, in the case of a physician, the limiting charge rule or, in the case of a practitioner, the mandatory assignment rule.

We are defining ''participating physician'' to mean a physician as defined in this section who has signed an agreement to participate in Part B.

We are defining ''physician'' to mean a doctor of medicine or a doctor of osteopathy (who is legally authorized to practice as such in the State in which he or she practices). This is the statutory definition of the term for purposes of this section as specified in section 1802(b)(5)(B) of the Act.

We are defining ''practitioner'' to mean any of the following to the extent that the individual is legally authorized to practice as such by the State where he or she furnishes services: a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, and clinical social worker. These practitioners are those included in the statutory definition of practitioner for this purpose in section 1802(b)(5)(C) of the Act, that incorporates by reference those practitioner types listed in section 1842(b)(18)(C) of the Act.

We are defining ''private contract'' to mean a document that meets the criteria in § 405.415.

We propose to define ''properly opt-out'' to mean to fully complete the requirements in § 405.410, each of which must be met for the physician or practitioner to opt-out of Medicare and furnish items or services under a private contract.

We propose to define ''properly terminate opt-out'' to mean to fully complete the requirements in § 405.445, each of which must be met for the physician or practitioner who has opted-out of Medicare to terminate his or her opt-out.

We are proposing to define ''urgent care services'' as services that are provided to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

We also adopted the concept of ''emergency medical condition'' as defined in § 489.24 to help define urgent care services because the former term has a longstanding history of use in Medicare with respect to when a hospital must furnish emergency care to an individual who appears at its door (specifically, the ''anti-dumping'' rules). We have no standardized definition of ''urgent care services.'' We have been unable to find a definition of an ''urgent care service'' in standard usage. However, we think that an urgent care service would appropriately be any service that needs to be furnished without significant delay so as to avoid the onset of an emergency medical condition. Therefore, we are proposing that an ''urgent care service'' is one that needs to be furnished within 12 hours of the determination of need in order to avoid the individual's condition from becoming an emergency medical condition. The chief distinction between urgent care services and emergency care services is that urgent care services do not have to be furnished ''immediately'' as do ''emergency care services.''

General Rules

In § 405.405, we specify the general rules that apply to private contracting. Specifically, in § 405.405(a), we state that a physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare when the requirements of these rules are met. This is required by section 1802(b)(1)of the Act.

In § 405.405(b), we specify that a physician or practitioner who enters into at least one private contract with a Medicare beneficiary under this provision, and who submits one or more affidavits in accordance with these rules, opts out of Medicare for a 2-year period. This is required by section 1802(b)(3)(B)(ii) of the Act. We also specify that the physician's or practitioner's opt-out may be renewed for subsequent 2-year periods. Since the statute specifies that the physician or practitioner who meets the criteria for private contracting cannot be paid by Medicare for a 2-year period and does not address continuance of this period, we have chosen to make the opt-out period 2 years but to permit subsequent opt-out periods. There is no limit on the number of subsequent periods for which a physician or practitioner may opt-out.

In § 405.405(c), we specify that both the private contracts described in paragraph (a) and the physician's or practitioner's opt-out described in paragraph (b) are null and void if the physician or practitioner fails to complete opt-out in accordance with these rules or fails to remain in compliance with the conditions for opting-out. We specify the results of failure to properly opt-out or to maintain the conditions for opting-out in § 405.430 and § 405.435. Sections 1802(b)(2) and (b)(3)(A) of the Act, the criteria that governs the private contract and the affidavit, must be met by physicians and practitioners that want to opt-out and to privately contract with Medicare beneficiaries.

In § 405.405(d), we specify that services furnished under private contracts meeting the requirements of this Subpart are not covered services under Medicare and that no Medicare payment will be made for such services either directly or indirectly. This implements section 1862(a)(19) of the Act, which causes services furnished under private contracts by physicians and practitioners who opt-out to be excluded from coverage under Medicare.

Conditions for Opting-Out of Medicare

In § 405.410, we specify the conditions that must be met for a physician or practitioner to opt-out of Medicare and to furnish services under private contracts with Medicare beneficiaries. Specifically, in § 405.410(a), we specify that each private contract between a physician or a practitioner and a Medicare beneficiary must meet the specifications of § 405.415. In § 405.410(b), we specify that the physician or practitioner who wants to privately contract with Medicare beneficiaries must submit to Medicare one or more affidavits that meet the specifications of § 405.420. The physician or practitioner must submit an affidavit to each Medicare carrier to which the physician or practitioner submits claims for Medicare payment.

In § 405.410(c), we specify that a nonparticipating physician or a practitioner may opt-out of Medicare at any time. We also specify that the 2-year opt-out period begins the date the affidavit meeting the requirements of § 405.420 is signed, as long as the affidavit is timely filed (that is, within 10 days after the first private contract is entered into). In addition, we specify that if any required affidavit is not timely filed, the 2-year opt-out period begins when the last of the affidavits is filed. In this event, the private contracts signed by the parties before the last required affidavit is properly filed become effective upon the filing of the last required affidavit, and the furnishing of any items or services to Medicare beneficiaries under contracts before the last required affidavit is properly filed are subject to standard Medicare rules. Section 1802(b)(3)(B)(ii) provides that the opt-out period begins when the affidavit is signed, and section 1802(b)(3)(B)(iii) of the Act specifies that the affidavit must be filed within 10 days of the date the first private contract is signed.

In § 405.410(d), we specify that a participating physician may opt-out of Medicare at the beginning of any calendar quarter, provided the affidavit described in § 405.420 is submitted to Medicare at least 30 days before the beginning of such quarter. Private contracts signed by the parties before the beginning of the calendar quarter become effective at the beginning of such calendar quarter, and the furnishing of any items or services to Medicare beneficiaries under these contracts before the beginning of that calendar quarter is subject to standard Medicare rules.

It is necessary to treat participating physicians differently from nonparticipating physicians because each participating physician has entered into a contract with Medicare to be paid at the full fee schedule for the services they furnish to Medicare beneficiaries (rather than at 95 percent of the payment amount for nonparticipating physicians). When a participating physician opts-out of Medicare, he or she, in effect, terminates his or her participation agreement with Medicare since he or she no longer agrees to accept assignment on all services furnished to Medicare beneficiaries. When a participating physician opts-out of Medicare, the carrier (that is, each applicable carrier) must make systems changes to ensure the system pays the physician at the higher participating-physician rate for the period before the effective date of the opt-out, pays the physician as a nonparticipating-physician for emergency and urgent care services effective the date of the opt-out, and does not pay at all for all other items and services effective the date of the opt-out. Therefore, carriers need at least 30 days advance notice when a participating physician opts-out to ensure that the systems changes are made correctly. Moreover, carriers generally make systems changes no less frequently than at the beginning of each calendar quarter. Therefore, participating physicians must provide 30 days notice that they intend to opt-out at the beginning of the next calendar quarter for the changes to be made properly. We do not anticipate that this requirement will cause significant hardship on participating physicians who choose to opt-out or on beneficiaries who choose to privately contract with them.

Requirements of Private Contracts

In § 405.415, we are specifying criteria for a physician or practitioner to opt-out of Medicare. To opt-out of Medicare, the physician or practitioner must meet all of the criteria in this section.

In § 405.415, we specify the requirements for a private contract. In § 405.415(a) we specify that it must be in writing, in accordance with section 1802(b)(2)(A)(i) of the Act. In addition, we are proposing requiring that the contract be printed in sufficiently large type to ensure that beneficiaries are able to read the contract.

In § 405.415(b), we specify that, as required by 1802(b)(2)(B) of the Act, it must state whether the physician or practitioner has been excluded from Medicare under section 1128 of the Act.

In § 405.415(c), we specify that, as required by 1802(b)(2)(B)(ii) of the Act, it must state that the beneficiary or legal representative accepts full responsibility for payment of the physician's or practitioner's charge for the services furnished.

In § 405.415(d), as required by section 1802(b)(2)(B)(iii) of the Act, it must state that the beneficiary or legal representative understands that there are no limits on what the physician or practitioner may charge for items or services furnished by the physician or practitioner.

In § 405.415(e), we specify that, as required by 1802(b)(2)(B)(i) of the Act, it must state that the beneficiary or legal representative agrees not to submit a claim to Medicare nor to ask the physician or practitioner to submit a claim to Medicare.

In § 405.415(f), we specify that, as required by section 1802(b)(2)(B)(ii) of the Act, it must state that the beneficiary or legal representative understands that no Medicare payment will be made for any services furnished by the physician or practitioner, although such Medicare-covered services would likely be covered and paid by Medicare if they were provided by a physician or practitioner who had not opted-out of Medicare.

In § 405.415(g), we specify that, in accordance with section 1802(b)(2)(B)(v) of the Act, it must state that the beneficiary or legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services

from physicians and practitioners who have not opted-out of Medicare.

In § 405.415(h), we propose that the private contract contain the beginning effective date and expiration date of the opt-out period. The private contract must expire on the expiration date of the opt-out period since, after the expiration of the opt-out period, the physician or practitioner is no longer authorized to privately contract unless he or she enters into a new opt-out period.

In § 405.415(i), we specify, in accord with section 1802(b)(2)(B)(iv) of the Act, that the private contract must state that the beneficiary understands that Medigap plans do not, and that other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made by Medicare.

In § 405.415(j), we specify that the contract must be signed by the beneficiary or by the beneficiary's legal representative and by the physician or practitioner. Section 1802(b)(2)(A)(i) of the Act expressly requires that the contract must be signed by the beneficiary. Although there is no parallel express requirement for the physician or practitioner, we believe that such a requirement is implicit in the statute, and we are, therefore, proposing that the physician or practitioner also sign the contract.

In § 405.415(k), in accordance with 1802(b)(2)(A)(iii), we specify that the contract must not have been entered into during a time when the beneficiary requires emergency care services or urgent care services.

405.415(l), we propose that the beneficiary or legal representative must receive a copy of the contract before items or services are furnished under the contract. This is standard practice when parties sign binding contracts, and we believe it is important in this case so that the beneficiary or family members have the contract available if questions about charges for the services furnished arise.

In § 405.415(m), we propose that the physician or practitioner must retain a copy of each private contract for the duration of the opt-out period to which the contract applies. Physicians and practitioners may want to retain the private contracts for a longer period of time in case a beneficiary disputes whether a valid contract was signed.

In § 405.415(n), we propose that the physician or practitioner must permit us to inspect each such contract upon request. We propose these requirements to ensure that the contracts will be available if there are allegations that the physician or practitioner has failed properly opt-out or maintain opt-out or if there is need to review them to process an appeal under § 405.450.

In § 405.415(o), we propose that a private contract must be entered into for each opt-out period.

We have been requested to create a standard form for the private contract. We have decided that such a form is not necessary. While the minimal content of the contract is controlled by Federal law and regulation, the contracts are otherwise private agreements. Moreover, such contracts will not generally be provided to nor inspected by the Government.

Requirements for Opt-Out Affidavits

In § 405.420, we specify the required elements of the affidavit that the physician or practitioner must file with Medicare to opt-out. In § 405.420(a), as required by section 1802(b)(3)(B)(i) of the Act, we specify that the affidavit must be in writing and be signed by the physician or practitioner.

In § 405.420(b), we specify that the affidavit must contain the physician or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number if one has been assigned, uniform provider identification number (UPIN) if one has been assigned, or, if neither a NPI, billing number nor a UPIN has been assigned, the physician or practitioner's tax identification number (TIN). This information is necessary to enable the Medicare carrier to positively and uniquely identify the opt-out physician or practitioner, as required by section 1802(b)(3)(B)(i), and to ensure that no Medicare payment is made to the physician or practitioner or to any party for the services of the physician or practitioner (except for emergency and urgent care services), as required by section 1802(b)(1)(B)of the Act. Medicare carriers will provide the identifying information to Medicare+Choice (M+C) plans to ensure that they do not pay opt-out physicians or practitioners or enable them to be paid by Medicare funds for services they furnish to Medicare beneficiaries.

The TIN is necessary for physicians and practitioners that do not have a NPI, billing number, or UPIN so that the carrier can establish a means of tracking them without forcing them to complete the full Medicare enrollment process in order to opt-out of Medicare.

Recent data indicate that approximately 4 percent of physicians in the nation do not provide services to Medicare beneficiaries. We believe that some of these physicians (and some practitioners who are currently not enrolled in Medicare) are likely to choose to privately contract with Medicare beneficiaries under section 1802(b) of the Act, since doing so will open a market to them. It is also likely that many of these physicians and practitioners do not have Medicare billing numbers or UPINs because they have not been providing care to Medicare beneficiaries. Now, however, if such physicians and practitioners wish to privately contract with Medicare beneficiaries under section 1802 of the Act, they will need to be enumerated, for purposes of monitoring compliance with the law and particularly in case they furnish emergency or urgent care services for which they must bill and be paid by Medicare, notwithstanding that they have opted-out. Since we expect the provision of emergency or urgent care services by opt-out physicians to be very infrequent, and since we intend to monitor for potential abuse, we believe that the burden associated with collecting this information is very slight, is far outweighed by the benefit to beneficiaries of having these physicians available to provide emergency or urgent care services if they need such care, and is necessary to monitor compliance.

In § 405.420(c), we specify, pursuant to sections 1802(b)(3)(A), 1802(b)(3)(B), and 1802(b)(3)(C) of the Act, that the affidavit must state that the physician or practitioner will provide items and services to Medicare beneficiaries only through private contracts that meet the criteria of § 405.415.

In § 405.420(d), we specify that, in accordance with section 1802(b)(3)(B)(ii) of the Act, the affidavit must state that the physician or practitioner will not submit a claim to Medicare for any item or service furnished to a Medicare beneficiary, nor will the physician or practitioner permit any entity acting on his or her behalf to submit a claim to Medicare for any item or service furnished to a Medicare beneficiary. The extension of the requirement to include any ''entity'' reflects our belief that very few physicians and practitioners themselves submit claims for services. Rather, we believe that most physicians and practitioners use a billing service or reassign benefits to organizations that bill and are paid for the physician's or practitioner's services.

In § 405.420(e), we specify that, in accordance with section 1802(b)(3)(B)(ii) of the Act, the affidavit must state that the physician or practitioner understands that he or she may receive no direct or indirect payment from Medicare for services to Medicare beneficiaries who have signed

private contracts, whether as an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a M+C plan. As with the prohibition on billing, this provision reflects the reality that most physician and practitioner services are billed by and paid to organizations to whom the physician or practitioner reassigns benefits.

When a physician or practitioner opts-out of Medicare, no payment may be made for the services of the physician or practitioner, regardless of whether another entity bills and is paid for those services. In our experience, physicians and practitioners frequently fail to understand that organizations to which they have reassigned benefits are not, under Medicare law, considered to be the entity that furnishes the service. Therefore, where a physician reassigns benefits to an organization and subsequently decides to opt-out of Medicare, he or she no longer has any Medicare benefits to reassign and that organization can no longer bill and be paid by Medicare for the services of the physician or practitioner. This has been a source of confusion for physicians and practitioners since the implementation of the private contracting provisions on January 1, 1998, and has resulted in some physicians being terminated by organizations that can no longer bill and be paid by Medicare for their services. Hence, we believe that this important information should be placed in a document that the physician or practitioner must sign before opting-out.

Moreover, we believe that it is important the physicians and practitioners understand that opting-out of Medicare means that they cannot be paid by a Medicare risk or cost contractor or, after June 1, 1998, a M+C organization (for example, an HMO, provider service organizations, M+C fee for service plans, etc.), since payment by these organizations for services to Medicare beneficiaries would constitute payment by Medicare and would be a violation of the private contracting rules.

In § 405.420(f), as required by section 1802(b)(3)(B)(ii) of the Act, the affidavit must state that the physician or practitioner acknowledges that the services provided by the physician or practitioner who opts-out of Medicare are not covered by Medicare and that no Medicare payment may be made to any entity for those services, directly or on a capitated basis. This is important to note since, when Medicare does not cover a service, it neither pays for the item or service as primary payer nor makes secondary payment when other insurers are primary. (Also, many other insurers will not make any payment because the service is not covered by Medicare.)

In § 405.420(g), we specify that the affidavit must bind the physician or practitioner to the terms of both the affidavit and the private contracts for the 2-year opt-out period. Section 1802(b)(3)(B)(ii) of the Act requires that the physician or practitioner may opt-out for a period of not less than 2 years. Accordingly, we have defined the opt-out period to be 2 years and have tied the duration of the private contract to the opt-out period.

In § 405.420(h), we propose that the affidavit must acknowledge that the physician or practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished by the physician or practitioner to Medicare beneficiaries, regardless of any payment arrangement in which the physician or practitioner participates. It is not unusual for physicians and practitioners to have multiple sources of income and to reassign benefits to multiple entities (for example, multiple HMOs, preferred provider organizations, private practice, and part time employment by a facility). When a physician or practitioner opts-out, we want to ensure that he or she understands that he or she opts-out for all Medicare-covered items and services, regardless of where or on whose behalf they are provided. For example, a physician who is employed by a facility and who also has a private practice cannot opt-out of Medicare with respect to only the private practice and not opt-out for services he furnishes on behalf of a facility or other organization for which such services are billed to a carrier and paid under Part B. If the physician opts-out, no Medicare payment can be made either to the private practice or to the facility or other organization for the services of the physician. However, if the physician is paid by the facility for administrative functions which are not billable to individual beneficiaries as physician services, such as direction of a department of a hospital or administrative oversight of a teaching program, the payment by the facility to the physician is not affected.

In § 405.420(i), we propose that the affidavit must acknowledge that the physician or practitioner who has previously signed a Part B participation agreement understands that he or she terminates that agreement as of the effective date of the affidavit. We believe that this is necessary to ensure that the physician or practitioner understands that he or she is no longer a Medicare-participating physician or practitioner. This is important with regard to post opt-out billing for emergency and urgent care services. The physician or practitioner who provides such care (for which Medicare will pay) will be paid as a nonparticipating physician if he or she submits those claims for payment, notwithstanding that he or she had a Part B participation agreement before he or she opted-out.

In § 405.420(j), we specify that the affidavit must acknowledge that the physician or practitioner understands that a beneficiary who has not signed a private contract and who requires emergency or urgent care services may not be asked to sign a private contract with respect to receiving those services. If a physician or practitioner who opts out of Medicare provides emergency or urgent care services to a beneficiary who has not previously signed a private contract, the physician or practitioner must submit a claim to Medicare for those services and may not charge the beneficiary more than the limiting charge for those services.

In § 405.420(k), we propose that the affidavit must be filed with each Medicare carrier to which the physician or practitioner has submitted claims in the previous 2 years. This is necessary to ensure that each Medicare claims payment system that needs to know of the opt-out is advised promptly so that no Medicare payment is made for the services of the opt-out physician or practitioner. This is based on sections 1802(b)(1)(B) and 1802(b)(3)(B)(iii) of the Act.

In § 405.420(l), we specify that in the case of a nonparticipating physician or a practitioner, all required affidavits must be filed within 10 days after the physician or practitioner signs his or her first private contract with a Medicare beneficiary. In the case of a participating physician, we specify that all required affidavits must be filed in accordance with § 405.410(d), which requires that the affidavits be filed no later than 30 days before the beginning of a calender quarter and must be effective on the first day of the calender quarter. Section 1802(b)(3)(B)(iii) of the Act requires that the physician or practitioner file the affidavit within 10 days after the physician or practitioner signs his or her first private contract with a Medicare beneficiary. As discussed previously in this preamble, participating physicians are permitted to opt-out only on a quarterly basis because of the systems changes that must be made to reverse the effect of the participation agreements they previously entered into.

Various members of the public have requested we create a standard affidavit for submission to the Medicare carrier. We do not see a reason to do this. The criteria of a legally sufficient affidavit will be clearly specified in regulations, and we are confident that physicians and practitioners and their counsel can produce an affidavit without needing a Government form to sign.

Effect of Opting-Out of Medicare

In section § 405.425, we specify the effects of opting-out of Medicare. Specifically, we state that, a physician's or practitioner's opt-out of Medicare, for the 2-year period for which the opt-out is effective, has the following effects:

• In § 405.425(a), we state that (except as provided in § 405.440), in accordance with section 1802(b)(1)(B) of the Act, no payment may be made directly by Medicare or by any M+C plan to the physician or practitioner or to any entity to which the physician or practitioner reassigns his or her right to receive payment for services.

• In § 405.425(b), we state that, in accord with section 1802(b)(3)(B)(ii) of the Act, the physician or practitioner may not furnish any item or service that would otherwise be covered by Medicare (except for emergency or urgent care services) to any Medicare beneficiary except through a private contract that meets the requirements of these rules.

• In § 405.425(c), we state that the physician or practitioner is not subject to the requirement to submit a claim for items or services furnished to a Medicare beneficiary (as specified in § 424.5(a)(6)), except as provided in § 405.440 with respect to emergency and urgent care services.

• In § 405.425(d), in accordance with section 1802(b)(3)(B)(ii) of the Act, we state that the physician or practitioner is prohibited from submitting a claim to Medicare for items or services furnished to a Medicare beneficiary, except as provided in § 405.440 in the case of emergency or urgent care services.

• In § 405.425(e), we state that, in accordance with 1802(b)(4) of the Act, the physician who has properly opted-out is not subject to the limiting charge provisions of § 414.48.

• In § 405.425(f), we state that a physician or practitioner who has properly opted-out is not subject to the prohibition-on-reassignment provisions of § 414.80. These are the rules that restrict when physicians and practitioners can reassign Medicare benefits to organizations with which they have financial arrangements.

• In § 405.425(g), we propose that in the case of a practitioner, he or she is not prohibited from billing or collecting amounts from beneficiaries in excess of those provided in section 1842(b)(18)(B) of the Act. This is not specifically provided for by section 4507 of BBA 1997; however, we believe that this provision is consistent with sections 1802(b)(1) and (2)(B) of the Act, that, when read together, permit practitioners to collect more than the deductible and coinsurance to which they are limited under section 1842(b)(18)(B) of the Act when they provide covered services to Medicare beneficiaries under standard Medicare rules. Section 1842(b)(18)(B) of the Act specifies that practitioners must take assignment on all claims and may not collect more than Medicare deductibles and coinsurance from Medicare beneficiaries. We believe that the private contracting provisions exempt practitioners from these restrictions.

• In § 405.425(h), we propose that the death of a beneficiary who (or whose legal representative) has entered into a private contract does not invoke § 424.62 or § 424.64 with respect to the physician or practitioner with whom the beneficiary (or legal representative) has privately contracted. These sections of the regulations permit claims to be filed and payment to be made for services furnished to a beneficiary who has died. We propose to include this section to ensure that it is clear that the terms of a private contract are not superseded by the provisions of § 424.62 or § 424.64.

• In § 405.425(i), we specify that the opt-out physician or practitioner may make referrals and may order or certify the need for Medicare-covered items and services provided the physician or practitioner is not paid directly or indirectly by Medicare for those services. A physician or practitioner who has properly opted-out may continue to act as a physician or practitioner for purposes of ordering Medicare-covered services (for example, laboratory tests), making necessary certifications (for example, home health plan of care), attestations (for example, hospital inpatient), etc., as long as he or she is not being paid directly or indirectly by Medicare for these services.

Failure to Properly Opt-Out

In § 405.430(a), we specify that a physician or practitioner fails to properly opt-out if any private contract between the physician or practitioner and a Medicare beneficiary does not meet the standards of § 405.415 or if the physician or practitioner fails to submit affidavit(s) in accordance with § 405.420. Sections 1802(b)(2) and 1802(b)(3) of the Act specify the criteria that private contracts and affidavits must meet in order for the physician or practitioner to successfully opt-out of Medicare.

In section § 405.430(b), we specify that if a physician or practitioner fails to properly opt-out as specified in § 405.430(a), the following result:

• All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.

• The physician's or practitioner's attempt to opt-out of Medicare is nullified.

• The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries. Section 1802(b)(4) of the Act, which would excuse the physician and practitioner from the mandatory claims submission requirements of section 1848(g)(4) of the Act, is not effective when the opt-out rules are not met.

• The physician is subject to the limiting charge provisions of § 414.48. Sections 1802(b)(1) and 1802(b)(2)(B)(iii), which excuse the physician from the limiting charge rules, do not apply and he or she continues to be subject to the limiting charge rules of section 1848(g) of the Act.

• The physician or practitioner may not reassign any claim except as provided in § 424.80. Medicare payment may be made only to the beneficiary, to the physician or practitioner under an assignment of benefits or to another party for the services of a physician or practitioner only when the requirements of the reassignment of benefits provision of § 424.80 are met.

• The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts. Section 1842(b)(18)(B) of the Act explicitly prohibits practitioners from collecting more than the deductible or coinsurance from the beneficiary. While this requirement would not apply if the requirements to properly opt-out had been satisfied, it does apply when the criteria to properly opt-out have not been met.

• The physician or practitioner may attempt to properly opt-out at any time. The statute does not preclude a physician or practitioner who has not complied totally with the statute's criteria for opting-out of Medicare from subsequently meeting the criteria and thus at that time properly opting-out.

Failure to Maintain Opt-out

In § 405.435(a), we specify four circumstances, under any one of which

the physician or practitioner would be considered to have failed to maintain opt-out, that is, failed to remain in compliance with the requirements of these rules. Specifically, in § 405.435(a)(1), we state that a physician or practitioner would be considered to have failed to maintain the opt-out if he or she knowingly and willfully submits a claim for Medicare payment (except a claim for emergency care services or urgent care services) or receives Medicare payment directly or indirectly for services furnished to a Medicare beneficiary (except when the services are emergency care services or urgent care services). This implements section 1802(b)(3)(C) of the Act.

In § 405.435(a)(2), we state that the physician or practitioner would be considered to have violated the terms of the opt-out if he or she enters into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare when the contracts fail to meet the requirements of § 405.415. This implements section 1802(b)(2) of the Act that requires that the physician or practitioner must enter into private contracts that meet certain criteria for the opt-out to be valid. This provision is also consistent with the enforcement provisions of section 1802(b)(3)(C) of the Act.

In addition, in § 405.435(a)(3), we specify that the physician or practitioner would be considered to have failed to maintain the opt-out if he or she fails to comply with the provisions of § 405.440 regarding billing for emergency care services or urgent care services. In part, this provision implements section 1802(b)(2)(A)(iii) of the Act that prohibits a physician or practitioner from requesting that a beneficiary enter into a private contract when he or she is in need of emergency or urgent care services and is otherwise necessary to ensure access by Medicare beneficiaries to emergency and urgent care services.

In § 405.435(a)(4), we propose that the physician or practitioner would be considered to have failed to maintain opt-out if he or she fails to retain a copy of each private contract that he or she entered into for the duration of the opt-out period for which such contracts are applicable or fails to permit us to inspect such contracts upon request. The issue of retaining copies of private contracts is discussed in § 405.415, requirements of the private contract.

We intend to continue the administrative process currently in place for dealing with the submission of claims by physicians and practitioners who have opted-out of Medicare. Specifically, we have instructed carriers to pend claims they receive from physicians and practitioners who have filed an affidavit opting-out of Medicare and to send the physician or practitioner a letter asking him or her if the submission of the claim was intentional or accidental, and if the latter by what date the physician or practitioner can remedy the problem. We recognize that most physicians and practitioners may be somewhat distant from the billing of their claims and that the use of automation and billing services increases the chance that one or more claims may be accidentally submitted to Medicare for an opt-out physician or practitioner. We also recognize that if the problem is systematic, it may take some time to correct. Hence, under the current process, we give physicians and practitioners 45 days from the date of the postmark on the carrier's letter to respond to the carrier and to advise them of when they believe the problem can be fixed. Carrier notices to beneficiaries will advise them that no payment can be made for the services of the opt-out physician, and that there are no limits on what the physician or practitioner can charge the beneficiary, unless the physician or practitioner does not respond timely to the carrier's letter, does not timely correct the billing problem, or states that the submission of the claim was intentional. We do not believe that any of these scenarios will happen often since physicians and practitioner who opt-out of Medicare clearly have an incentive to ensure that they abide by the terms of the opt-out and that neither they nor any party on their behalf submit claims to Medicare.

In section § 405.435(b), we specify that the effects of a physician or practitioner failing to maintain opt-out as specified in paragraph (a) are as follows:

- All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.
- The physician's or practitioner's opt-out of Medicare is nullified.
- The physician or practitioner again becomes subject to the mandatory claims submission rule. Therefore, the physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.
- The physician or practitioner will not receive Medicare payment on such claims for the remainder of the opt-out period. This is required by section 1802(b)(3)(C)(ii) of the Act.
- The physician is subject to the limiting charge provisions of § 414.48. This is required by section 1848(g) of the Act pursuant to section 1802(b)(3)(C)(i) of the Act.
- The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts. This is required by section 1842(b)(18)(B) of the Act pursuant to section 1802(b)(3)(C)(i) of the Act.
- The physician or practitioner may not opt-out until the now-nullified 2-year opt-out period expires. This is necessary to give meaning to the enforcement provisions specified in section 1802(b)(3)(C) of the Act.

Emergency and Urgent Care Services

In § 405.440, we specify the rules that apply to furnishing and billing for emergency and urgent care services. Specifically, in § 405.440(a), we specify that a private contract is not necessary for a physician or practitioner to furnish emergency care services or urgent care services to a Medicare beneficiary. Accordingly, a physician or practitioner will not be determined to have failed to maintain opt-out if he or she furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not entered into a private contract, provided the physician or practitioner complies with the Medicare billing requirements with respect to emergency care services or urgent care services.

In § 405.440(b), we specify that when a physician or practitioner furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not entered into a private contract, the physician or practitioner must submit a claim to Medicare in accordance with 42 CFR Part 424 and Medicare instructions issued pursuant to such regulations, including instructions on coding emergency or urgent care services. Also, we propose that the physician may collect no more than the Medicare limiting charge and that the practitioner may collect no more than the applicable deductible and coinsurance amounts. We specify these requirements because the physician or practitioner cannot ask a beneficiary to enter into a private contract when a beneficiary is in need of emergency or urgent care services. Therefore, when the beneficiary has not previously signed a private contract, the beneficiary has not agreed to give up Medicare coverage for the services of the physician or practitioner and the services are not excluded from coverage under Medicare, nor is the physician or

practitioner excluded from the mandatory claims submission and charge rules that would not apply had he or she been able to sign a private contract with the beneficiary.

In § 405.440(c), we specify that emergency care services or urgent care services furnished to a Medicare beneficiary with whom the physician or practitioner has previously entered into a private contract (that is, entered into before the onset of the emergency medical condition or urgent medical condition) are furnished under the terms of the private contract. Although section 1802(b)(2)(A)(iii) of the Act precludes the physician or practitioner from entering into a private contract with a beneficiary when the beneficiary needs emergency or urgent care services, the private contracting rules apply to a beneficiary who has previously entered into a private contract (at a time when the beneficiary was not in need of emergency or urgent care services).

In § 405.440(d), we specify that Medicare may make payment for the emergency care services or urgent care services furnished by a physician or practitioner who has properly opted-out, provided that no private contract has been entered into by the beneficiary to whom emergency care services or urgent care services were furnished. Although the statute does not explicitly address whether payment may be made in these cases, we believe that it is both permissible and desirable to do so since this provision will facilitate access to needed care in the circumstance when the beneficiary or their legal representative has not signed a private contract and the physician or practitioner who has opted-out cannot lawfully request that the beneficiary or their legal representative now do so.

Renewal and Early Termination of Opt-out

In § 405.445, we specify the terms of renewal and early termination of the opt-out. In § 405.445(a), we specify that a physician or practitioner may renew his or her opt-out by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period (as specified in § 405.420) and to each carrier to which a claim was submitted under § 405.440 during the previous opt-out period, provided such affidavits are filed within 30 days after the current opt-out period expires. While section 1802(b)(3)(B)(ii) of the Act provides that the physician or practitioner opts-out for a period of 2 years, it does not address renewal of opt-out. Our proposal is to establish reasonable standards and procedures for the physician or practitioner to again opt-out of Medicare for subsequent opt-out periods.

In § 405.445(b), we propose that the physician or practitioner may terminate the opt-out for any reason within the 90 days following the effective date of the first affidavit filed with Medicare if he or she agrees to do the following:

- Notify all Medicare carriers with which he or she filed an affidavit to properly opt-out of the termination of the opt-out, no later than 90 days after the effective date of the opt-out period.
- Refund to beneficiaries all payment collected in excess of the Medicare limiting charge, in the case of physicians, or in excess of the deductible and coinsurance, in the case of practitioners.
- Notify all beneficiaries with whom the physician or practitioner signed private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have the physician or practitioner file claims on their behalf, without charge, with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out.

In § 405.445(c), we propose that when the physician or practitioner properly terminates opt-out in accordance with paragraph (b), he or she will be reinstated in Medicare as if there had been no opt-out and the provisions of ' 405.425 will not apply for the 2 years following the signing of the affidavit unless the physician or practitioner subsequently properly opts-out again.

We recognize that there may be cases when the physician or practitioner may not have understood the opt-out rules and may want to return to Medicare. We believe that it is advantageous to all parties to permit a first-time opt-out physician or practitioner to properly terminate opt-out. However, we are requiring that to properly terminate opt-out, the termination must be accomplished within 90 days following the effective date of the first opt-out, and we are permitting only one termination of opt-out by the physician or practitioner. We believe that it would be a mistake to permit repeated terminations of opt-out, since it could be abused to manipulate payment, could create a significant expense for Medicare systems, and would be confusing to beneficiaries.

Appeals

In § 405.450, we propose procedures for appeals by physicians or practitioners and beneficiaries who believe that they have been adversely affected by these rules.

In § 405.450(a), we address appeals of determinations by Medicare that a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out by proposing that a determination with respect to any such matter is an initial determination for purposes of § 405.803. The effect of this provision is that the appeals mechanism found in Part 405, Subpart H is made available to physicians or practitioners for the purpose of administrative review of Medicare determinations on matters addressed in this subpart. Although we believe that these procedures will rarely be needed for this purpose, we believe that it is important to provide this mechanism because of the potential adverse impact on the physician or practitioner of any such determination.

In § 405.450(b), we propose that a determination by Medicare that no payment can be made to the beneficiary as a result of the application of any provision of this subpart is a initial determination for the purposes of § 405.803. We believe that the beneficiary must have the right to appeal a denial of Medicare payment on a claim submitted by or on behalf of the beneficiary when the basis for that denial is the application of the provisions of this subpart. The effect of this provision is that the appeals mechanism of Part 405, Subpart H is made available to beneficiaries whose claims for Medicare payment are denied on the basis of the opt-out provisions of this rule.

Under the BBA 1997 requirements, the physician who opts out under these provisions must sign an affidavit agreeing for 2 years not to furnish services to any Medicare beneficiary without signing a private contract. We expect that the vast majority of opt-out physicians will fully comply with these terms. Although we expect that physicians will tell beneficiaries that they have opted-out, we are concerned that there may be cases when an opt-out physician delivers non-emergency or non-urgent services to a beneficiary without entering into a private contract. The beneficiary may be unaware that the physician has opted out. Nevertheless, the beneficiary would be billed for the physician's full charges for the service. If the beneficiary seeks reimbursement from Medicare, the claim would be denied and the beneficiary would be informed that the reason for denial is that the physician has opted-out of the Medicare program. We do not believe that the Congress intended that beneficiaries who have

not chosen to sign a private contract would be financially harmed because they unknowingly received services from an opt-out physician. While the statute does not provide a specific remedy for this situation and we expect the physician will tell beneficiaries that they have opted-out, we believe that we have authority to develop some beneficiary protections in this case in the limited cases when physicians do not do so. One possibility would be to indemnify the beneficiary for the amount that Medicare would have normally paid, ensuring that the beneficiary is informed that the physician is an opt-out physician. The program would then recoup this amount from the physician and the physician would refund to the beneficiary any balanced billing amounts above Medicare's limiting charge. The beneficiary would remain liable for any coinsurance and deductible amounts that would have been paid in the absence of a private contract. A means of informing beneficiaries enrolled in M+C organizations may be to require that such organizations disclose information on opt-out physicians upon request by the beneficiary. We would welcome comments on these and other approaches to providing protection for beneficiaries in these circumstances.

Medicare+Choice

In § 405.455, we propose to specify the requirements that are to be imposed on an organization that has a contract with us to provide one or more M+C plans to beneficiaries (Part 422 of this chapter). The location of this section may change to part 422 with the final rule, once the M+C interim rules are published. Part 422 will be the location of the regulations that govern Part C of Medicare, commonly known as M+C.

In § 405.455(a), we propose that the M+C organization must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

In § 405.455(b), we specify that the M+C organization must make no payment directly or indirectly for Medicare-covered services furnished to an enrolled Medicare beneficiary by a physician or practitioner who has opted-out of Medicare. The services of physicians and practitioners who properly opt-out are excluded from Medicare under section 1862(a)(19) of the Act. Therefore, no payment may be made for them as Medicare-covered services.

In § 405.455(c), we specify that M+C organizations may make payment to a physician or practitioner who has properly opted-out if he or she furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner. This is consistent with our policy in § 405.440 where Medicare payment is made by carriers rather than through M+C contracts.

C. Payment for Outpatient Rehabilitation Services

The term outpatient rehabilitation therapy encompasses outpatient physical therapy (including speech-language pathology) and outpatient occupational therapy.

1. Overview of Policies Before BBA 1997

a. Coverage. Section 1861(p) of the Act defines outpatient physical therapy services as physical therapy services furnished to a beneficiary as an outpatient who meets the following criteria:

- Is under the care of a physician.
- Has a plan of treatment or care established by either a physician or by a qualified physical therapist.
- Has the plan of treatment or care periodically reviewed by a physician.

The statute also incorporates speech language pathology services within the definition of outpatient physical therapy services.

Section 1861(g) of the Act states that the term ''outpatient occupational therapy services'' has the same meaning given the term ''outpatient physical therapy services'' in section 1861(p), except that the word ''occupational'' is substituted for the word ''physical'' each time it is used in section 1861(p).

b. Providers of Outpatient Rehabilitation Services. Outpatient physical therapy services (including speech-language pathology services) and outpatient occupational therapy services are furnished by providers of services, clinics, rehabilitation agencies, public health agencies, or by others under an arrangement with, and under the supervision of such entities. As defined in section 1861(w) of the Act, the term ''arrangements'' is limited to arrangements under which receipt of payment by the provider discharges the liability of the beneficiary to pay for services.

Providers that furnish outpatient physical and occupational therapy services include hospitals, skilled nursing facilities (SNFs), rehabilitation agencies, home health agencies (HHAs), hospices, and comprehensive outpatient rehabilitation facilities (CORFs) furnishing services to patients other than those who receive SNF or inpatient hospital benefits.

Hospital inpatients who have exhausted their hospital inpatient benefits and who are entitled to Part B, and SNF patients who have exhausted their SNF benefits and who are entitled to Part B may receive outpatient physical therapy services (including speech-language pathology services) and outpatient occupational therapy services even though they are inpatients of the provider. Section 1861(p) of the Act defines outpatient physical therapy services as those services that meet the requirements of the first sentence of 1861(p), yet that are furnished to a beneficiary as an inpatient of a hospital or extended care facility. Section 1861(p) of the Act must be read in conjunction with section 1833(d) of the Act. The latter section provides that Medicare Part B payments, such as payment for outpatient physical and occupational therapy services, may be made only when there is no eligibility for Medicare Part A payments for the service, such as payments for inpatient hospital or SNF care. Part B payment may be made for inpatients only when there is no eligibility for Medicare Part A payments; this means only a beneficiary who is not entitled to Medicare Part A benefits or who has exhausted his or her Part A benefits. Also see § 410.60(b) (Outpatient physical therapy services: Conditions, Outpatient physical therapy services to certain inpatients of a hospital or a CAH or SNF).

Outpatient physical therapy (including speech-language pathology) and occupational therapy services furnished by a home health agency may be covered as ''medical and other health services'' under section 1861(s) of the Act when the beneficiary is not entitled to receive home health benefits under section 1814(a)(2)(C) because he or she is not homebound. To qualify for home health benefits, the beneficiary must be homebound and need or have needed skilled nursing care on an intermittent basis or physical or speech therapy, or in the case of an individual who no longer has need for such care or therapy, continues to need occupational therapy. Thus, most rehabilitative services furnished by home health agencies under section 1861(s)(2)(D) provisions are furnished to beneficiaries who are not homebound.

Section 1861(cc)(1) of the Act defines the services that can be provided by a CORF. In addition to outpatient rehabilitation services, CORF services include: physician services; respiratory therapy; prosthetic and orthotic devices; social and psychological services; nursing care; drugs and biologicals that cannot be self-administered; supplies

and medical equipment; and, such other services as are medically necessary and are ordinarily furnished by CORFs.

Services furnished by either a qualified physical therapist or a qualified occupational therapist in his or her office or in the beneficiary's home, for example, services of a physical therapist in independent practice (PTIP) or occupational therapist in independent practice (OTIP), are included as outpatient physical therapy services and outpatient occupational therapy services. Medicare does not cover the services of a speech-language pathologist in independent practice.

c. Payment for Services. (1) Reasonable Cost-Based Payments Outpatient physical, occupational, and speech-language pathology services furnished by a provider of services, a clinic, a rehabilitation agency or public health agency are paid based on the lesser of the charges imposed for the services or the reasonable costs of providing the services.

The reasonable cost of services furnished under arrangements may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by such provider or other organization had the services been performed by an employee. See § 413.106 (Reasonable cost of physical and other therapy services furnished under arrangements).

The salary equivalency guideline amounts currently in effect were published as a final rule on January 30, 1998, (63 FR 5106). In that final rule, we updated the physical and respiratory therapy guideline amounts and introduced new salary equivalency guidelines for occupational therapy and speech-language pathology services furnished under an arrangement. These guideline amounts are effective for services furnished on or after April 10, 1998. The guidelines are used by fiscal intermediaries to determine the maximum allowable cost of those services. In general, the salary equivalency guideline amounts are comprised of a prevailing hourly salary rate based on the 75th percentile of the range of salaries paid to full-time employee therapists by providers in the geographic area, by type of therapy, and a fringe benefit and expense factor; a standard travel allowance and additional allowances for costs incurred for services furnished by an outside supplier.

(2) Fee Schedule Payments. Physical and occupational therapy services furnished by physicians and certain other recognized practitioners are payable by the carriers under the physician fee schedule. This includes services of PTIPs and OTIPs. The fee schedule also applies to nonphysician practitioners who furnish services that would be physician services if furnished by a physician. Nonphysician practitioners include physician assistants (section 1861(s)(2)(K)(i) of the Act); and nurse practitioners and clinical nurse specialists (sections 1861(s)(2)(K)(ii) and 1861(s)(2)(K)(iii) of the Act) operating within the scope of their State licenses and within certain settings. Physical and occupational therapy services provided incident to the services of physicians or incident to the services of the recognized nonphysician practitioners cited above are payable by the carriers under the physician fee schedule.

d. Financial Limitation. Outpatient physical therapy services provided by a PTIP and outpatient occupational therapy services furnished by an OTIP are subject to an annual financial limitation. This annual limitation or cap is $900 per beneficiary of incurred expenses for physical therapy services and $900 per beneficiary of incurred expenses for occupational therapy services. There is a beneficiary liability that is comprised of the Part B deductible amount and 20-percent coinsurance. If a beneficiary has already satisfied the Part B deductible, the maximum amount payable by the Medicare program under each of these benefits is $720, for example, 80 percent of $900. The limit on expenses applies only to items and services covered under the therapy benefit. When a beneficiary exceeds the annual limitation or cap, the beneficiary is financially liable for any additional therapy services that are furnished during the calendar year.

2. BBA 1997 Provisions Affecting Payment for Outpatient Rehabilitation Services

a. Reasonable Cost-Based Payments. Section 4541(a) of BBA 1997 added new section 1834(k) of the Act. Section 1834(k)(2) established a 10 percent reduction in the reasonable cost of therapy services furnished during 1998. The 10-percent reduction does not apply to outpatient therapy services furnished by hospitals or critical access hospitals. In accordance with this provision, we are proposing to make payment for outpatient rehabilitation services furnished during 1998 based upon the lesser of the charges imposed or the reasonable cost determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to outpatient physical therapy or occupational therapy services furnished by a hospital to an outpatient or to a hospital inpatient entitled to benefits under Part A but who has exhausted benefits or is otherwise not in a covered Part A stay.

The salary equivalency guidelines will continue to remain in effect until all BBA 1997 provisions regarding a prospective payment system for outpatient rehabilitation services are implemented. The prospective payment system will negate the need for salary equivalency guidelines because providers will no longer be paid on a reasonable cost basis for their therapy services. The salary equivalency guidelines were a tool used to determine the reasonable cost of therapy services provided by practitioners other than physicians.

b. Prospective Payment System for Outpatient Rehabilitation Services. (1) Overview. Section 4541 of BBA 1997 adds a new section 1834(k) to the Act that provides for a prospective payment system for outpatient rehabilitation services and all services provided by CORFs. The prospective payment system is effective for services furnished on or after January 1, 1999. Section 1834(k)(1)(B) of the Act provides for payment for those services to be made at 80 percent of the lesser of (1) the actual charge for the services, or (2) the applicable fee schedule. Section 1834(k)(3) defines the applicable fee schedule amount as the amount determined under the physician fee schedule, or, if there is no such fee schedule established for those services, the amount determined under the fee schedule established for comparable services as specified by the Secretary.

The physician fee schedule is currently applied to certain outpatient rehabilitation therapy services. It is now the basis of payment for outpatient rehabilitation services furnished by PTIPs and OTIPs, physicians, and certain nonphysician practitioners or incident to the services of such physicians or nonphysician practitioners. The physician fee schedule has been the method of payment for outpatient rehabilitation therapy services provided by such entities for several years. Fee schedule payment will now apply when outpatient physical therapy, occupational therapy, and speech language pathology services are furnished by rehabilitation agencies, public health agencies, clinics, SNFs, home health agencies for beneficiaries who are not eligible for home health benefits because they are not homebound, hospitals (when such services are provided to an outpatient or to a hospital inpatient who is entitled to

benefits under Part A but who has exhausted benefits or is not entitled), and CORFs. The fee schedule also applies to outpatient rehabilitation services furnished under an arrangement with any of the cited entities that are to be paid on the basis of the physician fee schedule. The fee schedule will not apply to outpatient rehabilitation services furnished by critical access hospitals. Under section 1833 of the Act as amended by Section 4541 of BBA 1997, these services will be paid on a reasonable cost basis.

(2) Services Furnished by Skilled Nursing Facilities. Section 4432(a) of BBA 1997 added a new subsection(e) to section 1888 of the Act to establish a prospective payment systems for SNFs. Under the statute, effective for cost reporting periods beginning on or after July 1, 1998, Medicare pays for covered Part A SNF stays on the basis of prospectively determined payment rates which encompass all costs of ''covered skilled nursing facility services'' furnished to a SNF resident. The statute defines covered SNF services to include (1) post-hospital extended care services paid for under Part A, as well as (2) certain services that may be paid under Part B and which are furnished to SNF residents receiving covered post-hospital extended care services. Section 1888(e)(2) provides for exclusion of specific services from the definition of covered SNF services, but the statute explicitly states that the exclusions do not encompass ''any physical, occupational or speech language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.'' Thus, if a SNF resident is in a covered Part A stay, therapy services furnished to the SNF resident are encompassed in the PPS payment and Medicare does not make a separate Part B payment.

Under the new payment system for SNF inpatient services, and consistent with current policy (which applied before enactment of BBA 1997, services furnished to SNF residents that are not covered under Part A may nevertheless be covered under Part B. Section 4432(b) of BBA 1997 amended section 1842(b)(6) of the Act to require that payment for most services furnished to an individual who is a resident of a SNF, including outpatient rehabilitation services, be made to the facility (without regard to whether the service was furnished by the facility, by others under arrangement with the facility, or under any other arrangement). When the services are not being furnished directly, the facility then pays the provider of therapy services. The consolidated billing provision is effective for services furnished on or after July 1, 1998.

Section 4432(b)(3) of BBA 1997 added a new paragraph (9) to section 1888(e) of the Act to provide that, with respect to a service covered under Part B that is furnished to a SNF resident, the amount of payment for the service shall be the amount provided under the fee schedule for such item or service. This provision must be read in conjunction with the provisions of section 4541 of BBA 1997. Section 4541 added a new section 1833(a)(8) to specify that the amounts payable for outpatient rehabilitation services furnished by a SNF will be the amounts determined under section 1834(k) of the Act. Section 1834(k) of the Act provides that payment in 1998 shall be based on adjusted reasonable costs and in 1999 and thereafter, the physician fee schedule. Thus, we are proposing that SNF Part B inpatient services remain payable on a reasonable cost basis until January 1, 1999. Effective January 1, 1999, the services will be paid under the physician fee schedule.

The physician fee schedule amount applicable to services furnished in a non-facility setting will apply to the Part B services to inpatients and other outpatient rehabilitation services furnished by the SNF. The non-facility amount applies because the consolidated billing provision requires that the SNF be directly paid for the entire therapy service (including facility costs) based on the physician fee schedule. This is in contrast to the amount applicable to physician services, excluding outpatient rehabilitation services, billed for SNF residents. In this case, the physician payment is not intended to cover the facility costs associated with the service and the fee schedule amount applicable to services furnished in a facility applies.

(3) Services Furnished by Home Health Agencies. Section 1833(a)(8)(A) requires that the physician fee schedule applies to outpatient rehabilitation services furnished by a HHA to an individual who is not homebound. The likelihood is great that most individuals who are homebound and are receiving physical therapy, speech-language pathology, or occupational therapy are entitled to home health benefits. Therefore, most outpatient rehabilitation services furnished by a HHA under section 1861(s)(2)(D) is to individuals who are not homebound. There may be, however, some individuals who are not homebound and have not required a qualifying service for home health benefits but who need occupational therapy services. If provided by a HHA, these services could be provided under section 1861(s)(2)(D) of the Act. Since section 4541 of BBA 1997 did not expressly address these services, they remain payable on a reasonable cost basis under section 1861(v)(1) of the Act. All other services furnished by the HHA will be paid under a prospective payment system (effective October 1, 1999 with respect to home health services). Section 1861(v)(1) provides that the reasonable cost of any service shall be the cost actually incurred, excluding any costs unnecessary to the efficient delivery of needed health services. Since all other outpatient rehabilitation services are to be paid under the physician fee schedule, we believe it would be unreasonable for the costs of the services furnished to homebound beneficiaries who are not entitled to home health benefits to exceed the amount payable under the physician fee schedule. Therefore, we are proposing to modify § 413.125 to provide that effective for services furnished on or after January 1, 1999, the reasonable cost of outpatient rehabilitation services furnished by a HHA to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under the physician fee schedule.

(4) Services Furnished by Comprehensive Outpatient Rehabilitation Facilities. Section 4541(a)(1) adds a new section 1832(a)(2)(D)(9) of the Act to provide that all services furnished by a CORF, and not just outpatient rehabilitation services, will be paid the applicable fee schedule amount. In cases where there is no physician fee schedule amount for the services, section 1834(k) specifies that the applicable fee schedule amount will be the amount established for comparable services as specified by the Secretary. Therefore, we are proposing that the existing fee schedules for prosthetic and orthotic devices, durable medical equipment, and supplies, and drugs and biologicals apply when these services are furnished by a CORF. We believe that these fee schedules, together with the physician fee schedule, will encompass all CORF services other than nursing services. The physician fee schedule amount applicable to services furnished in a non-facility setting will apply to the services furnished by the CORF since no separate payment will be made for facility costs.

To establish a fee schedule amount for nursing services delivered within a CORF, we created a new HCPCS code, G0128. We are defining this code as

direct face-to-face skilled nursing services delivered to a CORF patient as part of a rehabilitative plan of care. It is a timed code and can be billed for 10-minute intervals (when the initial interval is longer than 5 minutes). G0128 is to be used for services that are not included in the work or practice expense of another therapy or physician service. An example might be a nurse who spends 33 minutes instructing a patient in the proper procedure of ''in and out'' urethral catheterization; in this situation, 3 units of G0128 would be billed. We are proposing to set the RVUs for this code at 0.26, based upon half the value of the lowest level physician follow-up visit, HCPCS code 99211, in the non-facility setting. This results in a payment for the time slightly more than the average wage reported by the Bureau of Labor Statistics (BLS) for RNs, inflated to reflect benefits and overhead (using the fringe benefit and expense factor used to establish the salary equivalency guideline).

(5) Site-of-Service Differential. Providers of outpatient rehabilitation services have suggested that we should consider making a site-of-service differential, specifically, a payment amount greater than that provided by the physician fee schedule for some of the types of providers or sites at which outpatient rehabilitation services are furnished. We are not proposing such a differential.

First, the law requires that these services be paid the amount determined ''under the fee schedule established under section 1848.'' Furthermore, we believe higher payment amounts for certain facilities, such as CORFs or rehabilitation agencies, would create payment incentives that favor one site or setting over another. We believe the statute establishes a ''level playing field'' for these services. We find no direction in the statutory language or legislative history that we recognize higher costs that some providers argue might be associated with furnishing services in a provider setting. To the extent that CORFs or rehabilitation facilities provide services to patients who need additional care, CORFs or rehabilitation facilities may bill for additional, medically necessary services. For these reasons, a site of service adjustment or higher payment amount for specific settings is not being proposed; however, we welcome any comments that you may present regarding differences in services furnished in the various settings that would justify a differential payment.

(6) Mandatory Assignment. Section 1834(k)(6) of the Act, as added by BBA 1997, establishes a restraint on billing for outpatient rehabilitation therapy services; that is, this provision requires that services paid under section 1834(k) of the Act are subject to mandatory assignment under the same terms applicable to practitioners under section 1842(b)(18) of the Act. We propose, therefore, in accordance with this provision to require mandatory assignment for services provided under the outpatient rehabilitation prospective payment system by hospitals, SNFs, HHAs, rehabilitation agencies, public health agencies, clinics, and CORFs. The mandatory assignment provision does not apply to therapy services furnished by a physician or ''incident to'' a physician's service or to services furnished by a physical therapist in private practice or an occupational therapist in private practice. However, when these services are not furnished on an assignment-related basis, the limiting charge applies.

3. Uniform Procedure Codes for Outpatient Rehabilitation Services

Section 4541(a)(2) of BBA 1997 added section 1834(k)(5) of the Act. This new statutory provision requires that claims submitted on or after April 1, 1998 for outpatient physical therapy services, including speech language pathology services and outpatient occupational therapy services, include a code under a uniform coding system that identifies the services furnished.

The uniform coding requirement is needed to assure proper payment under the physician fee schedule. Hospitals, SNFs, HHAs (for individuals who are not eligible for home health services), CORFs, and outpatient physical therapy providers must use HCPCS codes to report outpatient rehabilitation services when furnished to their outpatients. Hospitals and SNFs that provide outpatient rehabilitation services to their inpatients who are entitled to benefits under Part A but who have exhausted their benefits for inpatient services during a spell of illness or to their inpatients who are not entitled to benefits under Part A are also required to report HCPCS codes.

In March, 1998, we issued a program memorandum AB–98–8 which described the coding for outpatient rehabilitation services. This memorandum identifies the HCPCS codes that will be considered to be outpatient rehabilitation services and specifies how these codes will be reported on the UB–92. We assigned the various codes to revenue centers, that is, physical therapy, occupational therapy, and speech-language pathology, for purposes of applying the financial limitation described below. Assigning codes to revenue centers was not intended to limit the scope of practice or range of procedures that could be furnished by therapists in a particular discipline. We are in the process of revising AB–98–8 because we intend to implement the financial limitation by using modifiers, as described below, rather than assigning the HCPCS codes to revenue centers.

In the program memorandum, we also identify certain HCPCS codes available for billing by CORFs that are not generally rehabilitation services, including vaccinations and nursing services.

4. Financial Limitation

Outpatient rehabilitation therapy services are subject to annual financial limitations or caps commencing January 1, 1999. (The amount of the current cap is $900.) There will be a $1,500 per beneficiary annual limitation or cap on incurred expenses for outpatient physical therapy services including outpatient speech-language pathology services. A separate $1,500 per beneficiary limitation will apply on incurred expenses for outpatient occupational therapy services. The annual limitation does not apply to services furnished directly or under arrangements by a hospital or critical access hospital to an outpatient or to an inpatient who is not in a covered Part A stay. The limitation will apply to outpatient rehabilitation services furnished by a separately certified hospital-based provider, such as a hospital-based SNF. The limitation also applies to outpatient rehabilitation services furnished by a physician or nonphysician practitioner, or incident to a physician's professional services or to a nonphysician practitioner's professional services.

As stated above, there is a single $1,500 limitation for outpatient physical therapy services and outpatient speech-language pathology services. As amended, section 1833(g) of the Act applies a single $1,500 limitation to ''physical therapy services of the type described in section 1861(p).'' Section 1861(p) defines outpatient physical therapy services and includes speech-language pathology services within that definition.

Outpatient rehabilitation services are subject to a 20 percent coinsurance amount. Under the outpatient prospective payment system, the beneficiary will be responsible for 20 percent of the applicable fee schedule amounts. The $1,500 limitation is on incurred expenses. If a beneficiary has already satisfied the Part B deductible, the maximum amount payable by the

Medicare program is $1,200, that is, 80 percent of $1,500. Beginning January 1, 2002, the $1,500 annual limitations or caps will be increased by the percentage increase in the MEI.

In addition to outpatient physical therapy services and outpatient occupational therapy services (other than those provided by a hospital), the limitation applies to physical therapy services (including speech-language pathology services) and occupational therapy services ''of such type which are furnished by a physician or as incident to a physician service.'' As discussed elsewhere in this document, Medicare covers under certain conditions services performed by nurse practitioners, clinical nurse specialists, and physician assistants that would be physicians' services if furnished by a physician. We are proposing to apply the financial limitation to therapy services furnished by these nonphysician practitioners since such therapy services are by definition the same type as are furnished by physicians. Similarly, we propose to apply the financial limitation to therapy services furnished incident to these nonphysician practitioner's services. We have included in Addendum D a listing of the specific services that we propose would be subject to the limitation when furnished by a physician or practitioner directly or incident to their services. Such outpatient rehabilitation services included in Addendum D furnished either directly or incident to the services of a physician or practitioner are always subject to the financial limitation. Other services such as casting, splinting, and strapping may be used in the treatment of conditions (for example, fractures or sprains) or as part of the postsurgical treatment or medical treatment when no other rehabilitation services are delivered. If the services are delivered by a physical or occupational therapist, speech-language pathologist, therapy assistant or therapy aide, are part of a rehabilitation plan of care, or involve services included in the aforementioned Addendum D, then the services are subject to the cap. These outpatient rehabilitation services are delineated in Addendum E and must be identified with a discipline-specific modifier.

Addendum E contains a listing of outpatient rehabilitation therapy codes. Payment for certain HCPCS codes will be made on a basis other than the physician fee schedule in hospital outpatient departments. Other HCPCS codes are considered as CORF services. Further program instructions will be provided in a forthcoming program memorandum regarding the use of HCPCS codes for outpatient rehabilitation therapy services.

With regard to ''incident to'' services, we note that section 4541(b) of BBA 1997 amended section 1862(a) of the Act to require that outpatient physical therapy service (including speech-language pathology services) and outpatient occupational therapy services furnished ''incident to'' a physician's professional services meet the standards and conditions (other than any licensing requirement specified by the Secretary) that apply to therapy services furnished by a therapist. This provision was effective January 1, 1998 and was implemented through program instructions.

The financial limitations apply only to items and services furnished by non-hospital providers and therapists under the outpatient physical therapy (including speech-language pathology) and the outpatient occupational therapy benefit (section 1861(s)(2)(D) of the Act) and therapy services furnished by physicians and nonphysician practitioners or incident to their services. The limitations do not apply to diagnostic tests covered under section 1861(s)(3) of the Act.

To track the financial limitation or cap, we are proposing to use modifiers that will be discipline-specific. Many of the services, for example, physical modalities or therapeutic procedures as described by HCPCS codes, are commonly delivered by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. For these services, we expect the claim to include a modifier which describes the type of therapist who delivered the service; if the service was not delivered by a therapist, then the type of therapy plan of care under which the service is delivered would be specified. If the type of therapy is not listed in the modifier field, the claim would be rejected and sent to the provider for resubmission.

As required by section 1833(g) of the Act, as amended by section 4541 of BBA, we propose to establish two annual per beneficiary limits of $1,500. There will be (1) an annual per beneficiary limit for all outpatient physical therapy services excluding hospital outpatient therapy services and (2) an annual per beneficiary limit for all outpatient occupational therapy services excluding hospital outpatient therapy services. As stated previously, outpatient physical therapy services include speech-language pathology services. A provider of outpatient rehabilitation services with a provider agreement under section 1866 of the Act as will as physicians, PTIPs and OTIPs will be allowed to collect payment from a beneficiary for therapy services after the $1,500 limit is reached. This is consistent with current policy allowing PTIPs and OTIPs to collect payment from a beneficiary for therapy services in excess of the current $900 limit.

We note that a report to the Congress is due from the Secretary no later than January 1, 2001. This report is to include recommendations on the establishment of a revised coverage policy of outpatient physical therapy services, including speech-language pathology services and outpatient occupational therapy services. The revised policy is to be based on a classification of individuals by diagnosis category and prior use of services in both inpatient and outpatient settings. The report should include recommendations on how such durational limits by diagnostic category could be implemented in a budget-neutral manner.

5. Qualified Therapists

Section 1861(p) includes services furnished an individual by a physical therapist who meets licensing and other standards prescribed by the Secretary if the services meet such conditions relating to health and safety as the Secretary may find necessary. The services must be furnished in the therapist's office or the individual's home. By regulation, we have defined therapists meeting the conditions for coverage of services under this provision as physical therapists in independent practice. The conditions for coverage are set forth in Part 486, Subpart D (Conditions for coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists in Independent Practice) and require that the services be provided by a therapist in independent practice under § 410.60. Under § 410.60, a therapist in independent practice is one who:

- Engages in the practice of therapy on a regular basis.
- Furnishes services on his or her own responsibility without the administrative and professional control of an employer.
- Maintains at his or her own expense office space and equipment.
- Furnishes services only in the office or patient's home.
- Treats individuals who are his or her own patients and collects fees or other compensation for the services.

Under § 486.151 (Conditions for coverage: Supervision), all therapy services must be furnished under the direct supervision of a qualified therapist in independent practice. In

other words, the therapist in independent practice must be on the premises whenever services are provided to Medicare beneficiaries, including services provided by a licensed physical therapist. This long-standing requirement has been controversial with therapists in independent practice. For example, a therapist in independent practice cannot have more than one office open for services at the same time since he or she could not be on both premises at once.

We are proposing to replace the existing ''Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists in Independent Practice'' (Part 486, Subpart D), which requires survey and certification, with a simplified criteria for physical therapists in private practice that would use a carrier enrollment process. The impetus for this change comes from congressional statements associated with the fiscal year 1997 appropriations process. Statements in both the House and Senate committee reports accompanying HCFA's fiscal year 1997 appropriations addressed the issue of requiring that the certified physical or occupational therapist in independent practice directly supervise all services performed by his or her employees, even if those employees are fully licensed therapists. The House committee report urged that we modify the regulations so that the certified therapist need not be on premises to supervise other licensed therapists. The Senate urged us to review this concern and recommend regulatory or instructional changes.

We are proposing to redefine those therapists who are qualified pursuant to section 1861(p) of the Act. That is, we would discontinue the focus of the regulation on their ''independent'' status (which is not statutory) and recognize therapists in private practice who are employed by others and therefore, do not meet our current ''independent'' criteria. This would be consistent with health and safety concerns and would conform to normal private sector practice standards. The following new requirements would replace the current ones for qualified therapists:

- The term ''independent'' would be dropped and the benefit would be for an individual physical therapist or occupational therapist in private practice.

Private practice would include an ''individual'' whose practice is in an unincorporated solo practice, unincorporated partnership, or unincorporated group practice. Private practice also would include an ''individual'' who is practicing therapy as an employee of one of the above or of a professional corporation or other incorporated therapy practice. However, private practice would not include individuals when they are working as employees of a provider. A provider as defined in § 400.202 includes a hospital, CAH, SNF, HHA, hospice, CORF, CMHC, or an organization qualified under Part 485, Subpart H (Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services), as a clinic, rehabilitation agency, or public health agency.

- In implementing the statutory requirement that services be furnished to an individual in the therapist's office, or in the individual's home, ''in his office'' would be defined as the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location.

A therapist in private practice would not be required to maintain a private office, if services always are furnished in patients' homes. However, when services are furnished in private practice office space, that space would have to be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For example, because of the statutory restriction on the site of services, a therapist in private practice cannot furnish covered services in a SNF. Therefore, if a therapist wished to locate his or her own private office on site at a nursing facility, special care would need to be taken. The private office space could not be part of the Medicare-participating SNF's space, and the therapist's services could be furnished only within that private office space. Neither the therapist nor any assistants or aides who help render services could be employed by the SNF during the same hours that they are working in the private practice. Another example where special attention would be needed is space that generally serves other purposes and is only used by a therapy practice during limited hours. For example, a therapist in private practice may furnish aquatic therapy in a community center pool on Wednesday mornings. The practice would have to rent or lease the pool for those hours, and the use of the pool during that time would have to be restricted to the therapist's patients, in order to recognize the pool as part of the therapist's own private office during those hours.

In describing other services that are specifically limited to the patient's home, the statute uses qualifying language. For example, the durable medical equipment definition in section 1861(n) refers to a patient's home as ''including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1).'' This definition of home is codified at § 410.38(b). The same definition always has been used in the Medicare Carriers Manual for purposes of covering therapists' services in a patient's home. We propose to continue the current practice and to adopt that definition formally in this regulation.

- Assistants and aides would have to be personally supervised by the therapist and employed directly by the therapist, by the partnership or group to which the therapist belongs, or by the same private practice that employs the therapist. Personal supervision requires that the therapist be in the room during the performance of the service. Levels of supervision are defined in § 410.32.
- The therapist must be licensed or otherwise legally authorized to engage in private practice. We understand that all States license or certify physical therapists, so no alternative personnel qualifications need to be specified.
- Each therapist would enroll ''as an individual'' with the carrier.

There would be no survey and no certification by HCFA. The Medicare carrier would verify that the qualifications proposed in § 410.59(c)(1) or § 410.60(c)(1) are met. All applicants for new enrollment would become subject to these new rules and procedures upon the effective date of the final rule. For transition purposes, we intend that independent therapists who are certified and enrolled at that time would be ''grandfathered'' temporarily and would become subject to the new enrollment rules and procedures at the time of their next regular periodic reenrollment.

These changes would address the concern that current rules require each independent therapist to personally supervise services performed by any other licensed therapists that he or she employs. Under our proposal, each individual therapist in a practice could qualify to separately enroll, and enrolled therapists would not be required for purposes of Medicare to be supervised by their employer. These changes also address the concern that current rules prohibit an independent therapist from being employed by any entity. Under our proposal, a variety of

employment situations would be permitted. The following examples illustrate how our proposals would apply:

- Three PTs operate an unincorporated group practice, which employs several physical therapy assistants and aides and maintains two offices in two towns. Each therapist could enroll as a physical therapist in private practice and could furnish services in either office, while personally supervising any of the assistants or aides who are helping to render therapy.
- A corporation operates a physical therapy practice which employs four physical therapists and several physical therapy assistants and aides. Each therapist could enroll as a physical therapist in private practice and could personally supervise any of the assistants or aides who help to render therapy. If two additional PTs are hired, each must enroll before their services could be covered without supervision by one of the enrolled physical therapists.

A physical therapist works for a hospital's rehabilitation department during the day. During evening hours, he operates his own incorporated professional practice and goes to patient's homes to furnish therapy. He could enroll as a physical therapist in private practice for the evening hours and would not need to maintain an office for furnishing therapy.

A physician's professional corporation employs three physical therapists and six physical therapy assistants in a private therapy practice associated with the physician's office. Each of the PTs could enroll as a therapist in private practice. The physician is not required to supervise any of the therapy. All physical therapy services for which Medicare payment is sought are supervised by one of the physical therapists.

These new requirements would be established in a revised § 410.60(c) for physical therapists. To date, the statutory requirements for coverage of outpatient occupational therapy services have not been codified. We are proposing to codify these requirements by establishing a new § 410.59 for outpatient occupational therapy services. The proposed regulations section for outpatient occupational therapy parallels the § 410.60 requirements for outpatient physical therapy, as revised in this proposed rule. We are also proposing to make conforming changes in § 410.61 to include occupational therapy.

Therapists in private practice do not participate in the Medicare program in the same way that ''providers of services'' do. Though they must be approved as meeting certain requirements, unlike ''providers of services,'' they do not execute a formal provider agreement with the Secretary as described in Part 489 (Provider Agreements and Supplier Approval) of the CFR. Like physicians, they do have the option of accepting a beneficiary's assignment of his or her claim for Medicare Part B benefits and of becoming a Medicare participating supplier who agrees to accept assignment in all cases.

6. Plan of Treatment

We are proposing to revise §§ 410.61(e), 424.24(c)(4)(i), and 485.711(b), which concern the plan of treatment review requirements for outpatient rehabilitation therapy services. Section 1861(p) of the Act defines these therapy services, in part, as services furnished to an individual who is under the care of a physician and for whom a plan, prescribing the type, amount, and duration of therapy services that are to be furnished, has been established by a physician or a qualified therapist and is periodically reviewed by a physician.

Currently, providers that furnish outpatient rehabilitation therapy services are required to have a physician review the plan of treatment and recertify the need for care at least every 30 days. We are proposing that the physician review and recertify the required plan of treatment within the first 62 days and at least every 31 days after the first review and recertification. The current requirement for the review of a plan of treatment for patients of physical therapists in independent practice is similar in that the physician must review the plan at least every 30 days. We are proposing to change this review requirement as well to require that the physician review and recertify the plan of treatment within the first 62 days and at least every 31 days thereafter.

We are recommending these changes because it is our understanding that an initial 2-month (62 day) review is consistent with usual therapy course of treatment. It is also consistent with our current therapy requirements in the home health setting. These changes would reduce the burden on providers, patients, and physicians by eliminating the current requirement for an initial review within the first 30 days. After the first 62 days, we believe that patients receiving outpatient rehabilitation services are likely to show significant progress that warrants subsequent reviews every 31 days. Changes in the patients' level of function and need for continued therapy can be expected to occur more frequently after the first 2 months of therapy. We believe this subsequent review schedule will help control potential over-utilization that results in excessive therapy to some Medicare patients.

Under our proposal, the therapists would be required to immediately notify the physician of any changes in the patient's condition, and physicians would retain the ability to review the care at closer intervals if necessary.

D. Payment for Services of Certain Nonphysician Practitioners and Services Furnished Incident to Their Professional Services

Nonphysician practitioner services have been covered by Medicare since the inception of the program; originally the law did not provide for separate payments for these services. Coverage and payment of nonphysician services was primarily within the context of section 1861(s)(2)(A) of the Act as implemented by section 2050 of the Medicare Carriers Manual, for the payment of services incident to a physician's professional services. In recent years, the Congress has expanded Medicare coverage of nonphysician practitioner services in certain settings to improve beneficiary access to medical services. Separate Part B coverage is specifically authorized for certain nonphysician practitioner services and for services and supplies furnished as incident to those services.

For purposes of this proposal as it applies to nonphysician practitioners, we define nonphysician practitioners as nurse practitioners, clinical nurse specialists, certified nurse-midwives, and physician assistants. With respect to services and supplies furnished as incident to a nonphysician practitioner's services, we are proposing that to be covered by Medicare, the services must meet the longstanding requirements in section 2050 of the Medicare Carriers Manual applicable to services furnished as incident to the professional services of a physician. Therefore, we would specify, in proposed new §§ 410.74(b), 410.75(d), 410.76(d), and 410.77(c) that Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) furnished as incident to the nonphysician's services only if these services and supplies would be covered if furnished by a physician or furnished as incident to a physician's professional services. In addition, §§ 410.74(b), 410.75(d), 410.76(d), and 410.77(c) would specify

the various requirements for these incidental services and supplies.

1. Coverage and Payment for Nurse Practitioner Services Before BBA 1997

Effective for services furnished on or after April 1, 1990, section 6114 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239) authorized separate payment for the services of nurse practitioners when furnished to patients in SNFs and nursing facilities. The services of nurse practitioners are covered if they are furnished in collaboration with a physician, they are within the scope of services authorized by State law, and they are the type of services that would be covered when furnished by a physician. The term, collaboration is defined as a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines, or other mechanisms as defined by State law, in the State in which the services are performed.

Section 6114 of OBRA 1989 limited routine visits by nurse practitioners who are serving as members of a team to 1.5 team visits per month per resident of a SNF or nursing facility. The team must include a physician and a physician assistant acting under the supervision of the physician, or a nurse practitioner or a clinical nurse specialist working in collaboration with a physician.

Section 6114 of OBRA 1989 requires that payment for nurse practitioner services furnished to patients in SNFs and nursing facilities be made on an assignment-related basis to the nurse practitioner's employer only. This provision also limited the prevailing charges for the services of nurse practitioners furnished before January 1, 1992, to 85 percent of the prevailing charge rate determined for these services when furnished by nonspecialist physicians. For services furnished on or after January 1, 1992, OBRA 1989 limits the payment to 85 percent of the physician fee schedule amount for those services furnished by physicians who are not specialists.

The qualifications for nurse practitioners require individuals to:

- Be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of a nurse practitioner in accordance with State law, and have a master's degree in nursing;
- Be certified as a nurse practitioner by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in the paragraph above; or
- Meet the requirements for a nurse practitioner set forth in the first paragraph, except for the master's degree requirement, and have received before 3 years prior to the effective date of a final rule, a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

Section 4155 of OBRA 1990 (Pub. L. 101–508) extended coverage of nurse practitioner services that was previously restricted to SNFs and nursing facilities, to all settings in rural areas. Additionally, nurse practitioners were authorized to either receive direct payment or arrange for payment to be made directly to their employer for services furnished in collaboration with a physician in all settings in a rural area, with the exception of hospitals. This provision also allowed for coverage of services and supplies furnished as an incident to a nurse practitioner's services if the services would have been covered if furnished as an incident to a physician's professional services.

The term, ''rural area'' as defined at section 1886(d)(2)(D) of the Act means any area outside a Metropolitan Statistical Area or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget, or outside any similar area the Secretary has recognized by regulation as an urban area.

Sections 4155(b) and (c) of OBRA 1990 imposes a civil monetary penalty not to exceed $2,000 on any person who knowingly and willfully presents a bill or request for payment to a Medicare beneficiary (except for coinsurance and deductible amounts) for nurse practitioner services furnished in a rural area, or for services and supplies furnished as an incident to those services, and for nurse practitioner services furnished in a SNF or nursing facility.

Section 147(e)(4) of the Social Security Act Amendments of 1994 (SSAA'94) (Pub. L. 103–432) unbundled payment for nurse practitioner services in SNFs and nursing facilities. It also added nurse practitioner services to the list of services that are excluded from the definition of inpatient hospital services. Accordingly, nurse practitioners or their employer or contractor were authorized to bill directly for services furnished to patients in SNFs or nursing facilities and hospitals located in rural areas.

2. Coverage and Payment for Nurse Practitioner Services Subsequent to BBA 1997

Effective for services furnished on or after January 1, 1998, section 4511 of BBA 1997 authorizes nurse practitioners to bill the program directly for services furnished in any setting, regardless of whether the settings are located in rural or urban areas, but only if the facility or other providers of services do not charge or are not paid any amounts with respect to the furnishing of nurse practitioner services. Accordingly, a new § 410.75 of this proposed rule specifies the qualifications for nurse practitioners, lists the requirements for the professional services of a nurse practitioner and the requirements for services furnished incident to the professional services of a nurse practitioner. This new section also proposes a definition for the collaboration process that is applicable to the provision of nurse practitioner services.

A new § 405.520(a), (b), and (c) of this proposed rule provides the general rule, requirements, and penalties for nurse practitioners. A new paragraph (15) is added to § 410.150(b) to authorize payment for nurse practitioner services when furnished in collaboration with a physician in all settings located in both rural and urban areas. A new paragraph (c) is added to § 414.56 of this rule to set forth the payment amount for nurse practitioner services.

3. Coverage and Payment for Clinical Nurse Specialist Services Before BBA 1997

In addition to authorizing Medicare coverage of nurse practitioner services furnished in rural areas, section 4155 of OBRA 1990 also authorized the coverage of services furnished by clinical nurse specialists in rural areas. The coverage provisions for clinical nurse specialist services furnished in a rural area parallel those established for nurse practitioner services furnished in rural areas. That is, clinical nurse specialist services must be furnished in collaboration with a physician and be the type of physician services that would otherwise be covered if furnished by a physician. Additionally, the services must be services that the clinical nurse specialist is authorized by State law to furnish in the State in which they are practicing. Furthermore, services furnished as an incident to the professional services of a clinical nurse specialist are covered if they are the type of services that would be covered if furnished incident to a physician's

professional services and all the incident to requirements are met.

A clinical nurse specialist is defined as an individual who is legally authorized to perform such services in accordance with State law, and who meets training, education, and experience requirements as the Secretary may prescribe in regulations.

Section 147(e)(4) of the SSAA'94 also unbundled payment for clinical nurse specialist services furnished in SNFs, nursing facilities, and hospitals. The services of clinical nurse specialists are now paid under a separate benefit.

Payment for clinical nurse specialist services is made to the clinical nurse specialist or to his or her employer. As is the case with nurse practitioners, the services of clinical nurse specialists furnished to patients in rural health clinics (RHCs), federally qualified health centers (FQHCs), and health maintenance organizations (HMOs) are not paid under the respective nurse practitioner or clinical nurse specialist benefits. Instead, the services that nonphysician practitioners furnish in RHCs, FQHCs, and HMOs education, and experience requirements as the Secretary may prescribe in regulations.

Section 147 (e)(4) of the SSAA'94 also unbundled payment for clinical nurse specialist services furnished in SNFs, nursing facilities, and hospitals. The services of clinical nurse specialists are now paid under a separate benefit.

Payment for clinical nurse specialist services is made to the clinical nurse specialist or to his or her employer. As is the case with nurse practitioners, the services of clinical nurse specialists furnished to patients in rural health clinics (RHCs), federally qualified health centers paid under the respective nurse practitioner or clinical nurse specialist benefits. Instead, the services that nonphysician practitioners furnish in RHCs, FQHCs, and HMOs are a part of the facilities' services and cannot be billed or paid separately.

The payment provisions for clinical nurse specialist services furnished in a rural area parallel those established for nurse practitioner services furnished in rural areas. Accordingly, payment for services is made on an assignment-related basis, the civil monetary penalty provision for violation of the assignment agreement applies, and the current Medicare-approved amount for covered clinical nurse specialist services furnished in rural areas (other than in hospitals) is limited to the lesser of the actual charge or 85 percent of the physician fee schedule amount for nonspecialist physician services. For covered services furnished in hospitals located in rural areas, the Medicare-approved amount is limited to the lesser of the actual charge or 75 percent of the physician fee schedule amount for nonspecialist physician services.

4. Coverage and Payment for Clinical Nurse Specialist Services Subsequent to BBA 1997

Effective for services furnished on or after January 1, 1998, Section 4511 of BBA 1997 authorizes clinical nurse specialists to bill the program directly for services furnished in any setting, regardless of whether the settings are located in rural or urban areas, but only if the facility or other providers of services does not charge or is not paid any amounts with respect to the furnishing of nurse practitioner services. A new § 410.76(e) of this proposed rule sets forth this provision.

The new § 410.76(b) sets forth new qualifications for clinical nurse specialists. Section 410.76(c) describes the conditions of coverage for clinical nurse specialists services, defines the collaboration process, and paragraph (d) lists the requirements for services furnished incident to the professional services of a clinical nurse specialist.

A new § 405.520(a), (b), and (c) of this proposed rule provides the general rule, requirements, and civil monetary penalties for clinical nurse specialists. A new paragraph (15) is added to section 410.150(b) to authorize payment for clinical nurse specialist services when furnished in collaboration with a physician in all settings located in both rural and urban areas. A new paragraph (c) is added to section 414.56 of this rule to set forth the payment amounts for clinical nurse specialist services.

5. Coverage and Payment for Certified Nurse-Midwife Services

Certified nurse-midwife services were only covered under the Medicare program when furnished incident to the professional services of a physician or under the supervision of a physician in RHCs prior to these individuals gaining statutory authorization to perform services as independent nonphysician practitioners.

Certified nurse-midwives were defined initially section 1861(gg)(2) of the Act and 42 CFR 405.2401 (b) as a registered professional nurse who:

- Is currently licensed to practice in the State as a registered professional nurse;
- Is legally authorized under State law or regulations to practice as a certified nurse-midwife;
- Has completed a program of study and clinical experience for certified nurse-midwives, as specified by the State, or, if the State does not specify a program—

+ Is currently certified as a nurse-midwife by the American College of Nurse-Midwives;

+ Has satisfactorily completed a formal education program (of at least 1 academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or

+ Has successfully completed a formal educational program that prepares registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to newborns, and practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.

Certified nurse-midwife services are defined at section 1861(gg)(1) of the Act as services furnished by a certified nurse-midwife, and services and supplies furnished as an incident to those services, that the certified nurse-midwife is legally authorized to furnished under State law and that would be covered by Medicare if furnished by a physician or as an incident to a physician's service.

Effective for services furnished on or after July 1, 1988, section 4073 of OBRA 1987 (Pub. L. 100–203) expanded Part B coverage of the services of certified nurse-midwives to include services furnished independently of the supervision of a physician. Subsequently, section 411(h)(4) of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Pub. L. 100–360) made several technical amendments to section 4073 of OBRA 1987 to categorize and cover certified nurse-midwife services as medical and other health services, specify that payment for the services of a certified nurse-midwife is 80 percent of the lesser of the actual charge or the amount determined by a fee schedule established by the Secretary, and limit the fee schedule to 65 percent of the prevailing charge that would be allowed for the same services furnished by a physician. Additionally, section 4073 of OBRA 1987 requires that payment for certified nurse-midwife services be paid on an assignment-related basis and that violators of the assignment requirements be subject to civil monetary penalties.

Section 6102(f)(7) of OBRA 1989 (Pub. L. 101–239) provided that for services furnished on or after January 1, 1992, payment is determined based on the lesser or the actual charge or 65 percent of the Medicare physician fee schedule.

In 1990, in section 4157 of OBRA 1990 (Pub. L. 101–508) the Congress

recognized certified nurse-midwife services as separate and distinct from hospital services. Accordingly, certified nurse-midwife services are unbundled from hospital services and are paid separately under the certified nurse-midwife benefit.

Ultimately, section 13554 of OBRA 1993 (Pub. L. 103–66) amended section 1861(gg)(2) of the Act to revise the definition of certified nurse-midwife. The revision eliminated the limitation on coverage to include services furnished by certified nurse-midwives outside the maternity cycle. This change was made effective for services furnished on or after January 1, 1994.

A new § 410.77 of this proposed rule lists the qualifications for certified nurse-midwives and provides for the conditions for coverage of certified nurse-midwife services. Paragraph (d) of § 410.77 lists the coverage requirements for the professional services of certified nurse-midwives, while paragraph (c) lists the requirements for services furnished incident to the professional services of a certified nurse-midwife.

6. Coverage and Payment for Physician Assistant Services Before BBA 1997

For physician assistant services furnished on or after January 1, 1987, section 9338(a) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Pub. L. 99–509) authorized physician assistants to bill the Medicare program for the type of services that would be considered as physicians' services, provided that the physician assistant is legally authorized by the State to furnish such services. Services furnished incident to the physician assistant's professional services are also covered if these same services would have been covered when furnished incident to the professional services of a physician. Under this OBRA provision, physician assistants furnished their services under the general supervision of a physician in a hospital, SNF, nursing facility, or as an assistant at surgery in both rural and urban areas. In order to have furnished services under the physician assistant benefit, individuals must have met the qualifications as follows:

1. Be certified currently by the National Commission on Certification of Physician Assistants to assist primary care physicians;

2. Have completed satisfactorily a program for preparing physician assistants that—

- Was at least 1 academic year in length;
- Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction that prepared students to deliver health care; and
- Is accredited by the AMA's Committee on Allied Health Education and Accreditation; or

3. Have completed satisfactorily a formal educational program for preparing physician assistants (that does not meet the requirements listed above) and assisted primary care physicians for a total of 12 months during the 18-month period immediately preceding January 1, 1987. Additionally, effective January 1, 1989, section 4076 of OBRA 1987 (Pub. L. 100–203) authorized physician assistants to furnish their services under the supervision of a physician in all settings located in rural areas that were designated under section 332(a)(1)(A) of the Public Health Service Act as health professional shortage areas (HPSAs).

Payment for physician assistant services prior to January 1, 1998 was made only on an assignment-related basis to the actual employer of the physician assistant at 85 percent of the physician fee schedule for professional services. Payment for the services of a physician assistant performing as an assistant at surgery was made at 65 percent of the physician fee schedule. The employer of a physician assistant might have been a physician, medical group, professional corporation, hospital, SNF, or nursing facility.

7. Coverage and Payment for Physician Assistant Services Subsequent to BBA 1997

Effective for services furnished on or after January 1, 1998, the majority of the conditions for coverage of physician assistant services as indicated by new §§ 410.74(a) and (b) remain unchanged with the exception of the condition for coverage of physician assistant services furnished in certain areas and settings. Section 4512 of BBA 1997 removes the restrictions on the site of services in which physician assistants may furnish their professional services, regardless of whether the settings are located in rural or urban areas. Physician assistants are authorized to furnish their professional services as independent nonphysician practitioners to practically all providers of services and suppliers of services only if the facility or other provider of services does not charge or is not paid any amounts with respect to the furnishing of physician assistant professional services. Accordingly, separate payment may be made for physician assistant services in all settings with the exception of rural health clinics (RHCs) and Federally qualified health centers (FQHCs) because Medicare payment for their services is included in the all-inclusive payment rate that the program makes to these facilities.

Under new § 410.74(c), we are proposing to amend the qualifications for physician assistants to recognize certification of physician assistants by the National Board of Certification of Orthopedic Physician Assistants. These qualifications will also recognize academic programs for physician assistants that are accredited by either the Commission on Accreditation of Allied Health Education Programs or the American Society of Orthopedic Physician Assistants.

Additionally, effective January 1, 1998, physician assistants have the option of furnishing services under a different employment arrangement with a physician. They can furnish services as an employee of a physician under a W–2 form employment arrangement or they can furnish services as an employee of a physician under a 1099 form, independent contractor arrangement. Under either arrangement, the employer of the physician assistant must bill the program for physician assistant services as required under § 410.150(b)(14). However, when an individual furnishes services ''incident'' to the professional services of a physician assistant, these ancillary services must meet the requirements under § 410.74(a)(2)(vi)(B).

The Medicare payment amount for physician assistant professional services as of January 1, 1998, as stated under new paragraph (d) of § 414.52, remains at 80 percent of the lesser of either the actual charge or 85 percent of the physician fee schedule amount for professional services. However, payment for physician assistant at surgery services, as also described at new paragraph (d) of § 414.52, increased to allow Medicare payment at 80 percent of the lesser of either the actual charge or 85 percent of the physician fee schedule amount paid to a physician assistant serving as an assistant at surgery. Also, new § 405.520 provides the general rule, requirements, and civil monetary penalties for physician assistants who furnish services under the Medicare program.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information

collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency.
- The accuracy of the agency's estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements (ICRs) discussed below.

- New ICRs and Related Burden.

§ 405.410 (Conditions for opting-out of Medicare.)

Section 405.410(a) states that each private contract between a physician or a practitioner and a Medicare beneficiary must meet the specifications of § 405.415.

The burden associated with these requirements is the time to draft, and then read, sign, photocopy and retain the private contract. It is estimated that it will take 300 physicians and/or practitioners 2 hours each to create a contract for a total of 600 hours. It is estimated that it will take 10 minutes for each to read, sign, photocopy and retain the private contract for 25,000 beneficiaries for a total of 4,167 hours. The burden for these ICRs total 4,767 hours.

Section 405.410(b) states that the physician or practitioner must submit to each Medicare carrier with which he or she files claims an affidavit that meets the specifications of § 405.420.

The burden associated with these requirements is the burden to draft, sign and submit the affidavit to the Medicare carrier. It is estimated that it will take 300 physicians and/or practitioners approximately 2 hours each for a total of 600 burden hours.

§ 405.445 (Renewal and early termination of opt-out.)

Section 405.445(b)(2) states that a physician or practitioner must notify all Medicare carriers with which he or she filed an affidavit of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.

The burden associated with this requirement is the time for the physician or practitioner to notify all Medicare carriers of the affidavit. It is estimated that it will take 30 physicians and/or practitioners 10 minutes each for a total of 5 hours.

Section 405.445(b)(4) states that a physician or practitioner must notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

The burden associated with this requirement is the time for the physician and/or practitioner to notify all beneficiaries of his or her decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare. It is estimated that it will take 30 physicians and/or practitioners each 2 hours to notify their beneficiaries via bulk mailings for a total of 60 hours.

§ 405.455 (Medicare+Choice.)

Section 405.455(a) states that an organization that has a contract with HCFA to provide one or more Medicare+Choice (M+C) plans to beneficiaries must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

The burden associated with these requirements is the time associated with acquiring and maintaining information provided by Medicare carriers on physicians and practitioners who have opted-out of Medicare. It is estimated that 500 organizations will spend 1 hour annually to acquire and maintain this information for a total of 500 hours. The total burden for these ICRs is 500 hours.

ESTIMATED ANNUAL BURDEN

CFR section	Responses	Average burden per response	Annual burden hours
405.410(a)			
—Draft document	300	2 hours	600
—Read, sign, photocopy, retain document	25,000	10 minutes	4,167
Sub-total			4,767
405.410(b)	300	2 hours	600
405.445(b)(2)	30	10 minutes	5
405.445(b)(4)	30	2 hours	60
405.455(a)	500	1 hour	500
Total			5,932

- *New ICRs Without Burden.*

The ICR below is subject to the Act. However, we believe the burden associated with this ICR is exempt since the burden is imposed by § 405.410 and meets the specifications in § 405.420.

§ 405.445 (Renewal and early termination of opt-out.)

Section 405.445(a) states that a physician or practitioner may renew opt-out by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period (as specified in § 405.420), and to each carrier to which a claim was submitted under § 405.440 during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

The ICRs below are subject to the Act. However, we believe the burden associated with these ICRs are exempt, as defined by 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with these requirements would be incurred by persons in the normal course of their activities. Physicians and practitioners routinely develop and update a plan of treatment so the patient understands how often and when he or she will require care. In addition, physicians and practitioners routinely maintain

documentation in the patient's medical record.

§ 410.61 (Plan of treatment requirements for outpatient physical therapy and speech language pathology services.)

Section 410.61(e) states that the physician review the plan as often as the individual's condition requires, but at least within the first 62 days and at least 31 days after each previous review.

§ 415.110 (Conditions for payment: Medically directed anesthesiology services.)

Section 415.110(b) states that the physician inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting personal participation in the most demanding aspects of the anesthesia plan.

The ICRs below are subject to the Act. However, we believe the burden associated with these ICRs are exempt, as defined by 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with these requirements would be incurred by persons in the normal course of their activities. We believe the record keeping requirements described below are a reasonable and customary part of the plan of treatment described in section 410.61.

§ 424.24 (Requirements for medical and other health services furnished by providers under Medicare Part B.)

In summary *§ 424.24(c)(1)(iii) and (3)* requires that the services that were furnished under a plan of treatment that meets the requirements in § 410.61. If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician who has knowledge of the case.

Section 424.24(c)(4) states that the first recertification is required by no later than the 62nd day and subsequent recertifications are required at least every 31 days. The recertification statement must indicate the continuing need for physical therapy or speech-language pathology services and an estimate of how much longer the services will be needed. Recertifications must be signed by the physician who reviews the plan of treatment.

- Currently Approved ICRs.

While the ICRs below are subject to the Act; the burden associated with this requirement is captured in the HCFA–1500, OMB Number 0938–0008, Medicare Common Claim Form, which expires on August 31, 1998.

§ 405.430 (Failure to perfect opt-out.)

Section 405.430(b)(3) states that the physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

§ 405.435 (Failure to maintain opt-out.)

Section 405.435(b)(3) states that the physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

§ 405.440 (Emergency and urgent care services.)

Section 405.440(b)(1) states that when a physician or practitioner furnishes emergency or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, the physician or practitioner must submit a claim to Medicare in accordance with both 42 CFR Part 424 and Medicare instruction (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).

We have submitted a copy of this proposed rule to OMB for its review of the ICRs described above. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Health Care Financing Administration, office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn.: Louis Blank, HCFA–1006,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, D.C. 20503, Attn.: Allison Herron Eydt, HCFA Desk Officer

V. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

We have examined the impacts of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

This proposed rule is expected to have varying effects on the distribution of Medicare physician payments and services. With few exceptions, we expect that the impact would be limited.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

A. Regulatory Flexibility Act

Consistent with the provisions of the Regulatory Flexibility Act, we analyze options for regulatory relief for small businesses and other small entities. We prepare a Regulatory Flexibility Analysis (RFA) unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The RFA is to include a justification of why action is being taken, the kinds and number of small entities the proposed rule would affect, and an explanation of any considered meaningful options that achieve the objectives and would lessen any significant adverse economic impact on the small entities.

For purposes of the RFA, all physicians are considered to be small entities. There are about 700,000 physicians and other practitioners who receive Medicare payment under the physician fee schedule. Thus, we have prepared the following analysis, which, together with the rest of this preamble, meets all three assessment requirements. It explains the rationale for and purposes of the rule, details the costs and benefits of the rule, analyzes

alternatives, and presents the measures we propose to minimize the burden on small entities.

B. Resource-Based Practice Expense Relative Value Units

Our proposal uses a methodology for implementing resource-based practice expense RVUs for each physician service. The methodology considers the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings, including those that cannot be attributed to specific procedures. We are required to begin the transition to the new practice expense relative value units on January 1, 1999.

By law, the conversion to a resource-based determination for the payment of physician practice expenses must be budget-neutral. In other words, the total Medicare expenditures for calendar year 1999 must be the same as the amount that would have been paid under the prior method of paying practice expenses.

Each year since the fee schedule has been implemented, our actuaries have determined any adjustments needed to meet this requirement. A key component of the actuarial determination of budget neutrality involves estimating the impact of changes in the volume-and-intensity of physician services provided to Medicare beneficiaries as a result of the proposed changes.

In estimating the impacts of proposed changes under the physician fee schedule on the volume-and-intensity of services, the actuaries have historically used a model that assumes that 50 percent of the change in net revenue for a practice would be recouped. This does not mean that payments are reduced by 50 percent. In fact, payments have typically been reduced only a few percent or less. The actuaries also assume that there is no offsetting reduction in volume-and-intensity for physicians whose Medicare revenue increases.

Our actuaries have reviewed the literature and conducted data analysis of the volume-and-intensity response. For the purpose of establishing budget neutrality for the physician practice expense determination, the actuaries plan to use a model that assumes a 30 percent volume-and-intensity response to price reductions but no reduction in volume-and-intensity in response to a price increase. We plan to make the actuary's analysis of the volume-and-intensity response available soon. We expect it to be available on our homepage (www.hcfa.gov).

Using the revised actuarial model, achieving budget neutrality for the practice expense per hour method would require lowering physician payments in calendar year 1999 by 0.33 percent (1.31 percent cumulative from 1999–2002). The 0.33 percent volume-and-intensity adjustment results in a reduction in the 1999 physician CF of $0.1223. (The corresponding figures for the modified June 1997 proposed rule method would be 0.61 percent in 1999, 2.43 percent cumulative, and a $0.2248 reduction in the 1999 CF. The adjustments are larger due to the greater payment redistributions under this method.) We do not believe that we can use the Sustainable Growth Rate (SGR) mechanism alone, without the adjustment for volume-and-intensity for 1999, because any SGR adjustment would be in the future and the actuaries would not determine us to be in compliance with the statutory budget-neutrality requirement for 1999. To the extent that the volume-and-intensity response does not occur, the SGR system enacted as part of the BBA 1997 will return the volume-and-intensity adjustment in the form of higher future updates to the Medicare physician fee schedule conversion factor.

Table 8, ''Impact on Total Allowed Charges by Specialty of the Resource-Based Practice Expense Relative Value Units under the Practice Expense per Hour and Modified June 97 NPRM Methods'' shows the change in Medicare physician fees resulting from the practice expense per hour and the modified proposed rule methodologies discussed earlier in this proposed rule. The impact of the changes on the total revenue (Medicare and non-Medicare) for a given specialty is less than the impact displayed in Table 8 since physicians furnish services to both Medicare and non-Medicare patients.

The magnitude of the Medicare impact depends generally on the mix of services the specialty provides and the sites in which the services are performed. In general, those specialties that furnish more office-based services are expected to experience larger increases in Medicare payments than specialties that provide fewer office-based services. Table 8 also includes the impact on the conversion factor of the volume and intensity adjustments discussed above, but not the impact of the volume response on revenues.

TABLE 8.—IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY OF THE RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS UNDER THE PRACTICE EXPENSE PER HOUR (TOP-DOWN) AND MODIFIED JUNE 97 NPRM (BOTTOM-UP) METHODS (PERCENT CHANGE)

Specialty	Impact per year		Cumulative four year	
	PE/HR	Modified June 97 NPRM	PE/HR	Modified June 97 NPRM
M.D./D.O. Physicians:				
Anesthesiology	0	2	2	9
Cardiac Surgery	−4	−11	−14	−37
Cardiology	−3	−6	−13	−21
Clinics	−1	−1	−3	−5
Dermatology	6	8	27	36
Emergency Medicine	−3	−2	−13	−6
Family Practice	1	2	6	7
Gastroenterology	−4	−7	−14	−24
General Practice	1	1	3	5
General Surgery	−1	−4	−6	−16
Hematology/Oncology	1	4	2	15
Internal Medicine	0	0	1	−2
Nephrology	−1	−5	−5	−17
Neurology	0	−2	0	−7
Neurosurgery	−3	−7	−10	−27

TABLE 8.—IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY OF THE RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS UNDER THE PRACTICE EXPENSE PER HOUR (TOP-DOWN) AND MODIFIED JUNE 97 NPRM (BOTTOM-UP) METHODS (PERCENT CHANGE)—Continued

Specialty	Impact per year		Cumulative four year	
	PE/HR	Modified June 97 NPRM	PE/HR	Modified June 97 NPRM
Obstetrics/Gynecology	1	0	5	0
Ophthalmology	3	−1	11	−3
Orthopedic Surgery	0	−4	−1	−14
Other Physician*	0	0	0	2
Otolaryngology	1	2	6	8
Pathology	−3	1	−10	5
Plastic Surgery	1	−2	5	−9
Psychiatry	1	4	4	19
Pulmonary	−1	−3	−3	−10
Radiation Oncology	−3	3	−13	15
Radiology	−4	−3	−13	−13
Rheumatology	4	3	15	11
Thoracic Surgery	−4	−10	−13	−33
Urology	2	0	7	2
Vascular Surgery	−3	−6	−12	−23
Others:				
Chiropractic	0	4	−2	19
Nonphysician Practitioner	0	6	−1	26
Optometry	8	7	36	30
Podiatry	1	9	5	44
Suppliers	−5	9	−18	39

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

For several reasons, it is difficult to compare the impacts between the impacts in last year's June 18, 1997, proposed rule and the impacts in this proposed rule since BBA 1997 made several changes in physician payment. Although BBA 1997 delayed the initial implementation of the resource-based practice expense system until 1999, it created a down payment for the new system by increasing the practice expense payments for office visits in 1998 funded through decreases in the 1998 practice expense payments for certain procedures. For comparison purposes, the cumulative 4-year impacts displayed in Table 8 are shown below alongside the impacts in last year's June 1997 proposed rule adjusted for the down payment.

TABLE 9.—COMPARISON OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS IMPACTS ON TOTAL ALLOWED CHARGES BY SPECIALTY WITH THE JUNE 97 NPRM NET OF THE DOWN PAYMENT (PERCENT CHANGE)

Specialty	June 97 NPRM	Impact of practice expense	June 97 NPRM	Modified June 97	PE/HR
M.D./D.O. Physicians:					
Anesthesiology	4.0	0.2	3.8	9	2
Cardiac Surgery	−32.0	−2.9	−30.0	−37	−14
Cardiology	−17.0	−1.1	−16.1	−21	−13
Clinics	−3.0	0.1	−3.1	−5	−3
Dermatology	18.0	0.6	17.2	36	27
Emergency Medicine	−2.0	−0.1	−1.9	−6	−13
Family Practice	12.0	2.0	9.8	7	6
Gastroenterology	−20.0	−0.9	−19.3	−24	−14
General Practice	9.0	1.5	7.4	5	3
General Surgery	−9.0	−0.2	−8.8	−16	−6
Hematology/Oncology	11.0	1.2	9.7	15	2
Internal Medicine	3.0	1.2	1.8	−2	1
Nephrology	−13.0	−0.7	−12.4	−17	−5
Neurology	−3.0	0.5	−3.4	−7	0
Neurosurgery	−21.0	−1.6	−19.7	−27	−10
Obstetrics/Gynecology	4.0	1.5	2.5	0	5
Ophthalmology	−11.0	−3.3	−8.0	−3	11
Orthopedic Surgery	−11.0	−0.9	−10.1	−14	−1
Other Physician*	4.0	0.2	3.8	2	0
Otolaryngology	7.0	0.5	6.5	8	6
Pathology	1.0	−0.6	1.6	5	−10
Plastic Surgery	−3.0	−0.3	−2.7	−9	5
Psychiatry	3.0	−0.1	3.1	19	4
Pulmonary	−6.0	0.1	−6.1	−10	−3

TABLE 9.—COMPARISON OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS IMPACTS ON TOTAL ALLOWED CHARGES BY SPECIALTY WITH THE JUNE 97 NPRM NET OF THE DOWN PAYMENT (PERCENT CHANGE)—Continued

Specialty	June 97 NPRM	Impact of practice expense	June 97 NPRM	Modified June 97	PE/HR
Radiation Oncology	10.0	−0.4	10.4	15	−13
Radiology	−9.0	−0.3	−8.7	−13	−13
Rheumatology	15.0	2.0	12.8	11	15
Thoracic Surgery	−28.0	−2.3	−26.3	−33	−13
Urology	1.0	0.1	0.9	2	7
Vascular Surgery	−17.0	0.3	−17.2	−23	−12
Others:					
Chiropractic	14.0	−0.3	14.3	−2	−2
Nonphysician Practitioner	4.0	−0.7	4.8	−1	−1
Optometry	15.0	0.7	14.2	36	36
Podiatry	24.0	0.6	23.3	5	5
Suppliers	14.0	−0.8	14.9	−18	−18

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

Note: Columns do not add because figures are multiplicative. For example, the −30 June 97 NPRM net of the downpayment for cardiac surgery is derived from (1−(32/100))/(1−(2.9/100)).

In addition to the downpayment, other 1998 changes that significantly impacted Medicare physician fee schedule payments were the BBA 1997 move to a single CF and changes to the work RVUs contained in the October 31, 1997 final rule for the 1998 Medicare physician fee schedule. To provide a context for the current proposal, we are again publishing the impacts of these changes published in the October 1997 final notice (62 FR 59262). We are also expanding that table to separate the total change due to relative value units into change due to the downpayment and change due to work RVU revisions.

TABLE 10.—IMPACT ON 1998 ALLOWED CHARGES BY SPECIALTY OF THE SINGLE CONVERSION FACTOR, PRACTICE EXPENSE DOWN PAYMENT, AND WORK RVU CHANGES

[Percent change]

Specialty	Impact of the move to a single CF	Impact of the practice expense down payment	Impact of changes in work relative value units	Combined impact of the single CF, down payment, and work RVU
M.D./D.O. Physicians:				
Anesthesiology	1.2	0.2	0.7	2.1
Cardiac Surgery	−8.1	−2.9	2.3	−8.8
Cardiology	7.9	−1.1	−0.3	6.4
Clinics	4.5	0.1	−0.2	4.4
Dermatology	−4.8	0.6	−0.4	−4.6
Emergency Medicine	3.8	−0.1	−0.5	3.2
Family Practice	5.0	2.0	−0.6	6.4
Gastroenterology	8.5	−0.9	−0.4	7.1
General Practice	4.7	1.5	−0.3	6.0
General Surgery	−4.0	−0.2	2.0	−2.3
Hematology/Oncology	7.1	1.2	−0.3	8.0
Internal Medicine	6.4	1.2	−0.5	7.0
Nephrology	6.0	−0.7	−0.5	4.7
Neurology	7.9	0.5	−0.4	7.9
Neurosurgery	−5.7	−1.6	1.5	−5.9
Obstetrics/Gynecology	−2.3	1.5	1.5	0.6
Ophthalmology	−3.3	−3.3	0.7	−5.8
Orthopedic Surgery	−4.8	−0.9	1.8	−4.0
Other Physician*	6.4	0.2	−0.4	6.2
Otolaryngology	−0.1	0.5	0.1	0.5
Pathology	9.3	−0.6	−0.5	8.1
Plastic Surgery	−6.9	−0.3	2.0	−5.3
Psychiatry	9.0	−0.1	−0.6	8.2
Pulmonary	8.1	0.1	−0.5	7.7
Radiation Oncology	9.2	−0.4	−0.3	8.4
Radiology	9.0	−0.3	−0.4	8.2
Rheumatology	5.7	2.0	−0.6	7.2
Thoracic Surgery	−7.0	−2.3	2.2	−7.2
Urology	−3.3	0.1	0.3	−2.9
Vascular Surgery	−4.0	0.3	1.3	−2.6
Others:				
Chiropractic	9.3	−0.3	−0.5	8.4
Nonphysician Practitioner	5.1	−0.7	0.2	4.5
Optometry	5.7	0.7	−0.6	5.8

TABLE 10.—IMPACT ON 1998 ALLOWED CHARGES BY SPECIALTY OF THE SINGLE CONVERSION FACTOR, PRACTICE EXPENSE DOWN PAYMENT, AND WORK RVU CHANGES—Continued

[Percent change]

Specialty	Impact of the move to a single CF	Impact of the practice expense down payment	Impact of changes in work relative value units	Combined impact of the single CF, down payment, and work RVU
Podiatry	−5.2	0.6	0.2	−4.4
Suppliers	9.3	−0.8	−0.1	8.2

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

Finally, it is difficult to compare the impacts from last year's proposed rule to this proposed rule because of technical modifications to last year's methodology that are incorporated into this year's modified proposed rule approach. Technical modifications include elimination of last year's limits and caps on the CPEP estimates of clinical and administrative labor. We had received many comments (including from GAO) questioning this element of last year's methodology. The elimination of the caps partially explains the difference between the 9.8 percent increase for family practitioners last year (after netting out the effects of the downpayment) and the 7 percent increase that would occur with the modified proposed rule approach in this year's rule. It also partially explains the increase in payments for dermatologists from last year's 17.2 percent (netting out the effect of the downpayment) to the 36 percent increase which would occur under the modified proposed rule approach in this year's rule.

Table 11. ''Total Payment for Selected Procedures,'' shows the percentage change in total payment allowances (in 1998 dollars) between the current and the fully phased-in resource-based practice expense system for certain high volume procedures.

TABLE 11.—TOTAL PAYMENT FOR SELECTED PROCEDURES

Code	Mod	Description	Current non-facility	Resource based non-facility	Non-facility percent change	Current facility	Resource based facility
11721		Debride nail, 6 or more	$39.81	$31.69	−20	$29.91	$30.90
17000		Destroy benign/premal lesion	36.69	52.12	42	28.99	42.82
27130		Total hip replacement	NA	NA	NA	1,656.80	1,383.69
27236		Repair of thigh fracture	NA	NA	NA	1,244.62	1,065.87
27244		Repair of thigh fracture	NA	NA	NA	1,230.38	1,083.55
27447		Total knee replacement	NA	NA	NA	1,771.16	1,454.99
33533		CABG, arterial, single	NA	NA	NA	2,107.91	1,764.20
35301		Rechanneling of artery	NA	NA	NA	1,262.70	1,069.02
43239		Upper GI endoscopy, biopsy	228.81	241.66	6%	211.20	140.58
45378		Diagnostic colonoscopy	290.30	292.34	1	288.10	208.17
45385		Colonoscopy, lesion removal	443.89	375.88	−15	414.17	277.71
66821		After cataract laser surgery	187.65	192.66	3	187.65	184.24
66984		Remove cataract, insert lens	NA	NA	NA	795.26	677.97
67210		Treatment of retinal lesion	686.27	639.55	−7	520.81	596.86
71010	26	Chest x-ray	9.36	8.49	−9	9.36	8.49
71020		Chest x-ray	34.55	27.71	−20	34.55	27.71
71020	26	Chest x-ray	11.44	10.36	−9	11.44	10.36
77430		Weekly radiation therapy	188.62	171.24	−9	188.62	171.24
78465		Heart image (3D) multiple	514.68	397.85	−23	514.68	397.85
88305		Tissue exam by pathologist	65.95	66.01	0	65.95	66.01
88305	26	Tissue exam by pathologist	46.14	37.58	−19	46.14	37.58
90801		Psy dx interview	122.08	135.64	11	122.08	134.08
90806		Psytx, office (45–50)	80.95	86.09	6	80.95	82.49
90807		Psytx, office (45–50) w/e&m	90.03	98.66	10	90.03	94.67
90862		Medication management	47.37	46.51	−2	47.37	45.88
90921		ESRD related services, month	235.86	226.79	−4	235.86	226.79
90935		Hemodialysis, one evaluation	NA	NA	NA	93.87	64.99
92004		Eye exam, new patient	77.83	113.47	46	67.37	87.79
92012		Eye exam established pt	39.42	68.43	74	31.35	35.68
92014		Eye exam & treatment	57.55	82.39	43	47.65	58.21
92980		Insert intracoronary stent	NA	NA	NA	1,142.75	899.31
92982		Coronary artery dilation	NA	NA	NA	857.33	680.44
93000		Electrocardiogram, complete	28.83	15.87	−45	28.83	15.87
93010		Electrocardiogram report	11.96	8.45	−29	11.96	8.45
93015		Cardiovascular stress test	116.95	98.79	−16	116.95	98.79
93307		Echo exam of heart	215.85	103.39	−52	215.85	103.39
93307	26	Echo exam of heart	70.94	50.80	−28	70.94	50.80
93510	26	Left heart catheterization	266.37	222.31	−17	266.37	222.31
98941		Chiropractic manipulation	32.87	32.55	−1	27.55	28.26
99202		Office/outpatient visit, new	50.15	71.19	42	39.69	49.05
99203		Office/outpatient visit, new	68.93	100.60	46	56.82	73.17

TABLE 11.—TOTAL PAYMENT FOR SELECTED PROCEDURES—Continued

Code	Mod	Description	Current non-facility	Resource based non-facility	Non-facility percent change	Current facility	Resource based facility
99204		Office/outpatient visit, new	102.50	141.83	38	84.53	105.52
99205		Office/outpatient visit, new	128.35	173.06	35	108.72	135.83
99211		Office/outpatient visit, est	14.16	17.96	27	9.94	12.22
99212		Office/outpatient visit, est	27.61	32.09	16	21.01	25.83
99213		Office/outpatient visit, est	39.42	43.39	10	30.61	35.86
99214		Office/outpatient visit, est	59.39	68.39	15	47.65	57.82
99215		Office/outpatient visit, est	93.67	101.73	9	76.06	90.38
99221		Initial hospital care	NA	NA	NA	69.84	67.71
99222		Initial hospital care	NA	NA	NA	113.45	108.20
99223		Initial hospital care	NA	NA	NA	144.98	147.84
99231		Subsequent hospital care	NA	NA	NA	36.57	32.35
99232		Subsequent hospital care	NA	NA	NA	53.64	52.07
99233		Subsequent hospital care	NA	NA	NA	74.65	73.72
99236		Observ/hosp same date	NA	NA	NA	188.78	207.45
99238		Hospital discharge day	NA	NA	NA	63.24	64.40
99239		Hospital discharge day	NA	NA	NA	79.05	86.11
99241		Office consultation	47.95	50.20	5	36.21	38.46
99242		Office consultation	74.95	86.81	16	60.82	69.87
99243		Office consultation	97.12	111.83	15	79.33	92.28
99244		Office consultation	135.96	154.79	14	113.40	132.87
99245		Office consultation	183.26	196.49	7	152.26	174.83
99251		Initial inpatient consult	NA	NA	NA	49.72	39.47
99252		Initial inpatient consult	NA	NA	NA	75.59	72.93
99253		Initial inpatient consult	NA	NA	NA	99.75	98.25
99254		Initial inpatient consult	NA	NA	NA	136.88	137.30
99255		Initial inpatient consult	NA	NA	NA	185.53	186.50
99261		Follow-up inpatient consult	NA	NA	NA	27.34	25.99
99262		Follow-up inpatient consult	NA	NA	NA	46.94	47.05
99263		Follow-up inpatient consult	NA	NA	NA	68.77	67.16
99282		Emergency dept visit	NA	NA	NA	33.55	24.76
99283		Emergency dept visit	NA	NA	NA	61.16	52.53
99284		Emergency dept visit	NA	NA	NA	93.48	81.10
99285		Emergency dept visit	NA	NA	NA	147.34	125.14
99291		Critical care, first hour	191.07	189.23	−1	191.07	191.13
99292		Critical care, addl 30 min	91.86	96.23	5	91.86	96.62
99301		Nursing facility care	NA	NA	NA	57.98	65.81
99302		Nursing facility care	NA	NA	NA	73.98	87.08
99303		Nursing facility care	NA	NA	NA	105.04	107.40
99311		Nursing facility care, subseq	NA	NA	NA	33.76	34.61
99312		Nursing facility care, subseq	NA	NA	NA	49.78	53.24
99313		Nursing facility care, subseq	NA	NA	NA	66.12	73.34
99348		Home visit, estab patient	63.30	65.30	3	63.30	74.41
99350		Home visit, estab patient	132.39	148.19	12	132.39	141.51

BBA 1997 requires that we consider the geographic impacts of the new payment system. The following table displays the impact of the practice expense per hour methodology by Medicare payment locality, including the volume-and-intensity increase and corresponding conversion factor adjustment discussed earlier.

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
All	Alabama	−0.3	−1.0
All	Alaska	0.1	0.5
All	Arizona	0.1	0.3
All	Arkansas	−0.1	−0.3
Marin/Napa/Solano	California	0.8	3.4
San Francisco	California	0.9	3.5
San Mateo	California	0.6	2.5
Oakland/Berkeley	California	0.3	1.1
Santa Clara	California	0.3	1.0
Rest of California	California	0.2	0.8

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY—Continued

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
Ventura	California	0.3	1.4
Los Angeles	California	0.5	1.9
Anaheim/Santa Ana	California	0.6	2.6
Rest of California	California	0.7	3.0
All	Colorado	0.3	1.1
All	Connecticut	0.1	0.3
All	Delaware	−0.2	−0.7
All	District of Columbia	−0.1	−0.3
Ft Lauderdale	Florida	0.5	2.1
Miami	Florida	−0.3	−1.3
Rest of Florida	Florida	0.0	0.0
Atlanta	Georgia	−0.3	−1.2
Rest of Georgia	Georgia	−0.1	−0.4
All	Hawaii	0.9	3.7
All	Idaho	0.1	0.5
East St Louis	Illinois	0.1	0.3
Suburban Chicago	Illinois	0.0	0.1
Chicago	Illinois	−0.3	−1.1
Rest of Illinois	Illinois	−0.2	−0.6
All	Indiana	−0.2	−0.7
All	Iowa	0.2	0.9
All	Kansas	−0.1	−0.2
All	Kentucky	−0.2	−0.8
New Orleans	Louisiana	0.0	0.1
Rest of Louisiana	Louisiana	−0.1	−0.5
Southern Maine	Maine	−0.1	−0.4
Rest of Maine	Maine	0.2	0.7
Balto/Surr Ctys	Maryland	−0.3	−1.2
Rest of Maryland	Maryland	−0.1	−0.6
Boston	Massachusetts	0.2	1.0
Rest of Massachusetts	Massachusetts	0.2	1.0
Detroit	Michigan	−0.3	−1.2
Rest of Michigan	Michigan	−0.2	−1.0
All	Minnesota	−0.2	−0.9
All	Mississippi	−0.2	−0.9
Metro Kansas City	Missouri	−0.6	−2.2
Rest of Missouri	Missouri	0.1	0.3
St Louis	Missouri	−0.1	−0.5
Rest of Missouri	Missouri	0.3	1.2
All	Montana	0.1	0.4
All	Nebraska	0.1	0.4
All	Nevada	−0.3	−1.2
All	New Hampshire	0.2	0.8
Northern New Jersey	New Jersey	−0.1	−0.4
Rest of New Jersey	New Jersey	−0.1	−0.5
All	New Mexico	0.3	1.3
Rest of New York	New York	−0.2	−0.6
Manhattan	New York	0.3	1.1
NYC Suburbs/LI	New York	−0.1	−0.5
Poughkpsie/N NYC	New York	0.3	1.2
Queens	New York	0.3	1.0
All	North Carolina	0.0	0.0
All	North Dakota	−0.3	−1.2
All	Ohio	−0.1	−0.2
All	Oklahoma	0.1	0.3
Portland	Oregon	0.0	0.0
Rest of Oregon	Oregon	0.5	2.1
Philadelphia	Pennsylvania	−0.2	−0.8
Rest of Pennsylvania	Pennsylvania	−0.1	−0.4
All	Puerto Rico	0.8	3.2
All	Rhode Island	0.0	0.2
All	South Carolina	0.0	0.0
All	South Dakota	−0.3	−1.1
All	Tennessee	−0.3	−1.0
Brazoria	Texas	0.8	3.4
Dallas	Texas	−0.1	−0.4
Galveston	Texas	0.1	0.6
Houston	Texas	−0.3	−1.2

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY—Continued

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
Beaumont	Texas	−0.4	−1.8
Fort Worth	Texas	−0.2	−0.8
Austin	Texas	−0.4	−1.5
Rest of Texas	Texas	0.0	−0.2
All	Utah	0.3	1.0
All	Vermont	0.5	2.1
All	Virgin Islands	0.6	2.6
All	Virginia	0.1	0.5
Seattle (King Co)	Washington	0.1	0.3
Rest of Washington	Washington	0.2	0.8
All	West Virginia	−0.1	−0.4
All	Wisconsin	−0.1	−0.6
All	Wyoming	0.5	2.1

BBA 1997 requires that we consider the impacts of the new system on urban and rural localities. The geographic payment areas we use for payment under the physician fee schedule do not follow urban and rural configurations. For example, in 34 States (plus the District of Columbia, Puerto Rico, and the Virgin Islands) the payment areas are statewide; that is, the Medicare payment is the same in both urban and rural areas. In those States, there would be no differential impact of this proposal on urban and rural areas. Since our payment areas do not track urban and rural locations, our claims payment system does not distinguish between urban and rural locations, and we do not have data easily available to undertake an urban-rural impact analysis. We do not believe that this proposal will have much urban-rural impact, particularly since 34 States (plus the District of Columbia, Puerto Rico, and the Virgin Islands) have statewide payment areas. Any urban-rural impact should largely be explained by differences in the mix and site of services among urban and rural localities.

BBA 1997 requires us to consider impact projections that compare new proposed payment amounts to data on actual physician practice expenses. We have satisfied this requirement by basing the new proposed payments amounts on actual physician practice expense data.

C. Medical Direction for Anesthesia Services

We are proposing to revise the conditions for payment of medical direction performed by a physician. Thus, we are proposing to revise our regulations in § 415.10 (Conditions for payment: Anesthesiology services) to state that we will pay a physician for medical direction of anesthesia services, for a single case or for two, three, or four concurrent cases if the services meet the condition in § 415.102(a) (Conditions for fee schedule payment for physician services to beneficiaries in providers). This proposal has no payment implications. The payment rate for medical direction, which is included in the statute, would not change.

D. Separate Payment for Physician Interpretation of an Abnormal Papanicolaou Smear

Under our proposed policy, we would allow separate payment, under the physician fee schedule, for the physician interpretation of Pap smears in all sites. Currently, separate payment to physicians is limited to services furnished for hospital inpatients. We estimate that there would be a minimal cost impact in payments under the physician fee schedule for this change in Pap smear interpretations. This cost would be more than offset by the savings resulting from the change in the calculation of the median for payment of drugs and biologicals.

E. Rebasing and Revising the Medicare Economic Index

There is negligible impact on Medicare expenditures as a result of this change.

F. Payment for Nurse Midwives' Services

The provision for nurse midwives' services would place into regulations text a provision of OBRA 1993 that eliminates the limitation on coverage of services furnished outside the maternity cycle by nurse midwives. This provision has been implemented previously through program instructions; therefore, this change in the regulations text would have no impact.

G. BBA 1997 Provisions Included in This Proposed Rule

The following four provisions of BBA 1997 are included in this proposed rule. This proposed rule conforms the regulations text to the BBA 1977 provisions. The following table provides the cost and savings estimates (in millions of dollars) for these provisions for the fiscal years shown:

Provision Section	Subject	1999	2000	2001	2002	2003
4511	Nurse practitioners and Clinical Nurse Specialists.	290	330	370	440	490
4512	Physician Assistants	60	60	70	90	100
4541	Outpatient Physical Therapy	−130	−190	−200	−230	−250
4556	Drugs	−60	−70	−70	−80	−80

1. Payment for Services of Certain Nonphysician Practitioners and Services Furnished Incident to Their Professional Services

Sections 4511 and 4512 of BBA 1997 provide for the expanded coverage of nurse practitioner, clinical nurse specialist, and physician assistant services. This provision is self-implementing. This proposed rule changes the regulations text to conform to the BBA 1997 provisions. We are taking this opportunity to clarify the following two existing issues unrelated to the BBA 1997 provisions for nonphysician practitioners.

- Proposing a revised definition of physician collaboration for nurse practitioners and clinical nurse specialists.
- Modifying the qualifications of physicians assistants to recognize orthopedic physician assistants as physician assistants.

The impact of the BBA 1997 provision is shown in the table above (a combination of sections 4511 and 4512 of BBA 1997). The proposals being made in this proposed rule would have negligible budgetary impact.

2. Payment for Outpatient Rehabilitation Services

Sections 4541(a)(2)(B) and 4541(a)(3) of BBA 1997 change the payment of outpatient rehabilitation services from cost-based to a payment system based on the physician fee schedule. These provisions are self-implementing. The impact of this proposal is shown in the table above. The regulatory changes are to conform our regulations to the provisions of BBA 1997.

The following proposals are being made in this proposed rule to furnish information for identification of the outpatient rehabilitation services and for administrative purposes:

- Specifying HCPCS as the coding system for rehabilitation services since it is used by the fee schedule in section 1848 of the Act.
- Providing for discipline-specific modifiers to be used in coding services.
- Providing for a code for nursing services performed in CORFs.

These proposals will have a negligible impact.

We are providing some additional impact information regarding this BBA 1997 provision. There are several different types of providers that will be affected by this BBA 1997 provision. They are SNFs, outpatient rehabilitation facilities, and hospital outpatient departments. There about 15,000 SNFs, 2,500 outpatient rehabilitation facilities, and about 5,600 outpatient hospital facilities. In estimating the impacts of this provision on these entities, we determined that the services that would be affected by these changes account for about 5 percent of facility payments in these providers.

We realize there may be an impact on small rural hospitals; however, we have been unable to assess this impact because we do not have the data to make this analysis. Also, data that would identify the extent to which these services are currently being furnished in small rural hospitals to serve as the baseline for comparing impact of the legislative changes are not available. In addition, we do not maintain data that identify services furnished under the physician fee schedule in areas where rural hospitals are located. Although there are localities designated for payment purposes, there is very little correlation between the payment localities (most of which are state-wide) and areas where small rural hospitals are located.

3. Payment for Drugs and Biologicals

The impact of this BBA 1997 provision is shown in the table above. This proposed rule modifies the current regulatory language regarding drug reimbursement to conform to the BBA 1997 changes. The proposal in this proposed rule to modify the method used to calculate the median to include the brand name of the drug is not related to the BBA 1997 drug provision but would have a slight program savings. This is offset by the cost for the proposal to provide a separate payment for the interpretation of an abnormal Pap smear, which was described above.

4. Private Contracting with Medicare Beneficiaries

We anticipate that there would be a negligible impact on Medicare trust fund payments as a result of the regulation that implements the law. The program impact of the provision when it was assessed in the legislative process was negligible and vanished under our rounding rules. The impact on beneficiaries, physicians, and practitioners is impossible to assess in any quantitative way.

Specifically, beneficiaries who have had difficulty in finding physicians or practitioners to furnish services because the physicians or practitioners were dissatisfied with the Medicare payment rates may find it easier to acquire care. On the other hand, beneficiaries who cannot afford to privately contract with physicians or practitioners who opt-out of Medicare may have more limited access to care as they try to seek care from reduced numbers of physicians and practitioners who will accept Medicare payment rules.

Physicians and practitioners who opt-out of Medicare may see increased incomes as a result of their ability to charge without regard to the Medicare limiting charge. However, to the extent that beneficiaries cease to seek treatment from them because they have opted-out of Medicare, their incomes may decline. Moreover, organizations to which physicians and practitioners had reassigned Medicare benefits may cease their contracts with them if they opt-out since they could no longer be paid by Medicare for the physician or practitioner service. Managed care plans that have a contract with Medicare may cease their contractual arrangement with physicians and practitioners who opt-out of Medicare since the plan cannot pay for any of their services to Medicare beneficiaries and, hence, their services no longer offer access to care under the plan. Similarly, insurance plans other than Medicare can choose to not pay for the services provided to any of their enrollees by physicians and practitioners who opt-out of Medicare, causing the physicians and practitioners who opt-out further loss of income.

H. Impact on Beneficiaries

Although changes in physician payments when the physician fee schedule was implemented in 1992 were large, we detected no problems with beneficiary access to care. Because there is a 4-year transition to the proposed values, we anticipate a minimal impact on beneficiaries.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare,

Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 415

Health facilities, Health professions, Medicare Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV would be amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as set forth below:

1. A new subpart D, consisting of §§ 405.400, 405.405, 405.410, 405.415, 405.420, 405.425, 405.430, 405.435, 405.440, 405.445, 405.450, and 405.455 is added to read as follows:

Subpart D—Private Contracts

Secs.
405.400 Definitions.
405.405 General rules.
405.410 Conditions for properly opting-out of Medicare.
405.415 Requirements of private contracts.
405.420 Requirements of opt-out affidavit.
405.425 Effects of opting-out of Medicare.
405.430 Failure to properly opt-out.
405.435 Failure to maintain opt-out.
405.440 Emergency and urgent care services.
405.445 Renewal and early termination of opt-out.
405.450 Appeals.
405.455 Medicare+Choice.

Subpart D—Private Contracts

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 405.400 Definitions.

For purposes of this subpart, the following definitions apply:

Beneficiary means an individual who is enrolled in Part B of Medicare.

Emergency care services means services furnished to an individual for treatment of an ''emergency medical condition'' as that term is defined in § 489.24 of this chapter.

Legal representative means an individual who has been appointed as the beneficiary's legal guardian under State law or who has been granted a power of attorney from the beneficiary, which power of attorney is sufficient to permit the individual to enter into private contracts on the beneficiary's behalf.

Opt-out means the status of meeting the conditions specified in § 405.410.

Opt-out period means the 2-year period beginning on the effective date of the affidavit as specified by § 405.410(c)(1) or § 405.410(c)(2), as applicable.

Participating physician means a ''physician'' as defined in this section who has signed an agreement to participate in Part B of Medicare.

Physician means a doctor of medicine or a doctor of osteopathy who is currently licensed as that type of doctor in each State in which he or she furnishes services to patients.

Practitioner means a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker, who is currently legally authorized to practice in that capacity by each State in which he or she furnishes services to patients or clients.

Private contract means a document that meets the criteria specified in § 405.415.

Properly opt-out means to complete, without defect, the requirements for opt-out as specified in § 405.410.

Properly terminate opt-out means to complete, without defect, the requirements for terminating opt-out as specified in § 405.445.

Urgent care services means services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

§ 405.405 General rules.

(a) A physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare, provided the conditions of this subpart are met.

(b) A physician or practitioner who enters into at least one private contract with a Medicare beneficiary under the conditions of this subpart, and who submits one or more affidavits in accordance with this subpart, opts-out of Medicare for a 2-year period. The physician's or practitioner's opt-out may be renewed for subsequent 2-year periods.

(c) Both the private contracts described in paragraph (a) of this section and the physician's or practitioner's opt-out described in paragraph (b) of this section are null and void if the physician or practitioner fails to properly opt-out in accordance with the conditions of this subpart, or fails to remain in compliance with the conditions of this subpart during the opt-out period.

(d) Services furnished under private contracts meeting the requirements of this subpart are not covered services under Medicare, and no Medicare payment would be made for such services either directly or indirectly.

§ 405.410 Conditions for properly opting-out of Medicare.

The following conditions must be met for a physician or practitioner to properly opt-out of Medicare:

(a) Each private contract between a physician or a practitioner and a Medicare beneficiary must meet the specifications of § 405.415.

(b) The physician or practitioner must submit to each Medicare carrier with which he or she files claims an affidavit that meets the specifications of § 405.420.

(c) A nonparticipating physician or a practitioner may opt-out of Medicare at any time in accordance with the following:

(1) The 2-year opt-out period begins the date the affidavit meeting the requirements of § 405.420 is signed, provided the affidavit is timely filed (that is, within 10 days after the first private contract is entered into).

(2) If the physician or practitioner does not timely file any required affidavit, the 2-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit and the furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

(d) A participating physician may properly opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit described in § 405.420 is submitted to the participating physician's Medicare carriers at least 30 days before the beginning of the selected calendar quarter. A private contract entered into before the beginning of the selected calendar quarter becomes effective at the beginning of the selected calendar quarter and the furnishing of any items or services to a Medicare beneficiary under such contract before the beginning of the selected calendar quarter is subject to standard Medicare rules.

§ 405.415 Requirements of the private contract.

A private contract under this subpart must:

(a) Be in writing and in print sufficiently large to ensure that beneficiaries are able to read the contract.

(b) State whether the physician or practitioner is excluded from Medicare under section 1128 of the Social Security Act.

(c) State that the beneficiary or his or her legal representative accepts full responsibility for payment of the physician's or practitioner's charge for the services furnished.

(d) State that the beneficiary or his or her legal representative understands that Medicare limits do not apply to what the physician or practitioner may charge for items or services furnished by the physician or practitioner.

(e) State that the beneficiary or his or her legal representative agrees not to submit a claim to Medicare or to ask the physician or practitioner to submit a claim to Medicare.

(f) State that the beneficiary or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

(g) State that the beneficiary or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare.

(h) State the expected effective date and expected expiration date of the opt-out period.

(i) State that the beneficiary or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

(j) Be signed by the beneficiary or his or her legal representative and by the physician or practitioner.

(k) Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services. (However, a physician or practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with § 405.440.)

(l) Be provided (a photocopy is permissible) to the beneficiary or to his or her legal representative before items or services are furnished to the beneficiary under the terms of the contract.

(m) Be retained (original signatures of both parties required) by the physician or practitioner for the duration of the opt-out period.

(n) Be made available to HCFA upon request.

(o) Be entered into for each opt-out period.

§ 405.420 Requirements of the opt-out affidavit.

An affidavit under this subpart must:

(a) Be in writing and be signed by the physician or practitioner.

(b) Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number, if one has been assigned, uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, the physician's or practitioner's tax identification number (TIN).

(c) State that, during the opt-out period, the physician or practitioner will provide services to Medicare beneficiaries only through private contracts that meet the criteria of paragraph § 405.415 for services that, except for their provision under a private contract, would have been Medicare-covered services.

(d) State that the physician or practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the physician or practitioner permit any entity acting on his or her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 405.440.

(e) State that, during the opt-out period, the physician or practitioner understands that he or she may receive no direct or indirect Medicare payment for services that he or she furnishes to Medicare beneficiaries with whom he or she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.

(f) State that a physician or practitioner who opts-out of Medicare acknowledges that, during the opt-out period, his or her services are not covered under Medicare and that no Medicare payment may be made to any entity for his or her services, directly or on a capitated basis.

(g) State a promise by the physician or practitioner to the effect that, during the opt-out period, the physician or practitioner agrees to be bound by the terms of both the affidavit and the private contracts that he or she has entered into.

(h) Acknowledge that the physician or practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician or practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he or she has not previously privately contracted) without regard to any payment arrangements the physician or practitioner may make.

(i) With respect to a physician who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit.

(j) Acknowledge that the physician or practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of § 405.440 apply if the physician furnishes such services.

(k) Be submitted to:

(1) Each Medicare carrier to which the physician or practitioner has submitted claims within the past 2 years.

(2) To any additional carriers to which claims would be sent on the date the first private contract is entered into, in accordance with Medicare instructions on claim submission then in effect.

(l) With respect to nonparticipating physicians and with respect to practitioners, be submitted within 10 days after the nonparticipating physician or practitioner signs his or her first private contract with a Medicare beneficiary.

(m) With respect to participating physicians, be submitted in accordance with § 405.410(d).

§ 405.425 Effects of opting-out of Medicare.

If a physician or practitioner opts-out of Medicare in accordance with this subpart for the 2-year period for which the opt-out is effective, the following results obtain:

(a) Except as provided in § 405.440, no payment may be made directly by Medicare or by any Medicare+Choice plan to the physician or practitioner or to any entity to which the physician or practitioner reassigns his right to receive payment for services.

(b) The physician or practitioner may not furnish any item or service that would otherwise be covered by

Medicare (except for emergency or urgent care services) to any Medicare beneficiary except through a private contract that meets the requirements of this subpart.

(c) The physician or practitioner is not subject to the requirement to submit a claim for items or services furnished to a Medicare beneficiary, as specified in § 424.5(a)(6) of this chapter, except as provided in § 405.440.

(d) The physician or practitioner is prohibited from submitting a claim to Medicare for items or services furnished to a Medicare beneficiary except as provided in § 405.440.

(e) In the case of a physician, he or she is not subject to the limiting charge provisions of § 414.48 of this chapter.

(f) The physician or practitioner is not subject to the prohibition-on-reassignment provisions of § 414.80 of this chapter.

(g) In the case of a practitioner, he or she is not prohibited from billing or collecting amounts from beneficiaries (as provided in 42 U.S.C. 1395u(b)(18)(B)).

(h) The death of a beneficiary who has entered into a private contract (or whose legal representative has done so) does not invoke § 424.62 or § 424.64 of this chapter with respect to the physician or practitioner with whom the beneficiary (or legal representative) has privately contracted.

(i) The physician or practitioner may order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the physician or practitioner is not paid, directly or indirectly, for such ordering, certifying, or referring services.

§ 405.430 Failure to properly opt-out.

(a) A physician or practitioner fails to properly opt-out if—

(1) Any private contract between the physician or practitioner and a Medicare beneficiary, that was entered into before the affidavit described in § 405.420 was filed, does not meet the specifications of § 405.415; or

(2) He or she fails to submit the affidavit(s) in accordance with § 405.420.

(b) If a physician or practitioner fails to properly opt-out in accordance with paragraph (a) of this section, the following results obtain:

(1) All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.

(2) The physician's or practitioner's attempt to opt-out of Medicare is nullified.

(3) The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

(4) The physician is subject to the limiting charge provisions of § 414.48 of this chapter.

(5) The practitioner may not reassign any claim except as provided in § 424.80 of this chapter.

(6) The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts.

(7) The physician or practitioner may make another attempt to properly opt-out at any time.

§ 405.435 Failure to maintain opt-out.

(a) A physician or practitioner fails to maintain opt-out under this subpart if, during the opt-out period—

(1) He or she knowingly and willfully—

(i) Submits a claim for Medicare payment (except as provided in § 405.440); or

(ii) Receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided in § 405.440).

(2) He or she enters into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, but such contracts fail to meet the specifications of § 405.415; or

(3) He or she fails to comply with the provisions of § 405.440 regarding billing for emergency care services or urgent care services; or

(4) He or she fails to retain a copy of each private contract that he or she has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit HCFA to inspect them upon request.

(b) If a physician or practitioner fails to maintain opt-out in accordance with paragraph (a) of this section, the following results obtain:

(1) All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.

(2) The physician's or practitioner's opt-out of Medicare is nullified.

(3) The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

(4) The physician or practitioner will not receive Medicare payment on Medicare claims for the remainder of the opt-out period.

(5) The physician is subject to the limiting charge provisions of § 414.48 of this chapter.

(6) The practitioner may not reassign any claim except as provided in § 424.80 of this chapter.

(7) The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts.

(8) The physician or practitioner may not attempt to once more meet the criteria for properly opting-out until the now-nullified 2-year opt-out period expires.

§ 405.440 Emergency and urgent care services.

(a) A physician or practitioner who has opted-out of Medicare under this subpart need not enter into a private contract to furnish emergency care services or urgent care services to a Medicare beneficiary. Accordingly, a physician or practitioner will not be determined to have failed to maintain opt-out if he or she furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, provided the physician or practitioner complies with the billing requirements specified in paragraph (b) of this section.

(b) When a physician or practitioner furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, he or she:

(1) Must submit a claim to Medicare in accordance with both 42 CFR part 424 and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).

(2) May collect no more than—

(i) The Medicare limiting charge, in the case of a physician; or

(ii) The deductible and coinsurance, in the case of a practitioner.

(c) Emergency care services or urgent care services furnished to a Medicare beneficiary with whom the physician or practitioner has previously entered into a private contract (that is, entered into before the onset of the emergency medical condition or urgent medical condition), are furnished under the terms of the private contract.

(d) Medicare may make payment for emergency care services or urgent care services furnished by a physician or practitioner who has properly opted-out when the services are furnished and the claim for services is made in accordance with this section.

§ 405.445 Renewal and early termination of opt-out.

(a) A physician or practitioner may renew opt-out by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period, (as specified in § 405.420), and to each carrier to which a claim was submitted under § 405.440 during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

(b) To properly terminate opt-out a physician or practitioner must:

(1) Not have previously opted out of Medicare.

(2) Notify all Medicare carriers with which he or she filed an affidavit of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.

(3) Refund to each beneficiary with whom he or she has privately contracted all payment collected in excess of:

(i) In the case of physicians: the Medicare limiting charge; or

(ii) In the case of practitioners: the deductible and coinsurance.

(4) Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

(c) When the physician or practitioner properly terminates opt-out in accordance with paragraph (b), he or she will be reinstated in Medicare as if there had been no opt-out, and the provision of § 405.425 shall not apply unless the physician or practitioner subsequently properly opts out.

§ 405.450 Appeals.

(a) A determination by HCFA that a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out is an initial determination for purposes of § 405.803.

(b) A determination by HCFA that no payment can be made to a beneficiary for the services of a physician who has opted-out is an initial determination for purposes of § 405.803.

§ 405.455 Medicare+Choice.

An organization that has a contract with HCFA to provide one or more Medicare+Choice (M+C) plans to beneficiaries (part 422 of this chapter):

(a) Must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

(b) Must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted-out of Medicare.

(c) May make payment to a physician or practitioner who furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner.

Subpart E—Criteria for Determining Reasonable Charges

2. The authority citation for part 405, subpart E, continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

3. Section 405.517 is revised to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* Payment for a drug or biological that is not paid on a cost or prospective payment basis is determined by the standard methodology described in paragraph (b) of this section. Examples of when this procedure applies include a drug or biological furnished incident to a physician service, a drug or biological furnished by an independent dialysis facility that is not included in the ESRD composite rate set forth in § 413.170(c) of this chapter, and a drug or biological furnished as part of the durable medical equipment benefit.

(b) *Methodology.* Payment for a drug or biological described in paragraph (a) of this section is based on the lower of the actual charge on the Medicare claim for benefits or 95 percent of the national average wholesale price of the drug or biological.

(c) *Multiple-source drugs.* For multiple-source drugs and biologicals, for purposes of this regulation, the average wholesale price is defined as the lesser of the median average wholesale price for all sources of the generic forms of the drug or biological or the lowest average wholesale price of the brand name forms of the drug or biological.

4. A new § 405.520 is added to read as follows:

§ 405.520 Payment for physician assistant, nurse practitioner, and clinical nurse specialist services and services furnished incident to their professional services.

(a) *General rule.* Physician assistant, nurse practitioner, and clinical nurse specialist services, and services and supplies furnished incident to their professional services, are paid in accordance with the physician fee schedule. The payment for physician assistant services may not exceed the limits at § 414.52 of this chapter. The payment for nurse practitioner and clinical nurse specialist services may not exceed the limits at § 414.56 of this chapter.

(b) *Requirements.* Medicare payment is made only if all claims for payment are made on an assignment-related basis in accordance with § 424.55 of this chapter, that sets forth, respectively, the conditions for coverage of physician assistant services, nurse practitioner services and clinical nurse specialist services, and services and supplies furnished incident to their professional services.

(c) *Civil money penalties.* Any person or entity who knowingly and willingly bills a Medicare beneficiary amounts in excess of the appropriate coinsurance and deductible is subject to a civil money penalty not to exceed $2,000 for each bill or request for payment.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 410.32 [Amended]

2. In § 410.32(a)(3), the last word, ''section,'' is removed and the word ''paragraph'' is added in its place.

3. A new section 410.59 is added to read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Medicare Part B pays for outpatient occupational therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the personal supervision of an occupational therapist in private practice as described in paragraph (c) of this section.

(b) *Outpatient occupational therapy services to certain inpatients of a*

hospital or a CAH or SNF. Medicare Part B pays for outpatient occupational therapy services to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by occupational therapists in private practice.* (1) *Basic Qualifications.* In order to qualify under Medicare as a supplier of outpatient occupational therapy services, each individual occupational therapist in private practice must meet the following requirements:

(i) Is legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of occupational therapy by the State in which he or she practices, and practices only within the scope of his or her license, certification, or registration.

(ii) Engages in the private practice of occupational therapy on a regular basis, in one of the following practice types:

(A) An individual operating an unincorporated solo practice.

(B) An individual practicing as a member of a partnership or unincorporated group practice.

(C) An individual practicing as an employee of an unincorporated solo practice, partnership, or group practice, or an employee of a professional corporation or other incorporated occupational therapy practice. Private practice does not include any individual during the time he or she is working as an employee of a provider.

(iii) Bills Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, an CAH, or a SNF.

(iv) Treats individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) Supervision of occupational therapy services. Occupational therapy services are performed by, or under the personal supervision of, the occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded expenses.* No service is included as an outpatient occupational therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) *Amount of limitation.* (i) In 1999, no more than $1500 of allowable charges incurred in a calendar year for outpatient occupational therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(2) For purposes of applying the limitation, outpatient physical therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient occupational therapy services furnished under this section;

(ii) Outpatient occupational therapy services furnished by a comprehensive outpatient rehabilitation facility;

(iii) Outpatient occupational therapy services furnished by a physician or incident to a physician's service;

(iv) Outpatient occupational therapy services furnished by a nurse practitioner, certified nurse specialist, or physician assistant or incident to their services.

(3) For purposes of applying the limitation, outpatient occupational therapy services excludes services furnished by a hospital or CAH directly or under arrangements.

4. Section 410.60 is revised to read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the personal supervision of a physical therapist in private practice as described in paragraph (c) of this section.

(b) *Outpatient physical therapy services to certain inpatients of a hospital or a CAH or SNF.* Medicare Part B pays for outpatient occupational therapy services to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by physical therapists in private practice. (1) Basic Qualifications.*

In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

(i) Is legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of physical therapy by the State in which he or she practices, and practices only within the scope of his or her license, certification, or registration.

(ii) Engages in the private practice of physical therapy on a regular basis, in one of the following practice types:

(A) An individual operating an unincorporated solo practice.

(B) An individual practicing as a member of an unincorporated partnership or unincorporated group practice.

(C) An individual practicing as an employee of an unincorporated solo practice, partnership, or group practice, or an employee of a professional corporation or other incorporated physical therapy practice. Private practice does not include any individual during the time he or she is working as an employee of a provider.

(iii) Bills Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

(iv) Treats individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the personal supervision of, the physical therapist in

private practice. All services not performed personally by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded expenses.* No service is included as an outpatient physical therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) Amount of limitation. In 1999, no more than $1500 of allowable charges incurred in a calendar year for outpatient physical therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(2) For purposes of applying the limitation, outpatient occupational therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient physical therapy services furnished under this section;

(ii) Except as provided in paragraph (e)(3) of this section, outpatient speech-language pathology services furnished under § 410.62;

(iii) Outpatient physical therapy and speech-language pathology services furnished by a comprehensive outpatient rehabilitation facility;

(iv) Outpatient physical therapy and speech-language pathology services furnished by a physician or incident to a physician's service;

(v) Outpatient physical therapy and speech-language pathology services furnished by a nurse practitioner, certified nurse specialist, or physician assistant or incident to their services.

(3) For purposes of applying the limitation, outpatient physical therapy excludes services furnished by a hospital or CAH directly or under arrangements.

5. In § 410.61 pargraphs (a) through (d) and (e)(1) are revised to read as follows:

§ 410.61 Plan of treatment requirements for outpatient rehabilitation services.

(a) *Basic requirement.* Outpatient rehabilitation services (including services furnished by a qualified physical or occupational therapist in private practice), must be furnished under a written plan of treatment that meets the requirements of paragraphs (b) through (e) of this section.

(b) *Establishment of the plan.* The plan is established before treatment is begun by one of the following:

(1) A physician.

(2) A physical therapist who will furnish the physical therapy services.

(3) A speech-language pathologist who will furnish the speech-language pathology services.

(4) An occupational therapist who will furnish the occupational therapy services.

(c) *Content of the plan.* The plan prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan—

(1) Are made in writing and signed by one of the following:

(i) The physician.

(ii) The physical therapist who furnished the physical therapy services.

(iii) The occupational therapist who furnishes the physical therapy services.

(iv) The speech-language pathologist who furnishes the speech-language pathology services.

(v) A registered professional nurse or a staff physician, in accordance with oral orders from the physician, physical therapist, occupational therapist, or speech-language pathologist who furnishes the services.

(2) The changes are incorporated in the plan immediately.

(e) *Review of the plan.* (1) The physician reviews the plan as often as the individual's condition requires, but at least within the first 62 days and at least every 31 days after each previous review.

* * * * *

6. In § 410.62, the section heading is revised, paragraph (a)(3) is amended to add ''as defined in § 489.2'' after the words, ''by a provider'', and a new paragraph (d) is added to read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

* * * * *

(d) *Limitation.* After 1998, outpatient speech pathology services are subject to the limitation in 410.60(e).

* * * * *

7. New §§ 410.74, 410.75, 410.76, and 410.77 are added to subpart B to read as follows:

Subpart B—Medical and Other Health Services

* * * * *

§ 410.74 Physician assistant services.

(a) *Basic rule.* Medicare Part B covers physician assistant services only if the following conditions are met:

(1) The services would be covered as physician services if furnished by a physician (as used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act).

(2) The physician assistant—

(i) Meets the qualification requirements set forth in paragraph (c) of this section;

(ii) Is legally authorized to perform the services in the State which they are performed;

(iii) Performs services that are not otherwise precluded from coverage because of a statutory exclusion;

(iv) Performs the services under the general supervision of a physician (that is, the supervising physician need not be physically present when the physician assistant is performing the services unless required by State law; however, the supervising physician must be immediately available to the physician assistant for consultation); and

(v) Furnishes services that are billed by the employer of a physician assistant; and

(vi) Performs the services—

(A) In all settings in either rural and urban areas; or

(B) As an assistant at surgery.

(b) *Services and supplies furnished incident to physician assistant services.* Medicare covers services and supplies (including drugs and biologicals that cannot be self-administered) that are furnished incident to the physician assistant services described in paragraph (a) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the physician assistant services;

(3) Are, although incidental, an integral part of the professional service performed by the physician;

(4) Are performed under the direct supervision of the physician assistant (that is, the physician assistant is physically present and immediately available); and

(5) Are performed by the employee of a physician assistant or an entity that employs both the physician assistant or ancillary personnel.

(c) *Qualifications.* For Medicare Part B coverage of his or her services, a

physician assistant must meet the applicable State requirements governing the qualifications for physician assistants and at least one of the following conditions:

(1) Be certified by either the National Commission on Certification of Physician Assistants to assist primary care physicians or the National Board for Certification of Orthopedic Physician assistants to assist orthopedic surgeons; or

(2) Have satisfactorily completed a program for preparing physician assistants that was at least 1 academic year in length, consisted of supervised clinical practice and at least 4 months (in aggregate) of classroom instruction directed toward preparing students to deliver health care, and was accredited by either the Commission on Accreditation of Allied Health Education Programs or the American Society of Orthopedic Physician Assistants; or

(3) Have satisfactorily completed a formal education program for preparing physician assistants that does not meet the requirements of § 410.74(c)(2) and have assisted physicians for a total of 12 months during the 18-month period that ended on [Insert 18 months from the effective date of final rule].

(d) *Professional services.* Physician assistants can be paid for professional services only if the services have been professionally performed by them and no facility or other provider charges for the service or is paid any amount for the furnishing of those professional services.

(1) Supervision of other nonphysician staff by physician does not constitute personal performance of a professional service by physician assistants.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Physician assistants may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, physician assistants must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that physician assistants may furnish include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can be furnished by physician assistants only if State law or regulation governing the physician assistant scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.75 Nurse practitioner services.

(a) *Definition.* As used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act.

(b) *Qualifications.* For Medicare Part B coverage of his or her services, a nurse practitioner must—

(1) Be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of a nurse practitioner in accordance with State law, and have a master's degree in nursing;

(2) Be certified as a nurse practitioner by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (b)(1) of this section; or

(3) Meet the requirements for a nurse practitioner set forth in paragraph (b)(1) of this section, except for the master's degree requirement, and have received before [Insert 3 years from effective date of final rule] a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(c) *Services.* Medicare Part B covers nurse practitioner services in all settings in both rural and urban areas, only if the services would be covered if furnished by a physician and the nurse practitioner—

(1) Is legally authorized to perform them in the State in which they are performed;

(2) Performs them while working in collaboration with a physician;

(i) Collaboration is a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the practitioner and the physician, or as provided for by other mechanisms defined by Federal regulations, or by the law of the State in which the services are performed.

(ii) The absence of State law or guidelines does not negate the requirement for collaboration.

(iii) The collaborating physician does not need to be present with the nurse practitioner when the service is furnished or to make an independent evaluation of each patient seen by the nurse practitioner.

(iv) Collaboration involves systematic formal planning, assessment, and a practice arrangement that reflects and demonstrates evidence of consultation, recognition of statutory limits, clinical authority and accountability for patient care, according to a mutual agreement that allows the physician and the nurse practitioner to function independently as appropriate; and

(3) Is not performing services otherwise precluded from coverage because of one of the statutory exclusions.

(d) *Services and supplies incident to nurse practitioner services.* Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) incident to nurse practitioner services that meet the requirements in paragraph (c) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the nurse practitioner services;

(3) Although incidental, are an integral part of the professional service performed by the nurse practitioner; and

(4) Are performed under the direct supervision of the nurse practitioner (that is, the nurse practitioner must be physically present and immediately available).

(e) *Professional services.* Nurse practitioners can be paid for professional services only when the services have been personally performed by them and no facility or other provider charges or is paid any amount for the furnishing of such professional services.

(1) Supervision of other nonphysician staff by nurse practitioners does not constitute personal performance of a professional service by nurse practitioners.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Nurse practitioners may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, the nurse practitioner must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that nurse practitioners may provide include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can only be furnished by

nurse practitioners if State law or regulation governing the nurse practitioner scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.76 Clinical nurse specialist services.

(a) *Definition.* As used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act.

(b) *Qualifications.* For Medicare Part B coverage of his or her services, a clinical nurse specialist must—

(1) Be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of a clinical nurse specialist in accordance with State law, and have a master's degree in a defined clinical area of nursing from an accredited educational institution;

(2) Be certified as a clinical nurse specialist by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (b)(1) of this section; or

(3) Meet the requirements for a clinical nurse specialist set forth in paragraph (b)(1) of this section, except for the master's degree requirement, and have received before [Insert 3 years from effective date of final rule] a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(c) *Services.* Medicare Part B covers clinical nurse specialist services in all settings in both rural and urban areas only if the services would be covered if furnished by a physician and the clinical nurse specialist—

(1) Is legally authorized to perform them in the State in which they are performed; and

(2) Performs them while working in collaboration with a physician.

(i) Collaboration is a process in which a clinical nurse specialist works with a physician to deliver health care services within the scope of the clinical nurse specialist's expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the clinical nurse specialist and the physician, or as provided for by other mechanisms defined by Federal regulations, or by the law of the State in which the services are performed.

(ii) The absence of State law or guidelines does not negate the requirement for collaboration.

(iii) The collaborating physician does not need to be present with the clinical nurse specialist when the service is furnished or to make an independent evaluation of each patient seen by the clinical nurse specialist.

(iv) Collaboration involves systematic formal planning, assessment, and a practice arrangement that reflects and demonstrates evidence of consultation, recognition of statutory limits, clinical authority and accountability for patient care, according to a mutual agreement that allows the physician and the clinical nurse specialist to function independently as appropriate; and

(3) Is not performing services that are otherwise precluded from coverage by one of the statutory exclusions.

(d) *Services and supplies incident to clinical nurse specialist services.* Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) incident to a clinical nurse specialist's services that meet the requirements in paragraph (c) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the clinical nurse specialist services;

(3) Although incidental, are an integral part of the professional service performed by the clinical nurse specialist; and

(4) Are performed under the direct supervision of the clinical nurse specialist (that is, the clinical nurse specialist must be physically present and immediately available).

(e) *Professional services.* Clinical nurse specialists can be paid for professional services only when the services have been personally performed by them and no facility or other provider charges or is paid any amount for the furnishing of such professional services.

(1) Supervision of other nonphysician staff by clinical nurse specialists does not constitute personal performance of a professional service by clinical nurse specialists.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Clinical nurse specialists may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, the clinical nurse specialist must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that clinical nurse specialists may provide include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can only be furnished by clinical nurse specialists if State law or regulation governing the clinical nurse specialist scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.77 Certified nurse-midwife services: Qualifications and conditions.

(a) *Qualifications.* For Medicare coverage of his or her services, a certified nurse-midwife must—

(1) Be currently licensed to practice in the State as a registered professional nurse;

(2) Be legally authorized under State law or regulations to practice as a nurse-midwife in the State in which the services are performed;

(3) Have successfully completed a program of study and clinical experience for nurse-midwives, as specified by the State, or, if the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, meet one of the following criteria:

(i) Be currently certified as a nurse-midwife by the American College of Nurse-Midwives, in accordance with its October 1994 requirements or subsequent amendments to those requirements recognized by the Secretary, or by another certifying entity recognized by the Secretary.

(ii) Have successfully completed a formal educational program (of at least 1 academic year) that, upon completion, qualifies him or her to take the certification examination offered by the American College of Nurse-Midwives or by another certifying entity recognized by the Secretary. (The individual is not required to take the examination, however.)

(iii) Have successfully completed a formal educational program for preparing registered nurses to furnish gynecological and obstetrical care during pregnancy, delivery, and the postpartum period and care to normal newborns, and practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976 to July 16, 1982.

(b) *Services.* Certified nurse-midwife services are services furnished by a certified nurse-midwife and services and supplies furnished as an incident to the certified nurse-midwife services that—

(1) Are within the scope of practice authorized by the law of the State in which they are furnished and would otherwise be covered if furnished by a physician or as an incident to a physician service; and

(2) Unless required by State law, are provided without regard to whether the certified nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

(c) *Incident to services: Basic rule.* Medicare covers services and supplies furnished incident to the services of a certified nurse-midwife, including drugs and biologicals that cannot be self-administered, if the services and supplies meet the following conditions:

(1) They would be covered if furnished by a physician or as incident to the professional services of a physician.

(2) They are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the certified nurse-midwife services.

(3) Although incidental, they are an integral part of the professional service performed by the certified nurse-midwife.

(4) They are furnished under the direct supervision of a certified nurse-midwife (that is, the midwife is physically present and immediately available).

(d) *Professional services.* A nurse-midwife can be paid for a professional service only when the service has been personally performed by the nurse-midwife.

(1) Supervision of other nonphysician staff by a nurse-midwife does not constitute personal performance of a professional service by the nurse-midwife.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. A nurse-midwife may not charge a beneficiary for a service not payable under this provision. If the beneficiary has made payment for the service, the nurse-midwife must make the appropriate refund to the beneficiary.

(3) A nurse-midwife may provide services related to the maternity cycle that includes pregnancy, labor, and the immediate post partum period and other services including obstetrical and gynecological services.

(4) The services that the nurse-midwife performs are not services otherwise precluded from coverage because of one of the statutory exclusions.

7. In § 410.150, the introductory text to paragraph (b) is republished, and new paragraphs (b)(15) and (b)(16) are added to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(15) To the qualified employer of a physician assistant for professional services furnished by the physician assistant and for services and supplies furnished incident to their services. Payment is made to the employer of a physician assistant regardless of whether the physician assistant is employed as a W–2 employee or whether the physician assistant is a 1099 employee who is acting as an independent contractor. A qualified employer is not a group of physician assistants that incorporate to bill for their services. Payment is made only if no facility or other provider charges or is paid any amount for services furnished by a physician assistant.

(16) To a nurse practitioner or clinical nurse specialist for professional services furnished by a nurse practitioner or clinical nurse specialist in all settings in both rural and nonrural areas and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for the furnishing of the professional services of the nurse practitioner or clinical nurse specialist.

8. In § 410.152, the headings to paragraphs (a) and (a)(1) are republished, and paragraph (a)(1)(v) is revised to read as follows:

§ 410.152 Amount of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses.* * * *

(v) In the case of expenses incurred for outpatient physical therapy services including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.60(e). In the case of expenses incurred for outpatient occupational therapy including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.59(e).

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

c. Part 413 is amended as set forth below.

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. Section 413.125 is revised to read as follows:

§ 413.125 Payment for home health agency services.

The reasonable cost of outpatient rehabilitation services furnished by a home health agency to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under part 414 of this chapter for comparable services.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

C. Part 414 is amended as set forth below:

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. In § 414.1, the introductory text is republished, and the following statutory authority is added in numerical order to read as follows:

§ 414.1 Basis and scope.

This part implements the indicated provisions of the following sections of the Act:

1802—Rules for private contracts by Medicare beneficiaries.

* * * * *

3. Sections 414.20 through 414.62 are redesignated as subpart B, and a new heading is added to read ''Physicians and Other Practitioners''.

4. In § 414.22, the introductory text to the section and the heading to paragraph (b) are republished, and new paragraph (b)(5) is added to read as follows:

§ 414.22 Relative value units (RVUs).

HCFA establishes RVUs for physician work, physician practice expense, and malpractice insurance.

* * * * *

(b) *Practice expense RVUs.* * * *

(5) For services furnished in 1999, the practice expense RVUs are based on 75 percent of the practice expense RVUs applicable to services furnished in 1998 and 25 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2000, the practice expense RVUs are based on 50 percent of the practice expense RVUs applicable to services furnished in 1998 and 50 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2001, the practice expense RVUs are based on 25 percent of the practice expense RVUs applicable to services furnished in 1998 and 75 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

(i) Usually one of two levels of practice expense RVUs per code can be applied to each service. The lower practice expense RVUs apply to services furnished to hospital or ambulatory surgical center patients. The higher practice expense RVUs apply to services performed in a physician office; services, other than evaluation and management services, furnished to patients in a nursing facility, in a facility or institution other than a hospital or ambulatory surgical center, or in the home; and other services furnished to facility patients for which the facility payment does not include physician practice costs.

(ii) Only one practice expense RVU per code can be applied for each of the following services: services that have only technical component practice expense RVUs or only professional component practice expense RVUs; evaluation and management services, such as hospital or nursing facility visits, that are furnished exclusively in one setting; and major surgical services.

* * * * *

6. In § 414.32, paragraph (b) is revised to read as follows:

§ 414.32 Determining payments for certain physician services furnished in facility settings.

* * * * *

(b) *General rule.* If physician services of the type routinely furnished in physician offices are furnished in facility settings before January 1, 1999, the physician fee schedule amount for those services is determined by reducing the practice expense RVUs for the services by 50 percent. For services furnished on or after January 1, 1999, the practice expense RVUs are determined in accordance with § 414.22(b)(5).

* * * * *

7. In § 414.34, the section heading is revised, and a new paragraph (a)(2)(iii) is added to read as follows:

§ 414.34 Payment for services and supplies incident to a physician service.

* * * * *

(a) *Medical supplies.* * * *

(2) * * *

(iii) It is furnished before January 1, 1999.

* * * * *

8. In § 414.52, the section heading and the introductory text are revised, and a new paragraph (d) is added to read as follows:

§ 414.52 Payment for physician assistant services.

Allowed amounts for the services of a physician assistant furnished beginning January 1, 1992 and ending December 31, 1997, may not exceed the limits specified in paragraphs (a) through (c) of this section. Allowed amounts for the services of a physician assistant furnished beginning January 1, 1998, may not exceed the limits specified in paragraph (d) of this section.

* * * * *

(d) For services (other than assistant-at-surgery services) furnished beginning January 1, 1998, 85 percent of the physician fee schedule amount for the service. For assistant-at-surgery services, 85 percent of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant-at-surgery services were furnished by a physician.

9. Section 414.56 is revised to read as follows:

§ 414.56 Payment for nurse practitioner and clinical nurse specialist services.

(a) *Rural areas.* For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a rural area (as described in section 1861(s)(2)(K)(iii) of the Act) may not exceed the following limits.

(1) for services furnished in a hospital (including assistant-at-surgery services), 75 percent of the physician fee schedule amount for the service.

(2) For all other services, 85 percent of the physician fee schedule amount for the service.

(b) *Non-rural areas.* For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed 85 percent of the physician fee schedule amount for the service.

(c) *Beginning January 1, 1998.* For services (other than assistant at surgery services) furnished beginning January 1, 1998, allowed amounts for the services of a nurse practitioner or clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount for the service. For assistant at surgery services, allowed amounts for the services of a nurse practitioner or clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant at surgery service were furnished by a physician.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

D. Part 415 is amended as set forth below:

1. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. In § 415.110, the section heading is revised, paragraph (a) is revised, paragraph (b) is redesignated as paragraph (c), and a new paragraph (b) is added to read as follows:

§ 415.110 Conditions for payment: Medically directed anesthesia services.

(a) *General payment rule.* The Medicare carrier pays for the physician's medical direction of anesthesia services for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in § 415.102(a) and the following additional conditions:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation, or reviews one performed by another qualified individual permitted by the State to administer anesthetics;

(ii) Participates in the development of the anesthesia plan and gives final approval of the proposed plan;

(iii) Personally participates in the most demanding aspects of the anesthesia plan;

(iv) Ensures that any aspect of the anesthesia plan not performed by the anesthesiologist is performed by a qualified individual as specified in operating instructions;

(v) Monitors the course of anesthesia at intervals medically indicated by the nature of the procedure and the patient's condition;

(vi) Remains physically present in the facility and immediately available for diagnostic and therapeutic emergencies;

(vii) Provides indicated post-anesthesia care or ensures that it is provided by a qualified individual as described in paragraph (a)(1)(iv) of this section.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in § 414.46(c) of this chapter (Physician personally performs the anesthesia procedure) apply.

(b) *Medical documentation.* The physician inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting personal participation in the most demanding aspects of the anesthesia plan.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

E. Part 424 is amended as set forth below:

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. In § 424.24, paragraphs (c)(1)(iii), (c)(3)(ii), and (c)(4) are revised to read as follows:

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

* * * * *

(c) *Outpatient physical therapy and speech-language pathology services*—(1) *Content of certification.* * * *

(iii) The services were furnished under a plan of treatment that meets the requirements of § 410.61.

* * * * *

(3) *Signature.* * * *

(ii) If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician who has knowledge of the case.

(4) *Recertification*—(i) *Timing.* The first recertification is required by no later than the 62nd day and subsequent recertifications are required at least every 31 days.

(ii) *Content.* The recertification statement must indicate the continuing need for physical therapy or speech-language pathology services and an estimate of how much longer the services will be needed.

(iii) *Signature.* Recertifications must be signed by the physician who reviews the plan of treatment.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

F. Part 485 is amended as set forth below:

1. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. Section 485.705 is revised to read as follows:

§ 485.705 Personnel qualifications.

(a) *General qualification requirements.* Except as specified in paragraphs (b) and (c) of this section, all personnel who are involved in the furnishing of outpatient physical therapy, occupational therapy, and speech-language pathology services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which he or she performs the functions or actions, and must act only within the scope of his or her state license or State certification or registration.

(b) *Exception for Federally defined qualifications.* The following Federally defined qualifications must be met:

(1) For a physician, the qualifications and conditions as defined in section 1861(r) of the Act and the requirements in part 484 of this chapter.

(2) *For a speech-language pathologist,* the qualifications specified in section 1861(11)(1) of the Act and the requirements in part 484.

(c) *Exceptions when no State Licensing laws or State certification or registration requirements exist.* If no State licensing laws or State certification or registration requirements exist for the profession, the following requirements must be met:

(1) An *administrator* is a person who has a bachelor's degree and:

(i) Has experience or specialized training in the administration of health institutions or agencies; or

(ii) Is qualified and has experience in one of the professional health disciplines.

(2) An *occupational therapist* must meet the requirements in part 484.

(3) An *occupational therapy assistant* must meet the requirements in part 484.

(4) A *physical therapist* must meet the requirements in part 484.

(5) A *physical therapist assistant* must meet the requirements in part 484.

(6) A *social worker* must meet the requirements in part 484.

(7) A *vocational specialist* is a person who has a baccalaureate degree and:

(i) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, State employment service agency, etc.; or

(ii) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and 1 year of experience in vocational counseling in a rehabilitation setting; or

(iii) A master's degree in vocational counseling.

3. In § 485.711, paragraph (b)(3) is revised to read as follows:

§ 485.711 Conditions of participation: Plan of care and physician involvement.

* * * * *

(b) * * *

(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken. (For Medicare patients, the plan must be reviewed by a physician within the first 62 days and at least every 31 days thereafter, in accordance with § 410.61(e) of this chapter.)

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 15, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: May 21, 1998.

Donna E. Shalala,

Secretary.

Note: The following addendums will not appear in the Code of Federal Regulations.

Addendum A—Description of Clinical Practice Expert Panel Data and Methodology

To aid us in collecting the data to implement our methodology for a resource-based system for determining practice expense RVUs for each physician service, we awarded a contract to Abt Associates in March 1995. Under the contract, Abt used Clinical Practice Expert Panels (CPEPs)

to collect data that could be used to generate direct practice expense RVUs for each service. Through the use of CPEPs, Abt furnished us with the direct inputs of physician services. Direct inputs are the quantity and type of nonphysician labor, medical supplies, and medical equipment associated with a service, such as the minutes of a registered nurse's time, a pair of sterile gloves, and a surgical mask. The CPEPs also reported additional items as direct inputs, such as administrative services, including the amount of time medical secretaries and billing and insurance personnel spend in activities related to specific services. Abt priced the direct inputs and determined the direct costs for each service.

The direct inputs do not include the physician's time. Physician time and effort are components of work RVUs and are paid under the work component of the physician fee schedule.

The general approach for establishing a resource-based practice expense system was to use CPEPs to identify as many direct inputs as possible for a physician service furnished to a typical patient (across all age groups) in various settings.

The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (such as registered nurses, psychologists, and physical therapists). Physician specialty societies and other groups nominated individuals for these positions. Final selections were made by Abt with our assistance.

In all, there were 15 CPEPs. The panels consisted of over 180 members from more than 61 specialties and subspecialties; approximately 50 percent of the panelists were physicians. Each CPEP consisted of 12 to 15 members.

The CPEPs identified the direct inputs involved in each physician service in an office setting and an out-of-office setting (such as a hospital and an ambulatory surgical center). Generally, if a service was furnished both in an office setting and an out-of-office setting but less than 10 percent of the time in either of these settings, it was not profiled in that setting.

We assisted Abt in identifying approximately 6,300 procedure codes for which resource-based practice expense RVUs were to be developed. Approximately 850 of these procedure codes have both technical components (TCs) and professional components (PCs), and we developed practice expense RVUs for both the TC and PC for each of the 850 procedures.

Abt grouped procedure codes included under the physician fee schedule into families of codes clinically related and with relatively comparable direct costs. The classification system for families of procedure codes is a hybrid of the Ambulatory Patient Groups System developed by 3M and the Berenson-Eggers-Holahan (Urban Institute) system. Abt assigned each family of codes to a CPEP based on the physician specialty that predominantly furnished the services. For example, the panels were categorized as integumentary, male genital and urinary, orthopedics, obstetrics and gynecology, ophthalmology, radiology, evaluation and management, general surgery, otolaryngology, miscellaneous internal medicine, gastroenterology, cardiothoracic and vascular, cardiology, anesthesia and pathology, and neurosurgery CPEPs.

Our medical staff, Abt's clinical consultants, and other advisors reviewed this system. Some families of codes were assigned to more than one CPEP to validate resource inputs across CPEPs. For example, the evaluation and management family of codes was assigned to every CPEP except the radiology CPEP and the anesthesia and pathology CPEP.

Abt selected a reference service for each family of codes. (Abt compiled the initial list of reference services based on recommendations from numerous specialty societies.) The following four criteria were established to guide the selection process for the reference service:

- It had to be commonly performed.
- It had to have a mid-range level of resource use relative to other codes in the family.
- It had to be a code whose definition or coding application has not markedly changed in the last several years.
- It had to be performed with minimal variation by all physicians.

In August 1995, physician specialty groups were given an opportunity to review and comment on a draft document containing the procedure code family classification system, the reference code (to serve as a benchmark for creating resource profiles for the remainder of services within each family of procedure codes), and the CPEP to which the family was assigned. The comments were considered by Abt and HCFA in designing the final classification system including the number of CPEPs.

The final classification system contained 229 unique families of codes assigned to 15 CPEP panels. Twelve to 29 families of procedure codes were assigned to each CPEP with most CPEPs reviewing 19 to 23 families of procedure codes.

The CPEPs met twice. During the first CPEP session in February 1996, the CPEPs identified the direct inputs for designated reference services. The CPEPs met again in June 1996 to identify the inputs for the remaining procedure codes covered under the physician fee schedule.

a. Collection of Information From the Clinical Practice Expert Panels

Abt designed the following four uniform worksheets that were used to collect the inputs identified by the CPEPs:

- Worksheet Package G: Services with a global period.
- Worksheet Package P: Services without a global period.
- Worksheet Package M: Evaluation and Management services.
- Worksheet Package Pa: Pathology services.

For labor inputs, either clinical or administrative, the worksheets identified the function or activity with the occupational category of the individual furnishing the service. For clinical functions, examples of occupational categories included a registered nurse, licensed practical nurse, and certified medical assistant. For administrative functions, examples of occupational categories included medical secretaries, insurance or billing clerks, transcriptionists, and scheduling secretaries. The clinical labor worksheets accumulated labor inputs by preservice, service, and postservice periods for surgical procedures with a global period. For surgical procedures without a global period, evaluation and management services, and pathology services, the worksheets accumulated labor inputs by the service period. The administrative labor worksheets collected labor inputs by preservice and postservice periods.

During the first round of the CPEPs, Abt collected detailed data by each of the functions listed within the preservice, service, and postsurgical visit periods of each service. These were activities performed by nonphysician clinical and administrative personnel, not physicians. For example, the evaluation and management services worksheet listed the following clinical activities in the preservice period:

- Obtain medical history/review patient charts.
- Greet patient/provide gowning.
- Perform room preparation/prepare medical equipment.
- Prepare patient.
- Obtain vital signs.
- Other.

Similarly, the following administrative activities were listed in the preservice period:

- Obtain referral from referring M.D.
- Schedule patient/remind patient of appointment.
- Obtain medical records, manage/recall patient database, assemble/develop patient chart.
- Precertify patient/conduct preservice billing.
- Verify insurance/review coverage/register patient.

For the intraservice period, the following clinical activities were listed:

- Obtain medical history.
- Record notes.
- Other.

The following clinical activities were listed in the postservice period:

- Clean room/equipment/shut down equipment.
- Provide postservice education.
- Complete diagnostic medical forms, x-ray requisitions, prescriptions.
- Review results.
- Checkout/provide discharge instructions/complete nursing forms.
- Conduct follow-up phone calls to patient/respond to patient calls/call-in prescription refills.
- Other.

Similarly the following administrative activities were listed in the postservice period:

- Transcribe results/file and manage patient records.
- Schedule postoperative return evaluation and management services/arrange for hospital readmission.
- Notify and complete reports to referring MDs.
- Conduct billing activities (coordinate bill collection/rebilling, collect coinsurance payments or deductibles, postcertify patient).

During the second round of the CPEPs, Abt collected the inputs by the broader category of service. For example, for additional evaluation and management services codes in the same family as the reference code, Abt collected totals on clinical times for the preservice period, the intraservice period, and the postservice period. Similarly, the same process was followed for administrative inputs. This less detailed, more aggregated, process was used because of the large volume of procedure codes the CPEPs had to review during the second round and because the CPEPs believed this level of detail was sufficient.

b. Pricing of Clinical Practice Expert Panels' Direct Inputs

Having identified the type and quantity of direct inputs from the CPEP process, our methodology required the assignment of a national price for each resource input. Abt priced each of the CPEP direct inputs (nonphysician labor, medical supplies, and medical equipment) using a specific methodology. The methodology for each of these items is discussed below.

(1) Nonphysician Labor

Abt calculated the total compensation per minute for approximately 100 occupational categories that include clinical and administrative staff. The data sources for these staff identified hourly wages, including fringe benefits, per person for 1993 or 1994. These wages were updated to 1995 using the Employment Cost Index for Wages and Salaries in Private Health Industries (published by the Bureau of Labor Statistics). They were converted to total compensation by adjusting the wage rate by a fringe benefits multiplier. The fringe benefits multiplier is 36.6 percent for all occupational categories. This is estimated from the Bureau of Labor Statistics Employer Costs for Employee Compensation for March 1995. Abt calculated the fringe benefit multiplied from the Bureau of Labor Statistics data using the ratio of the total cost of all benefits to the wage rate for all workers in private health services industries.

Three specific data sources were used. They were: (1) The Bureau of Labor Statistics' ''White Collar Pay Survey of Service-Producing Industries'' dated 1989 and the ''Occupational Compensation Survey'' dated 1994; (2) ''The Survey of Hospital and Medical School Salaries'' dated 1994 performed by the University of Texas Medical Branch; and (3) the Current Population Survey dated 1993. Although all three data sources were used, in cases of similar categories across data sets, the Bureau of Labor Statistics data were considered to be the primary data set. The University of Texas Medical Branch and Current Population Survey data were treated as supplements to be used when the Bureau of Labor Statistics' data could not furnish sufficient detail.

Abt categorized all personnel into five broad categories: clinical staff, administrative staff, clinical composite staff, administrative composite staff, and clinical/administrative composite staff. The administrative composite staff refers, for example, to a function described by a CPEP that could be performed by different personnel. A composite labor rate was calculated for this function for this CPEP.

We use the occupational category of the medical secretary to illustrate the mapping of the price for an administrative staff position. Every CPEP reported that a medical secretary performed certain functions as part of the procedure codes reviewed by that CPEP. From the Bureau of Labor Statistics' data, the updated 1995 total compensation, including fringe benefits, for a level II medical secretary is $16.43 per hour. (The Bureau of Labor Statistics furnishes skilled level variations in wages and duties for registered nurses, licensed practical nurses, secretaries, office clerks, and nursing assistants. In general, as we advised, Abt used the Bureau of Labor Statistics' wage for level II staff.) This converts to a total compensation per minute of $0.274 for a medical secretary, and this labor rate was made uniform across all CPEPs. If, for example, a CPEP specified that a medical secretary was needed for 10 minutes to provide administrative services for a specific CPT code, that labor input would be costed at $2.74.

Similarly, we use the occupational category of a registered nurse to illustrate the mapping of the price for a clinical staff position. Every CPEP, except the gastroenterology CPEP, reported that a registered nurse performed certain functions with respect to the procedure codes reviewed by that CPEP. The hourly wage for a level II registered nurse was $18.52 under the Bureau of Labor Statistics' survey. The total compensation, including fringe benefits, for a registered nurse is $25.30 per hour. This converts to a total compensation per minute of $0.422. Thus, for each CPEP, the minutes of a registered nurse's time are costed at $0.422. If, for example, a CPEP specified that a registered nurse was needed for 10 minutes to provide clinical services for a specific CPT code for a patient, that direct input would be costed at $4.22.

(2) Medical Supplies

Overall, the CPEPs identified 665 supply items for which Abt obtained prices from three types of sources:

- Published catalogs—These were used for the most common supplies and CPEP panelists often provided recommendations of catalogs or other sources.
- Contacts with suppliers—This source was used primarily for specialized supplies.
- CPEP members—This source was used if prices were unavailable from catalogs or suppliers.

Examples of medical supplies include disposable gowns, examination table paper, disposable pillow cases, nonsterile or sterile gloves, disposable suture removal kit, Vicryl suture, 4–0 and 5–0, and sterile gauze. Abt used the same prices for these supplies across all CPEPs. For example, for all CPEPs, the

price of the disposable gown is $0.57 per item and is based on a representative price from Baxter Healthcare Corporation, a major medical supplier. Similarly, the price of the disposable suture removal kit for all CPEPs is $5.45 per kit and is based on a representative price from Darby Drug Company.

(3) Medical Equipment

Medical equipment was divided into two categories—procedure-specific equipment and overhead equipment. Procedure-specific medical equipment is used for a specific subset of services within a specialty, such as a stress-test treadmill as part of a cardiology procedure. Overhead medical equipment is either used for all services furnished or is rarely used (for example, a crash cart containing emergency supplies) but is routinely purchased and maintained in a practice and is difficult to attribute to a specific service. Only equipment with costs equal to or exceeding $500 was costed under the medical equipment methodology. The cost per use for equipment costing less than $500 was considered to be trivial.

Information about the type of equipment used to furnish each service was obtained from the CPEPs. Abt applied price data to the resource profiles generated by the CPEPs. In most cases, Abt collected list prices from equipment suppliers. For example, the list price for a flexible laryngoscope is $5,080 (this information is from Welch-Allyn, a medical equipment supplier). Prices were obtained for almost 400 equipment items.

To cost procedure-specific and overhead equipment, Abt assumed 70-percent and 100-percent utilization rates, respectively. Based on comments from the physician specialty groups, we have changed the utilization level for procedure-specific equipment from 70 percent to 50 percent.

Procedure-specific equipment was costed based on the number of minutes the equipment was used for the procedure. The proxy for this is usually technician time. Overhead equipment was costed based on the estimated time for the staff with the most involvement in the procedure. For example, if a procedure involving a piece of equipment was performed in the office and involved 15 minutes of registered nurse time and 30 minutes of physician assistant time, the time of the procedure would be 30 minutes since this is the longest of the nonphysician clinical staff times.

The objective in pricing medical equipment was to establish an equipment cost per minute. The equipment pricing model uses the following variables:

- The purchase price of the equipment with primary sources of information from national manufacturers.
- The useful life of the equipment with primary sources of information from ''Useful Life Guidelines'' from the American Hospital Association.
- The annual maintenance cost with primary sources of information from the Medical Group Management Association.
- The cost of capital.
- The time per procedure with primary sources of information from CPEP labor estimates.
- The hours of practice (that is, 50 hours per week and 50 weeks per year) with primary sources of information from the Medical Group Management Association and the AMA.
- The machine capacity, based on a practice's hours, with the assumption that the equipment operates at a fixed percentage (in this case 50 percent) of capacity.

Ideally, a cost of capital would be established from a nationally representative sample of data containing loan rates and length of loan for physician practices. Such data do not exist. As a result, Abt developed proxy data based on prevailing loan rates for small businesses. In this model, interest rates varied by the loan period (one rate for periods less than or equal to 7 years and another for periods greater than 7 years) and based on the purchase price of the equipment (one rate for equipment costing less than or equal to $25,000 and another for equipment costing more than $25,000).

Amount	Interest rate (percent)	
	Loan period ≤7 years	Loan period >7 Years
>$25,000	9.5	10.
≤$25,000	10.5	11

For example, the cost of capital for an item of medical equipment costing more than $25,000 and with a useful life less than 7 years was assigned an interest rate of 9.5 percent.

The following example illustrates the application of the pricing model for equipment that is used to perform only one type of procedure code, assuming the following:

- The equipment is operated at 50 percent of capacity.
- The practice operates 50 hours per week or 105,000 minutes per year (60 minutes/hour×50 hours/week×50 weeks/year×.50=75,000 minutes).
- The cost of capital (that is, the interest cost of a loan or opportunity cost of invested funds is 9.5 percent).
- The purchase price of the equipment is $30,000.
- The useful life of the equipment is 5 years.
- The annual maintenance costs are 5 percent of the annual purchase price (.05×$30,000) or $1,500.
- The procedure performed on the equipment takes 10 minutes.

Cost per procedure=10×[$30,000/(75,000×3.8397)+1,500/75,000]

Cost per procedure=$1.24

Note: 3.38397 represents $\Sigma 1/(1+r)^t$ where t=0 to 5. The cost of capital is discounted by the number of years of useful life. The annualized capitalized cost for the equipment is $9,313, which is the annual maintenance cost of $1,500, plus the annualized purchase price ($7,813), taking into account the opportunity cost of capital or $30,000 divided by 3.8397.

Addendum B. Resource Based Practice Expense Methodology and Example

Step 1: By specialty, use the American Medical Association's Socioeconomic Monitoring Survey actual cost data for 1995–1997 (SMS data) to determine practice expenses per hour by cost category.

Methodology

(1) Derive the expenses at the physician practice level using the SMS data by cost category. The cost categories are:

(a) total non-physician payroll expenses, which are payroll expenses (including fringe benefits) for non-physician personnel;

(b) administrative payroll expenses, which are payroll expenses (including fringe benefits) for non-physician personnel involved in administrative, secretarial, or clerical activities;

(c) office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephone;

(d) medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products;

(e) medical equipment expenses, which include expenses for depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients;

(f) all other expenses, which include expenses for legal services, accounting services, office management services, professional association memberships, journals and continuing education, professional car upkeep and depreciation, and any professional expenses not mentioned above.

We refer to the difference between the total nonphysician payroll expense category and the clerical payroll expense category as the clinical payroll expense category.

(2) Derive the number of hours spent in patient care activities by physicians in the practice.

(3) Divide the expenses at the practice level by the number of hours spent in patient care activities by the physicians in the practice.

Derivations

$$\text{Practice expenses per hour for cost category x of specialty j} = PEHR_{x,j} = \frac{\sum_i \frac{\left(pe_{i,j,x} * o_{i,j}\right)}{\left(rh_{i,j} * o_{i,j}\right) + \left(e_{i,j} * eh_j\right)} * w_{i,j}}{\sum_i w_{i,j}}$$

i,j = respondent physician i of specialty j

$pe_{i,j,x}$ = category x practice expenses for respondent i of specialty j

$o_{i,j}$ = number of physician owners in the practice of respondent i of specialty j

$rh_{i,j}$ = number of hours worked in patient care activities during the year by respondent i of specialty j

$e_{i,j}$ = number of employee physicians in the practice of respondent i of specialty j

eh_j = average number of hours worked in patient care activities for employee physician's in specialty j

$w_{i,j}$= SMS weight for respondent i of specialty j to correct for potential nonresponse bias

Step 2: By specialty, determine the number of physician hours spent treating Medicare patients as reflected in the Medicare claims data.

Methodology

By specialty, determine the number of physician hours reflected in the Medicare physician fee schedule claims data as a weighted sum of the physician time associated with each procedure code on the fee schedule.

$$\text{physician hours for specialty j} = HOURS_J = \sum_k \left(t_k * f_{k,j}\right)$$

K = procedure code performed by specialty j

t_k = the physician time associated with procedure k, taken primarily from the AMA Relative Value Update committee surveys (where available) or surveys done for the initial establishment of the work relative value units

$f_{k,j}$ = the frequency with which procedure code k is performed on Medicare patients by the physicians in specialty j as reflected in the Medicare allowed claims data

Step 3: By specialty, multiply the SMS practice expenses per hour for each cost category (as calculated in Step 1) by the number of physician hours reflected in the Medicare physician fee schedule claims data (as calculated in Step 2).

Methodology

$$\text{The practice expense pool for cost category x of specialty j} = POOL_{X,J} = PEHR_{x,j} * HOURS_J$$

calculated for each × from 1 to 4, with 1 = clinical payroll expense, 2 = medical materials and supplies expense, 3 = medical equipment expense, 4 = a combined category of clerical payroll expense, office expense, and all other expenses.

Step 4: For each specialty and cost category, allocate the practice expense pool calculated in Step 3 to the procedures performed by that specialty.

Methodology

(1) Clinical payroll expense, medical materials and supplies, and medical equipment SMS pools.

The CPEP cost categories of clinical labor, medical supplies, and medical equipment in the facility and nonfacility place of service settings are used to allocate, respectively, the SMS cost category pools for clinical payroll expense, medical materials and supplies, and medical equipment.

$$\text{Practice expense pool allocation for category x to procedure code k for specialty j in place of service p} = costs_{x,k,j,p} = cpep_{x,k,p} * \frac{POOL_{x,j}}{\sum_k \sum_p cpep_{x,k,p} * f_{k,j,p}}$$

p = place of service where the procedure is performed with p=1 the facility setting (eg hospital) and p=2 the nonfacility setting (eg physician's office)

$cpep_{x,k,p}$ = CPEP costs for category x for procedure code k in setting p (procedure codes costed in a setting as nonzero by more than one CPEP are averaged)

$f_{k,j,p}$ = the frequency with which procedure code k was performed in place of service p on Medicare patients by the physicians in

specialty j as reflected in the Medicare allowed claims data

calculate for each × from 1 to 3

(2) Administrative payroll expense, office expense, and other expense SMS pools.

A combination of the clinical payroll, medical materials and supplies, and medical equipment code allocations calculated in (1) and the physician fee schedule work relative value units are used to allocate the combined SMS cost category pool for administrative payroll expense, office expense, and other expense (category 4).

$$\text{Practice expense pool allocation for category 4 to procedure code k for specialty j in setting p} = \text{costs}_{4,k,j,p} = \left[\left(\sum_{x=1}^{3}\text{costs}_{x,k,j,p}\right)+\left(w_k * s\right)\right] * \frac{\text{POOL}_{x,j}}{\sum_k\sum_p\left[\left(\left(\sum_{x=1}^{3}\text{costs}_{x,k,j,p}\right)+\left(w_k * s\right)\right) * f_{k,j,p}\right]}$$

w_k = the work relative value units for procedure code k

s = factor to convert work relative value units to SMS category pool dollars

Step 5: Weight average the allocations calculated in Step 4 to account for procedure codes performed by more than one specialty.

Methodology

For procedure codes performed by only one specialty, use that specialty's allocation. For procedure codes performed by more than one specialty, take a weighted average of the allocations for the specialties which perform the procedure, where the weight is the frequency with which the procedure is performed by that specialty.

Practice expense pool allocation for category x to procedure code k in place of service p = $\text{costs}_{x,k,p}$ =

$$\text{Practice expense pool allocation for category x to procedure code k in place of service p} = \text{costs}_{x,k,p} = \frac{\sum_j\left(\text{costs}_{x,j,k,p} * f_{k,j,p}\right)}{\sum_j f_{k,j,p}}$$

Step 6: From the allocations calculated in Step 5, create the new practice expense relative units by place of service for each procedure code.

Methodology

For each procedure code, multiply the sum of the allocations from Step 5 for the four cost categories by the ratio of the available pool of practice expense relative value units to the weighted sum of all the procedure code allocations. Although not illustrated below, procedure codes with professional and technical components were adjusted as described earlier in this **Federal Register** notice to ensure that the technical and professional components sum to the global for the service. New practice expense relative value unit for procedure code k in place of service p = $\text{rvunew}_{k,p}$ =

$$\text{new practice expense relative value unit for procedure code k in place of service p} = \text{rvunew}_{k,p} = \sum_x \text{costs}_{x,k,p} * \frac{\sum_k\sum_p\left(\text{rvuold}_{k,p} * f_{k,p}\right)}{\sum_k\sum_p\left(\left(\sum_x \text{costs}_{x,k,p}\right) * f_{k,p}\right)}$$

Example

The following example is designed to illustrate the resource based practice expense methodology described above. For simplicity, the entire Medicare physician fee schedule universe is assumed to consist of two specialties and six procedure codes. This example does not yield the actual resource based practice expense relative value units found in Addendum C for the six codes.

BILLING CODE 4120–03–P

TABLE 1

Step 1: Results of practice expense per hour derivation

	(A)	(B)	(C)	(D)	(E)	(F)	(G)
	Practice Expenses per Hour						
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll	Office Expenses	All Other Expenses	Total*
Family Practice	$15.10	$8.10	$3.60	$15.10	$18.20	$8.60	$68.60
General Surgery	$6.80	$3.10	$2.00	$15.70	$17.20	$9.40	$54.10

*Components may not add to totals due to rounding

TABLE 2

Step 2: Determine the number of hours spent treating Medicare patients as reflected in Medicare claims data

Specialty	CPT	Description	(A) Physician Time for Procedure (mins)	(B) Physician Time for Procedure (hours)	(C) Medicare Frequency	(D) Total Physician Time (hours)
Family Practice						
	99213	Office/outpatient visit, est	23	0.38	17,720,998	6,793,049
	99232	Subsequent hospital care	30	0.50	3,558,740	1,779,370
					Total	8,572,419
General Surgery						
	35301	Rechanneling of artery	390	6.50	35,239	229,054
	44140	Sigmoidoscopy, diagnostic	511	8.52	47,620	405,564
	45330	Partial removal of colon	28	0.47	48,815	22,780
	56340	Laparoscopic cholecystectomy	313	5.22	79,501	414,730
	99213	Office/outpatient visit, est	23	0.38	1,691,272	648,321
	99232	Subsequent hospital care	30	0.50	566,202	283,101
					Total	2,003,550

Notes:
(B) = (A) / 60
(D) = (B) * (C)

TABLE 3

Step 3: Multiply practice expenses per hour (from Step 1) by the number of physician hours (from Step 2)

	(A)	(B)	(C)	(D)	(E)
	Practice Expenses per Hour				Total Physician Time (hours)
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll, Office, and all other	
Family Practice	$15.10	$8.10	$3.60	$41.90	8,572,419
General Surgery	$6.80	$3.10	$2.00	$42.30	2,003,550

	(F)	(G)	(H)	(I)	(J)
	Practice Expense Pool				
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll, Office, and all other	Total
Family Practice	$129,443,530	$69,436,596	$30,860,709	$359,184,366	$588,925,201
General Surgery	$13,624,138	$6,211,004	$4,007,099	$84,750,150	$108,592,391
				Total	$697,517,592

Notes:
(D) = TABLE 1 COL (D) + TABLE 1 COL (E) + TABLE 1 COL (F)
(E) = TABLE 2 COL (D) "TOTAL"
(F) = (A) * (E)
(G) = (B) * (E)
(H) = (C) * (E)
(I) = (D) * (E)
(J) = (F) + (G) + (H) + (I)

TABLE 4

Step 4(1): For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

CPEP Data

	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data			CPEP Nonfacility Data		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
35301	$144.94	$1.04	$13.97			
44140	$188.13	$1.21	$12.74			
45330	$4.76	$0.00	$0.00	$28.85	$5.47	$116.12
56340	$96.30	$0.86	$8.68			
99213	$8.15	$0.00	$0.00	$16.43	$0.77	$2.85
99232	$3.72	$0.00	$0.00			

TABLE 5

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

Medicare Frequency Data

Specialty	CPT	(A) Medicare Frequency Facility	(B) Medicare Frequency Nonfacility	(C) Medicare Frequency Total
Family Practice				
	99213	420,181	17,300,817	17,720,998
	99232	3,558,740	0	3,558,740
General Surgery				
	35301	35,239	0	35,239
	44140	47,620	0	47,620
	45330	19,406	29,409	48,815
	56340	79,501	0	79,501
	99213	49,952	1,641,320	1,691,272
	99232	566,202	0	566,202
		470,133	18,942,137	19,412,270
		4,124,942	0	4,124,942
				23,537,212

TABLE 6

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

	CPEP Data * Medicare Frequency					
	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data *Medicare Freq			CPEP Nonfacility Data *Medicare Freq		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
Family Practice						
99213	$3,424,055	$0	$0	$284,326,950	$13,272,388	$49,323,188
99232	$13,237,623	$0	$0			
General Surgery						
35301	$5,107,682	$36,596	$492,130			
44140	$8,958,751	$57,715	$606,822			
45330	$92,276	$0	$0	$848,361	$160,729	$3,414,885
56340	$7,656,105	$67,973	$689,989			
99213	$407,059	$0	$0	$26,973,958	$1,259,145	$4,679,267
99232	$2,106,130	$0	$0			

Notes:
(A) = TABLE 4 COL (A) * TABLE 5 COL (A)
(B) = TABLE 4 COL (B) * TABLE 5 COL (A)
(C) = TABLE 4 COL (C) * TABLE 5 COL (A)
(D) = TABLE 4 COL (D) * TABLE 5 COL (B)
(E) = TABLE 4 COL (E) * TABLE 5 COL (B)
(F) = TABLE 4 COL (F) * TABLE 5 COL (B)

TABLE 7

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

Calculate Ratios

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Sum Table 6 Facility and Nonfacility			Table 3 Practice Expense Pool			Ratio		
	Clinical	Supplies	Equipment	Clinical Payroll	Medical Mat. and Supplies	Medical Equipment	Clinical Payroll	Medical Mat. and Supplies	Medical Equipment
Family Practice									
99213	$287,751,005	$13,272,388	$49,323,188						
99232	$13,237,623	$0	$0						
Total	$300,988,628	$13,272,388	$49,323,188	$129,443,530	$69,436,596	$30,860,709	0.430	5.232	0.626
General Surgery									
35301	$5,107,682	$36,596	$492,130						
44140	$8,958,751	$57,715	$606,822						
45330	$940,637	$160,729	$3,414,885						
56340	$7,656,105	$67,973	$689,989						
99213	$27,381,017	$1,259,145	$4,679,267						
99232	$2,106,130	$0	$0						
Total	$52,150,321	$1,582,158	$9,883,092	$13,624,138	$6,211,004	$4,007,099	0.261	3.926	0.405

Notes:
(A) = TABLE 6 COL (A) + TABLE 6 COL (D)
(B) = TABLE 6 COL (B) + TABLE 6 COL (E)
(C) = TABLE 6 COL (C) + TABLE 6 COL (F)
(G) = (D) / (A)
(H) = (E) / (B)
(I) = (F) / (C)

TABLE 8

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

Apply Ratios to CPEP Data

	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data * Ratio			CPEP Nonfacility Data * Ratio		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
Family Practice						
99213	$3.50	$0.00	$0.00	$7.07	$4.01	$1.78
99232	$1.60	$0.00	$0.00			
General Surgery						
35301	$37.87	$4.08	$5.66			
44140	$49.15	$4.76	$5.17			
45330	$1.24	$0.00	$0.00	$7.54	$21.45	$47.08
56340	$25.16	$3.36	$3.52			
99213	$2.13	$0.00	$0.00	$4.29	$3.01	$1.16
99232	$0.97	$0.00	$0.00			

Notes:
(A) = TABLE 4 COL (A) * TABLE 7 COL (G)
(B) = TABLE 4 COL (B) * TABLE 7 COL (H)
(C) = TABLE 4 COL (C) * TABLE 7 COL (I)
(D) = TABLE 4 COL (D) * TABLE 7 COL (G)
(E) = TABLE 4 COL (E) * TABLE 7 COL (H)
(F) = TABLE 4 COL (F) * TABLE 7 COL (I)

TABLE 9

Step 4(2) : For category 4, allocate the practice expense pool calculated in Step 3 to the procedure codes

Determine the Pool 4 Allocators

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
	Table 8 Facility			Table 8 Nonfacility						Pool 4 Allocators	
	Clinical	Supplies	Equip	Clinical	Supplies	Equip	Work RVU	Factor to Convert	Work RVU Converted	Facility	Nonfacility
Family Practice											
99213	$3.50	$0.00	$0.00	$7.07	$4.01	$1.78	0.67	$58.99	$39.53	$43.03	$52.39
99232	$1.60	$0.00	$0.00				1.06	$58.99	$62.53	$64.13	
General Surgery											
35301	$37.87	$4.08	$5.66				18.70	$58.99	$1,103.21	$1,150.81	
44140	$49.15	$4.76	$5.17				18.35	$58.99	$1,082.56	$1,141.63	
45330	$1.24	$0.00	$0.00	$7.54	$21.45	$47.08	0.96	$58.99	$56.64	$57.88	$132.71
56340	$25.16	$3.36	$3.52				11.09	$58.99	$654.25	$686.29	
99213	$2.13	$0.00	$0.00	$4.29	$3.01	$1.16	0.67	$58.99	$39.53	$41.66	$47.99
99232	$0.97	$0.00	$0.00				1.06	$58.99	$62.53	$63.51	

Notes:
(H) = TABLE 3 COL (J) "TOTAL" / TABLE 12 COL (L) "TOTAL 2"
(I) = (G) * (H)
(J) = (A) + (B) + (C) + (I)
(K) = (D) + (E) + (F) + (I) if applicable to nonfacility

TABLE 10

Step 4(2) cont : For category 4, allocate the practice expense pool calculated in Step 3 to the procedure codes

Calculate Pool 4 Allocation

		(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
		Medicare Frequency			Pool 4 Allocators		Allocators *	Pool 4 Allocation	
Specialty	CPT	Facility	Nonfacility	Total	Facility	Nonfacility	Medicare Freq	Facility	Nonfacility
Family Practice									
	99213	420,181	17,300,817	17,720,998	$43.03	$52.39	$924,499,497	$13.41	$16.32
	99232	3,558,740	0	3,558,740	$64.13		$228,237,715	$19.98	
						Total	$1,152,737,212		
						Pool 4	$359,184,366		
						Ratio	0.3116		
General Surgery									
	35301	35,239	0	35,239	$1,150.81		$40,553,457	$359.49	
	44140	47,620	0	47,620	$1,141.63		$54,364,478	$356.62	
	45330	19,406	29,409	48,815	$57.88	$132.71	$5,025,916	$18.08	$41.45
	56340	79,501	0	79,501	$686.29		$54,560,622	$214.38	
	99213	49,952	1,641,320	1,691,272	$41.66	$47.99	$80,843,708	$13.01	$14.99
	99232	566,202	0	566,202	$63.51		$35,957,491	$19.84	
						Total	$271,305,673		
						Pool 4	$84,750,150		
						Ratio	0.3124		

Notes:
(F) = [(A) * (D)] + [(B) * (E)]
(G) = (D) * [(F) "Ratio"]
(H) = (E) * [(F) "Ratio"] ,

TABLE 11

Step 5: Weight average the allocations from Step 4

	Facility				Nonfacility				Medicare Frequency	
	Table 8			Table 10	Table 8			Table 10		
	Clinical	Supplies	Equip	Pool 4	Clinical	Supplies	Equip	Pool 4	Facility	Nonfacility
Family Practice										
99213	$3.50	$0.00	$0.00	$13.41	$7.07	$4.01	$1.78	$16.32	420,181	17,300,817
99232	$1.60	$0.00	$0.00	$19.98					3,558,740	0
General Surgery										
35301	$37.87	$4.08	$5.66	$359.49					35,239	0
44140	$49.15	$4.76	$5.17	$356.62					47,620	0
45330	$1.24	$0.00	$0.00	$18.08	$7.54	$21.45	$47.08	$41.45	19,406	29,409
56340	$25.16	$3.36	$3.52	$214.38					79,501	0
99213	$2.13	$0.00	$0.00	$13.01	$4.29	$3.01	$1.16	$14.99	49,952	1,641,320
99232	$0.97	$0.00	$0.00	$19.84					566,202	0

Weighted Average					Total Facility					Total Nonfacility
35301	$37.87	$4.08	$5.66	$359.49	$407.09					
44140	$49.15	$4.76	$5.17	$356.62	$415.69					
45330	$1.24	$0.00	$0.00	$18.08	$19.32	$7.54	$21.45	$47.08	$41.45	$117.53
56340	$25.16	$3.36	$3.52	$214.38	$246.42					
99213	$3.36	$0.00	$0.00	$13.37	$16.72	$6.77	$3.91	$1.72	$16.18	$28.58
99232	$1.51	$0.00	$0.00	$19.96	$21.48					

TABLE 12

Step 6: Create New Practice Expense Relative Value Units

	(A)	(B)	(C)	(D)	(E)	(F)
	Total from Table 11		1998 PERVU		Medicare Frequency	
	Facility	Nonfacility	Facility	Nonfacility	Facility	Nonfacility
35301	$407.09		14.46	14.46	35,239	0
44140	$415.69		11.37	11.37	47,620	0
45330	$19.32	$117.53	0.53	1.23	19,406	29,409
56340	$246.42		7.99	7.99	79,501	0
99213	$16.72	$28.58	0.19	0.43	470,133	18,942,137
99232	$21.48		0.45	0.45	4,124,942	0

	(G)	(H)	(I)	(J)	(K)	(L)
	Total from Table 11 * Medicare Freq			1998 PERVU* Medicare Freq		
	Facility	Nonfacility	Total	Facility	Nonfacility	Total
35301	$14,345,607		$14,345,607	509,556	0	509,556
44140	$19,795,370		$19,795,370	541,439	0	541,439
45330	$374,961	$3,456,297	$3,831,258	10,285	36,173	46,458
56340	$19,590,317		$19,590,317	635,213	0	635,213
99213	$7,862,762	$541,368,781	$549,231,542	89,325	8,145,119	8,234,444
99232	$88,592,748		$88,592,748	1,856,224	0	1,856,224
		Total 1	$695,386,842		Total 2	11,823,335
					Ratio = Total 2 / Total 1 =	0.017

	(M)	(N)
	New RVUPE=Total from Table 11 * Ratio	
	Facility	Nonfacility
35301	6.92	
44140	7.07	
45330	0.33	2.00
56340	4.19	
99213	0.28	0.49
99232	0.37	

Notes:
(C) = 1998 PERVU with 50% reduction for current SOS policy where applicable
(G) = (A) * (E)
(H) = (B) * (F)
(I) = (G) + (H)
(J) = (C) * (E)
(K) = (D) * (F)
(L) = (J) + (K)
(M) = (A) * [(L) "Ratio"]
(N) = (B) * [(L) "Ratio"]

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
10040	.....	A	Acne surgery of skin abscess	1.18	1.47	4.46	0.03	2.68	15.78	010
10060	.....	A	Drainage of skin abscess	1.17	0.86	0.52	0.04	2.07	1.73	010
10061	.....	A	Drainage of skin abscess	2.40	1.49	1.06	0.06	3.95	3.52	010
10080	.....	A	Drainage of pilonidal cyst	1.17	1.41	0.51	0.05	2.63	1.73	010
10081	.....	A	Drainage of pilonidal cyst	2.45	1.95	1.25	0.16	4.56	3.86	010
10120	.....	A	Remove foreign body	1.22	1.23	0.48	0.05	2.50	1.75	010
10121	.....	A	Remove foreign body	2.69	2.08	1.35	0.12	4.89	4.16	010
10140	.....	A	Drainage of hematoma/fluid	1.53	0.94	0.79	0.05	2.52	2.37	010
10160	.....	A	Puncture drainage of lesion	1.20	1.07	0.61	0.05	2.32	1.86	010

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
10180		A	Complex drainage, wound	2.25	1.17	1.18	0.18	3.60	3.61	010
11000		A	Debride infected skin	0.60	0.37	0.24	0.04	1.01	0.88	000
11001		A	Debride infect skin add	0.30	0.20	0.13	0.02	0.52	0.45	ZZZ
11010		A	Debride skin, fx	4.20	2.01	1.78	0.65	6.86	6.63	010
11011		A	Debride skin/muscle, fx	4.95	2.88	2.44	0.77	8.60	8.16	000
11012		A	Debride skin/muscle/bone, fx	6.88	3.82	3.58	1.07	11.77	11.53	000
11040		A	Debride skin partial	0.50	0.32	0.20	0.04	0.86	0.74	000
11041		A	Debride skin full	0.82	0.47	0.35	0.06	1.35	1.23	000
11042		A	Debride skin/tissue	1.12	0.68	0.48	0.08	1.88	1.68	000
11043		A	Debride tissue/muscle	2.38	1.79	1.30	0.34	4.51	4.02	010
11044		A	Debride tissue/muscle/bone	3.06	2.35	1.77	0.49	5.90	5.32	010
11055		R	Trim skin lesion	0.27	0.32	0.12	0.02	0.61	0.41	000
11056		R	Trim 2 to 4 skin lesions	0.39	0.36	0.17	0.03	0.78	0.59	000
11057		R	Trim over 4 skin lesions	0.50	0.41	0.22	0.03	0.94	0.75	000
11100		A	Biopsy of skin lesion	0.81	1.26	0.73	0.04	2.11	1.58	000
11101		A	Biopsy, each added lesion	0.41	0.72	0.53	0.02	1.15	0.96	ZZZ
11200		A	Removal of skin tags	0.77	1.72	0.56	0.04	2.53	1.37	010
11201		A	Removal of added skin tags	0.29	0.69	0.67	0.02	1.00	0.98	ZZZ
11300		A	Shave skin lesion	0.51	1.04	0.70	0.05	1.60	1.26	000
11301		A	Shave skin lesion	0.85	1.10	0.95	0.06	2.01	1.86	000
11302		A	Shave skin lesion	1.05	1.19	1.13	0.09	2.33	2.27	000
11303		A	Shave skin lesion	1.24	1.34	1.29	0.17	2.75	2.70	000
11305		A	Shave skin lesion	0.67	0.81	0.75	0.05	1.53	1.47	000
11306		A	Shave skin lesion	0.99	1.06	1.01	0.07	2.12	2.07	000
11307		A	Shave skin lesion	1.14	1.15	1.12	0.10	2.39	2.36	000
11308		A	Shave skin lesion	1.41	1.21	1.30	0.17	2.79	2.88	000
11310		A	Shave skin lesion	0.73	1.11	0.83	0.06	1.90	1.62	000
11311		A	Shave skin lesion	1.05	1.21	1.12	0.08	2.34	2.25	000
11312		A	Shave skin lesion	1.20	1.27	1.28	0.11	2.58	2.59	000
11313		A	Shave skin lesion	1.62	1.62	1.57	0.15	3.39	3.34	000
11400		A	Removal of skin lesion	0.91	1.57	0.60	0.05	2.53	1.56	010
11401		A	Removal of skin lesion	1.32	1.65	0.77	0.06	3.03	2.15	010
11402		A	Removal of skin lesion	1.61	1.77	0.86	0.09	3.47	2.56	010
11403		A	Removal of skin lesion	1.92	1.67	0.99	0.13	3.72	3.04	010
11404		A	Removal of skin lesion	2.20	1.81	1.10	0.17	4.18	3.47	010
11406		A	Removal of skin lesion	2.76	2.42	1.33	0.33	5.51	4.42	010
11420		A	Removal of skin lesion	1.06	1.33	0.68	0.05	2.44	1.79	010
11421		A	Removal of skin lesion	1.53	1.62	0.90	0.07	3.22	2.50	010
11422		A	Removal of skin lesion	1.76	1.75	0.97	0.10	3.61	2.83	010
11423		A	Removal of skin lesion	2.17	1.77	1.14	0.15	4.09	3.46	010
11424		A	Removal of skin lesion	2.62	1.97	1.33	0.16	4.75	4.11	010
11426		A	Removal of skin lesion	3.78	2.86	1.83	0.29	6.93	5.90	010
11440		A	Removal of skin lesion	1.15	1.72	0.82	0.06	2.93	2.03	010
11441		A	Removal of skin lesion	1.61	1.85	1.05	0.08	3.54	2.74	010
11442		A	Removal of skin lesion	1.87	1.96	1.14	0.11	3.94	3.12	010
11443		A	Removal of skin lesion	2.49	2.39	1.47	0.15	5.03	4.11	010
11444		A	Removal of skin lesion	3.42	2.60	1.96	0.14	6.16	5.52	010
11446		A	Removal of skin lesion	4.49	3.52	2.47	0.18	8.19	7.14	010
11450		A	Removal, sweat gland lesion	2.73	5.45	1.79	0.44	8.62	4.96	090
11451		A	Removal, sweat gland lesion	3.95	7.23	2.48	0.46	11.64	6.89	090
11462		A	Removal, sweat gland lesion	2.51	5.50	1.83	0.36	8.37	4.70	090
11463		A	Removal, sweat gland lesion	3.95	6.91	2.02	0.34	11.20	6.31	090
11470		A	Removal, sweat gland lesion	3.25	6.63	1.90	0.45	10.33	5.60	090
11471		A	Removal, sweat gland lesion	4.41	7.55	2.63	0.48	12.44	7.52	090
11600		A	Removal of skin lesion	1.41	1.75	0.84	0.10	3.26	2.35	010
11601		A	Removal of skin lesion	1.93	2.67	1.11	0.12	4.72	3.16	010
11602		A	Removal of skin lesion	2.09	1.91	1.17	0.16	4.16	3.42	010
11603		A	Removal of skin lesion	2.35	1.86	1.25	0.21	4.42	3.81	010
11604		A	Removal of skin lesion	2.58	1.99	1.35	0.26	4.83	4.19	010
11606		A	Removal of skin lesion	3.43	2.74	1.68	0.49	6.66	5.60	010
11620		A	Removal of skin lesion	1.34	1.71	0.87	0.12	3.17	2.33	010
11621		A	Removal of skin lesion	1.97	1.88	1.20	0.16	4.01	3.33	010
11622		A	Removal of skin lesion	2.34	2.06	1.34	0.19	4.59	3.87	010
11623		A	Removal of skin lesion	2.93	2.17	1.59	0.25	5.35	4.77	010
11624		A	Removal of skin lesion	3.43	2.48	1.86	0.32	6.23	5.61	010
11626		A	Removal of skin lesion	4.30	3.20	2.28	0.51	8.01	7.09	010
11640		A	Removal of skin lesion	1.53	1.77	1.02	0.15	3.45	2.70	010
11641		A	Removal of skin lesion	2.44	2.15	1.51	0.18	4.77	4.13	010
11642		A	Removal of skin lesion	2.93	2.24	1.74	0.23	5.40	4.90	010
11643		A	Removal of skin lesion	3.50	2.57	2.05	0.28	6.35	5.83	010
11644		A	Removal of skin lesion	4.55	3.17	2.61	0.33	8.05	7.49	010
11646		A	Removal of skin lesion	5.95	4.21	3.41	0.60	10.76	9.96	010
11719		R	Trim nail(s)	0.11	0.16	0.05	0.02	0.29	0.18	000
11720		A	Debride nail, 1–5	0.32	0.23	0.21	0.03	0.58	0.56	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
11721		A	Debride nail, 6 or more	0.54	0.33	0.31	0.05	0.92	0.90	000
11730		A	Removal of nail plate	1.13	0.59	0.55	0.04	1.76	1.72	000
11731		A	Removal of second nail plate	0.57	0.27	0.27	0.05	0.89	0.89	ZZZ
11732		A	Remove additional nail plate	0.57	0.27	0.30	0.02	0.86	0.89	ZZZ
11740		A	Drain blood from under nail	0.37	0.32	0.08	0.04	0.73	0.49	000
11750		A	Removal of nail bed	1.86	1.37	1.16	0.19	3.42	3.21	010
11752		A	Remove nail bed/finger tip	2.67	1.49	1.93	0.36	4.52	4.96	010
11755		A	Biopsy, nail unit	1.31	0.82	0.96	0.12	2.25	2.39	000
11760		A	Reconstruction of nail bed	1.58	1.10	1.24	0.09	2.77	2.91	010
11762		A	Reconstruction of nail bed	2.89	1.54	2.05	0.24	4.67	5.18	010
11765		A	Excision of nail fold, toe	0.69	0.53	0.55	0.05	1.27	1.29	010
11770		A	Removal of pilonidal lesion	2.61	2.05	1.21	0.44	5.10	4.26	010
11771		A	Removal of pilonidal lesion	5.74	4.26	3.31	0.92	10.92	9.97	090
11772		A	Removal of pilonidal lesion	6.98	5.22	3.81	1.01	13.21	11.80	090
11900		A	Injection into skin lesions	0.52	0.84	0.24	0.02	1.38	0.78	000
11901		A	Added skin lesions injection	0.80	0.97	0.38	0.03	1.80	1.21	000
11920		R	Correct skin color defects	1.61	2.43	0.94	0.23	4.27	2.78	000
11921		R	Correct skin color defects	1.93	1.87	1.13	0.28	4.08	3.34	000
11922		R	Correct skin color defects	0.49	2.10	0.52	0.07	2.66	1.08	ZZZ
11950		R	Therapy for contour defects	0.84	1.01	0.33	0.11	1.96	1.28	000
11951		R	Therapy for contour defects	1.19	1.65	0.77	0.11	2.95	2.07	000
11952		R	Therapy for contour defects	1.69	2.47	0.99	0.11	4.27	2.79	000
11954		R	Therapy for contour defects	1.85	2.20	0.82	0.11	4.16	2.78	000
11960		A	Insert tissue expander(s)	9.08	NA	8.08	1.48	NA	18.64	090
11970		A	Replace tissue expander	7.06	NA	4.67	1.61	NA	13.34	090
11971		A	Remove tissue expander(s)	2.13	4.01	2.53	0.82	6.96	5.48	090
11975		N	Insert contraceptive cap	+1.48	2.81	1.48	0.25	4.54	3.21	XXX
11976		R	Removal of contraceptive cap	1.78	1.34	0.71	0.30	3.42	2.79	XXX
11977		N	Removal/reinsert contra cap	+3.30	4.63	3.30	0.55	8.48	7.15	XXX
12001		A	Repair superficial wound(s)	1.70	1.69	0.53	0.05	3.44	2.28	010
12002		A	Repair superficial wound(s)	1.86	1.78	0.56	0.07	3.71	2.49	010
12004		A	Repair superficial wound(s)	2.24	1.95	0.66	0.10	4.29	3.00	010
12005		A	Repair superficial wound(s)	2.86	2.32	0.87	0.14	5.32	3.87	010
12006		A	Repair superficial wound(s)	3.67	3.11	1.27	0.19	6.97	5.13	010
12007		A	Repair superficial wound(s)	4.12	3.52	1.64	0.19	7.83	5.95	010
12011		A	Repair superficial wound(s)	1.76	1.77	0.52	0.06	3.59	2.34	010
12013		A	Repair superficial wound(s)	1.99	1.88	0.57	0.08	3.95	2.64	010
12014		A	Repair superficial wound(s)	2.46	2.15	0.71	0.10	4.71	3.27	010
12015		A	Repair superficial wound(s)	3.19	2.56	0.83	0.14	5.89	4.16	010
12016		A	Repair superficial wound(s)	3.93	2.85	1.06	0.19	6.97	5.18	010
12017		A	Repair superficial wound(s)	4.71	3.97	1.78	0.31	8.99	6.80	010
12018		A	Repair superficial wound(s)	5.53	3.98	2.22	0.48	9.99	8.23	010
12020		A	Closure of split wound	2.62	2.06	1.36	0.18	4.86	4.16	010
12021		A	Closure of split wound	1.84	1.67	1.03	0.11	3.62	2.98	010
12031		A	Layer closure of wound(s)	2.15	1.98	0.96	0.07	4.20	3.18	010
12032		A	Layer closure of wound(s)	2.47	2.05	0.98	0.10	4.62	3.55	010
12034		A	Layer closure of wound(s)	2.92	2.29	1.13	0.15	5.36	4.20	010
12035		A	Layer closure of wound(s)	3.43	2.44	1.38	0.23	6.10	5.04	010
12036		A	Layer closure of wound(s)	4.05	3.93	2.13	0.37	8.35	6.55	010
12037		A	Layer closure of wound(s)	4.67	3.69	2.57	0.48	8.84	7.72	010
12041		A	Layer closure of wound(s)	2.37	2.19	0.97	0.08	4.64	3.42	010
12042		A	Layer closure of wound(s)	2.74	2.24	1.10	0.12	5.10	3.96	010
12044		A	Layer closure of wound(s)	3.14	2.38	1.30	0.17	5.69	4.61	010
12045		A	Layer closure of wound(s)	3.64	2.67	1.63	0.23	6.54	5.50	010
12046		A	Layer closure of wound(s)	4.25	3.76	2.25	0.37	8.38	6.87	010
12047		A	Layer closure of wound(s)	4.65	4.47	2.50	0.56	9.68	7.71	010
12051		A	Layer closure of wound(s)	2.47	2.18	1.09	0.10	4.75	3.66	010
12052		A	Layer closure of wound(s)	2.77	2.19	0.99	0.14	5.10	3.90	010
12053		A	Layer closure of wound(s)	3.12	2.36	1.08	0.17	5.65	4.37	010
12054		A	Layer closure of wound(s)	3.46	2.64	1.25	0.25	6.35	4.96	010
12055		A	Layer closure of wound(s)	4.43	3.33	1.73	0.37	8.13	6.53	010
12056		A	Layer closure of wound(s)	5.24	4.75	2.72	0.52	10.51	8.48	010
12057		A	Layer closure of wound(s)	5.96	4.47	3.39	0.48	10.91	9.83	010
13100		A	Repair of wound or lesion	3.12	2.60	1.76	0.13	5.85	5.01	010
13101		A	Repair of wound or lesion	3.92	2.88	2.18	0.21	7.01	6.31	010
13120		A	Repair of wound or lesion	3.30	2.73	1.64	0.17	6.20	5.11	010
13121		A	Repair of wound or lesion	4.33	3.12	2.15	0.33	7.78	6.81	010
13131		A	Repair of wound or lesion	3.79	3.02	2.11	0.23	7.04	6.13	010
13132		A	Repair of wound or lesion	5.95	3.98	3.12	0.44	10.37	9.51	010
13150		A	Repair of wound or lesion	3.81	3.86	2.37	0.23	7.90	6.41	010
13151		A	Repair of wound or lesion	4.45	3.92	2.75	0.35	8.72	7.55	010
13152		A	Repair of wound or lesion	6.33	4.71	3.73	0.68	11.72	10.74	010
13160		A	Late closure of wound	10.48	NA	5.87	0.58	NA	16.93	090
13300		A	Repair of wound or lesion	5.27	3.69	2.87	0.86	9.82	9.00	010

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
14000		A	Skin tissue rearrangement	5.89	5.26	3.91	0.38	11.53	10.18	090
14001		A	Skin tissue rearrangement	8.47	6.60	5.33	0.76	15.83	14.56	090
14020		A	Skin tissue rearrangement	6.59	5.78	4.49	0.49	12.86	11.57	090
14021		A	Skin tissue rearrangement	10.06	7.47	6.47	0.94	18.47	17.47	090
14040		A	Skin tissue rearrangement	7.87	6.25	5.40	0.65	14.77	13.92	090
14041		A	Skin tissue rearrangement	11.49	8.13	7.41	1.02	20.64	19.92	090
14060		A	Skin tissue rearrangement	8.50	6.81	6.12	1.04	16.35	15.66	090
14061		A	Skin tissue rearrangement	12.29	8.96	8.34	1.27	22.52	21.90	090
14300		A	Skin tissue rearrangement	11.76	8.29	7.69	1.84	21.89	21.29	090
14350		A	Skin tissue rearrangement	9.61	NA	5.87	1.05	NA	16.53	090
15000		A	Skin graft procedure	1.95	1.26	1.04	0.53	3.74	3.52	ZZZ
15050		A	Skin pinch graft procedure	4.30	3.65	3.16	0.30	8.25	7.76	090
15100		A	Skin split graft procedure	9.05	5.64	6.52	0.89	15.58	16.46	090
15101		A	Skin split graft procedure	1.72	1.16	0.83	0.33	3.21	2.88	ZZZ
15120		A	Skin split graft procedure	9.83	6.78	6.22	0.94	17.55	16.99	090
15121		A	Skin split graft procedure	2.67	1.58	1.40	0.53	4.78	4.60	ZZZ
15200		A	Skin full graft procedure	8.03	7.04	5.00	0.69	15.76	13.72	090
15201		A	Skin full graft procedure	1.32	0.84	0.69	0.50	2.66	2.51	ZZZ
15220		A	Skin full graft procedure	7.87	6.91	5.28	0.85	15.63	14.00	090
15221		A	Skin full graft procedure	1.19	0.77	0.66	0.50	2.46	2.35	ZZZ
15240		A	Skin full graft procedure	9.04	7.11	6.10	1.03	17.18	16.17	090
15241		A	Skin full graft procedure	1.86	1.25	1.04	0.58	3.69	3.48	ZZZ
15260		A	Skin full graft procedure	10.06	7.34	6.92	0.99	18.39	17.97	090
15261		A	Skin full graft procedure	2.23	1.40	1.27	0.60	4.23	4.10	ZZZ
15350		A	Skin homograft procedure	4.36	6.41	5.19	0.42	11.19	9.97	090
15400		A	Skin heterograft procedure	5.78	3.84	4.86	0.17	9.79	10.81	090
15570		A	Form skin pedicle flap	9.21	5.97	6.57	2.08	17.26	17.86	090
15572		A	Form skin pedicle flap	9.27	6.35	6.52	1.86	17.48	17.65	090
15574		A	Form skin pedicle flap	9.88	6.89	6.44	1.66	18.43	17.98	090
15576		A	Form skin pedicle flap	8.69	6.95	5.87	0.60	16.24	15.16	090
15580		A	Attach skin pedicle graft	9.46	NA	6.38	1.30	NA	17.14	090
15600		A	Skin graft procedure	1.91	3.27	1.71	0.88	6.06	4.50	090
15610		A	Skin graft procedure	2.42	3.45	1.90	0.80	6.67	5.12	090
15620		A	Skin graft procedure	2.94	3.88	2.55	0.86	7.68	6.35	090
15625		A	Skin graft procedure	1.91	NA	2.88	0.78	NA	5.57	090
15630		A	Skin graft procedure	3.27	4.16	2.83	0.90	8.33	7.00	090
15650		A	Transfer skin pedicle flap	3.97	4.02	2.95	0.93	8.92	7.85	090
15732		A	Muscle-skin graft, head/neck	17.84	NA	11.45	3.46	NA	32.75	090
15734		A	Muscle-skin graft, trunk	17.79	NA	10.90	3.24	NA	31.93	090
15736		A	Muscle-skin graft, arm	16.27	NA	10.22	3.02	NA	29.51	090
15738		A	Muscle-skin graft, leg	17.92	NA	10.91	3.29	NA	32.12	090
15740		A	Island pedicle flap graft	10.25	7.20	6.61	1.62	19.07	18.48	090
15750		A	Neurovascular pedicle graft	11.41	NA	7.69	2.03	NA	21.13	090
15756		A	Free muscle flap, microvasc	35.23	NA	21.75	5.33	NA	62.31	090
15757		A	Free skin flap, microvasc	35.23	NA	21.75	5.33	NA	62.31	090
15758		A	Free fascial flap, microvasc	35.10	NA	21.68	5.33	NA	62.11	090
15760		A	Composite skin graft	8.74	7.06	7.41	1.11	16.91	17.26	090
15770		A	Derma-fat-fascia graft	7.52	NA	5.51	0.95	NA	13.98	090
15775		R	Hair transplant punch grafts	3.96	6.08	3.99	0.56	10.60	8.51	000
15776		R	Hair transplant punch grafts	5.54	5.09	3.61	0.79	11.42	9.94	000
15780		A	Abrasion treatment of skin	7.29	5.50	5.53	0.13	12.92	12.95	090
15781		A	Abrasion treatment of skin	4.85	3.91	4.03	0.39	9.15	9.27	090
15782		A	Abrasion treatment of skin	4.32	3.14	3.04	0.13	7.59	7.49	090
15783		A	Abrasion treatment of skin	4.29	3.36	3.58	0.19	7.84	8.06	090
15786		A	Abrasion treatment of lesion	2.03	1.40	1.30	0.06	3.49	3.39	010
15787		A	Abrasion, added skin lesions	0.33	0.24	0.20	0.03	0.60	0.56	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	2.41	1.20	0.12	4.62	3.41	090
15789		R	Chemical peel, face, dermal	4.92	4.08	3.54	0.12	9.12	8.58	090
15792		R	Chemical peel, nonfacial	1.86	1.84	1.37	0.05	3.75	3.28	090
15793		A	Chemical peel, nonfacial	3.74	NA	2.90	0.05	NA	6.69	090
15810		A	Salabrasion	4.74	3.54	3.60	0.29	8.57	8.63	090
15811		A	Salabrasion	5.39	4.95	4.14	0.73	11.07	10.26	090
15819		A	Plastic surgery, neck	9.38	NA	5.81	0.87	NA	16.06	090
15820		A	Revision of lower eyelid	5.15	7.71	6.23	0.64	13.50	12.02	090
15821		A	Revision of lower eyelid	5.72	7.98	6.68	0.68	14.38	13.08	090
15822		A	Revision of upper eyelid	4.45	7.04	5.85	0.56	12.05	10.86	090
15823		A	Revision of upper eyelid	7.05	8.71	7.43	0.61	16.37	15.09	090
15831		A	Excise excessive skin tissue	12.40	NA	8.16	2.01	NA	22.57	090
15832		A	Excise excessive skin tissue	11.59	NA	8.09	1.33	NA	21.01	090
15833		A	Excise excessive skin tissue	10.64	NA	7.38	1.12	NA	19.14	090
15834		A	Excise excessive skin tissue	10.85	NA	5.52	1.22	NA	17.59	090
15835		A	Excise excessive skin tissue	11.67	NA	6.43	1.22	NA	19.32	090
15836		A	Excise excessive skin tissue	9.34	NA	7.09	1.10	NA	17.53	090
15837		A	Excise excessive skin tissue	8.43	5.69	5.87	0.85	14.97	15.15	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
15838		A	Excise excessive skin tissue	7.13	NA	5.97	0.73	NA	13.83	090
15839		A	Excise excessive skin tissue	9.38	6.20	5.68	0.46	16.04	15.52	090
15840		A	Graft for face nerve palsy	13.26	NA	9.23	2.28	NA	24.77	090
15841		A	Graft for face nerve palsy	23.26	NA	13.57	2.76	NA	39.59	090
15842		A	Graft for face nerve palsy	37.96	NA	23.74	2.68	NA	64.38	090
15845		A	Skin and muscle repair, face	12.57	NA	8.35	2.54	NA	23.46	090
15850		B	Removal of sutures	+0.78	2.24	0.82	0.04	3.06	1.64	XXX
15851		A	Removal of sutures	0.86	1.17	0.37	0.03	2.06	1.26	000
15852		A	Dressing change,not for burn	0.86	1.14	0.41	0.07	2.07	1.34	000
15860		A	Test for blood flow in graft	1.95	1.26	0.99	0.25	3.46	3.19	000
15920		A	Removal of tail bone ulcer	7.95	NA	4.64	0.63	NA	13.22	090
15922		A	Removal of tail bone ulcer	9.90	NA	5.97	1.19	NA	17.06	090
15931		A	Remove sacrum pressure sore	9.24	NA	4.66	0.55	NA	14.45	090
15933		A	Remove sacrum pressure sore	10.85	NA	6.91	1.43	NA	19.19	090
15934		A	Remove sacrum pressure sore	12.69	NA	7.56	1.50	NA	21.75	090
15935		A	Remove sacrum pressure sore	14.57	NA	9.07	2.27	NA	25.91	090
15936		A	Remove sacrum pressure sore	12.38	NA	7.87	2.05	NA	22.30	090
15937		A	Remove sacrum pressure sore	14.21	NA	9.27	2.67	NA	26.15	090
15940		A	Removal of pressure sore	9.34	NA	5.24	0.73	NA	15.31	090
15941		A	Removal of pressure sore	11.43	NA	8.15	1.39	NA	20.97	090
15944		A	Removal of pressure sore	11.46	NA	7.59	1.82	NA	20.87	090
15945		A	Removal of pressure sore	12.69	NA	8.41	2.09	NA	23.19	090
15946		A	Removal of pressure sore	21.57	NA	13.57	3.24	NA	38.38	090
15950		A	Remove thigh pressure sore	7.54	NA	4.19	0.58	NA	12.31	090
15951		A	Remove thigh pressure sore	10.72	NA	6.78	1.58	NA	19.08	090
15952		A	Remove thigh pressure sore	11.39	NA	6.66	1.37	NA	19.42	090
15953		A	Remove thigh pressure sore	12.63	NA	7.55	1.87	NA	22.05	090
15956		A	Remove thigh pressure sore	15.52	NA	9.76	3.39	NA	28.67	090
15958		A	Remove thigh pressure sore	15.48	NA	9.87	3.76	NA	29.11	090
16000		A	Initial treatment of burn(s)	0.89	0.76	0.21	0.03	1.68	1.13	000
16010		A	Treatment of burn(s)	0.87	0.82	0.34	0.03	1.72	1.24	000
16015		A	Treatment of burn(s)	2.35	1.40	1.08	0.38	4.13	3.81	000
16020		A	Treatment of burn(s)	0.80	0.80	0.23	0.03	1.63	1.06	000
16025		A	Treatment of burn(s)	1.85	1.31	0.64	0.05	3.21	2.54	000
16030		A	Treatment of burn(s)	2.08	1.93	0.99	0.08	4.09	3.15	000
16035		A	Incision of burn scab	4.82	2.95	2.15	0.34	8.11	7.31	090
16040		A	Burn wound excision	1.02	1.63	0.49	0.53	3.18	2.04	000
16041		A	Burn wound excision	2.70	2.10	1.31	0.53	5.33	4.54	000
16042		A	Burn wound excision	2.35	NA	1.17	0.53	NA	4.05	000
17000		A	Destroy benign/premal lesion	0.60	0.86	0.60	0.03	1.49	1.23	010
17003		A	Destroy 2–14 lesions	0.15	0.54	0.38	0.01	0.70	0.54	ZZZ
17004		A	Destroy 15 & more lesions	2.79	2.05	1.74	0.20	5.04	4.73	010
17106		A	Destruction of skin lesions	4.59	3.21	2.78	0.18	7.98	7.55	090
17107		A	Destruction of skin lesions	9.16	5.82	5.26	0.39	15.37	14.81	090
17108		A	Destruction of skin lesions	13.20	8.55	7.73	0.69	22.44	21.62	090
17110		A	Destruct lesion, 1–14	0.65	1.18	0.71	0.03	1.86	1.39	010
17111		A	Destruct lesion, 15 or more	0.92	1.30	0.83	0.05	2.27	1.80	010
17250		A	Chemical cautery, tissue	0.50	0.45	0.20	0.04	0.99	0.74	000
17260		A	Destruction of skin lesions	0.91	1.21	0.56	0.10	2.22	1.57	010
17261		A	Destruction of skin lesions	1.17	1.30	0.70	0.12	2.59	1.99	010
17262		A	Destruction of skin lesions	1.58	1.52	0.91	0.16	3.26	2.65	010
17263		A	Destruction of skin lesions	1.79	1.64	1.00	0.21	3.64	3.00	010
17264		A	Destruction of skin lesions	1.94	1.73	1.11	0.26	3.93	3.31	010
17266		A	Destruction of skin lesions	2.34	1.98	1.21	0.49	4.81	4.04	010
17270		A	Destruction of skin lesions	1.32	1.43	0.77	0.12	2.87	2.21	010
17271		A	Destruction of skin lesions	1.49	1.47	0.87	0.16	3.12	2.52	010
17272		A	Destruction of skin lesions	1.77	1.62	1.01	0.19	3.58	2.97	010
17273		A	Destruction of skin lesions	2.05	1.79	1.14	0.25	4.09	3.44	010
17274		A	Destruction of skin lesions	2.59	2.08	1.30	0.32	4.99	4.21	010
17276		A	Destruction of skin lesions	3.20	2.09	1.76	0.51	5.80	5.47	010
17280		A	Destruction of skin lesions	1.17	1.33	0.70	0.15	2.65	2.02	010
17281		A	Destruction of skin lesions	1.72	1.60	1.01	0.18	3.50	2.91	010
17282		A	Destruction of skin lesions	2.04	1.77	1.19	0.23	4.04	3.46	010
17283		A	Destruction of skin lesions	2.64	2.11	1.51	0.28	5.03	4.43	010
17284		A	Destruction of skin lesions	3.21	2.42	1.86	0.33	5.96	5.40	010
17286		A	Destruction of skin lesions	4.44	2.80	2.58	0.60	7.84	7.62	010
17304		A	Chemosurgery of skin lesion	7.60	5.90	4.28	0.31	13.81	12.19	000
17305		A	2nd stage chemosurgery	2.85	2.23	1.66	0.17	5.25	4.68	000
17306		A	3rd stage chemosurgery	2.85	2.23	1.67	0.11	5.19	4.63	000
17307		A	Followup skin lesion therapy	2.85	2.23	1.69	0.12	5.20	4.66	000
17310		A	Extensive skin chemosurgery	0.95	0.87	0.54	0.01	1.83	1.50	000
17340		A	Cryotherapy of skin	0.76	1.54	0.86	0.02	2.32	1.64	010
17360		A	Skin peel therapy	1.43	1.38	0.91	0.02	2.83	2.36	010
19000		A	Drainage of breast lesion	0.84	1.16	0.28	0.07	2.07	1.19	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
19001		A	Drain added breast lesion	0.42	0.86	0.14	0.05	1.33	0.61	ZZZ
19020		A	Incision of breast lesion	3.57	4.63	2.48	0.28	8.48	6.33	090
19030		A	Injection for breast x-ray	1.53	9.38	0.94	0.04	10.95	2.51	000
19100		A	Biopsy of breast	1.27	2.45	0.79	0.13	3.85	2.19	000
19101		A	Biopsy of breast	3.18	5.91	2.32	0.45	9.54	5.95	010
19110		A	Nipple exploration	4.30	5.66	3.12	0.51	10.47	7.93	090
19112		A	Excise breast duct fistula	3.67	4.79	2.33	0.35	8.81	6.35	090
19120		A	Removal of breast lesion	5.56	3.29	4.14	0.60	9.45	10.30	090
19125		A	Excision, breast lesion	6.06	3.61	4.75	0.60	10.27	11.41	090
19126		A	Excision, add/-El breast lesion	2.93	NA	1.28	0.31	NA	4.52	ZZZ
19140		A	Removal of breast tissue	5.14	6.25	2.91	0.91	12.30	8.96	090
19160		A	Removal of breast tissue	5.99	NA	3.57	0.88	NA	10.44	090
19162		A	Remove breast tissue, nodes	13.53	NA	7.01	1.96	NA	22.50	090
19180		A	Removal of breast	8.80	NA	5.01	1.17	NA	14.98	090
19182		A	Removal of breast	7.73	NA	4.40	1.27	NA	13.40	090
19200		A	Removal of breast	15.49	NA	8.03	2.15	NA	25.67	090
19220		A	Removal of breast	15.72	NA	8.48	2.38	NA	26.58	090
19240		A	Removal of breast	16.00	NA	7.96	1.99	NA	25.95	090
19260		A	Removal of chest wall lesion	15.44	NA	10.33	1.04	NA	26.81	090
19271		A	Revision of chest wall	18.90	NA	12.42	2.77	NA	34.09	090
19272		A	Extensive chest wall surgery	21.55	NA	14.21	2.56	NA	38.32	090
19290		A	Place needle wire, breast	1.27	5.74	0.85	0.07	7.08	2.19	000
19291		A	Place needle wire, breast	0.63	3.63	0.65	0.04	4.30	1.32	ZZZ
19316		A	Suspension of breast	10.69	NA	7.01	2.43	NA	20.13	090
19318		A	Reduction of large breast	15.62	NA	9.83	3.23	NA	28.68	090
19324		A	Enlarge breast	5.85	NA	3.44	0.67	NA	9.96	090
19325		A	Enlarge breast with implant	8.45	NA	5.87	1.13	NA	15.45	090
19328		A	Removal of breast implant	5.68	NA	3.94	0.73	NA	10.35	090
19330		A	Removal of implant material	7.59	NA	4.90	0.75	NA	13.24	090
19340		A	Immediate breast prosthesis	6.33	NA	3.57	2.06	NA	11.96	ZZZ
19342		A	Delayed breast prosthesis	11.20	NA	7.32	2.03	NA	20.55	090
19350		A	Breast reconstruction	8.92	9.60	6.05	1.38	19.90	16.35	090
19355		A	Correct inverted nipple(s)	7.57	10.44	5.12	1.00	19.01	13.69	090
19357		A	Breast reconstruction	18.16	NA	12.25	2.37	NA	32.78	090
19361		A	Breast reconstruction	19.26	NA	11.82	3.88	NA	34.96	090
19364		A	Breast reconstruction	29.04	NA	17.48	3.58	NA	50.10	090
19366		A	Breast reconstruction	21.28	NA	11.46	3.18	NA	35.92	090
19367		A	Breast reconstruction	25.73	NA	15.21	3.88	NA	44.82	090
19368		A	Breast reconstruction	32.42	NA	19.61	3.88	NA	55.91	090
19369		A	Breast reconstruction	29.82	NA	17.91	3.88	NA	51.61	090
19370		A	Surgery of breast capsule	8.05	NA	5.49	1.19	NA	14.73	090
19371		A	Removal of breast capsule	9.35	NA	5.70	1.54	NA	16.59	090
19380		A	Revise breast reconstruction	9.14	NA	6.24	1.57	NA	16.95	090
19396		A	Design custom breast implant	2.17	2.97	1.26	0.31	5.45	3.74	000
20000		A	Incision of abscess	2.12	1.59	1.03	0.08	3.79	3.23	010
20005		A	Incision of deep abscess	3.42	2.27	1.92	0.28	5.97	5.62	010
20100		A	Explore wound, neck	10.08	5.22	4.35	1.16	16.46	15.59	010
20101		A	Explore wound, chest	3.22	1.73	1.49	0.37	5.32	5.08	010
20102		A	Explore wound, abdomen	3.94	2.50	1.78	0.45	6.89	6.17	010
20103		A	Explore wound, extremity	5.30	3.52	2.68	0.60	9.42	8.58	010
20150		A	Excise epiphyseal bar	13.69	NA	19.46	2.03	NA	35.18	090
20200		A	Muscle biopsy	1.46	1.28	0.64	0.18	2.92	2.28	000
20205		A	Deep muscle biopsy	2.35	3.17	1.14	0.33	5.85	3.82	000
20206		A	Needle biopsy, muscle	0.99	2.14	0.92	0.14	3.27	2.05	000
20220		A	Bone biopsy, trocar/needle	1.27	1.67	1.36	0.09	3.03	2.72	000
20225		A	Bone biopsy, trocar/needle	1.87	0.73	1.76	0.28	2.88	3.91	000
20240		A	Bone biopsy, excisional	3.23	NA	2.69	0.18	NA	6.10	010
20245		A	Bone biopsy, excisional	3.95	NA	3.60	0.44	NA	7.99	010
20250		A	Open bone biopsy	5.03	NA	3.61	0.76	NA	9.40	010
20251		A	Open bone biopsy	5.56	NA	4.37	0.92	NA	10.85	010
20500		A	Injection of sinus tract	1.23	2.80	2.12	0.04	4.07	3.39	010
20501		A	Inject sinus tract for x-ray	0.76	7.35	0.42	0.02	8.13	1.20	000
20520		A	Removal of foreign body	1.85	3.00	1.93	0.08	4.93	3.86	010
20525		A	Removal of foreign body	3.50	3.75	3.05	0.33	7.58	6.88	010
20550		A	Inj tendon/ligament/cyst	0.86	2.07	0.29	0.04	2.97	1.19	000
20600		A	Drain/inject joint/bursa	0.66	1.25	0.39	0.05	1.96	1.10	000
20605		A	Drain/inject joint/bursa	0.68	1.76	0.38	0.05	2.49	1.11	000
20610		A	Drain/inject joint/bursa	0.79	1.38	0.45	0.05	2.22	1.29	000
20615		A	Treatment of bone cyst	2.28	2.75	1.84	0.06	5.09	4.18	010
20650		A	Insert and remove bone pin	2.23	2.45	2.05	0.14	4.82	4.42	010
20660		A	Apply,remove fixation device	2.51	NA	1.40	0.21	NA	4.12	000
20661		A	Application of head brace	4.89	NA	5.01	0.65	NA	10.55	090
20662		A	Application of pelvis brace	6.07	NA	4.67	1.03	NA	11.77	090
20663		A	Application of thigh brace	5.43	NA	4.52	0.76	NA	10.71	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
20664		A	Halo brace application	8.06	NA	6.77	0.65	NA	15.48	090
20665		A	Removal of fixation device	1.31	1.31	1.09	0.07	2.69	2.47	010
20670		A	Removal of support implant	1.74	3.72	2.50	0.11	5.57	4.35	010
20680		A	Removal of support implant	3.35	3.33	6.39	0.51	7.19	10.25	090
20690		A	Apply bone fixation device	3.52	NA	2.31	0.58	NA	6.41	ZZZ
20692		A	Apply bone fixation device	6.41	NA	3.92	0.89	NA	11.22	ZZZ
20693		A	Adjust bone fixation device	5.86	NA	8.69	0.42	NA	14.97	090
20694		A	Remove bone fixation device	4.16	6.02	4.74	0.41	10.59	9.31	090
20802		A	Replantation, arm, complete	41.15	NA	29.93	6.17	NA	77.25	090
20805		A	Replant forearm, complete	50.00	NA	34.58	7.56	NA	92.14	090
20808		A	Replantation, hand, complete	61.65	NA	46.78	9.40	NA	117.83	090
20816		A	Replantation digit, complete	30.94	NA	34.06	4.63	NA	69.63	090
20822		A	Replantation digit, complete	25.59	NA	27.59	3.83	NA	57.01	090
20824		A	Replantation thumb, complete	30.94	NA	25.23	4.63	NA	60.80	090
20827		A	Replantation thumb, complete	26.41	NA	29.76	3.94	NA	60.11	090
20838		A	Replantation, foot, complete	41.41	NA	28.93	6.17	NA	76.51	090
20900		A	Removal of bone for graft	5.58	4.53	5.00	0.45	10.56	11.03	090
20902		A	Removal of bone for graft	7.55	NA	7.14	0.80	NA	15.49	090
20910		A	Remove cartilage for graft	5.34	5.32	4.76	0.09	10.75	10.19	090
20912		A	Remove cartilage for graft	6.35	NA	4.97	0.64	NA	11.96	090
20920		A	Removal of fascia for graft	5.31	NA	4.72	0.50	NA	10.53	090
20922		A	Removal of fascia for graft	6.61	5.86	5.18	0.71	13.18	12.50	090
20924		A	Removal of tendon for graft	6.48	NA	5.62	0.85	NA	12.95	090
20926		A	Removal of tissue for graft	5.53	NA	4.71	0.39	NA	10.63	090
20931		A	Spinal bone allograft	1.81	NA	1.24	0.28	NA	3.33	ZZZ
20937		A	Spinal bone autograft	2.79	NA	1.84	0.44	NA	5.07	ZZZ
20938		A	Spinal bone autograft	3.02	NA	1.93	0.47	NA	5.42	ZZZ
20950		A	Record fluid pressure,muscle	1.26	NA	1.54	0.17	NA	2.97	000
20955		A	Fibula bone graft, microvasc	39.21	NA	26.94	5.87	NA	72.02	090
20956		A	Iliac bone graft, microvasc	39.27	NA	49.63	5.26	NA	94.16	090
20957		A	Mt bone graft, microvasc	40.65	NA	51.01	5.45	NA	97.11	090
20962		A	Other bone graft, microvasc	39.27	NA	25.47	5.26	NA	70.00	090
20969		A	Bone/skin graft, microvasc	43.92	NA	28.73	6.57	NA	79.22	090
20970		A	Bone/skin graft, iliac crest	43.06	NA	28.02	6.44	NA	77.52	090
20972		A	Bone-skin graft, metatarsal	42.99	NA	19.72	6.49	NA	69.20	090
20973		A	Bone-skin graft, great toe	45.76	NA	28.05	6.91	NA	80.72	090
20974		A	Electrical bone stimulation	0.62	0.32	0.35	0.53	1.47	1.50	000
20975		A	Electrical bone stimulation	2.60	NA	1.48	0.56	NA	4.64	ZZZ
21010		A	Incision of jaw joint	10.14	NA	7.03	0.93	NA	18.10	090
21015		A	Resection of facial tumor	5.29	NA	5.98	1.13	NA	12.40	090
21025		A	Excision of bone, lower jaw	10.06	6.82	6.53	0.38	17.26	16.97	090
21026		A	Excision of facial bone(s)	4.85	4.64	4.23	0.28	9.77	9.36	090
21029		A	Contour of face bone lesion	7.71	5.81	5.77	0.78	14.30	14.26	090
21030		A	Removal of face bone lesion	6.46	5.05	4.42	0.29	11.80	11.17	090
21031		A	Remove exostosis, mandible	3.24	3.24	2.14	0.32	6.80	5.70	090
21032		A	Remove exostosis, maxilla	3.24	3.21	2.19	0.35	6.80	5.78	090
21034		A	Removal of face bone lesion	16.17	9.87	10.61	0.89	26.93	27.67	090
21040		A	Removal of jaw bone lesion	2.11	2.89	1.77	0.24	5.24	4.12	090
21041		A	Removal of jaw bone lesion	6.71	5.24	4.24	0.50	12.45	11.45	090
21044		A	Removal of jaw bone lesion	11.86	NA	7.91	1.11	NA	20.88	090
21045		A	Extensive jaw surgery	16.17	NA	10.49	1.58	NA	28.24	090
21050		A	Removal of jaw joint	10.77	NA	10.16	1.08	NA	22.01	090
21060		A	Remove jaw joint cartilage	10.23	NA	8.88	1.04	NA	20.15	090
21070		A	Remove coronoid process	8.20	NA	6.32	0.82	NA	15.34	090
21076		A	Prepare face/oral prosthesis	13.42	6.70	5.60	1.35	21.47	20.37	010
21077		A	Prepare face/oral prosthesis	33.75	14.90	17.42	3.39	52.04	54.56	090
21079		A	Prepare face/oral prosthesis	22.34	10.55	9.52	2.25	35.14	34.11	090
21080		A	Prepare face/oral prosthesis	25.10	11.63	10.47	2.52	39.25	38.09	090
21081		A	Prepare face/oral prosthesis	22.88	10.89	9.62	2.30	36.07	34.80	090
21082		A	Prepare face/oral prosthesis	20.87	9.85	8.69	2.10	32.82	31.66	090
21083		A	Prepare face/oral prosthesis	19.30	9.20	8.08	1.94	30.44	29.32	090
21084		A	Prepare face/oral prosthesis	22.51	12.25	12.54	2.28	37.04	37.33	090
21085		A	Prepare face/oral prosthesis	9.00	5.01	3.87	0.90	14.91	13.77	010
21086		A	Prepare face/oral prosthesis	24.92	12.00	13.68	2.51	39.43	41.11	090
21087		A	Prepare face/oral prosthesis	24.92	11.66	11.30	2.51	39.09	38.73	090
21100		A	Maxillofacial fixation	4.22	4.14	3.69	0.11	8.47	8.02	090
21110		A	Interdental fixation	5.21	4.75	3.82	0.46	10.42	9.49	090
21116		A	Injection, jaw joint x-ray	0.81	5.51	0.27	0.06	6.38	1.14	000
21120		A	Reconstruction of chin	4.93	5.71	5.13	0.42	11.06	10.48	090
21121		A	Reconstruction of chin	7.64	6.30	6.30	0.66	14.60	14.60	090
21122		A	Reconstruction of chin	8.52	NA	7.00	0.73	NA	16.25	090
21123		A	Reconstruction of chin	11.16	NA	20.06	0.95	NA	32.17	090
21125		A	Augmentation lower jaw bone	10.62	7.69	7.67	0.54	18.85	18.83	090
21127		A	Augmentation lower jaw bone	11.12	8.30	7.47	0.92	20.34	19.51	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
21137		A	Reduction of forehead	9.82	NA	7.29	0.83	NA	17.94	090
21138		A	Reduction of forehead	12.19	NA	7.64	1.04	NA	20.87	090
21139		A	Reduction of forehead	14.61	NA	11.04	1.25	NA	26.90	090
21141		A	Reconstruct midface, lefort	18.10	NA	10.89	1.68	NA	30.67	090
21142		A	Reconstruct midface, lefort	18.81	NA	13.27	1.74	NA	33.82	090
21143		A	Reconstruct midface, lefort	19.58	NA	11.67	1.81	NA	33.06	090
21145		A	Reconstruct midface, lefort	19.94	NA	11.71	1.68	NA	33.33	090
21146		A	Reconstruct midface, lefort	20.71	NA	12.56	1.74	NA	35.01	090
21147		A	Reconstruct midface, lefort	21.77	NA	13.16	1.81	NA	36.74	090
21150		A	Reconstruct midface, lefort	25.24	NA	15.59	2.17	NA	43.00	090
21151		A	Reconstruct midface, lefort	28.30	NA	15.30	2.42	NA	46.02	090
21154		A	Reconstruct midface, lefort	30.52	NA	22.04	2.59	NA	55.15	090
21155		A	Reconstruct midface, lefort	34.45	NA	51.03	2.94	NA	88.42	090
21159		A	Reconstruct midface, lefort	42.38	NA	60.58	3.63	NA	106.59	090
21160		A	Reconstruct midface, lefort	46.44	NA	64.64	3.98	NA	115.06	090
21172		A	Reconstruct orbit/forehead	27.80	NA	21.24	2.37	NA	51.41	090
21175		A	Reconstruct orbit/forehead	33.17	NA	24.31	2.85	NA	60.33	090
21179		A	Reconstruct entire forehead	22.25	NA	18.66	1.90	NA	42.81	090
21180		A	Reconstruct entire forehead	25.19	NA	24.32	2.17	NA	51.68	090
21181		A	Contour cranial bone lesion	9.90	NA	8.05	0.83	NA	18.78	090
21182		A	Reconstruct cranial bone	32.19	NA	24.10	2.77	NA	59.06	090
21183		A	Reconstruct cranial bone	35.31	NA	25.88	3.03	NA	64.22	090
21184		A	Reconstruct cranial bone	38.24	NA	29.40	3.28	NA	70.92	090
21188		A	Reconstruction of midface	22.46	NA	18.26	1.90	NA	42.62	090
21193		A	Reconstruct lower jaw bone	17.15	NA	10.91	1.44	NA	29.50	090
21194		A	Reconstruct lower jaw bone	19.84	NA	12.92	1.67	NA	34.43	090
21195		A	Reconstruct lower jaw bone	17.24	NA	11.08	1.44	NA	29.76	090
21196		A	Reconstruct lower jaw bone	18.91	NA	13.53	1.58	NA	34.02	090
21198		A	Reconstruct lower jaw bone	14.16	NA	10.93	1.74	NA	26.83	090
21206		A	Reconstruct upper jaw bone	14.10	NA	10.52	1.19	NA	25.81	090
21208		A	Augmentation of facial bones	10.23	7.88	8.26	1.07	19.18	19.56	090
21209		A	Reduction of facial bones	6.72	6.05	6.22	0.76	13.53	13.70	090
21210		A	Face bone graft	10.23	7.72	7.87	1.29	19.24	19.39	090
21215		A	Lower jaw bone graft	10.77	7.83	7.13	1.42	20.02	19.32	090
21230		A	Rib cartilage graft	10.77	NA	9.34	1.69	NA	21.80	090
21235		A	Ear cartilage graft	6.72	8.15	7.42	1.09	15.96	15.23	090
21240		A	Reconstruction of jaw joint	14.05	NA	10.46	2.09	NA	26.60	090
21242		A	Reconstruction of jaw joint	12.95	NA	10.05	2.25	NA	25.25	090
21243		A	Reconstruction of jaw joint	20.79	NA	13.24	1.68	NA	35.71	090
21244		A	Reconstruction of lower jaw	11.86	NA	9.33	1.93	NA	23.12	090
21245		A	Reconstruction of jaw	11.86	8.63	9.93	1.31	21.80	23.10	090
21246		A	Reconstruction of jaw	12.47	8.83	9.24	1.04	22.34	22.75	090
21247		A	Reconstruct lower jaw bone	22.63	NA	14.51	2.27	NA	39.41	090
21248		A	Reconstruction of jaw	11.48	7.91	7.71	1.75	21.14	20.94	090
21249		A	Reconstruction of jaw	17.52	10.43	10.44	3.29	31.24	31.25	090
21255		A	Reconstruct lower jaw bone	16.72	NA	11.63	1.68	NA	30.03	090
21256		A	Reconstruction of orbit	16.19	NA	14.89	1.63	NA	32.71	090
21260		A	Revise eye sockets	16.52	NA	14.04	1.66	NA	32.22	090
21261		A	Revise eye sockets	31.49	NA	17.06	1.65	NA	50.20	090
21263		A	Revise eye sockets	28.42	NA	45.24	2.86	NA	76.52	090
21267		A	Revise eye sockets	18.90	NA	20.67	2.13	NA	41.70	090
21268		A	Revise eye sockets	24.48	NA	18.34	3.13	NA	45.95	090
21270		A	Augmentation cheek bone	10.23	5.40	9.69	1.41	17.04	21.33	090
21275		A	Revision orbitofacial bones	11.24	NA	13.42	1.26	NA	25.92	090
21280		A	Revision of eyelid	6.03	NA	8.21	0.61	NA	14.85	090
21282		A	Revision of eyelid	3.49	NA	6.72	0.79	NA	11.00	090
21295		A	Revision of jaw muscle/bone	1.53	NA	3.72	0.13	NA	5.38	090
21296		A	Revision of jaw muscle/bone	4.25	NA	5.02	0.22	NA	9.49	090
21300		A	Treatment of skull fracture	0.72	3.32	0.21	0.11	4.15	1.04	000
21310		A	Treatment of nose fracture	0.58	2.47	0.11	0.09	3.14	0.78	000
21315		A	Treatment of nose fracture	1.51	2.93	0.89	0.21	4.65	2.61	010
21320		A	Treatment of nose fracture	1.85	3.06	1.65	0.34	5.25	3.84	010
21325		A	Repair of nose fracture	3.77	NA	2.81	0.52	NA	7.10	090
21330		A	Repair of nose fracture	5.38	NA	5.97	0.86	NA	12.21	090
21335		A	Repair of nose fracture	8.61	NA	8.02	1.56	NA	18.19	090
21336		A	Repair nasal septal fracture	5.72	NA	5.91	0.52	NA	12.15	090
21337		A	Repair nasal septal fracture	2.70	4.38	2.39	0.38	7.46	5.47	090
21338		A	Repair nasoethmoid fracture	6.46	NA	6.39	0.66	NA	13.51	090
21339		A	Repair nasoethmoid fracture	8.09	NA	7.31	0.70	NA	16.10	090
21340		A	Repair of nose fracture	10.77	NA	9.73	1.04	NA	21.54	090
21343		A	Repair of sinus fracture	12.95	NA	9.61	1.08	NA	23.64	090
21344		A	Repair of sinus fracture	19.72	NA	14.46	1.08	NA	35.26	090
21345		A	Repair of nose/jaw fracture	8.16	7.04	7.45	0.81	16.01	16.42	090
21346		A	Repair of nose/jaw fracture	10.61	NA	9.74	1.04	NA	21.39	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
21347		A	Repair of nose/jaw fracture	12.69	NA	9.53	1.36	NA	23.58	090
21348		A	Repair of nose/jaw fracture	16.69	NA	12.22	2.22	NA	31.13	090
21355		A	Repair cheek bone fracture	3.77	3.40	1.74	0.17	7.34	5.68	010
21356		A	Repair cheek bone fracture	4.15	NA	4.79	0.89	NA	9.83	010
21360		A	Repair cheek bone fracture	6.46	NA	6.84	0.89	NA	14.19	090
21365		A	Repair cheek bone fracture	14.95	NA	11.74	1.63	NA	28.32	090
21366		A	Repair cheek bone fracture	17.77	NA	9.32	2.36	NA	29.45	090
21385		A	Repair eye socket fracture	9.16	NA	7.61	1.13	NA	17.90	090
21386		A	Repair eye socket fracture	9.16	NA	8.63	1.25	NA	19.04	090
21387		A	Repair eye socket fracture	9.70	NA	9.10	0.96	NA	19.76	090
21390		A	Repair eye socket fracture	10.13	NA	10.45	1.37	NA	21.95	090
21395		A	Repair eye socket fracture	12.68	NA	10.66	1.37	NA	24.71	090
21400		A	Treat eye socket fracture	1.40	3.31	0.65	0.17	4.88	2.22	090
21401		A	Repair eye socket fracture	3.26	3.98	2.31	0.32	7.56	5.89	090
21406		A	Repair eye socket fracture	7.01	NA	7.24	0.74	NA	14.99	090
21407		A	Repair eye socket fracture	8.61	NA	8.85	0.78	NA	18.24	090
21408		A	Repair eye socket fracture	12.38	NA	9.57	0.99	NA	22.94	090
21421		A	Treat mouth roof fracture	5.14	6.15	5.17	0.62	11.91	10.93	090
21422		A	Repair mouth roof fracture	8.32	NA	7.33	1.19	NA	16.84	090
21423		A	Repair mouth roof fracture	10.40	NA	8.31	1.19	NA	19.90	090
21431		A	Treat craniofacial fracture	7.05	NA	5.95	0.71	NA	13.71	090
21432		A	Repair craniofacial fracture	8.61	NA	7.78	0.84	NA	17.23	090
21433		A	Repair craniofacial fracture	25.35	NA	17.90	2.10	NA	45.35	090
21435		A	Repair craniofacial fracture	17.25	NA	13.29	1.88	NA	32.42	090
21436		A	Repair craniofacial fracture	28.04	NA	17.06	2.08	NA	47.18	090
21440		A	Repair dental ridge fracture	2.70	4.56	3.56	0.28	7.54	6.54	090
21445		A	Repair dental ridge fracture	5.38	5.56	5.29	0.56	11.50	11.23	090
21450		A	Treat lower jaw fracture	2.97	4.24	3.45	0.26	7.47	6.68	090
21451		A	Treat lower jaw fracture	4.87	5.43	4.60	0.74	11.04	10.21	090
21452		A	Treat lower jaw fracture	1.98	6.58	3.89	0.17	8.73	6.04	090
21453		A	Treat lower jaw fracture	5.54	5.95	5.49	0.55	12.04	11.58	090
21454		A	Treat lower jaw fracture	6.46	NA	5.76	1.42	NA	13.64	090
21461		A	Repair lower jaw fracture	8.09	8.12	7.14	1.30	17.51	16.53	090
21462		A	Repair lower jaw fracture	9.79	8.46	7.77	1.34	19.59	18.90	090
21465		A	Repair lower jaw fracture	11.91	NA	8.02	0.99	NA	20.92	090
21470		A	Repair lower jaw fracture	15.34	NA	10.11	1.74	NA	27.19	090
21480		A	Reset dislocated jaw	0.61	1.75	0.16	0.09	2.45	0.86	000
21485		A	Reset dislocated jaw	3.99	3.72	2.48	0.20	7.91	6.67	090
21490		A	Repair dislocated jaw	11.86	NA	7.48	0.52	NA	19.86	090
21493		A	Treat hyoid bone fracture	1.27	0.59	3.15	0.13	1.99	4.55	090
21494		A	Repair hyoid bone fracture	6.28	2.63	3.70	0.63	9.54	10.61	090
21495		A	Repair hyoid bone fracture	5.69	NA	5.95	0.51	NA	12.15	090
21497		A	Interdental wiring	3.86	4.11	3.29	0.38	8.35	7.53	090
21501		A	Drain neck/chest lesion	3.81	3.16	2.67	0.26	7.23	6.74	090
21502		A	Drain chest lesion	7.12	NA	9.17	0.75	NA	17.04	090
21510		A	Drainage of bone lesion	5.74	NA	7.85	0.50	NA	14.09	090
21550		A	Biopsy of neck/chest	2.06	1.72	1.17	0.12	3.90	3.35	010
21555		A	Remove lesion neck/chest	4.35	3.34	2.37	0.25	7.94	6.97	090
21556		A	Remove lesion neck/chest	5.57	NA	3.17	0.64	NA	9.38	090
21557		A	Remove tumor, neck or chest	8.88	NA	8.79	1.41	NA	19.08	090
21600		A	Partial removal of rib	6.89	NA	8.31	0.88	NA	16.08	090
21610		A	Partial removal of rib	14.61	NA	9.89	0.76	NA	25.26	090
21615		A	Removal of rib	9.87	NA	8.38	1.96	NA	20.21	090
21616		A	Removal of rib and nerves	12.04	NA	9.33	1.50	NA	22.87	090
21620		A	Partial removal of sternum	6.79	NA	7.60	1.23	NA	15.62	090
21627		A	Sternal debridement	6.81	NA	12.71	0.90	NA	20.42	090
21630		A	Extensive sternum surgery	17.38	NA	15.34	2.40	NA	35.12	090
21632		A	Extensive sternum surgery	18.14	NA	13.05	2.22	NA	33.41	090
21700		A	Revision of neck muscle	6.19	5.11	4.88	0.50	11.80	11.57	090
21705		A	Revision of neck muscle/rib	9.60	NA	10.23	0.96	NA	20.79	090
21720		A	Revision of neck muscle	5.68	6.36	4.90	0.52	12.56	11.10	090
21725		A	Revision of neck muscle	6.99	NA	6.16	0.74	NA	13.89	090
21740		A	Reconstruction of sternum	16.50	NA	13.90	1.64	NA	32.04	090
21750		A	Repair of sternum separation	10.77	NA	9.53	1.43	NA	21.73	090
21800		A	Treatment of rib fracture	0.96	1.33	0.63	0.07	2.36	1.66	090
21805		A	Treatment of rib fracture	2.75	NA	3.08	0.17	NA	6.00	090
21810		A	Treatment of rib fracture(s)	6.86	NA	8.65	0.61	NA	16.12	090
21820		A	Treat sternum fracture	1.28	1.74	0.99	0.17	3.19	2.44	090
21825		A	Repair sternum fracture	7.41	NA	7.42	1.12	NA	15.95	090
21920		A	Biopsy soft tissue of back	2.06	1.75	0.85	0.11	3.92	3.02	010
21925		A	Biopsy soft tissue of back	4.49	7.49	3.55	0.32	12.30	8.36	090
21930		A	Remove lesion, back or flank	5.00	3.64	2.52	0.49	9.13	8.01	090
21935		A	Remove tumor of back	17.96	NA	11.23	1.30	NA	30.49	090
22100		A	Remove part of neck vertebra	9.73	NA	7.68	1.09	NA	18.50	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
22101		A	Remove part, thorax vertebra	9.81	NA	7.77	1.38	NA	18.96	090
22102		A	Remove part, lumbar vertebra	9.81	NA	7.35	0.67	NA	17.83	090
22103		A	Remove extra spine segment	2.34	NA	1.45	0.37	NA	4.16	ZZZ
22110		A	Remove part of neck vertebra	12.74	NA	9.72	1.64	NA	24.10	090
22112		A	Remove part, thorax vertebra	12.81	NA	9.70	1.63	NA	24.14	090
22114		A	Remove part, lumbar vertebra	12.81	NA	9.69	1.17	NA	23.67	090
22116		A	Remove extra spine segment	2.32	NA	1.42	0.36	NA	4.10	ZZZ
22210		A	Revision of neck spine	23.82	NA	16.43	2.43	NA	42.68	090
22212		A	Revision of thorax spine	19.42	NA	14.76	2.83	NA	37.01	090
22214		A	Revision of lumbar spine	19.45	NA	13.95	2.68	NA	36.08	090
22216		A	Revise, extra spine segment	6.04	NA	3.51	0.89	NA	10.44	ZZZ
22220		A	Revision of neck spine	21.37	NA	14.66	2.63	NA	38.66	090
22222		A	Revision of thorax spine	21.52	NA	13.03	1.58	NA	36.13	090
22224		A	Revision of lumbar spine	21.52	NA	14.52	2.66	NA	38.70	090
22226		A	Revise, extra spine segment	6.04	NA	3.43	0.89	NA	10.36	ZZZ
22305		A	Treat spine process fracture	2.05	2.22	1.58	0.37	4.64	4.00	090
22310		A	Treat spine fracture	2.61	3.25	2.82	0.69	6.55	6.12	090
22315		A	Treat spine fracture	8.84	NA	7.92	0.86	NA	17.62	090
22325		A	Repair of spine fracture	18.30	NA	11.68	1.34	NA	31.32	090
22326		A	Repair neck spine fracture	19.59	NA	14.02	2.74	NA	36.35	090
22327		A	Repair thorax spine fracture	19.20	NA	13.47	2.35	NA	35.02	090
22328		A	Repair each add spine fx	4.61	NA	2.57	0.72	NA	7.90	ZZZ
22505		A	Manipulation of spine	1.87	2.43	1.66	0.17	4.47	3.70	010
22548		A	Neck spine fusion	25.82	NA	17.17	3.82	NA	46.81	090
22554		A	Neck spine fusion	18.62	NA	12.68	3.52	NA	34.82	090
22556		A	Thorax spine fusion	23.46	NA	16.24	3.58	NA	43.28	090
22558		A	Lumbar spine fusion	22.28	NA	15.16	3.38	NA	40.82	090
22585		A	Additional spinal fusion	5.53	NA	3.18	0.93	NA	9.64	ZZZ
22590		A	Spine & skull spinal fusion	20.51	NA	14.43	3.44	NA	38.38	090
22595		A	Neck spinal fusion	19.39	NA	13.40	3.87	NA	36.66	090
22600		A	Neck spine fusion	16.14	NA	11.81	3.32	NA	31.27	090
22610		A	Thorax spine fusion	16.02	NA	12.11	2.75	NA	30.88	090
22612		A	Lumbar spine fusion	21.00	NA	14.94	3.33	NA	39.27	090
22614		A	Spine fusion, extra segment	6.44	NA	3.78	0.92	NA	11.14	ZZZ
22630		A	Lumbar spine fusion	20.84	NA	14.85	3.15	NA	38.84	090
22632		A	Spine fusion, extra segment	5.23	NA	3.01	0.82	NA	9.06	ZZZ
22800		A	Fusion of spine	18.25	NA	13.50	3.58	NA	35.33	090
22802		A	Fusion of spine	30.88	NA	21.23	4.61	NA	56.72	090
22804		A	Fusion of spine	36.27	NA	24.20	4.61	NA	65.08	090
22808		A	Fusion of spine	26.27	NA	18.13	3.15	NA	47.55	090
22810		A	Fusion of spine	30.27	NA	19.97	3.15	NA	53.39	090
22812		A	Fusion of spine	32.70	NA	21.49	4.24	NA	58.43	090
22818		A	Kyphectomy, 1–2 segments	31.83	NA	19.42	4.85	NA	56.10	090
22819		A	Kyphectomy, 3 & more segment	36.44	NA	21.75	4.85	NA	63.04	090
22830		A	Exploration of spinal fusion	10.85	NA	8.96	2.18	NA	21.99	090
22840		A	Insert spine fixation device	12.54	NA	7.94	0.98	NA	21.46	ZZZ
22842		A	Insert spine fixation device	12.58	NA	7.54	1.12	NA	21.24	ZZZ
22843		A	Insert spine fixation device	13.46	NA	8.67	1.40	NA	23.53	ZZZ
22844		A	Insert spine fixation device	16.44	NA	10.38	1.71	NA	28.53	ZZZ
22845		A	Insert spine fixation device	11.96	NA	7.56	0.93	NA	20.45	ZZZ
22846		A	Insert spine fixation device	12.42	NA	7.87	1.29	NA	21.58	ZZZ
22847		A	Insert spine fixation device	13.80	NA	8.62	1.44	NA	23.86	ZZZ
22848		A	Insert pelvic fixation device	6.00	NA	4.63	0.94	NA	11.57	ZZZ
22849		A	Reinsert spinal fixation	18.51	NA	13.16	1.97	NA	33.64	090
22850		A	Remove spine fixation device	9.52	NA	7.79	1.50	NA	18.81	090
22851		A	Apply spine prosth device	6.71	NA	4.70	1.05	NA	12.46	ZZZ
22852		A	Remove spine fixation device	9.01	NA	7.52	1.57	NA	18.10	090
22855		A	Remove spine fixation device	15.13	NA	10.74	1.25	NA	27.12	090
22900		A	Remove abdominal wall lesion	5.80	NA	3.87	0.60	NA	10.27	090
23000		A	Removal of calcium deposits	4.36	5.42	5.20	0.47	10.25	10.03	090
23020		A	Release shoulder joint	8.93	NA	8.38	1.09	NA	18.40	090
23030		A	Drain shoulder lesion	3.43	3.56	3.34	0.35	7.34	7.12	010
23031		A	Drain shoulder bursa	2.74	3.26	3.12	0.05	6.05	5.91	010
23035		A	Drain shoulder bone lesion	8.61	NA	11.29	1.04	NA	20.94	090
23040		A	Exploratory shoulder surgery	9.20	NA	9.44	1.47	NA	20.11	090
23044		A	Exploratory shoulder surgery	7.12	NA	7.98	1.18	NA	16.28	090
23065		A	Biopsy shoulder tissues	2.27	2.22	1.28	0.09	4.58	3.64	010
23066		A	Biopsy shoulder tissues	4.16	4.62	4.33	0.10	8.88	8.59	090
23075		A	Removal of shoulder lesion	2.39	2.93	2.25	0.29	5.61	4.93	010
23076		A	Removal of shoulder lesion	7.63	NA	6.07	0.65	NA	14.35	090
23077		A	Remove tumor of shoulder	16.09	NA	11.47	1.38	NA	28.94	090
23100		A	Biopsy of shoulder joint	6.03	NA	6.40	1.24	NA	13.67	090
23101		A	Shoulder joint surgery	5.58	NA	6.34	1.21	NA	13.13	090
23105		A	Remove shoulder joint lining	8.23	NA	7.89	1.73	NA	17.85	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
23106		A	Incision of collarbone joint	5.96	NA	6.22	0.80	NA	12.98	090
23107		A	Explore,treat shoulder joint	8.62	NA	8.13	1.60	NA	18.35	090
23120		A	Partial removal, collar bone	7.11	NA	7.35	0.74	NA	15.20	090
23125		A	Removal of collarbone	9.39	NA	8.49	1.27	NA	19.15	090
23130		A	Partial removal, shoulderbone	7.55	NA	7.61	1.14	NA	16.30	090
23140		A	Removal of bone lesion	6.89	NA	5.98	0.73	NA	13.60	090
23145		A	Removal of bone lesion	9.09	NA	8.41	1.33	NA	18.83	090
23146		A	Removal of bone lesion	7.83	NA	17.31	1.01	NA	26.15	090
23150		A	Removal of humerus lesion	8.48	NA	7.89	1.01	NA	17.38	090
23155		A	Removal of humerus lesion	10.35	NA	9.85	1.37	NA	21.57	090
23156		A	Removal of humerus lesion	8.68	NA	8.40	1.25	NA	18.33	090
23170		A	Remove collarbone lesion	6.86	NA	7.68	0.78	NA	15.32	090
23172		A	Remove shoulder blade lesion	6.90	NA	7.76	0.73	NA	15.39	090
23174		A	Remove humerus lesion	9.51	NA	9.23	1.21	NA	19.95	090
23180		A	Remove collar bone lesion	8.53	NA	11.46	0.67	NA	20.66	090
23182		A	Remove shoulder blade lesion	8.15	NA	10.95	1.13	NA	20.23	090
23184		A	Remove humerus lesion	9.38	NA	12.03	1.48	NA	22.89	090
23190		A	Partial removal of scapula	7.24	NA	6.52	0.98	NA	14.74	090
23195		A	Removal of head of humerus	9.81	NA	8.88	1.45	NA	20.14	090
23200		A	Removal of collar bone	12.08	NA	9.81	1.26	NA	23.15	090
23210		A	Removal of shoulderblade	12.49	NA	10.38	1.41	NA	24.28	090
23220		A	Partial removal of humerus	14.56	NA	12.42	2.03	NA	29.01	090
23221		A	Partial removal of humerus	17.74	NA	13.26	1.19	NA	32.19	090
23222		A	Partial removal of humerus	23.92	NA	17.77	2.30	NA	43.99	090
23330		A	Remove shoulder foreign body	1.85	3.00	2.14	0.07	4.92	4.06	010
23331		A	Remove shoulder foreign body	7.38	NA	7.54	0.38	NA	15.30	090
23332		A	Remove shoulder foreign body	11.62	NA	10.00	1.57	NA	23.19	090
23350		A	Injection for shoulder x-ray	1.00	7.27	0.32	0.05	8.32	1.37	000
23395		A	Muscle transfer, shoulder/arm	16.85	NA	12.50	1.84	NA	31.19	090
23397		A	Muscle transfers	16.13	NA	12.69	2.34	NA	31.16	090
23400		A	Fixation of shoulder blade	13.54	NA	11.05	1.68	NA	26.27	090
23405		A	Incision of tendon & muscle	8.37	NA	7.26	0.99	NA	16.62	090
23406		A	Incise tendon(s) & muscle(s)	10.79	NA	9.63	1.58	NA	22.00	090
23410		A	Repair of tendon(s)	12.45	NA	10.34	1.75	NA	24.54	090
23412		A	Repair of tendon(s)	13.31	NA	10.87	2.16	NA	26.34	090
23415		A	Release of shoulder ligament	9.97	NA	8.38	0.83	NA	19.18	090
23420		A	Repair of shoulder	13.30	NA	11.39	2.34	NA	27.03	090
23430		A	Repair biceps tendon	9.98	NA	8.91	1.19	NA	20.08	090
23440		A	Removal/transplant tendon	10.48	NA	9.31	1.17	NA	20.96	090
23450		A	Repair shoulder capsule	13.40	NA	10.73	2.04	NA	26.17	090
23455		A	Repair shoulder capsule	14.37	NA	11.51	2.50	NA	28.38	090
23460		A	Repair shoulder capsule	15.37	NA	6.49	2.24	NA	24.10	090
23462		A	Repair shoulder capsule	15.30	NA	12.08	2.48	NA	29.86	090
23465		A	Repair shoulder capsule	15.85	NA	12.50	2.27	NA	30.62	090
23466		A	Repair shoulder capsule	14.22	NA	11.54	2.67	NA	28.43	090
23470		A	Reconstruct shoulder joint	17.15	NA	13.00	2.65	NA	32.80	090
23472		A	Reconstruct shoulder joint	16.92	NA	13.09	4.89	NA	34.90	090
23480		A	Revision of collarbone	11.18	NA	9.78	1.02	NA	21.98	090
23485		A	Revision of collar bone	13.43	NA	11.19	1.87	NA	26.49	090
23490		A	Reinforce clavicle	11.86	NA	9.43	0.80	NA	22.09	090
23491		A	Reinforce shoulder bones	14.21	NA	11.56	2.11	NA	27.88	090
23500		A	Treat clavicle fracture	2.08	2.63	1.61	0.21	4.92	3.90	090
23505		A	Treat clavicle fracture	3.69	4.24	3.17	0.38	8.31	7.24	090
23515		A	Repair clavicle fracture	7.41	NA	6.65	1.12	NA	15.18	090
23520		A	Treat clavicle dislocation	2.16	2.54	1.82	0.19	4.89	4.17	090
23525		A	Treat clavicle dislocation	3.60	4.07	3.00	0.27	7.94	6.87	090
23530		A	Repair clavicle dislocation	7.31	NA	5.55	0.91	NA	13.77	090
23532		A	Repair clavicle dislocation	8.01	NA	7.16	1.19	NA	16.36	090
23540		A	Treat clavicle dislocation	2.23	3.04	1.43	0.19	5.46	3.85	090
23545		A	Treat clavicle dislocation	3.25	3.55	2.57	0.29	7.09	6.11	090
23550		A	Repair clavicle dislocation	7.24	NA	6.40	1.46	NA	15.10	090
23552		A	Repair clavicle dislocation	8.45	NA	7.05	1.17	NA	16.67	090
23570		A	Treat shoulderblade fracture	2.23	2.68	2.01	0.25	5.16	4.49	090
23575		A	Treat shoulderblade fracture	4.06	4.54	3.46	0.43	9.03	7.95	090
23585		A	Repair scapula fracture	8.96	NA	7.78	1.29	NA	18.03	090
23600		A	Treat humerus fracture	2.93	4.15	2.57	0.43	7.51	5.93	090
23605		A	Treat humerus fracture	4.87	6.21	5.13	0.76	11.84	10.76	090
23615		A	Repair humerus fracture	9.35	NA	8.32	1.78	NA	19.45	090
23616		A	Repair humerus fracture	21.27	NA	14.86	3.54	NA	39.67	090
23620		A	Treat humerus fracture	2.40	3.85	2.21	0.46	6.71	5.07	090
23625		A	Treat humerus fracture	3.93	5.44	4.29	0.60	9.97	8.82	090
23630		A	Repair humerus fracture	7.35	NA	6.58	1.40	NA	15.33	090
23650		A	Treat shoulder dislocation	3.39	3.73	1.91	0.24	7.36	5.54	090
23655		A	Treat shoulder dislocation	4.57	NA	3.11	0.44	NA	8.12	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
23660		A	Repair shoulder dislocation	7.49	NA	6.16	1.40	NA	15.05	090
23665		A	Treat dislocation/fracture	4.47	5.60	4.59	0.51	10.58	9.57	090
23670		A	Repair dislocation/fracture	7.90	NA	7.09	1.85	NA	16.84	090
23675		A	Treat dislocation/fracture	6.05	6.66	5.56	0.61	13.32	12.22	090
23680		A	Repair dislocation/fracture	10.06	NA	8.32	2.13	NA	20.51	090
23700		A	Fixation of shoulder	2.52	NA	2.79	0.34	NA	5.65	010
23800		A	Fusion of shoulder joint	14.16	NA	11.49	2.63	NA	28.28	090
23802		A	Fusion of shoulder joint	16.60	NA	13.56	2.24	NA	32.40	090
23900		A	Amputation of arm & girdle	19.72	NA	13.23	2.40	NA	35.35	090
23920		A	Amputation at shoulder joint	14.61	NA	11.09	2.54	NA	28.24	090
23921		A	Amputation follow-up surgery	5.49	6.05	4.83	0.74	12.28	11.06	090
23930		A	Drainage of arm lesion	2.94	3.45	2.68	0.24	6.63	5.86	010
23931		A	Drainage of arm bursa	1.79	3.20	2.61	0.11	5.10	4.51	010
23935		A	Drain arm/elbow bone lesion	6.09	NA	8.88	0.78	NA	15.75	090
24000		A	Exploratory elbow surgery	5.82	NA	5.29	1.44	NA	12.55	090
24006		A	Release elbow joint	9.31	NA	7.32	1.17	NA	17.80	090
24065		A	Biopsy arm/elbow soft tissue	2.08	2.91	2.19	0.10	5.09	4.37	010
24066		A	Biopsy arm/elbow soft tissue	5.21	5.26	4.91	0.41	10.88	10.53	090
24075		A	Remove arm/elbow lesion	3.92	4.47	3.94	0.35	8.74	8.21	090
24076		A	Remove arm/elbow lesion	6.30	NA	5.29	0.67	NA	12.26	090
24077		A	Remove tumor of arm/elbow	11.76	NA	9.56	1.87	NA	23.19	090
24100		A	Biopsy elbow joint lining	4.93	NA	4.41	0.69	NA	10.03	090
24101		A	Explore/treat elbow joint	6.13	NA	5.48	1.41	NA	13.02	090
24102		A	Remove elbow joint lining	8.03	NA	5.02	1.81	NA	14.86	090
24105		A	Removal of elbow bursa	3.61	NA	3.83	0.63	NA	8.07	090
24110		A	Remove humerus lesion	7.39	NA	7.38	1.22	NA	15.99	090
24115		A	Remove/graft bone lesion	9.63	NA	9.08	1.33	NA	20.04	090
24116		A	Remove/graft bone lesion	11.81	NA	10.34	1.47	NA	23.62	090
24120		A	Remove elbow lesion	6.65	NA	5.69	0.98	NA	13.32	090
24125		A	Remove/graft bone lesion	7.89	NA	6.71	0.61	NA	15.21	090
24126		A	Remove/graft bone lesion	8.31	NA	5.16	1.21	NA	14.68	090
24130		A	Removal of head of radius	6.25	NA	5.61	1.08	NA	12.94	090
24134		A	Removal of arm bone lesion	9.73	NA	11.90	1.24	NA	22.87	090
24136		A	Remove radius bone lesion	7.99	NA	5.46	0.92	NA	14.37	090
24138		A	Remove elbow bone lesion	8.05	NA	6.86	1.06	NA	15.97	090
24140		A	Partial removal of arm bone	9.18	NA	12.04	1.45	NA	22.67	090
24145		A	Partial removal of radius	7.58	NA	8.91	1.03	NA	17.52	090
24147		A	Partial removal of elbow	7.54	NA	8.68	1.08	NA	17.30	090
24149		A	Radical resection of elbow	14.20	NA	9.65	2.07	NA	25.92	090
24150		A	Extensive humerus surgery	13.27	NA	11.56	2.24	NA	27.07	090
24151		A	Extensive humerus surgery	15.58	NA	12.80	2.11	NA	30.49	090
24152		A	Extensive radius surgery	10.06	NA	8.54	1.16	NA	19.76	090
24153		A	Extensive radius surgery	11.54	NA	6.20	1.71	NA	19.45	090
24155		A	Removal of elbow joint	11.73	NA	8.35	1.72	NA	21.80	090
24160		A	Remove elbow joint implant	7.83	NA	6.62	0.80	NA	15.25	090
24164		A	Remove radius head implant	6.23	NA	5.52	0.90	NA	12.65	090
24200		A	Removal of arm foreign body	1.76	2.87	1.96	0.06	4.69	3.78	010
24201		A	Removal of arm foreign body	4.56	5.46	4.53	0.49	10.51	9.58	090
24220		A	Injection for elbow x-ray	1.31	8.29	0.43	0.05	9.65	1.79	000
24301		A	Muscle/tendon transfer	10.20	NA	7.76	1.23	NA	19.19	090
24305		A	Arm tendon lengthening	7.45	NA	6.23	0.29	NA	13.97	090
24310		A	Revision of arm tendon	5.98	NA	6.20	0.48	NA	12.66	090
24320		A	Repair of arm tendon	10.56	NA	7.53	1.29	NA	19.38	090
24330		A	Revision of arm muscles	9.60	NA	7.25	1.43	NA	18.28	090
24331		A	Revision of arm muscles	10.65	NA	8.39	1.57	NA	20.61	090
24340		A	Repair of biceps tendon	7.89	NA	6.50	1.13	NA	15.52	090
24341		A	Repair tendon/muscle arm	7.90	NA	6.57	1.14	NA	15.61	090
24342		A	Repair of ruptured tendon	10.62	NA	8.13	1.76	NA	20.51	090
24350		A	Repair of tennis elbow	5.25	NA	4.97	0.69	NA	10.91	090
24351		A	Repair of tennis elbow	5.91	NA	5.44	0.73	NA	12.08	090
24352		A	Repair of tennis elbow	6.43	NA	5.76	0.93	NA	13.12	090
24354		A	Repair of tennis elbow	6.48	NA	5.81	0.94	NA	13.23	090
24356		A	Revision of tennis elbow	6.68	NA	5.85	1.18	NA	13.71	090
24360		A	Reconstruct elbow joint	12.34	NA	9.03	2.47	NA	23.84	090
24361		A	Reconstruct elbow joint	14.08	NA	10.28	2.00	NA	26.36	090
24362		A	Reconstruct elbow joint	14.99	NA	8.91	0.80	NA	24.70	090
24363		A	Replace elbow joint	18.49	NA	12.86	4.13	NA	35.48	090
24365		A	Reconstruct head of radius	8.39	NA	6.95	1.19	NA	16.53	090
24366		A	Reconstruct head of radius	9.13	NA	7.19	1.80	NA	18.12	090
24400		A	Revision of humerus	11.06	NA	10.14	1.37	NA	22.57	090
24410		A	Revision of humerus	14.82	NA	11.94	2.06	NA	28.82	090
24420		A	Revision of humerus	13.44	NA	13.08	2.01	NA	28.53	090
24430		A	Repair of humerus	12.81	NA	10.71	2.34	NA	25.86	090
24435		A	Repair humerus with graft	13.17	NA	11.46	2.84	NA	27.47	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
24470		A	Revision of elbow joint	8.74	NA	4.63	1.30	NA	14.67	090
24495		A	Decompression of forearm	8.12	NA	7.31	1.10	NA	16.53	090
24498		A	Reinforce humerus	11.92	NA	10.21	1.62	NA	23.75	090
24500		A	Treat humerus fracture	3.21	5.47	2.28	0.36	9.04	5.85	090
24505		A	Treat humerus fracture	5.17	8.36	5.37	0.71	14.24	11.25	090
24515		A	Repair humerus fracture	11.65	NA	9.55	1.54	NA	22.74	090
24516		A	Repair humerus fracture	11.65	NA	9.97	1.54	NA	23.16	090
24530		A	Treat humerus fracture	3.50	6.29	3.38	0.42	10.21	7.30	090
24535		A	Treat humerus fracture	6.87	8.76	5.80	0.78	16.41	13.45	090
24538		A	Treat humerus fracture	9.43	NA	8.63	1.26	NA	19.32	090
24545		A	Repair humerus fracture	10.46	NA	8.63	1.59	NA	20.68	090
24546		A	Repair humerus fracture	15.69	NA	11.88	1.59	NA	29.16	090
24560		A	Treat humerus fracture	2.80	5.22	1.84	0.30	8.32	4.94	090
24565		A	Treat humerus fracture	5.56	7.80	4.89	0.54	13.90	10.99	090
24566		A	Treat humerus fracture	7.79	NA	7.72	0.96	NA	16.47	090
24575		A	Repair humerus fracture	10.66	NA	7.63	1.24	NA	19.53	090
24576		A	Treat humerus fracture	2.86	5.19	2.32	0.33	8.38	5.51	090
24577		A	Treat humerus fracture	5.79	8.10	5.13	0.61	14.50	11.53	090
24579		A	Repair humerus fracture	11.60	NA	9.50	1.35	NA	22.45	090
24582		A	Treat humerus fracture	8.55	NA	7.95	1.06	NA	17.56	090
24586		A	Repair elbow fracture	15.21	NA	10.29	2.36	NA	27.86	090
24587		A	Repair elbow fracture	15.16	NA	10.16	2.17	NA	27.49	090
24600		A	Treat elbow dislocation	4.23	6.87	3.19	0.26	11.36	7.68	090
24605		A	Treat elbow dislocation	5.42	NA	4.19	0.37	NA	9.98	090
24615		A	Repair elbow dislocation	9.42	NA	7.03	1.48	NA	17.93	090
24620		A	Treat elbow fracture	6.98	NA	5.53	0.57	NA	13.08	090
24635		A	Repair elbow fracture	13.19	NA	17.15	1.78	NA	32.12	090
24640		A	Treat elbow dislocation	1.20	3.49	0.77	0.08	4.77	2.05	010
24650		A	Treat radius fracture	2.16	4.93	1.72	0.33	7.42	4.21	090
24655		A	Treat radius fracture	4.40	7.15	4.13	0.45	12.00	8.98	090
24665		A	Repair radius fracture	8.14	NA	7.41	1.14	NA	16.69	090
24666		A	Repair radius fracture	9.49	NA	8.31	1.60	NA	19.40	090
24670		A	Treatment of ulna fracture	2.54	4.99	2.09	0.27	7.80	4.90	090
24675		A	Treatment of ulna fracture	4.72	7.44	4.48	0.54	12.70	9.74	090
24685		A	Repair ulna fracture	8.80	NA	7.82	1.34	NA	17.96	090
24800		A	Fusion of elbow joint	11.20	NA	8.22	1.55	NA	20.97	090
24802		A	Fusion/graft of elbow joint	13.69	NA	10.51	1.99	NA	26.19	090
24900		A	Amputation of upper arm	9.60	NA	8.14	1.39	NA	19.13	090
24920		A	Amputation of upper arm	9.54	NA	9.61	1.19	NA	20.34	090
24925		A	Amputation follow-up surgery	7.07	NA	6.11	0.75	NA	13.93	090
24930		A	Amputation follow-up surgery	10.25	NA	9.60	1.17	NA	21.02	090
24931		A	Amputate upper arm & implant	12.72	NA	11.49	1.84	NA	26.05	090
24935		A	Revision of amputation	15.56	NA	10.07	2.24	NA	27.87	090
25000		A	Incision of tendon sheath	3.38	NA	5.29	0.62	NA	9.29	090
25020		A	Decompression of forearm	5.92	NA	7.99	0.77	NA	14.68	090
25023		A	Decompression of forearm	12.96	NA	13.16	0.94	NA	27.06	090
25028		A	Drainage of forearm lesion	5.25	NA	6.95	0.36	NA	12.56	090
25031		A	Drainage of forearm bursa	4.14	NA	6.81	0.09	NA	11.04	090
25035		A	Treat forearm bone lesion	7.36	NA	11.52	1.01	NA	19.89	090
25040		A	Explore/treat wrist joint	7.18	NA	7.45	0.90	NA	15.53	090
25065		A	Biopsy forearm soft tissues	1.99	1.90	2.55	0.09	3.98	4.63	010
25066		A	Biopsy forearm soft tissues	4.13	NA	6.13	0.22	NA	10.48	090
25075		A	Removal of forearm lesion	3.74	NA	5.14	0.37	NA	9.25	090
25076		A	Removal of forearm lesion	4.92	NA	8.53	0.67	NA	14.12	090
25077		A	Remove tumor, forearm/wrist	9.76	NA	10.69	1.67	NA	22.12	090
25085		A	Incision of wrist capsule	5.50	NA	7.81	0.71	NA	14.02	090
25100		A	Biopsy of wrist joint	3.90	NA	5.49	0.79	NA	10.18	090
25101		A	Explore/treat wrist joint	4.69	NA	5.99	0.98	NA	11.66	090
25105		A	Remove wrist joint lining	5.85	NA	8.15	1.19	NA	15.19	090
25107		A	Remove wrist joint cartilage	6.43	NA	8.52	0.89	NA	15.84	090
25110		A	Remove wrist tendon lesion	3.92	NA	5.83	0.46	NA	10.21	090
25111		A	Remove wrist tendon lesion	3.39	NA	4.52	0.55	NA	8.46	090
25112		A	Reremove wrist tendon lesion	4.53	NA	5.26	0.66	NA	10.45	090
25115		A	Remove wrist/forearm lesion	8.82	NA	11.76	1.23	NA	21.81	090
25116		A	Remove wrist/forearm lesion	7.11	NA	10.94	1.38	NA	19.43	090
25118		A	Excise wrist tendon sheath	4.37	NA	5.83	1.02	NA	11.22	090
25119		A	Partial removal of ulna	6.04	NA	8.38	1.32	NA	15.74	090
25120		A	Removal of forearm lesion	6.10	NA	10.24	1.14	NA	17.48	090
25125		A	Remove/graft forearm lesion	7.48	NA	10.82	1.04	NA	19.34	090
25126		A	Remove/graft forearm lesion	7.55	NA	11.84	1.12	NA	20.51	090
25130		A	Removal of wrist lesion	5.26	NA	6.41	0.67	NA	12.34	090
25135		A	Remove & graft wrist lesion	6.89	NA	7.29	0.97	NA	15.15	090
25136		A	Remove & graft wrist lesion	5.97	NA	6.61	0.85	NA	13.43	090
25145		A	Remove forearm bone lesion	6.37	NA	10.24	0.75	NA	17.36	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
25150		A	Partial removal of ulna	7.09	NA	8.99	1.12	NA	17.20	090
25151		A	Partial removal of radius	7.39	NA	11.22	1.02	NA	19.63	090
25170		A	Extensive forearm surgery	11.09	NA	12.78	1.51	NA	25.38	090
25210		A	Removal of wrist bone	5.95	NA	6.68	0.80	NA	13.43	090
25215		A	Removal of wrist bones	7.89	NA	9.32	1.42	NA	18.63	090
25230		A	Partial removal of radius	5.23	NA	6.38	0.85	NA	12.46	090
25240		A	Partial removal of ulna	5.17	NA	7.82	0.86	NA	13.85	090
25246		A	Injection for wrist x-ray	1.45	8.10	0.47	0.05	9.60	1.97	000
25248		A	Remove forearm foreign body	5.14	NA	6.89	0.37	NA	12.40	090
25250		A	Removal of wrist prosthesis	6.60	NA	7.13	0.91	NA	14.64	090
25251		A	Removal of wrist prosthesis	9.57	NA	10.66	1.39	NA	21.62	090
25260		A	Repair forearm tendon/muscle	7.80	NA	11.24	0.78	NA	19.82	090
25263		A	Repair forearm tendon/muscle	7.82	NA	10.83	1.03	NA	19.68	090
25265		A	Repair forearm tendon/muscle	9.88	NA	12.92	1.41	NA	24.21	090
25270		A	Repair forearm tendon/muscle	6.00	NA	10.35	0.55	NA	16.90	090
25272		A	Repair forearm tendon/muscle	7.04	NA	10.95	0.54	NA	18.53	090
25274		A	Repair forearm tendon/muscle	8.75	NA	11.62	1.13	NA	21.50	090
25280		A	Revise wrist/forearm tendon	7.22	NA	11.21	0.69	NA	19.12	090
25290		A	Incise wrist/forearm tendon	5.29	NA	12.04	0.41	NA	17.74	090
25295		A	Release wrist/forearm tendon	6.55	NA	9.86	0.52	NA	16.93	090
25300		A	Fusion of tendons at wrist	8.80	NA	8.20	1.19	NA	18.19	090
25301		A	Fusion of tendons at wrist	8.40	NA	7.92	1.18	NA	17.50	090
25310		A	Transplant forearm tendon	8.14	NA	11.53	1.17	NA	20.84	090
25312		A	Transplant forearm tendon	9.57	NA	12.17	1.31	NA	23.05	090
25315		A	Revise palsy hand tendon(s)	10.20	NA	13.02	1.34	NA	24.56	090
25316		A	Revise palsy hand tendon(s)	12.33	NA	14.28	1.78	NA	28.39	090
25320		A	Repair/revise wrist joint	10.77	NA	9.55	1.45	NA	21.77	090
25332		A	Revise wrist joint	11.41	NA	9.84	1.61	NA	22.86	090
25335		A	Realignment of hand	12.88	NA	12.17	1.56	NA	26.61	090
25337		A	Reconstruct ulna/radioulnar	10.17	NA	10.87	1.45	NA	22.49	090
25350		A	Revision of radius	8.78	NA	11.95	1.26	NA	21.99	090
25355		A	Revision of radius	10.17	NA	12.54	1.49	NA	24.20	090
25360		A	Revision of ulna	8.43	NA	11.72	0.99	NA	21.14	090
25365		A	Revise radius & ulna	12.40	NA	13.58	1.57	NA	27.55	090
25370		A	Revise radius or ulna	13.36	NA	15.03	1.92	NA	30.31	090
25375		A	Revise radius & ulna	13.04	NA	14.84	0.87	NA	28.75	090
25390		A	Shorten radius/ulna	10.40	NA	13.14	1.50	NA	25.04	090
25391		A	Lengthen radius/ulna	13.65	NA	14.69	1.93	NA	30.27	090
25392		A	Shorten radius & ulna	13.95	NA	13.19	2.04	NA	29.18	090
25393		A	Lengthen radius & ulna	15.87	NA	16.01	2.32	NA	34.20	090
25400		A	Repair radius or ulna	10.92	NA	13.41	1.75	NA	26.08	090
25405		A	Repair/graft radius or ulna	14.38	NA	15.51	2.02	NA	31.91	090
25415		A	Repair radius & ulna	13.35	NA	14.84	1.92	NA	30.11	090
25420		A	Repair/graft radius & ulna	16.33	NA	16.41	2.28	NA	35.02	090
25425		A	Repair/graft radius or ulna	13.21	NA	19.06	1.87	NA	34.14	090
25426		A	Repair/graft radius & ulna	15.82	NA	15.54	2.13	NA	33.49	090
25440		A	Repair/graft wrist bone	10.44	NA	9.35	1.50	NA	21.29	090
25441		A	Reconstruct wrist joint	12.90	NA	10.57	1.89	NA	25.36	090
25442		A	Reconstruct wrist joint	10.85	NA	9.78	1.22	NA	21.85	090
25443		A	Reconstruct wrist joint	10.39	NA	11.14	1.52	NA	23.05	090
25444		A	Reconstruct wrist joint	11.15	NA	11.18	1.66	NA	23.99	090
25445		A	Reconstruct wrist joint	9.69	NA	10.54	1.72	NA	21.95	090
25446		A	Wrist replacement	16.55	NA	12.82	3.49	NA	32.86	090
25447		A	Repair wrist joint(s)	10.37	NA	9.41	1.56	NA	21.34	090
25449		A	Remove wrist joint implant	14.49	NA	13.45	1.16	NA	29.10	090
25450		A	Revision of wrist joint	7.87	NA	6.29	1.19	NA	15.35	090
25455		A	Revision of wrist joint	9.49	NA	12.73	1.42	NA	23.64	090
25490		A	Reinforce radius	9.54	NA	12.48	1.42	NA	23.44	090
25491		A	Reinforce ulna	9.96	NA	12.22	1.49	NA	23.67	090
25492		A	Reinforce radius and ulna	12.33	NA	14.20	1.84	NA	28.37	090
25500		A	Treat fracture of radius	2.45	4.50	1.75	0.29	7.24	4.49	090
25505		A	Treat fracture of radius	5.21	7.56	4.57	0.51	13.28	10.29	090
25515		A	Repair fracture of radius	9.18	NA	8.04	1.22	NA	18.44	090
25520		A	Repair fracture of radius	6.26	7.33	5.16	0.94	14.53	12.36	090
25525		A	Repair fracture of radius	12.24	NA	9.89	1.83	NA	23.96	090
25526		A	Repair fracture of radius	12.98	NA	14.96	1.94	NA	29.88	090
25530		A	Treat fracture of ulna	2.09	4.66	1.88	0.35	7.10	4.32	090
25535		A	Treat fracture of ulna	5.14	7.62	4.56	0.54	13.30	10.24	090
25545		A	Repair fracture of ulna	8.90	NA	7.87	1.20	NA	17.97	090
25560		A	Treat fracture radius & ulna	2.44	4.72	1.52	0.27	7.43	4.23	090
25565		A	Treat fracture radius & ulna	5.63	7.84	4.83	0.70	14.17	11.16	090
25574		A	Treat fracture radius & ulna	7.01	NA	6.77	1.73	NA	15.51	090
25575		A	Repair fracture radius/ulna	10.45	NA	8.74	1.73	NA	20.92	090
25600		A	Treat fracture radius/ulna	2.63	5.04	1.96	0.42	8.09	5.01	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
25605		A	Treat fracture radius/ulna	5.81	8.09	5.07	0.61	14.51	11.49	090
25611		A	Repair fracture radius/ulna	7.77	NA	7.72	0.97	NA	16.46	090
25620		A	Repair fracture radius/ulna	8.55	NA	7.68	1.14	NA	17.37	090
25622		A	Treat wrist bone fracture	2.61	4.94	1.89	0.33	7.88	4.83	090
25624		A	Treat wrist bone fracture	4.53	7.20	4.03	0.57	12.30	9.13	090
25628		A	Repair wrist bone fracture	8.43	NA	7.54	1.16	NA	17.13	090
25630		A	Treat wrist bone fracture	2.88	5.15	1.89	0.30	8.33	5.07	090
25635		A	Treat wrist bone fracture	4.39	7.04	2.65	0.50	11.93	7.54	090
25645		A	Repair wrist bone fracture	7.25	NA	6.63	0.95	NA	14.83	090
25650		A	Repair wrist bone fracture	3.05	5.07	1.85	0.36	8.48	5.26	090
25660		A	Treat wrist dislocation	4.76	NA	3.77	0.26	NA	8.79	090
25670		A	Repair wrist dislocation	7.92	NA	7.24	1.12	NA	16.28	090
25675		A	Treat wrist dislocation	4.67	6.88	3.73	0.34	11.89	8.74	090
25676		A	Repair wrist dislocation	8.04	NA	7.31	1.11	NA	16.46	090
25680		A	Treat wrist fracture	5.99	NA	4.82	0.36	NA	11.17	090
25685		A	Repair wrist fracture	9.78	NA	8.08	1.44	NA	19.30	090
25690		A	Treat wrist dislocation	5.50	NA	5.30	0.73	NA	11.53	090
25695		A	Repair wrist dislocation	8.34	NA	7.53	1.17	NA	17.04	090
25800		A	Fusion of wrist joint	9.76	NA	9.00	1.80	NA	20.56	090
25805		A	Fusion/graft of wrist joint	11.28	NA	9.89	2.09	NA	23.26	090
25810		A	Fusion/graft of wrist joint	10.57	NA	9.51	2.06	NA	22.14	090
25820		A	Fusion of hand bones	7.45	NA	7.22	1.48	NA	16.15	090
25825		A	Fusion hand bones with graft	9.27	NA	8.75	1.99	NA	20.01	090
25830		A	Fusion radioulnar jnt/ulna	10.06	NA	12.33	1.45	NA	23.84	090
25900		A	Amputation of forearm	9.01	NA	10.20	1.31	NA	20.52	090
25905		A	Amputation of forearm	9.12	NA	10.56	1.15	NA	20.83	090
25907		A	Amputation follow-up surgery	7.80	NA	9.44	1.00	NA	18.24	090
25909		A	Amputation follow-up surgery	8.96	NA	9.25	1.06	NA	19.27	090
25915		A	Amputation of forearm	17.08	NA	27.86	2.59	NA	47.53	090
25920		A	Amputate hand at wrist	8.68	NA	7.64	1.20	NA	17.52	090
25922		A	Amputate hand at wrist	7.42	NA	8.39	1.02	NA	16.83	090
25924		A	Amputation follow-up surgery	8.46	NA	6.74	1.22	NA	16.42	090
25927		A	Amputation of hand	8.80	NA	9.39	1.22	NA	19.41	090
25929		A	Amputation follow-up surgery	7.59	NA	5.42	0.96	NA	13.97	090
25931		A	Amputation follow-up surgery	7.81	NA	9.81	0.90	NA	18.52	090
26010		A	Drainage of finger abscess	1.54	3.16	2.25	0.05	4.75	3.84	010
26011		A	Drainage of finger abscess	2.19	4.46	4.45	0.24	6.89	6.88	010
26020		A	Drain hand tendon sheath	4.67	NA	8.66	0.63	NA	13.96	090
26025		A	Drainage of palm bursa	4.82	NA	8.82	0.76	NA	14.40	090
26030		A	Drainage of palm bursa(s)	5.93	NA	9.38	0.98	NA	16.29	090
26034		A	Treat hand bone lesion	6.23	NA	10.41	0.71	NA	17.35	090
26035		A	Decompress fingers/hand	9.51	NA	11.92	0.86	NA	22.29	090
26037		A	Decompress fingers/hand	7.25	NA	7.75	1.05	NA	16.05	090
26040		A	Release palm contracture	3.33	NA	7.99	0.49	NA	11.81	090
26045		A	Release palm contracture	5.56	NA	9.39	0.81	NA	15.76	090
26055		A	Incise finger tendon sheath	2.69	5.15	8.67	0.56	8.40	11.92	090
26060		A	Incision of finger tendon	2.81	NA	5.19	0.17	NA	8.17	090
26070		A	Explore/treat hand joint	3.69	NA	7.33	0.42	NA	11.44	090
26075		A	Explore/treat finger joint	3.79	NA	7.85	0.62	NA	12.26	090
26080		A	Explore/treat finger joint	4.24	NA	8.63	0.51	NA	13.38	090
26100		A	Biopsy hand joint lining	3.67	NA	5.43	0.45	NA	9.55	090
26105		A	Biopsy finger joint lining	3.71	NA	8.19	0.67	NA	12.57	090
26110		A	Biopsy finger joint lining	3.53	NA	7.67	0.50	NA	11.70	090
26115		A	Removal of hand lesion	3.86	4.94	9.00	0.34	9.14	13.20	090
26116		A	Removal of hand lesion	5.53	NA	9.13	0.62	NA	15.28	090
26117		A	Remove tumor, hand/finger	8.55	NA	10.50	0.91	NA	19.96	090
26121		A	Release palm contracture	7.54	NA	10.65	1.61	NA	19.80	090
26123		A	Release palm contracture	9.29	NA	11.74	1.53	NA	22.56	090
26125		A	Release palm contracture	4.61	NA	2.91	0.45	NA	7.97	ZZZ
26130		A	Remove wrist joint lining	5.42	NA	10.50	0.86	NA	16.78	090
26135		A	Revise finger joint, each	6.96	NA	11.26	0.82	NA	19.04	090
26140		A	Revise finger joint, each	6.17	NA	10.68	0.75	NA	17.60	090
26145		A	Tendon excision, palm/finger	6.32	NA	10.64	0.80	NA	17.76	090
26160		A	Remove tendon sheath lesion	3.15	4.64	8.83	0.40	8.19	12.38	090
26170		A	Removal of palm tendon, each	4.77	NA	6.08	0.45	NA	11.30	090
26180		A	Removal of finger tendon	5.18	NA	6.32	0.71	NA	12.21	090
26185		A	Remove finger bone	5.25	NA	11.35	0.41	NA	17.01	090
26200		A	Remove hand bone lesion	5.51	NA	9.13	0.72	NA	15.36	090
26205		A	Remove/graft bone lesion	7.70	NA	10.26	1.03	NA	18.99	090
26210		A	Removal of finger lesion	5.15	NA	9.15	0.64	NA	14.94	090
26215		A	Remove/graft finger lesion	7.10	NA	10.24	0.94	NA	18.28	090
26230		A	Partial removal of hand bone	6.33	NA	9.17	0.69	NA	16.19	090
26235		A	Partial removal, finger bone	6.19	NA	8.93	0.71	NA	15.83	090
26236		A	Partial removal, finger bone	5.32	NA	8.66	0.66	NA	14.64	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
26250		A	Extensive hand surgery	7.55	NA	11.60	1.07	NA	20.22	090
26255		A	Extensive hand surgery	12.43	NA	13.32	1.54	NA	27.29	090
26260		A	Extensive finger surgery	7.03	NA	10.85	0.97	NA	18.85	090
26261		A	Extensive finger surgery	9.09	NA	12.59	1.31	NA	22.99	090
26262		A	Partial removal of finger	5.67	NA	9.35	0.76	NA	15.78	090
26320		A	Removal of implant from hand	3.98	NA	8.38	0.57	NA	12.93	090
26350		A	Repair finger/hand tendon	5.99	NA	11.30	0.99	NA	18.28	090
26352		A	Repair/graft hand tendon	7.68	NA	13.41	1.10	NA	22.19	090
26356		A	Repair finger/hand tendon	8.07	NA	13.66	1.24	NA	22.97	090
26357		A	Repair finger/hand tendon	8.58	NA	14.49	1.19	NA	24.26	090
26358		A	Repair/graft hand tendon	9.14	NA	14.42	1.27	NA	24.83	090
26370		A	Repair finger/hand tendon	7.11	NA	13.28	1.13	NA	21.52	090
26372		A	Repair/graft hand tendon	8.76	NA	14.09	1.15	NA	24.00	090
26373		A	Repair finger/hand tendon	8.16	NA	12.55	1.11	NA	21.82	090
26390		A	Revise hand/finger tendon	9.19	NA	11.26	1.23	NA	21.68	090
26392		A	Repair/graft hand tendon	10.26	NA	14.13	1.26	NA	25.65	090
26410		A	Repair hand tendon	4.63	NA	10.00	0.51	NA	15.14	090
26412		A	Repair/graft hand tendon	6.31	NA	11.04	0.97	NA	18.32	090
26415		A	Excision, hand/finger tendon	8.34	NA	11.11	0.90	NA	20.35	090
26416		A	Graft hand or finger tendon	9.37	NA	12.62	1.41	NA	23.40	090
26418		A	Repair finger tendon	4.25	NA	9.77	0.59	NA	14.61	090
26420		A	Repair/graft finger tendon	6.77	NA	11.47	0.96	NA	19.20	090
26426		A	Repair finger/hand tendon	6.15	NA	11.03	1.07	NA	18.25	090
26428		A	Repair/graft finger tendon	7.21	NA	11.25	1.00	NA	19.46	090
26432		A	Repair finger tendon	4.02	NA	8.58	0.51	NA	13.11	090
26433		A	Repair finger tendon	4.56	NA	9.01	0.66	NA	14.23	090
26434		A	Repair/graft finger tendon	6.09	NA	9.84	0.84	NA	16.77	090
26437		A	Realignment of tendons	5.82	NA	9.50	0.68	NA	16.00	090
26440		A	Release palm/finger tendon	5.02	NA	11.65	0.59	NA	17.26	090
26442		A	Release palm & finger tendon	8.16	NA	13.05	0.59	NA	21.80	090
26445		A	Release hand/finger tendon	4.31	NA	10.94	0.54	NA	15.79	090
26449		A	Release forearm/hand tendon	7.00	NA	12.08	0.96	NA	20.04	090
26450		A	Incision of palm tendon	3.67	NA	5.96	0.36	NA	9.99	090
26455		A	Incision of finger tendon	3.64	NA	5.84	0.33	NA	9.81	090
26460		A	Incise hand/finger tendon	3.46	NA	5.58	0.30	NA	9.34	090
26471		A	Fusion of finger tendons	5.73	NA	9.06	0.67	NA	15.46	090
26474		A	Fusion of finger tendons	5.32	NA	9.37	0.75	NA	15.44	090
26476		A	Tendon lengthening	5.18	NA	8.35	0.27	NA	13.80	090
26477		A	Tendon shortening	5.15	NA	9.42	0.73	NA	15.30	090
26478		A	Lengthening of hand tendon	5.80	NA	9.83	0.72	NA	16.35	090
26479		A	Shortening of hand tendon	5.74	NA	9.62	0.86	NA	16.22	090
26480		A	Transplant hand tendon	6.69	NA	12.55	1.11	NA	20.35	090
26483		A	Transplant/graft hand tendon	8.29	NA	13.35	1.40	NA	23.04	090
26485		A	Transplant palm tendon	7.70	NA	13.33	1.08	NA	22.11	090
26489		A	Transplant/graft palm tendon	9.55	NA	11.16	0.51	NA	21.22	090
26490		A	Revise thumb tendon	8.41	NA	11.00	1.28	NA	20.69	090
26492		A	Tendon transfer with graft	9.62	NA	11.46	1.21	NA	22.29	090
26494		A	Hand tendon/muscle transfer	8.47	NA	9.62	1.23	NA	19.32	090
26496		A	Revise thumb tendon	9.59	NA	11.45	1.53	NA	22.57	090
26497		A	Finger tendon transfer	9.57	NA	11.79	1.38	NA	22.74	090
26498		A	Finger tendon transfer	14.00	NA	14.34	2.04	NA	30.38	090
26499		A	Revision of finger	8.98	NA	9.91	1.25	NA	20.14	090
26500		A	Hand tendon reconstruction	5.96	NA	9.52	0.60	NA	16.08	090
26502		A	Hand tendon reconstruction	7.14	NA	10.61	0.95	NA	18.70	090
26504		A	Hand tendon reconstruction	7.47	NA	11.04	1.11	NA	19.62	090
26508		A	Release thumb contracture	6.01	NA	8.30	0.72	NA	15.03	090
26510		A	Thumb tendon transfer	5.43	NA	9.31	0.68	NA	15.42	090
26516		A	Fusion of knuckle joint	7.15	NA	10.32	0.67	NA	18.14	090
26517		A	Fusion of knuckle joints	8.83	NA	10.98	1.23	NA	21.04	090
26518		A	Fusion of knuckle joints	9.02	NA	11.97	1.22	NA	22.21	090
26520		A	Release knuckle contracture	5.30	NA	11.54	0.71	NA	17.55	090
26525		A	Release finger contracture	5.33	NA	11.66	0.62	NA	17.61	090
26530		A	Revise knuckle joint	6.69	NA	12.18	0.85	NA	19.72	090
26531		A	Revise knuckle with implant	7.91	NA	13.33	1.11	NA	22.35	090
26535		A	Revise finger joint	5.24	NA	5.91	0.58	NA	11.73	090
26536		A	Revise/implant finger joint	6.37	NA	11.33	1.19	NA	18.89	090
26540		A	Repair hand joint	6.43	NA	9.89	1.12	NA	17.44	090
26541		A	Repair hand joint with graft	8.62	NA	11.26	1.47	NA	21.35	090
26542		A	Repair hand joint with graft	6.78	NA	10.32	0.97	NA	18.07	090
26545		A	Reconstruct finger joint	6.92	NA	10.33	0.94	NA	18.19	090
26546		A	Repair non-union hand	8.92	NA	18.85	1.33	NA	29.10	090
26548		A	Reconstruct finger joint	8.03	NA	10.73	1.00	NA	19.76	090
26550		A	Construct thumb replacement	21.24	NA	20.05	3.24	NA	44.53	090
26551		A	Great toe-hand transfer	46.58	NA	60.48	6.92	NA	113.98	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
26553		A	Single toe-hand transfer	46.27	NA	60.17	6.87	NA	113.31	090
26554		A	Double toe-hand transfer	54.95	NA	68.86	8.20	NA	132.01	090
26555		A	Positional change of finger	16.63	NA	16.58	2.52	NA	35.73	090
26556		A	Toe joint transfer	47.26	NA	61.16	6.99	NA	115.41	090
26560		A	Repair of web finger	5.38	NA	8.35	0.66	NA	14.39	090
26561		A	Repair of web finger	10.92	NA	13.22	1.56	NA	25.70	090
26562		A	Repair of web finger	9.68	NA	12.46	0.82	NA	22.96	090
26565		A	Correct metacarpal flaw	6.74	NA	10.26	0.85	NA	17.85	090
26567		A	Correct finger deformity	6.82	NA	9.90	0.67	NA	17.39	090
26568		A	Lengthen metacarpal/finger	9.08	NA	11.61	1.06	NA	21.75	090
26580		A	Repair hand deformity	18.18	NA	12.16	2.76	NA	33.10	090
26585		A	Repair finger deformity	14.05	NA	12.14	2.12	NA	28.31	090
26590		A	Repair finger deformity	17.96	NA	13.66	2.72	NA	34.34	090
26591		A	Repair muscles of hand	3.25	NA	7.72	0.39	NA	11.36	090
26593		A	Release muscles of hand	5.31	NA	9.00	0.70	NA	15.01	090
26596		A	Excision constricting tissue	8.95	NA	7.08	1.35	NA	17.38	090
26597		A	Release of scar contracture	9.82	NA	11.96	1.37	NA	23.15	090
26600		A	Treat metacarpal fracture	1.96	4.60	1.62	0.22	6.78	3.80	090
26605		A	Treat metacarpal fracture	2.85	5.96	3.11	0.36	9.17	6.32	090
26607		A	Treat metacarpal fracture	5.36	NA	6.40	0.57	NA	12.33	090
26608		A	Treat metacarpal fracture	5.36	NA	6.27	0.57	NA	12.20	090
26615		A	Repair metacarpal fracture	5.33	NA	5.76	0.80	NA	11.89	090
26641		A	Treat thumb dislocation	3.94	5.89	2.68	0.14	9.97	6.76	090
26645		A	Treat thumb fracture	4.41	6.82	3.68	0.33	11.56	8.42	090
26650		A	Repair thumb fracture	5.72	NA	6.42	0.64	NA	12.78	090
26665		A	Repair thumb fracture	7.60	NA	6.85	1.09	NA	15.54	090
26670		A	Treat hand dislocation	3.69	6.06	2.34	0.10	9.85	6.13	090
26675		A	Treat hand dislocation	4.64	5.89	3.88	0.60	11.13	9.12	090
26676		A	Pin hand dislocation	5.52	NA	6.35	0.67	NA	12.54	090
26685		A	Repair hand dislocation	6.98	NA	6.54	0.91	NA	14.43	090
26686		A	Repair hand dislocation	7.94	NA	7.17	1.04	NA	16.15	090
26700		A	Treat knuckle dislocation	3.69	3.41	1.51	0.10	7.20	5.30	090
26705		A	Treat knuckle dislocation	4.19	5.82	3.33	0.27	10.28	7.79	090
26706		A	Pin knuckle dislocation	5.12	NA	4.71	0.75	NA	10.58	090
26715		A	Repair knuckle dislocation	5.74	NA	6.05	0.66	NA	12.45	090
26720		A	Treat finger fracture, each	1.66	2.06	1.08	0.15	3.87	2.89	090
26725		A	Treat finger fracture, each	3.33	3.74	2.59	0.23	7.30	6.15	090
26727		A	Treat finger fracture, each	5.23	NA	6.14	0.38	NA	11.75	090
26735		A	Repair finger fracture, each	5.98	NA	6.06	0.61	NA	12.65	090
26740		A	Treat finger fracture, each	1.94	2.52	1.77	0.16	4.62	3.87	090
26742		A	Treat finger fracture, each	3.85	6.77	3.77	0.32	10.94	7.94	090
26746		A	Repair finger fracture, each	5.81	NA	6.06	0.80	NA	12.67	090
26750		A	Treat finger fracture, each	1.70	2.33	1.28	0.10	4.13	3.08	090
26755		A	Treat finger fracture, each	3.10	3.50	2.15	0.15	6.75	5.40	090
26756		A	Pin finger fracture, each	4.39	NA	5.69	0.33	NA	10.41	090
26765		A	Repair finger fracture, each	4.17	NA	4.92	0.45	NA	9.54	090
26770		A	Treat finger dislocation	3.02	3.17	1.37	0.08	6.27	4.47	090
26775		A	Treat finger dislocation	3.71	5.64	2.73	0.17	9.52	6.61	090
26776		A	Pin finger dislocation	4.80	NA	5.88	0.35	NA	11.03	090
26785		A	Repair finger dislocation	4.21	NA	5.08	0.48	NA	9.77	090
26820		A	Thumb fusion with graft	8.26	NA	11.44	1.05	NA	20.75	090
26841		A	Fusion of thumb	7.13	NA	10.68	1.00	NA	18.81	090
26842		A	Thumb fusion with graft	8.24	NA	11.52	1.37	NA	21.13	090
26843		A	Fusion of hand joint	7.61	NA	10.80	1.10	NA	19.51	090
26844		A	Fusion/graft of hand joint	8.73	NA	11.85	1.19	NA	21.77	090
26850		A	Fusion of knuckle	6.97	NA	10.39	0.76	NA	18.12	090
26852		A	Fusion of knuckle with graft	8.46	NA	11.32	1.00	NA	20.78	090
26860		A	Fusion of finger joint	4.69	NA	8.73	0.68	NA	14.10	090
26861		A	Fusion of finger joint, added	1.74	NA	1.24	0.43	NA	3.41	ZZZ
26862		A	Fusion/graft of finger joint	7.37	NA	10.40	0.85	NA	18.62	090
26863		A	Fuse/graft added joint	3.90	NA	2.53	0.57	NA	7.00	ZZZ
26910		A	Amputate metacarpal bone	7.60	NA	9.46	0.93	NA	17.99	090
26951		A	Amputation of finger/thumb	4.59	NA	8.17	0.49	NA	13.25	090
26952		A	Amputation of finger/thumb	6.31	NA	9.37	0.69	NA	16.37	090
26990		A	Drainage of pelvis lesion	7.48	NA	11.61	0.51	NA	19.60	090
26991		A	Drainage of pelvis bursa	6.68	6.46	7.02	0.29	13.43	13.99	090
26992		A	Drainage of bone lesion	13.02	NA	16.12	1.05	NA	30.19	090
27000		A	Incision of hip tendon	5.62	NA	5.77	0.24	NA	11.63	090
27001		A	Incision of hip tendon	6.94	NA	6.57	0.38	NA	13.89	090
27003		A	Incision of hip tendon	7.34	NA	7.34	1.08	NA	15.76	090
27005		A	Incision of hip tendon	9.66	NA	8.44	0.54	NA	18.64	090
27006		A	Incision of hip tendons	9.68	NA	8.57	0.77	NA	19.02	090
27025		A	Incision of hip/thigh fascia	11.16	NA	8.69	1.02	NA	20.87	090
27030		A	Drainage of hip joint	13.01	NA	10.67	1.86	NA	25.54	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
27033		A	Exploration of hip joint	13.39	NA	10.76	1.85	NA	26.00	090
27035		A	Denervation of hip joint	16.69	NA	13.32	2.21	NA	32.22	090
27036		A	Excision of hip joint/muscle	12.88	NA	22.96	1.87	NA	37.71	090
27040		A	Biopsy of soft tissues	2.87	3.49	2.69	0.11	6.47	5.67	010
27041		A	Biopsy of soft tissues	9.89	NA	6.86	0.44	NA	17.19	090
27047		A	Remove hip/pelvis lesion	7.45	6.09	5.33	0.32	13.86	13.10	090
27048		A	Remove hip/pelvis lesion	6.25	NA	5.67	0.82	NA	12.74	090
27049		A	Remove tumor, hip/pelvis	13.66	NA	9.93	1.87	NA	25.46	090
27050		A	Biopsy of sacroiliac joint	4.36	NA	5.40	0.90	NA	10.66	090
27052		A	Biopsy of hip joint	6.23	NA	6.46	1.59	NA	14.28	090
27054		A	Removal of hip joint lining	8.54	NA	8.31	2.26	NA	19.11	090
27060		A	Removal of ischial bursa	5.43	NA	5.20	0.68	NA	11.31	090
27062		A	Remove femur lesion/bursa	5.37	NA	5.67	0.70	NA	11.74	090
27065		A	Removal of hip bone lesion	5.90	NA	6.39	0.90	NA	13.19	090
27066		A	Removal of hip bone lesion	10.33	NA	9.79	1.30	NA	21.42	090
27067		A	Remove/graft hip bone lesion	13.83	NA	12.28	1.93	NA	28.04	090
27070		A	Partial removal of hip bone	10.72	NA	14.61	1.21	NA	26.54	090
27071		A	Partial removal of hip bone	11.46	NA	14.77	1.45	NA	27.68	090
27075		A	Extensive hip surgery	17.23	NA	12.72	2.32	NA	32.27	090
27076		A	Extensive hip surgery	22.12	NA	16.75	2.61	NA	41.48	090
27077		A	Extensive hip surgery	23.13	NA	16.40	3.24	NA	42.77	090
27078		A	Extensive hip surgery	13.44	NA	12.41	1.67	NA	27.52	090
27079		A	Extensive hip surgery	13.75	NA	10.65	1.66	NA	26.06	090
27080		A	Removal of tail bone	6.39	NA	5.55	0.87	NA	12.81	090
27086		A	Remove hip foreign body	1.87	3.23	2.61	0.07	5.17	4.55	010
27087		A	Remove hip foreign body	8.54	NA	7.34	0.60	NA	16.48	090
27090		A	Removal of hip prosthesis	11.15	NA	9.72	1.46	NA	22.33	090
27091		A	Removal of hip prosthesis	22.14	NA	16.12	3.16	NA	41.42	090
27093		A	Injection for hip x-ray	1.30	7.97	0.49	0.11	9.38	1.90	000
27095		A	Injection for hip x-ray	1.50	8.30	0.50	0.13	9.93	2.13	000
27097		A	Revision of hip tendon	8.80	NA	8.03	1.26	NA	18.09	090
27098		A	Transfer tendon to pelvis	8.83	NA	7.42	1.26	NA	17.51	090
27100		A	Transfer of abdominal muscle	11.08	NA	9.91	1.42	NA	22.41	090
27105		A	Transfer of spinal muscle	11.77	NA	6.42	1.36	NA	19.55	090
27110		A	Transfer of iliopsoas muscle	13.26	NA	10.43	1.86	NA	25.55	090
27111		A	Transfer of iliopsoas muscle	12.15	NA	8.05	1.65	NA	21.85	090
27120		A	Reconstruction of hip socket	18.01	NA	13.42	2.95	NA	34.38	090
27122		A	Reconstruction of hip socket	14.98	NA	12.41	2.94	NA	30.33	090
27125		A	Partial hip replacement	14.69	NA	11.92	3.01	NA	29.62	090
27130		A	Total hip replacement	20.12	NA	15.19	4.58	NA	39.89	090
27132		A	Total hip replacement	23.30	NA	17.05	5.09	NA	45.44	090
27134		A	Revise hip joint replacement	28.52	NA	19.95	5.96	NA	54.43	090
27137		A	Revise hip joint replacement	21.17	NA	15.94	4.82	NA	41.93	090
27138		A	Revise hip joint replacement	22.17	NA	16.55	4.58	NA	43.30	090
27140		A	Transplant of femur ridge	12.24	NA	10.20	1.71	NA	24.15	090
27146		A	Incision of hip bone	17.43	NA	13.63	1.35	NA	32.41	090
27147		A	Revision of hip bone	20.58	NA	15.63	2.76	NA	38.97	090
27151		A	Incision of hip bones	22.51	NA	15.69	2.90	NA	41.10	090
27156		A	Revision of hip bones	24.63	NA	18.51	3.08	NA	46.22	090
27158		A	Revision of pelvis	19.74	NA	14.29	2.64	NA	36.67	090
27161		A	Incision of neck of femur	16.71	NA	12.80	2.31	NA	31.82	090
27165		A	Incision/fixation of femur	17.91	NA	13.59	2.63	NA	34.13	090
27170		A	Repair/graft femur head/neck	16.07	NA	12.55	2.65	NA	31.27	090
27175		A	Treat slipped epiphysis	8.46	NA	7.03	0.18	NA	15.67	090
27176		A	Treat slipped epiphysis	12.05	NA	9.33	1.70	NA	23.08	090
27177		A	Repair slipped epiphysis	15.08	NA	10.93	2.05	NA	28.06	090
27178		A	Repair slipped epiphysis	11.99	NA	8.19	1.55	NA	21.73	090
27179		A	Revise head/neck of femur	12.98	NA	18.75	1.83	NA	33.56	090
27181		A	Repair slipped epiphysis	14.68	NA	11.12	2.16	NA	27.96	090
27185		A	Revision of femur epiphysis	9.18	NA	8.55	0.87	NA	18.60	090
27187		A	Reinforce hip bones	13.54	NA	11.36	2.76	NA	27.66	090
27193		A	Treat pelvic ring fracture	5.56	5.61	4.69	0.39	11.56	10.64	090
27194		A	Treat pelvic ring fracture	9.65	8.18	7.22	0.50	18.33	17.37	090
27200		A	Treat tail bone fracture	1.84	2.14	1.29	0.17	4.15	3.30	090
27202		A	Repair tail bone fracture	7.04	NA	9.32	0.89	NA	17.25	090
27215		A	Pelvic fracture(s) treatment	10.05	NA	7.12	2.33	NA	19.50	090
27216		A	Treat pelvic ring fracture	15.19	NA	12.70	0.66	NA	28.55	090
27217		A	Treat pelvic ring fracture	14.11	NA	11.11	2.33	NA	27.55	090
27218		A	Treat pelvic ring fracture	20.15	NA	14.75	2.33	NA	37.23	090
27220		A	Treat hip socket fracture	6.18	5.95	5.07	0.64	12.77	11.89	090
27222		A	Treat hip socket fracture	12.70	NA	9.89	1.03	NA	23.62	090
27226		A	Treat hip wall fracture	14.91	NA	11.22	2.52	NA	28.65	090
27227		A	Treat hip fracture(s)	23.45	NA	15.66	3.20	NA	42.31	090
27228		A	Treat hip fracture(s)	27.16	NA	18.73	3.20	NA	49.09	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
27230		A	Treat fracture of thigh	5.50	5.79	4.53	0.41	11.70	10.44	090
27232		A	Treat fracture of thigh	10.68	NA	9.07	1.46	NA	21.21	090
27235		A	Repair of thigh fracture	12.16	NA	10.54	2.60	NA	25.30	090
27236		A	Repair of thigh fracture	15.60	NA	12.42	2.71	NA	30.73	090
27238		A	Treatment of thigh fracture	5.52	NA	4.93	0.71	NA	11.16	090
27240		A	Treatment of thigh fracture	12.50	NA	10.45	1.53	NA	24.48	090
27244		A	Repair of thigh fracture	15.94	NA	12.69	2.62	NA	31.25	090
27245		A	Repair of thigh fracture	20.31	NA	15.31	2.62	NA	38.24	090
27246		A	Treatment of thigh fracture	4.71	5.45	4.88	0.60	10.76	10.19	090
27248		A	Repair of thigh fracture	10.45	NA	9.43	2.11	NA	21.99	090
27250		A	Treat hip dislocation	6.95	NA	4.07	0.45	NA	11.47	090
27252		A	Treat hip dislocation	10.39	NA	7.43	0.68	NA	18.50	090
27253		A	Repair of hip dislocation	12.92	NA	9.77	2.11	NA	24.80	090
27254		A	Repair of hip dislocation	18.26	NA	12.68	2.27	NA	33.21	090
27256		A	Treatment of hip dislocation	4.12	NA	3.03	0.31	NA	7.46	010
27257		A	Treatment of hip dislocation	5.22	NA	3.86	0.73	NA	9.81	010
27258		A	Repair of hip dislocation	15.43	NA	12.39	2.25	NA	30.07	090
27259		A	Repair of hip dislocation	21.55	NA	14.58	2.82	NA	38.95	090
27265		A	Treatment of hip dislocation	5.05	NA	4.66	0.54	NA	10.25	090
27266		A	Treatment of hip dislocation	7.49	NA	6.43	0.71	NA	14.63	090
27275		A	Manipulation of hip joint	2.27	NA	2.72	0.30	NA	5.29	010
27280		A	Fusion of sacroiliac joint	13.39	NA	11.68	1.77	NA	26.84	090
27282		A	Fusion of pubic bones	11.34	NA	9.76	1.69	NA	22.79	090
27284		A	Fusion of hip joint	16.76	NA	13.03	2.40	NA	32.19	090
27286		A	Fusion of hip joint	16.79	NA	13.64	2.26	NA	32.69	090
27290		A	Amputation of leg at hip	23.28	NA	15.18	4.70	NA	43.16	090
27295		A	Amputation of leg at hip	18.65	NA	12.45	2.95	NA	34.05	090
27301		A	Drain thigh/knee lesion	6.49	8.70	8.59	0.40	15.59	15.48	090
27303		A	Drainage of bone lesion	8.28	NA	10.78	0.96	NA	20.02	090
27305		A	Incise thigh tendon & fascia	5.92	NA	6.41	0.68	NA	13.01	090
27306		A	Incision of thigh tendon	4.62	NA	5.49	0.32	NA	10.43	090
27307		A	Incision of thigh tendons	5.80	NA	6.03	0.48	NA	12.31	090
27310		A	Exploration of knee joint	9.27	NA	8.60	1.51	NA	19.38	090
27315		A	Partial removal, thigh nerve	6.97	NA	4.64	0.96	NA	12.57	090
27320		A	Partial removal, thigh nerve	6.30	NA	4.45	0.73	NA	11.48	090
27323		A	Biopsy thigh soft tissues	2.28	3.08	2.40	0.13	5.49	4.81	010
27324		A	Biopsy thigh soft tissues	4.90	NA	4.93	0.45	NA	10.28	090
27327		A	Removal of thigh lesion	4.47	4.69	4.36	0.40	9.56	9.23	090
27328		A	Removal of thigh lesion	5.57	NA	5.11	0.73	NA	11.41	090
27329		A	Remove tumor, thigh/knee	14.14	NA	10.87	2.14	NA	27.15	090
27330		A	Biopsy knee joint lining	4.97	NA	5.09	1.19	NA	11.25	090
27331		A	Explore/treat knee joint	5.88	NA	6.01	1.49	NA	13.38	090
27332		A	Removal of knee cartilage	8.27	NA	7.21	1.73	NA	17.21	090
27333		A	Removal of knee cartilage	7.30	NA	6.73	2.52	NA	16.55	090
27334		A	Remove knee joint lining	8.70	NA	7.78	1.77	NA	18.25	090
27335		A	Remove knee joint lining	10.00	NA	8.93	2.05	NA	20.98	090
27340		A	Removal of kneecap bursa	4.18	NA	4.60	0.62	NA	9.40	090
27345		A	Removal of knee cyst	5.92	NA	5.87	0.95	NA	12.74	090
27350		A	Removal of kneecap	8.17	NA	7.36	1.54	NA	17.07	090
27355		A	Remove femur lesion	7.65	NA	7.95	1.23	NA	16.83	090
27356		A	Remove femur lesion/graft	9.48	NA	9.14	1.34	NA	19.96	090
27357		A	Remove femur lesion/graft	10.53	NA	9.44	1.43	NA	21.40	090
27358		A	Remove femur lesion/fixation	4.74	NA	2.94	0.72	NA	8.40	ZZZ
27360		A	Partial removal leg bone(s)	10.50	NA	14.47	1.40	NA	26.37	090
27365		A	Extensive leg surgery	16.27	NA	12.69	2.43	NA	31.39	090
27370		A	Injection for knee x-ray	0.96	7.73	0.31	0.05	8.74	1.32	000
27372		A	Removal of foreign body	5.07	5.07	4.89	0.54	10.68	10.50	090
27380		A	Repair of kneecap tendon	7.16	NA	7.06	1.29	NA	15.51	090
27381		A	Repair/graft kneecap tendon	10.34	NA	8.92	1.82	NA	21.08	090
27385		A	Repair of thigh muscle	7.76	NA	7.40	1.42	NA	16.58	090
27386		A	Repair/graft of thigh muscle	10.56	NA	9.31	2.02	NA	21.89	090
27390		A	Incision of thigh tendon	5.33	NA	5.82	0.71	NA	11.86	090
27391		A	Incision of thigh tendons	7.20	NA	7.09	0.90	NA	15.19	090
27392		A	Incision of thigh tendons	9.20	NA	8.49	1.28	NA	18.97	090
27393		A	Lengthening of thigh tendon	6.39	NA	6.44	0.93	NA	13.76	090
27394		A	Lengthening of thigh tendons	8.50	NA	8.42	0.94	NA	17.86	090
27395		A	Lengthening of thigh tendons	11.73	NA	10.86	1.65	NA	24.24	090
27396		A	Transplant of thigh tendon	7.86	NA	8.07	1.11	NA	17.04	090
27397		A	Transplants of thigh tendons	11.28	NA	9.88	1.45	NA	22.61	090
27400		A	Revise thigh muscles/tendons	9.02	NA	8.62	1.24	NA	18.88	090
27403		A	Repair of knee cartilage	8.33	NA	7.30	1.44	NA	17.07	090
27405		A	Repair of knee ligament	8.65	NA	7.90	1.67	NA	18.22	090
27407		A	Repair of knee ligament	10.28	NA	8.42	1.42	NA	20.12	090
27409		A	Repair of knee ligaments	12.90	NA	10.23	2.48	NA	25.61	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
27418		A	Repair degenerated kneecap	10.85	NA	9.39	1.85	NA	22.09	090
27420		A	Revision of unstable kneecap	9.83	NA	8.26	1.74	NA	19.83	090
27422		A	Revision of unstable kneecap	9.78	NA	8.37	1.83	NA	19.98	090
27424		A	Revision/removal of kneecap	9.81	NA	8.18	1.89	NA	19.88	090
27425		A	Lateral retinacular release	5.22	NA	5.58	1.08	NA	11.88	090
27427		A	Reconstruction, knee	9.36	NA	8.06	2.25	NA	19.67	090
27428		A	Reconstruction, knee	14.00	NA	10.92	2.71	NA	27.63	090
27429		A	Reconstruction, knee	15.52	NA	12.11	1.83	NA	29.46	090
27430		A	Revision of thigh muscles	9.67	NA	8.21	1.50	NA	19.38	090
27435		A	Incision of knee joint	9.49	NA	8.02	1.13	NA	18.64	090
27437		A	Revise kneecap	8.46	NA	7.01	1.55	NA	17.02	090
27438		A	Revise kneecap with implant	11.23	NA	9.40	2.14	NA	22.77	090
27440		A	Revision of knee joint	10.43	NA	8.60	2.10	NA	21.13	090
27441		A	Revision of knee joint	10.82	NA	9.37	1.51	NA	21.70	090
27442		A	Revision of knee joint	11.89	NA	9.63	3.05	NA	24.57	090
27443		A	Revision of knee joint	10.93	NA	9.71	3.34	NA	23.98	090
27445		A	Revision of knee joint	17.68	NA	13.38	4.21	NA	35.27	090
27446		A	Revision of knee joint	15.84	NA	11.45	3.87	NA	31.16	090
27447		A	Total knee replacement	21.48	NA	15.54	4.95	NA	41.97	090
27448		A	Incision of thigh	11.06	NA	9.86	2.09	NA	23.01	090
27450		A	Incision of thigh	13.98	NA	11.94	2.36	NA	28.28	090
27454		A	Realignment of thigh bone	17.56	NA	13.71	2.82	NA	34.09	090
27455		A	Realignment of knee	12.82	NA	10.77	1.95	NA	25.54	090
27457		A	Realignment of knee	13.45	NA	10.24	2.14	NA	25.83	090
27465		A	Shortening of thigh bone	13.87	NA	11.42	2.00	NA	27.29	090
27466		A	Lengthening of thigh bone	16.33	NA	13.67	2.27	NA	32.27	090
27468		A	Shorten/lengthen thighs	18.97	NA	29.82	2.75	NA	51.54	090
27470		A	Repair of thigh	16.07	NA	13.53	2.60	NA	32.20	090
27472		A	Repair/graft of thigh	17.72	NA	14.45	3.16	NA	35.33	090
27475		A	Surgery to stop leg growth	8.64	NA	7.93	1.27	NA	17.84	090
27477		A	Surgery to stop leg growth	9.85	NA	8.01	2.57	NA	20.43	090
27479		A	Surgery to stop leg growth	12.80	NA	10.49	1.89	NA	25.18	090
27485		A	Surgery to stop leg growth	8.84	NA	7.73	1.30	NA	17.87	090
27486		A	Revise knee joint replace	19.27	NA	14.36	4.26	NA	37.89	090
27487		A	Revise knee joint replace	25.27	NA	17.79	5.97	NA	49.03	090
27488		A	Removal of knee prosthesis	15.74	NA	12.45	2.58	NA	30.77	090
27495		A	Reinforce thigh	15.55	NA	13.08	2.82	NA	31.45	090
27496		A	Decompression of thigh/knee	6.11	NA	5.36	0.74	NA	12.21	090
27497		A	Decompression of thigh/knee	7.17	NA	6.09	0.91	NA	14.17	090
27498		A	Decompression of thigh/knee	7.99	NA	5.92	1.04	NA	14.95	090
27499		A	Decompression of thigh/knee	9.00	NA	7.44	1.19	NA	17.63	090
27500		A	Treatment of thigh fracture	5.92	11.07	5.44	0.82	17.81	12.18	090
27501		A	Treatment of thigh fracture	5.92	11.72	6.52	0.82	18.46	13.26	090
27502		A	Treatment of thigh fracture	10.58	NA	9.32	1.21	NA	21.11	090
27503		A	Treatment of thigh fracture	10.58	NA	9.44	1.21	NA	21.23	090
27506		A	Repair of thigh fracture	17.45	NA	12.72	2.56	NA	32.73	090
27507		A	Treatment of thigh fracture	13.99	NA	11.03	2.56	NA	27.58	090
27508		A	Treatment of thigh fracture	5.83	7.50	4.61	0.65	13.98	11.09	090
27509		A	Treatment of thigh fracture	7.71	NA	7.80	0.65	NA	16.16	090
27510		A	Treatment of thigh fracture	9.13	NA	6.77	1.09	NA	16.99	090
27511		A	Treatment of thigh fracture	13.64	NA	11.72	2.56	NA	27.92	090
27513		A	Treatment of thigh fracture	17.92	NA	13.58	2.56	NA	34.06	090
27514		A	Repair of thigh fracture	17.30	NA	13.40	2.53	NA	33.23	090
27516		A	Repair of thigh growth plate	5.37	7.59	4.90	0.71	13.67	10.98	090
27517		A	Repair of thigh growth plate	8.78	9.97	6.87	1.28	20.03	16.93	090
27519		A	Repair of thigh growth plate	15.02	NA	12.54	2.05	NA	29.61	090
27520		A	Treat kneecap fracture	2.86	5.74	2.53	0.45	9.05	5.84	090
27524		A	Repair of kneecap fracture	10.00	NA	7.92	1.65	NA	19.57	090
27530		A	Treatment of knee fracture	3.78	6.31	3.37	0.51	10.60	7.66	090
27532		A	Treatment of knee fracture	7.30	6.38	5.78	0.91	14.59	13.99	090
27535		A	Treatment of knee fracture	11.50	NA	10.54	1.88	NA	23.92	090
27536		A	Repair of knee fracture	15.65	NA	11.30	1.88	NA	28.83	090
27538		A	Treat knee fracture(s)	4.87	7.56	4.48	0.51	12.94	9.86	090
27540		A	Repair of knee fracture	13.10	NA	9.57	1.74	NA	24.41	090
27550		A	Treat knee dislocation	5.76	7.18	3.99	0.36	13.30	10.11	090
27552		A	Treat knee dislocation	7.90	NA	6.78	0.53	NA	15.21	090
27556		A	Repair of knee dislocation	14.41	NA	12.43	1.95	NA	28.79	090
27557		A	Repair of knee dislocation	16.77	NA	14.14	2.43	NA	33.34	090
27558		A	Repair of knee dislocation	17.72	NA	14.48	2.43	NA	34.63	090
27560		A	Treat kneecap dislocation	3.82	6.18	2.00	0.16	10.16	5.98	090
27562		A	Treat kneecap dislocation	5.79	NA	4.57	0.76	NA	11.12	090
27566		A	Repair kneecap dislocation	12.23	NA	9.13	1.67	NA	23.03	090
27570		A	Fixation of knee joint	1.74	NA	2.47	0.28	NA	4.49	010
27580		A	Fusion of knee	19.37	NA	14.92	2.56	NA	36.85	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
27590		A	Amputate leg at thigh	12.03	NA	8.47	1.80	NA	22.30	090
27591		A	Amputate leg at thigh	12.68	NA	10.89	2.11	NA	25.68	090
27592		A	Amputate leg at thigh	10.02	NA	8.01	1.61	NA	19.64	090
27594		A	Amputation follow-up surgery	6.92	NA	5.82	0.68	NA	13.42	090
27596		A	Amputation follow-up surgery	10.60	NA	8.42	1.42	NA	20.44	090
27598		A	Amputate lower leg at knee	10.53	NA	8.21	1.78	NA	20.52	090
27600		A	Decompression of lower leg	5.65	NA	4.80	0.64	NA	11.09	090
27601		A	Decompression of lower leg	5.64	NA	4.66	0.67	NA	10.97	090
27602		A	Decompression of lower leg	7.35	NA	5.39	0.77	NA	13.51	090
27603		A	Drain lower leg lesion	4.94	8.33	6.14	0.41	13.68	11.49	090
27604		A	Drain lower leg bursa	4.47	5.29	4.08	0.14	9.90	8.69	090
27605		A	Incision of achilles tendon	2.87	6.16	2.85	0.14	9.17	5.86	010
27606		A	Incision of achilles tendon	4.14	9.65	4.04	0.35	14.14	8.53	010
27607		A	Treat lower leg bone lesion	7.97	NA	10.46	0.98	NA	19.41	090
27610		A	Explore/treat ankle joint	8.34	NA	7.48	1.13	NA	16.95	090
27612		A	Exploration of ankle joint	7.33	NA	6.22	1.30	NA	14.85	090
27613		A	Biopsy lower leg soft tissue	2.17	3.22	1.92	0.10	5.49	4.19	010
27614		A	Biopsy lower leg soft tissue	5.66	6.67	5.06	0.38	12.71	11.10	090
27615		A	Remove tumor, lower leg	12.56	NA	11.29	1.42	NA	25.27	090
27618		A	Remove lower leg lesion	5.09	6.78	4.63	0.32	12.19	10.04	090
27619		A	Remove lower leg lesion	8.40	8.20	6.66	0.67	17.27	15.73	090
27620		A	Explore, treat ankle joint	5.98	NA	6.09	0.96	NA	13.03	090
27625		A	Remove ankle joint lining	8.30	NA	7.31	1.27	NA	16.88	090
27626		A	Remove ankle joint lining	8.91	NA	8.21	1.25	NA	18.37	090
27630		A	Removal of tendon lesion	4.80	6.25	4.87	0.46	11.51	10.13	090
27635		A	Remove lower leg bone lesion	7.78	NA	8.23	1.27	NA	17.28	090
27637		A	Remove/graft leg bone lesion	9.85	NA	9.84	1.40	NA	21.09	090
27638		A	Remove/graft leg bone lesion	10.57	NA	10.21	1.52	NA	22.30	090
27640		A	Partial removal of tibia	11.37	NA	13.25	1.57	NA	26.19	090
27641		A	Partial removal of fibula	9.24	NA	11.40	1.18	NA	21.82	090
27645		A	Extensive lower leg surgery	14.17	NA	13.99	1.98	NA	30.14	090
27646		A	Extensive lower leg surgery	12.66	NA	12.92	1.71	NA	27.29	090
27647		A	Extensive ankle/heel surgery	12.24	NA	8.33	1.35	NA	21.92	090
27648		A	Injection for ankle x-ray	0.96	6.60	0.33	0.05	7.61	1.34	000
27650		A	Repair achilles tendon	9.69	NA	7.90	1.41	NA	19.00	090
27652		A	Repair/graft achilles tendon	10.33	NA	7.94	1.56	NA	19.83	090
27654		A	Repair of achilles tendon	10.02	NA	8.49	1.65	NA	20.16	090
27656		A	Repair leg fascia defect	4.57	7.73	4.37	0.54	12.84	9.48	090
27658		A	Repair of leg tendon, each	4.98	6.07	6.15	0.60	11.65	11.73	090
27659		A	Repair of leg tendon, each	6.81	13.52	6.92	0.86	21.19	14.59	090
27664		A	Repair of leg tendon, each	4.59	11.75	5.94	0.52	16.86	11.05	090
27665		A	Repair of leg tendon, each	5.40	12.69	6.38	0.76	18.85	12.54	090
27675		A	Repair lower leg tendons	7.18	NA	6.29	0.94	NA	14.41	090
27676		A	Repair lower leg tendons	8.42	NA	7.44	1.14	NA	17.00	090
27680		A	Release of lower leg tendon	5.74	NA	5.60	0.61	NA	11.95	090
27681		A	Release of lower leg tendons	6.82	NA	6.59	0.86	NA	14.27	090
27685		A	Revision of lower leg tendon	6.50	4.66	6.08	0.41	11.57	12.99	090
27686		A	Revise lower leg tendons	7.46	5.57	7.66	0.90	13.93	16.02	090
27687		A	Revision of calf tendon	6.24	NA	5.40	0.76	NA	12.40	090
27690		A	Revise lower leg tendon	8.71	NA	7.22	0.88	NA	16.81	090
27691		A	Revise lower leg tendon	9.96	NA	8.91	1.23	NA	20.10	090
27692		A	Revise additional leg tendon	1.87	NA	1.29	0.29	NA	3.45	ZZZ
27695		A	Repair of ankle ligament	6.51	NA	6.79	1.32	NA	14.62	090
27696		A	Repair of ankle ligaments	8.27	NA	7.80	1.16	NA	17.23	090
27698		A	Repair of ankle ligament	9.36	NA	7.13	1.86	NA	18.35	090
27700		A	Revision of ankle joint	9.29	NA	6.00	1.51	NA	16.80	090
27702		A	Reconstruct ankle joint	13.67	NA	11.18	3.99	NA	28.84	090
27703		A	Reconstruction, ankle joint	15.87	NA	11.86	2.25	NA	29.98	090
27704		A	Removal of ankle implant	7.62	NA	7.48	0.98	NA	16.08	090
27705		A	Incision of tibia	10.38	NA	9.24	1.76	NA	21.38	090
27707		A	Incision of fibula	4.37	NA	5.92	0.79	NA	11.08	090
27709		A	Incision of tibia & fibula	9.95	NA	9.21	2.14	NA	21.30	090
27712		A	Realignment of lower leg	14.25	NA	11.78	1.63	NA	27.66	090
27715		A	Revision of lower leg	14.39	NA	12.54	1.88	NA	28.81	090
27720		A	Repair of tibia	11.79	NA	10.92	2.25	NA	24.96	090
27722		A	Repair/graft of tibia	11.82	NA	11.09	1.64	NA	24.55	090
27724		A	Repair/graft of tibia	14.99	NA	12.75	2.87	NA	30.61	090
27725		A	Repair of lower leg	15.59	NA	13.20	1.53	NA	30.32	090
27727		A	Repair of lower leg	14.01	NA	12.46	1.84	NA	28.31	090
27730		A	Repair of tibia epiphysis	7.41	11.61	7.25	0.84	19.86	15.50	090
27732		A	Repair of fibula epiphysis	5.32	6.26	3.86	0.79	12.37	9.97	090
27734		A	Repair lower leg epiphyses	8.48	NA	8.56	1.23	NA	18.27	090
27740		A	Repair of leg epiphyses	9.30	3.15	6.39	1.36	13.81	17.05	090
27742		A	Repair of leg epiphyses	10.30	15.04	9.64	1.52	26.86	21.46	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
27745		A	Reinforce tibia	10.07	NA	9.10	1.39	NA	20.56	090
27750		A	Treatment of tibia fracture	3.19	5.92	2.96	0.50	9.61	6.65	090
27752		A	Treatment of tibia fracture	5.84	8.11	5.23	0.81	14.76	11.88	090
27756		A	Repair of tibia fracture	6.78	NA	7.87	1.70	NA	16.35	090
27758		A	Repair of tibia fracture	11.67	NA	10.04	2.22	NA	23.93	090
27759		A	Repair of tibia fracture	13.76	NA	11.36	2.22	NA	27.34	090
27760		A	Treatment of ankle fracture	3.01	5.55	2.40	0.37	8.93	5.78	090
27762		A	Treatment of ankle fracture	5.25	7.28	4.63	0.50	13.03	10.38	090
27766		A	Repair of ankle fracture	8.36	NA	7.06	1.26	NA	16.68	090
27780		A	Treatment of fibula fracture	2.65	3.74	2.30	0.26	6.65	5.21	090
27781		A	Treatment of fibula fracture	4.40	6.67	3.89	0.49	11.56	8.78	090
27784		A	Repair of fibula fracture	7.11	NA	6.76	0.87	NA	14.74	090
27786		A	Treatment of ankle fracture	2.84	5.55	2.43	0.38	8.77	5.65	090
27788		A	Treatment of ankle fracture	4.45	6.64	3.75	0.50	11.59	8.70	090
27792		A	Repair of ankle fracture	7.66	NA	6.66	1.17	NA	15.49	090
27808		A	Treatment of ankle fracture	2.83	6.23	2.93	0.39	9.45	6.15	090
27810		A	Treatment of ankle fracture	5.13	7.60	4.66	0.80	13.53	10.59	090
27814		A	Repair of ankle fracture	10.68	NA	9.06	1.60	NA	21.34	090
27816		A	Treatment of ankle fracture	2.89	5.90	2.93	0.55	9.34	6.37	090
27818		A	Treatment of ankle fracture	5.50	8.00	4.84	1.06	14.56	11.40	090
27822		A	Repair of ankle fracture	9.20	NA	26.99	1.88	NA	38.07	090
27823		A	Repair of ankle fracture	11.80	NA	28.40	2.05	NA	42.25	090
27824		A	Treat lower leg fracture	2.89	6.16	3.15	0.55	9.60	6.59	090
27825		A	Treat lower leg fracture	6.19	7.96	5.44	1.06	15.21	12.69	090
27826		A	Treat lower leg fracture	8.54	NA	26.59	1.88	NA	37.01	090
27827		A	Treat lower leg fracture	14.06	NA	29.89	1.88	NA	45.83	090
27828		A	Treat lower leg fracture	16.23	NA	31.03	2.05	NA	49.31	090
27829		A	Treat lower leg joint	5.49	NA	19.75	1.37	NA	26.61	090
27830		A	Treat lower leg dislocation	3.79	5.77	3.25	0.46	10.02	7.50	090
27831		A	Treat lower leg dislocation	4.56	NA	4.53	0.59	NA	9.68	090
27832		A	Repair lower leg dislocation	6.49	NA	7.05	0.89	NA	14.43	090
27840		A	Treat ankle dislocation	4.58	NA	3.17	0.21	NA	7.96	090
27842		A	Treat ankle dislocation	6.21	NA	4.00	0.34	NA	10.55	090
27846		A	Repair ankle dislocation	9.79	NA	8.29	1.37	NA	19.45	090
27848		A	Repair ankle dislocation	11.20	NA	22.13	1.32	NA	34.65	090
27860		A	Fixation of ankle joint	2.34	NA	2.68	0.23	NA	5.25	010
27870		A	Fusion of ankle joint	13.91	NA	11.49	2.22	NA	27.62	090
27871		A	Fusion of tibiofibular joint	9.17	NA	8.82	1.21	NA	19.20	090
27880		A	Amputation of lower leg	11.85	NA	8.36	1.60	NA	21.81	090
27881		A	Amputation of lower leg	12.34	NA	10.11	1.87	NA	24.32	090
27882		A	Amputation of lower leg	8.94	NA	8.19	1.42	NA	18.55	090
27884		A	Amputation follow-up surgery	8.21	NA	7.12	0.61	NA	15.94	090
27886		A	Amputation follow-up surgery	9.32	NA	7.73	1.34	NA	18.39	090
27888		A	Amputation of foot at ankle	9.67	NA	8.39	1.65	NA	19.71	090
27889		A	Amputation of foot at ankle	9.98	NA	7.15	1.55	NA	18.68	090
27892		A	Decompression of leg	7.39	NA	5.48	0.64	NA	13.51	090
27893		A	Decompression of leg	7.35	NA	5.87	0.67	NA	13.89	090
27894		A	Decompression of leg	10.49	NA	7.07	0.77	NA	18.33	090
28001		A	Drainage of bursa of foot	2.73	2.36	2.64	0.05	5.14	5.42	010
28002		A	Treatment of foot infection	4.62	3.28	3.68	0.33	8.23	8.63	010
28003		A	Treatment of foot infection	8.41	5.39	7.51	0.59	14.39	16.51	090
28005		A	Treat foot bone lesion	8.68	NA	7.52	0.61	NA	16.81	090
28008		A	Incision of foot fascia	4.45	3.40	3.82	0.29	8.14	8.56	090
28010		A	Incision of toe tendon	2.84	3.00	3.35	0.33	6.17	6.52	090
28011		A	Incision of toe tendons	4.14	4.82	4.92	0.19	9.15	9.25	090
28020		A	Exploration of a foot joint	5.01	4.78	4.46	0.56	10.35	10.03	090
28022		A	Exploration of a foot joint	4.67	3.52	4.02	0.31	8.50	9.00	090
28024		A	Exploration of a toe joint	4.38	3.91	3.97	0.24	8.53	8.59	090
28030		A	Removal of foot nerve	6.15	NA	3.17	0.42	NA	9.74	090
28035		A	Decompression of tibia nerve	5.09	4.87	4.14	0.90	10.86	10.13	090
28043		A	Excision of foot lesion	3.54	3.36	3.49	0.20	7.10	7.23	090
28045		A	Excision of foot lesion	4.72	3.80	3.88	0.46	8.98	9.06	090
28046		A	Resection of tumor, foot	10.18	7.36	7.71	0.79	18.33	18.68	090
28050		A	Biopsy of foot joint lining	4.25	3.01	3.79	0.53	7.79	8.57	090
28052		A	Biopsy of foot joint lining	3.94	3.12	4.25	0.43	7.49	8.62	090
28054		A	Biopsy of toe joint lining	3.45	4.08	4.07	0.28	7.81	7.80	090
28060		A	Partial removal foot fascia	5.23	4.14	4.05	0.53	9.90	9.81	090
28062		A	Removal of foot fascia	6.52	4.32	4.26	0.86	11.70	11.64	090
28070		A	Removal of foot joint lining	5.10	3.53	3.99	0.48	9.11	9.57	090
28072		A	Removal of foot joint lining	4.58	3.68	4.67	0.42	8.68	9.67	090
28080		A	Removal of foot lesion	3.58	3.13	3.36	0.45	7.16	7.39	090
28086		A	Excise foot tendon sheath	4.78	5.90	5.34	0.46	11.14	10.58	090
28088		A	Excise foot tendon sheath	3.86	4.26	4.80	0.40	8.52	9.06	090
28090		A	Removal of foot lesion	4.41	3.52	3.73	0.29	8.22	8.43	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
28092		A	Removal of toe lesions	3.64	3.86	3.97	0.25	7.75	7.86	090
28100		A	Removal of ankle/heel lesion	5.66	6.43	5.26	0.56	12.65	11.48	090
28102		A	Remove/graft foot lesion	7.73	NA	6.81	0.85	NA	15.39	090
28103		A	Remove/graft foot lesion	6.50	4.89	5.49	0.69	12.08	12.68	090
28104		A	Removal of foot lesion	5.12	3.88	4.63	0.49	9.49	10.24	090
28106		A	Remove/graft foot lesion	7.16	NA	5.32	0.79	NA	13.27	090
28107		A	Remove/graft foot lesion	5.56	3.69	5.13	0.48	9.73	11.17	090
28108		A	Removal of toe lesions	4.16	3.08	3.44	0.38	7.62	7.98	090
28110		A	Part removal of metatarsal	4.08	3.49	4.07	0.39	7.96	8.54	090
28111		A	Part removal of metatarsal	5.01	4.27	4.80	0.65	9.93	10.46	090
28112		A	Part removal of metatarsal	4.49	3.84	4.60	0.45	8.78	9.54	090
28113		A	Part removal of metatarsal	4.79	3.80	4.31	0.48	9.07	9.58	090
28114		A	Removal of metatarsal heads	9.79	8.36	8.15	1.42	19.57	19.36	090
28116		A	Revision of foot	7.75	4.54	5.19	0.57	12.86	13.51	090
28118		A	Removal of heel bone	5.96	4.43	4.86	0.66	11.05	11.48	090
28119		A	Removal of heel spur	5.39	3.77	4.09	0.57	9.73	10.05	090
28120		A	Part removal of ankle/heel	5.40	5.08	6.36	0.67	11.15	12.43	090
28122		A	Partial removal of foot bone	7.29	5.33	6.53	0.54	13.16	14.36	090
28124		A	Partial removal of toe	4.81	3.80	4.88	0.37	8.98	10.06	090
28126		A	Partial removal of toe	3.52	3.08	4.12	0.36	6.96	8.00	090
28130		A	Removal of ankle bone	8.11	NA	6.47	0.88	NA	15.46	090
28140		A	Removal of metatarsal	6.91	4.68	5.42	0.62	12.21	12.95	090
28150		A	Removal of toe	4.09	3.60	4.60	0.38	8.07	9.07	090
28153		A	Partial removal of toe	3.66	3.05	2.86	0.36	7.07	6.88	090
28160		A	Partial removal of toe	3.74	3.18	4.38	0.38	7.30	8.50	090
28171		A	Extensive foot surgery	9.60	NA	5.64	0.88	NA	16.12	090
28173		A	Extensive foot surgery	8.80	6.10	6.02	0.74	15.64	15.56	090
28175		A	Extensive foot surgery	6.05	4.62	4.13	0.58	11.25	10.76	090
28190		A	Removal of foot foreign body	1.96	2.82	1.70	0.05	4.83	3.71	010
28192		A	Removal of foot foreign body	4.64	4.21	3.75	0.24	9.09	8.63	090
28193		A	Removal of foot foreign body	5.73	4.89	4.33	0.30	10.92	10.36	090
28200		A	Repair of foot tendon	4.60	3.65	4.03	0.50	8.75	9.13	090
28202		A	Repair/graft of foot tendon	6.84	4.25	5.68	0.77	11.86	13.29	090
28208		A	Repair of foot tendon	4.37	3.33	3.57	0.28	7.98	8.22	090
28210		A	Repair/graft of foot tendon	6.35	4.43	4.37	0.60	11.38	11.32	090
28220		A	Release of foot tendon	4.53	3.27	3.85	0.43	8.23	8.81	090
28222		A	Release of foot tendons	5.62	3.78	4.41	0.63	10.03	10.66	090
28225		A	Release of foot tendon	3.66	3.15	3.53	0.25	7.06	7.44	090
28226		A	Release of foot tendons	4.53	3.24	3.86	0.40	8.17	8.79	090
28230		A	Incision of foot tendon(s)	4.24	3.29	4.49	0.22	7.75	8.95	090
28232		A	Incision of toe tendon	3.39	3.12	4.14	0.15	6.66	7.68	090
28234		A	Incision of foot tendon	3.37	2.99	3.82	0.14	6.50	7.33	090
28238		A	Revision of foot tendon	7.73	5.32	5.38	0.85	13.90	13.96	090
28240		A	Release of big toe	4.36	3.22	3.97	0.23	7.81	8.56	090
28250		A	Revision of foot fascia	5.92	4.03	4.24	0.50	10.45	10.66	090
28260		A	Release of midfoot joint	7.96	5.31	5.36	0.48	13.75	13.80	090
28261		A	Revision of foot tendon	11.73	6.39	7.41	0.58	18.70	19.72	090
28262		A	Revision of foot and ankle	15.83	8.31	12.72	1.44	25.58	29.99	090
28264		A	Release of midfoot joint	10.35	5.92	6.61	1.17	17.44	18.13	090
28270		A	Release of foot contracture	4.76	3.51	4.31	0.23	8.50	9.30	090
28272		A	Release of toe joint, each	3.80	2.94	3.54	0.18	6.92	7.52	090
28280		A	Fusion of toes	5.19	4.73	5.19	0.30	10.22	10.68	090
28285		A	Repair of hammertoe	4.59	3.54	4.03	0.39	8.52	9.01	090
28286		A	Repair of hammertoe	4.56	3.52	4.01	0.38	8.46	8.95	090
28288		A	Partial removal of foot bone	4.74	3.93	5.42	0.43	9.10	10.59	090
28290		A	Correction of bunion	5.66	4.30	6.27	0.63	10.59	12.56	090
28292		A	Correction of bunion	7.04	4.62	5.09	0.74	12.40	12.87	090
28293		A	Correction of bunion	9.15	5.73	5.49	0.98	15.86	15.62	090
28294		A	Correction of bunion	8.56	5.35	5.12	0.86	14.77	14.54	090
28296		A	Correction of bunion	9.18	5.60	6.12	0.98	15.76	16.28	090
28297		A	Correction of bunion	9.18	9.18	7.35	1.05	19.41	17.58	090
28298		A	Correction of bunion	7.94	5.03	5.50	0.79	13.76	14.23	090
28299		A	Correction of bunion	8.88	5.32	5.58	1.08	15.28	15.54	090
28300		A	Incision of heel bone	9.54	6.28	7.24	0.79	16.61	17.57	090
28302		A	Incision of ankle bone	9.55	5.33	6.63	1.12	16.00	17.30	090
28304		A	Incision of midfoot bones	9.16	5.85	6.00	0.70	15.71	15.86	090
28305		A	Incise/graft midfoot bones	10.50	7.76	7.22	1.03	19.29	18.75	090
28306		A	Incision of metatarsal	5.86	4.29	4.37	0.47	10.62	10.70	090
28307		A	Incision of metatarsal	6.33	5.57	6.27	0.76	12.66	13.36	090
28308		A	Incision of metatarsal	5.29	3.50	3.50	0.50	9.29	9.29	090
28309		A	Incision of metatarsals	12.78	NA	9.00	1.00	NA	22.78	090
28310		A	Revision of big toe	5.43	3.82	3.97	0.42	9.67	9.82	090
28312		A	Revision of toe	4.55	3.53	4.34	0.45	8.53	9.34	090
28313		A	Repair deformity of toe	5.01	3.89	6.32	0.31	9.21	11.64	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
28315		A	Removal of sesamoid bone	4.86	3.47	3.57	0.41	8.74	8.84	090
28320		A	Repair of foot bones	9.18	NA	7.29	1.03	NA	17.50	090
28322		A	Repair of metatarsals	8.34	5.66	6.58	0.52	14.52	15.44	090
28340		A	Resect enlarged toe tissue	6.98	4.31	4.45	0.91	12.20	12.34	090
28341		A	Resect enlarged toe	8.41	4.94	5.65	0.96	14.31	15.02	090
28344		A	Repair extra toe(s)	4.26	3.01	4.00	0.60	7.87	8.86	090
28345		A	Repair webbed toe(s)	5.92	4.96	5.47	0.73	11.61	12.12	090
28360		A	Reconstruct cleft foot	13.34	NA	12.53	1.95	NA	27.82	090
28400		A	Treatment of heel fracture	2.16	5.37	3.00	0.40	7.93	5.56	090
28405		A	Treatment of heel fracture	4.57	6.46	4.76	0.58	11.61	9.91	090
28406		A	Treatment of heel fracture	6.31	NA	6.85	0.93	NA	14.09	090
28415		A	Repair of heel fracture	15.97	NA	28.96	1.39	NA	46.32	090
28420		A	Repair/graft heel fracture	16.64	NA	30.12	1.63	NA	48.39	090
28430		A	Treatment of ankle fracture	2.09	5.07	2.26	0.35	7.51	4.70	090
28435		A	Treatment of ankle fracture	3.40	5.14	3.72	0.50	9.04	7.62	090
28436		A	Treatment of ankle fracture	4.71	NA	5.92	0.68	NA	11.31	090
28445		A	Repair of ankle fracture	9.33	NA	8.25	1.40	NA	18.98	090
28450		A	Treat midfoot fracture, each	1.90	4.76	2.28	0.25	6.91	4.43	090
28455		A	Treat midfoot fracture, each	3.09	4.07	3.81	0.34	7.50	7.24	090
28456		A	Repair midfoot fracture	2.68	NA	4.36	0.38	NA	7.42	090
28465		A	Repair midfoot fracture, each	7.01	NA	15.39	0.81	NA	23.21	090
28470		A	Treat metatarsal fracture	1.99	4.39	1.94	0.23	6.61	4.16	090
28475		A	Treat metatarsal fracture	2.97	4.47	3.30	0.30	7.74	6.57	090
28476		A	Repair metatarsal fracture	3.38	NA	4.92	0.45	NA	8.75	090
28485		A	Repair metatarsal fracture	5.71	NA	16.10	0.60	NA	22.41	090
28490		A	Treat big toe fracture	1.09	1.50	1.10	0.10	2.69	2.29	090
28495		A	Treat big toe fracture	1.58	1.50	1.56	0.13	3.21	3.27	090
28496		A	Repair big toe fracture	2.33	3.13	3.93	0.31	5.77	6.57	090
28505		A	Repair big toe fracture	3.81	11.81	12.54	0.43	16.05	16.78	090
28510		A	Treatment of toe fracture	1.09	1.26	1.02	0.09	2.44	2.20	090
28515		A	Treatment of toe fracture	1.46	1.35	1.31	0.11	2.92	2.88	090
28525		A	Repair of toe fracture	3.32	10.38	14.94	0.29	13.99	18.55	090
28530		A	Treat sesamoid bone fracture	1.06	1.70	1.61	0.10	2.86	2.77	090
28531		A	Treat sesamoid bone fracture	2.35	2.86	12.41	0.32	5.53	15.08	090
28540		A	Treat foot dislocation	2.04	2.37	2.11	0.06	4.47	4.21	090
28545		A	Treat foot dislocation	2.45	1.84	3.50	0.14	4.43	6.09	090
28546		A	Treat foot dislocation	3.20	7.60	4.19	0.45	11.25	7.84	090
28555		A	Repair foot dislocation	6.30	21.63	17.07	0.73	28.66	24.10	090
28570		A	Treat foot dislocation	1.66	3.36	2.59	0.17	5.19	4.42	090
28575		A	Treat foot dislocation	3.31	4.96	4.00	0.42	8.69	7.73	090
28576		A	Treat foot dislocation	4.17	6.82	5.28	0.42	11.41	9.87	090
28585		A	Repair foot dislocation	7.99	8.08	15.29	0.55	16.62	23.83	090
28600		A	Treat foot dislocation	1.89	3.83	2.55	0.08	5.80	4.52	090
28605		A	Treat foot dislocation	2.71	3.53	3.68	0.34	6.58	6.73	090
28606		A	Treat foot dislocation	4.90	5.37	5.57	0.55	10.82	11.02	090
28615		A	Repair foot dislocation	7.77	NA	20.06	0.78	NA	28.61	090
28630		A	Treat toe dislocation	1.70	1.64	1.21	0.11	3.45	3.02	010
28635		A	Treat toe dislocation	1.91	1.94	2.13	0.18	4.03	4.22	010
28636		A	Treat toe dislocation	2.77	1.93	2.86	0.42	5.12	6.05	010
28645		A	Repair toe dislocation	4.22	3.54	6.04	0.38	8.14	10.64	090
28660		A	Treat toe dislocation	1.23	2.55	1.12	0.06	3.84	2.41	010
28665		A	Treat toe dislocation	1.92	1.93	2.12	0.11	3.96	4.15	010
28666		A	Treat toe dislocation	2.66	8.44	2.68	0.40	11.50	5.74	010
28675		A	Repair of toe dislocation	2.92	4.34	9.17	0.41	7.67	12.50	090
28705		A	Fusion of foot bones	15.21	NA	11.62	2.35	NA	29.18	090
28715		A	Fusion of foot bones	13.10	NA	10.62	1.89	NA	25.61	090
28725		A	Fusion of foot bones	11.61	NA	9.76	1.44	NA	22.81	090
28730		A	Fusion of foot bones	10.76	NA	8.67	1.33	NA	20.76	090
28735		A	Fusion of foot bones	10.85	NA	8.94	1.37	NA	21.16	090
28737		A	Revision of foot bones	9.64	NA	7.47	1.13	NA	18.24	090
28740		A	Fusion of foot bones	8.02	8.02	6.91	0.72	16.76	15.65	090
28750		A	Fusion of big toe joint	7.30	8.03	6.99	0.82	16.15	15.11	090
28755		A	Fusion of big toe joint	4.74	3.64	4.51	0.45	8.83	9.70	090
28760		A	Fusion of big toe joint	7.75	5.31	6.10	0.65	13.71	14.50	090
28800		A	Amputation of midfoot	8.21	NA	6.55	1.19	NA	15.95	090
28805		A	Amputation thru metatarsal	8.39	NA	6.21	1.21	NA	15.81	090
28810		A	Amputation toe & metatarsal	6.21	NA	5.18	0.75	NA	12.14	090
28820		A	Amputation of toe	4.41	5.54	4.59	0.46	10.41	9.46	090
28825		A	Partial amputation of toe	3.59	5.41	4.10	0.41	9.41	8.10	090
29000		A	Application of body cast	2.25	7.59	1.34	0.21	10.05	3.80	000
29010		A	Application of body cast	2.06	9.76	1.22	0.34	12.16	3.62	000
29015		A	Application of body cast	2.41	6.34	1.07	0.33	9.08	3.81	000
29020		A	Application of body cast	2.11	6.03	1.05	0.23	8.37	3.39	000
29025		A	Application of body cast	2.40	8.76	1.43	0.14	11.30	3.97	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
29035		A	Application of body cast	1.77	10.29	1.11	0.32	12.38	3.20	000
29040		A	Application of body cast	2.22	7.79	0.91	0.30	10.31	3.43	000
29044		A	Application of body cast	2.12	13.00	1.35	0.34	15.46	3.81	000
29046		A	Application of body cast	2.41	11.41	1.46	0.36	14.18	4.23	000
29049		A	Application of figure eight	0.89	3.83	0.38	0.06	4.78	1.33	000
29055		A	Application of shoulder cast	1.78	8.03	0.98	0.17	9.98	2.93	000
29058		A	Application of shoulder cast	1.31	5.55	0.57	0.09	6.95	1.97	000
29065		A	Application of long arm cast	0.87	3.61	0.53	0.13	4.61	1.53	000
29075		A	Application of forearm cast	0.77	3.22	0.45	0.10	4.09	1.32	000
29085		A	Apply hand/wrist cast	0.87	3.14	0.48	0.08	4.09	1.43	000
29105		A	Apply long arm splint	0.87	2.50	0.31	0.08	3.45	1.26	000
29125		A	Apply forearm splint	0.59	1.99	0.18	0.05	2.63	0.82	000
29126		A	Apply forearm splint	0.77	2.55	0.41	0.06	3.38	1.24	000
29130		A	Application of finger splint	0.50	0.61	0.15	0.02	1.13	0.67	000
29131		A	Application of finger splint	0.55	0.82	0.25	0.06	1.43	0.86	000
29200		A	Strapping of chest	0.65	0.75	0.17	0.03	1.43	0.85	000
29220		A	Strapping of low back	0.64	0.79	0.25	0.05	1.48	0.94	000
29240		A	Strapping of shoulder	0.71	0.86	0.21	0.03	1.60	0.95	000
29260		A	Strapping of elbow or wrist	0.55	0.71	0.15	0.03	1.29	0.73	000
29280		A	Strapping of hand or finger	0.51	0.68	0.14	0.02	1.21	0.67	000
29305		A	Application of hip cast	2.03	10.18	1.27	0.31	12.52	3.61	000
29325		A	Application of hip casts	2.32	9.99	1.42	0.28	12.59	4.02	000
29345		A	Application of long leg cast	1.40	4.54	0.83	0.16	6.10	2.39	000
29355		A	Application of long leg cast	1.53	4.43	0.91	0.17	6.13	2.61	000
29358		A	Apply long leg cast brace	1.43	5.28	0.91	0.33	7.04	2.67	000
29365		A	Application of long leg cast	1.18	3.96	0.72	0.14	5.28	2.04	000
29405		A	Apply short leg cast	0.86	3.26	0.50	0.12	4.24	1.48	000
29425		A	Apply short leg cast	1.01	3.09	0.56	0.14	4.24	1.71	000
29435		A	Apply short leg cast	1.18	5.52	0.74	0.18	6.88	2.10	000
29440		A	Addition of walker to cast	0.57	1.67	0.30	0.03	2.27	0.90	000
29445		A	Apply rigid leg cast	1.78	4.94	0.98	0.28	7.00	3.04	000
29450		A	Application of leg cast	1.02	2.89	0.46	0.04	3.95	1.52	000
29505		A	Application long leg splint	0.69	2.84	0.26	0.07	3.60	1.02	000
29515		A	Application lower leg splint	0.73	1.81	0.25	0.06	2.60	1.04	000
29520		A	Strapping of hip	0.54	0.68	0.32	0.03	1.25	0.89	000
29530		A	Strapping of knee	0.57	0.72	0.16	0.05	1.34	0.78	000
29540		A	Strapping of ankle	0.51	0.32	0.18	0.03	0.86	0.72	000
29550		A	Strapping of toes	0.47	0.30	0.18	0.03	0.80	0.68	000
29580		A	Application of paste boot	0.57	0.60	0.27	0.04	1.21	0.88	000
29590		A	Application of foot splint	0.76	0.47	0.34	0.03	1.26	1.13	000
29700		A	Removal/revision of cast	0.57	0.54	0.26	0.05	1.16	0.88	000
29705		A	Removal/revision of cast	0.76	0.77	0.35	0.05	1.58	1.16	000
29710		A	Removal/revision of cast	1.34	1.22	0.89	0.07	2.63	2.30	000
29715		A	Removal/revision of cast	0.94	2.86	0.65	0.12	3.92	1.71	000
29720		A	Repair of body cast	0.68	3.21	0.42	0.04	3.93	1.14	000
29730		A	Windowing of cast	0.75	0.73	0.35	0.04	1.52	1.14	000
29740		A	Wedging of cast	1.12	2.35	0.64	0.06	3.53	1.82	000
29750		A	Wedging of clubfoot cast	1.26	1.03	0.65	0.07	2.36	1.98	000
29800		A	Jaw arthroscopy/surgery	6.43	NA	7.16	0.46	NA	14.05	090
29804		A	Jaw arthroscopy/surgery	8.14	NA	7.84	1.46	NA	17.44	090
29815		A	Shoulder arthroscopy	5.89	NA	6.09	0.76	NA	12.74	090
29819		A	Shoulder arthroscopy/surgery	7.62	NA	7.41	1.73	NA	16.76	090
29820		A	Shoulder arthroscopy/surgery	7.07	NA	7.33	1.73	NA	16.13	090
29821		A	Shoulder arthroscopy/surgery	7.72	NA	7.75	2.13	NA	17.60	090
29822		A	Shoulder arthroscopy/surgery	7.43	NA	7.54	1.74	NA	16.71	090
29823		A	Shoulder arthroscopy/surgery	8.17	NA	7.97	2.32	NA	18.46	090
29825		A	Shoulder arthroscopy/surgery	7.62	NA	7.65	2.05	NA	17.32	090
29826		A	Shoulder arthroscopy/surgery	8.99	NA	8.42	2.31	NA	19.72	090
29830		A	Elbow arthroscopy	5.76	NA	5.00	0.83	NA	11.59	090
29834		A	Elbow arthroscopy/surgery	6.28	NA	5.66	0.96	NA	12.90	090
29835		A	Elbow arthroscopy/surgery	6.48	NA	5.73	0.99	NA	13.20	090
29836		A	Elbow arthroscopy/surgery	7.55	NA	6.20	1.15	NA	14.90	090
29837		A	Elbow arthroscopy/surgery	6.87	NA	6.03	1.06	NA	13.96	090
29838		A	Elbow arthroscopy/surgery	7.71	NA	6.54	1.14	NA	15.39	090
29840		A	Wrist arthroscopy	5.54	NA	6.26	0.54	NA	12.34	090
29843		A	Wrist arthroscopy/surgery	6.01	NA	6.75	0.91	NA	13.67	090
29844		A	Wrist arthroscopy/surgery	6.37	NA	7.14	0.95	NA	14.46	090
29845		A	Wrist arthroscopy/surgery	7.52	NA	7.93	1.15	NA	16.60	090
29846		A	Wrist arthroscopy/surgery	6.75	NA	8.86	2.20	NA	17.81	090
29847		A	Wrist arthroscopy/surgery	7.08	NA	8.94	0.97	NA	16.99	090
29848		A	Wrist arthroscopy/surgery	5.44	NA	6.41	0.62	NA	12.47	090
29850		A	Knee arthroscopy/surgery	8.19	NA	5.47	1.74	NA	15.40	090
29851		A	Knee arthroscopy/surgery	13.10	NA	10.43	1.74	NA	25.27	090
29855		A	Tibial arthroscopy/surgery	10.62	NA	8.87	1.88	NA	21.37	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
29856		A	Tibial arthroscopy/surgery	14.14	NA	11.01	1.88	NA	27.03	090
29860		A	Hip arthroscopy, dx	8.05	NA	6.22	0.76	NA	15.03	090
29861		A	Hip arthroscopy/surgery	9.15	NA	7.11	1.73	NA	17.99	090
29862		A	Hip arthroscopy/surgery	9.90	NA	7.51	2.32	NA	19.73	090
29863		A	Hip arthroscopy/surgery	9.90	NA	7.80	1.73	NA	19.43	090
29870		A	Knee arthroscopy, diagnostic	5.07	NA	4.90	0.64	NA	10.61	090
29871		A	Knee arthroscopy/drainage	6.55	NA	6.54	0.96	NA	14.05	090
29874		A	Knee arthroscopy/surgery	7.05	NA	6.37	1.52	NA	14.94	090
29875		A	Knee arthroscopy/surgery	6.31	NA	6.16	1.61	NA	14.08	090
29876		A	Knee arthroscopy/surgery	7.92	NA	7.42	1.95	NA	17.29	090
29877		A	Knee arthroscopy/surgery	7.35	NA	6.80	1.81	NA	15.96	090
29879		A	Knee arthroscopy/surgery	8.04	NA	7.21	2.19	NA	17.44	090
29880		A	Knee arthroscopy/surgery	8.50	NA	7.47	2.22	NA	18.19	090
29881		A	Knee arthroscopy/surgery	7.76	NA	7.04	1.82	NA	16.62	090
29882		A	Knee arthroscopy/surgery	8.65	NA	7.05	1.90	NA	17.60	090
29883		A	Knee arthroscopy/surgery	9.46	NA	8.10	2.80	NA	20.36	090
29884		A	Knee arthroscopy/surgery	7.33	NA	7.08	1.56	NA	15.97	090
29885		A	Knee arthroscopy/surgery	9.09	NA	8.18	1.35	NA	18.62	090
29886		A	Knee arthroscopy/surgery	7.54	NA	7.14	1.12	NA	15.80	090
29887		A	Knee arthroscopy/surgery	9.04	NA	7.82	1.71	NA	18.57	090
29888		A	Knee arthroscopy/surgery	13.90	NA	10.66	3.18	NA	27.74	090
29889		A	Knee arthroscopy/surgery	15.13	NA	11.08	1.68	NA	27.89	090
29891		A	Ankle arthroscopy/surgery	8.40	NA	6.99	1.77	NA	17.16	090
29892		A	Ankle arthroscopy/surgery	9.00	NA	7.27	1.77	NA	18.04	090
29893		A	Scope, plantar fasciotomy	5.22	NA	3.78	0.46	NA	9.46	090
29894		A	Ankle arthroscopy/surgery	7.21	NA	6.37	1.47	NA	15.05	090
29895		A	Ankle arthroscopy/surgery	6.99	NA	6.23	1.51	NA	14.73	090
29897		A	Ankle arthroscopy/surgery	7.18	NA	6.81	1.77	NA	15.76	090
29898		A	Ankle arthroscopy/surgery	8.32	NA	6.72	1.91	NA	16.95	090
30000		A	Drainage of nose lesion	1.43	1.59	1.40	0.05	3.07	2.88	010
30020		A	Drainage of nose lesion	1.43	1.57	1.44	0.06	3.06	2.93	010
30100		A	Intranasal biopsy	0.94	0.93	0.58	0.08	1.95	1.60	000
30110		A	Removal of nose polyp(s)	1.63	1.81	0.99	0.14	3.58	2.76	010
30115		A	Removal of nose polyp(s)	4.35	NA	4.11	0.30	NA	8.76	090
30117		A	Removal of intranasal lesion	3.16	3.15	2.83	0.31	6.62	6.30	090
30118		A	Removal of intranasal lesion	9.69	NA	7.57	0.92	NA	18.18	090
30120		A	Revision of nose	5.27	4.23	5.03	1.00	10.50	11.30	090
30124		A	Removal of nose lesion	3.10	NA	2.96	0.16	NA	6.22	090
30125		A	Removal of nose lesion	7.16	NA	6.04	0.73	NA	13.93	090
30130		A	Removal of turbinate bones	3.38	NA	3.60	0.17	NA	7.15	090
30140		A	Removal of turbinate bones	3.43	NA	3.81	0.34	NA	7.58	090
30150		A	Partial removal of nose	9.14	NA	7.40	1.07	NA	17.61	090
30160		A	Removal of nose	9.58	NA	7.73	1.73	NA	19.04	090
30200		A	Injection treatment of nose	0.78	0.87	0.49	0.04	1.69	1.31	000
30210		A	Nasal sinus therapy	1.08	1.36	0.69	0.03	2.47	1.80	010
30220		A	Insert nasal septal button	1.54	1.68	0.98	0.16	3.38	2.68	010
30300		A	Remove nasal foreign body	1.04	1.56	0.39	0.05	2.65	1.48	010
30310		A	Remove nasal foreign body	1.96	NA	1.83	0.18	NA	3.97	010
30320		A	Remove nasal foreign body	4.52	NA	4.23	0.43	NA	9.18	090
30400		R	Reconstruction of nose	9.83	NA	7.98	1.36	NA	19.17	090
30410		R	Reconstruction of nose	12.98	NA	9.78	2.01	NA	24.77	090
30420		R	Reconstruction of nose	15.88	NA	11.71	2.22	NA	29.81	090
30430		R	Revision of nose	7.21	NA	6.28	0.66	NA	14.15	090
30435		R	Revision of nose	11.71	NA	9.29	1.10	NA	22.10	090
30450		R	Revision of nose	18.65	NA	13.35	0.91	NA	32.91	090
30460		A	Revision of nose	9.96	NA	7.10	0.93	NA	17.99	090
30462		A	Revision of nose	19.57	NA	13.86	1.87	NA	35.30	090
30520		A	Repair of nasal septum	5.70	NA	5.13	0.96	NA	11.79	090
30540		A	Repair nasal defect	7.75	NA	5.87	0.70	NA	14.32	090
30545		A	Repair nasal defect	11.38	NA	7.57	0.93	NA	19.88	090
30560		A	Release of nasal adhesions	1.26	1.52	1.38	0.06	2.84	2.70	010
30580		A	Repair upper jaw fistula	6.69	4.15	4.89	0.57	11.41	12.15	090
30600		A	Repair mouth/nose fistula	6.02	3.84	4.84	0.36	10.22	11.22	090
30620		A	Intranasal reconstruction	5.97	NA	5.50	1.10	NA	12.57	090
30630		A	Repair nasal septum defect	7.12	NA	6.14	0.71	NA	13.97	090
30801		A	Cauterization inner nose	1.09	1.55	1.84	0.05	2.69	2.98	010
30802		A	Cauterization inner nose	2.03	2.15	2.48	0.11	4.29	4.62	010
30901		A	Control of nosebleed	1.21	1.48	0.46	0.06	2.75	1.73	000
30903		A	Control of nosebleed	1.54	1.76	0.74	0.08	3.38	2.36	000
30905		A	Control of nosebleed	1.97	2.94	1.18	0.17	5.08	3.32	000
30906		A	Repeat control of nosebleed	2.45	3.23	1.76	0.11	5.79	4.32	000
30915		A	Ligation nasal sinus artery	7.20	NA	6.23	0.52	NA	13.95	090
30920		A	Ligation upper jaw artery	9.83	NA	7.88	1.32	NA	19.03	090
30930		A	Therapy fracture of nose	1.26	NA	1.93	0.08	NA	3.27	010

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
31000		A	Irrigation maxillary sinus	1.15	1.46	0.72	0.05	2.66	1.92	010
31002		A	Irrigation sphenoid sinus	1.91	NA	2.05	0.05	NA	4.01	010
31020		A	Exploration maxillary sinus	2.94	2.99	3.01	0.29	6.22	6.24	090
31030		A	Exploration maxillary sinus	5.92	3.80	4.65	0.86	10.58	11.43	090
31032		A	Explore sinus,remove polyps	6.57	NA	5.59	0.99	NA	13.15	090
31040		A	Exploration behind upper jaw	9.42	NA	6.12	0.86	NA	16.40	090
31050		A	Exploration sphenoid sinus	5.28	NA	4.68	0.64	NA	10.60	090
31051		A	Sphenoid sinus surgery	7.11	NA	5.98	0.85	NA	13.94	090
31070		A	Exploration of frontal sinus	4.28	NA	4.22	0.50	NA	9.00	090
31075		A	Exploration of frontal sinus	9.16	NA	7.54	1.10	NA	17.80	090
31080		A	Removal of frontal sinus	11.42	NA	8.20	1.12	NA	20.74	090
31081		A	Removal of frontal sinus	12.75	NA	9.00	1.30	NA	23.05	090
31084		A	Removal of frontal sinus	13.51	NA	10.25	1.62	NA	25.38	090
31085		A	Removal of frontal sinus	14.20	NA	10.54	1.76	NA	26.50	090
31086		A	Removal of frontal sinus	12.86	NA	9.98	1.15	NA	23.99	090
31087		A	Removal of frontal sinus	13.10	NA	10.08	1.33	NA	24.51	090
31090		A	Exploration of sinuses	9.53	NA	7.93	2.12	NA	19.58	090
31200		A	Removal of ethmoid sinus	4.97	NA	5.42	0.48	NA	10.87	090
31201		A	Removal of ethmoid sinus	8.37	NA	7.04	0.75	NA	16.16	090
31205		A	Removal of ethmoid sinus	10.24	NA	8.74	0.81	NA	19.79	090
31225		A	Removal of upper jaw	19.23	NA	15.40	2.37	NA	37.00	090
31230		A	Removal of upper jaw	21.94	NA	17.90	2.48	NA	42.32	090
31231		A	Nasal endoscopy, dx	1.10	1.33	0.66	0.15	2.58	1.91	000
31233		A	Nasal/sinus endoscopy, dx	2.18	2.02	1.36	0.31	4.51	3.85	000
31235		A	Nasal/sinus endoscopy, dx	2.64	2.33	1.69	0.26	5.23	4.59	000
31237		A	Nasal/sinus endoscopy, surg	2.98	2.57	1.85	0.37	5.92	5.20	000
31238		A	Nasal/sinus endoscopy, surg	3.26	2.87	2.07	0.45	6.58	5.78	000
31239		A	Nasal/sinus endoscopy, surg	8.70	NA	6.90	1.18	NA	16.78	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.94	0.37	NA	4.92	000
31254		A	Revision of ethmoid sinus	4.65	NA	3.27	0.69	NA	8.61	000
31255		A	Removal of ethmoid sinus	6.96	NA	4.84	1.14	NA	12.94	000
31256		A	Exploration maxillary sinus	3.29	NA	2.38	0.41	NA	6.08	000
31267		A	Endoscopy, maxillary sinus	5.46	NA	3.74	0.81	NA	10.01	000
31276		A	Sinus surgical endoscopy	8.85	NA	5.94	0.73	NA	15.52	000
31287		A	Nasal/sinus endoscopy, surg	3.92	NA	2.76	0.65	NA	7.33	000
31288		A	Nasal/sinus endoscopy, surg	4.58	NA	3.19	0.78	NA	8.55	000
31290		A	Nasal/sinus endoscopy, surg	17.24	NA	12.19	1.80	NA	31.23	010
31291		A	Nasal/sinus endoscopy, surg	18.19	NA	12.96	1.88	NA	33.03	010
31292		A	Nasal/sinus endoscopy, surg	14.76	NA	10.38	1.45	NA	26.59	010
31293		A	Nasal/sinus endoscopy, surg	16.21	NA	11.96	1.59	NA	29.76	010
31294		A	Nasal/sinus endoscopy, surg	19.06	NA	12.98	1.83	NA	33.87	010
31300		A	Removal of larynx lesion	14.29	NA	14.31	1.28	NA	29.88	090
31320		A	Diagnostic incision larynx	5.26	NA	9.19	0.48	NA	14.93	090
31360		A	Removal of larynx	17.08	NA	17.11	2.19	NA	36.38	090
31365		A	Removal of larynx	24.16	NA	21.72	3.10	NA	48.98	090
31367		A	Partial removal of larynx	21.86	NA	21.02	1.88	NA	44.76	090
31368		A	Partial removal of larynx	27.09	NA	25.77	3.06	NA	55.92	090
31370		A	Partial removal of larynx	21.38	NA	20.44	1.88	NA	43.70	090
31375		A	Partial removal of larynx	20.21	NA	18.73	1.56	NA	40.50	090
31380		A	Partial removal of larynx	20.21	NA	18.65	1.88	NA	40.74	090
31382		A	Partial removal of larynx	20.52	NA	19.85	1.78	NA	42.15	090
31390		A	Removal of larynx & pharynx	27.53	NA	25.76	4.05	NA	57.34	090
31395		A	Reconstruct larynx & pharynx	31.09	NA	30.56	4.42	NA	66.07	090
31400		A	Revision of larynx	10.31	NA	11.89	0.91	NA	23.11	090
31420		A	Removal of epiglottis	10.22	NA	12.46	0.84	NA	23.52	090
31500		A	Insert emergency airway	2.33	NA	0.62	0.14	NA	3.09	000
31502		A	Change of windpipe airway	0.65	1.09	0.28	0.07	1.81	1.00	000
31505		A	Diagnostic laryngoscopy	0.61	1.05	0.35	0.05	1.71	1.01	000
31510		A	Laryngoscopy with biopsy	1.92	1.90	1.01	0.07	3.89	3.00	000
31511		A	Remove foreign body, larynx	2.16	2.12	0.70	0.10	4.38	2.96	000
31512		A	Removal of larynx lesion	2.07	2.07	1.23	0.20	4.34	3.50	000
31513		A	Injection into vocal cord	2.10	NA	1.55	0.38	NA	4.03	000
31515		A	Laryngoscopy for aspiration	1.80	1.03	1.13	0.14	2.97	3.07	000
31520		A	Diagnostic laryngoscopy	2.56	NA	1.66	0.18	NA	4.40	000
31525		A	Diagnostic laryngoscopy	2.63	2.29	1.84	0.23	5.15	4.70	000
31526		A	Diagnostic laryngoscopy	2.57	NA	1.85	0.38	NA	4.80	000
31527		A	Laryngoscopy for treatment	3.27	NA	2.00	0.30	NA	5.57	000
31528		A	Laryngoscopy and dilatation	2.37	NA	1.56	0.30	NA	4.23	000
31529		A	Laryngoscopy and dilatation	2.68	NA	1.89	0.25	NA	4.82	000
31530		A	Operative laryngoscopy	3.39	NA	1.97	0.39	NA	5.75	000
31531		A	Operative laryngoscopy	3.59	NA	2.54	0.60	NA	6.73	000
31535		A	Operative laryngoscopy	3.16	NA	2.16	0.45	NA	5.77	000
31536		A	Operative laryngoscopy	3.56	NA	2.53	0.59	NA	6.68	000
31540		A	Operative laryngoscopy	4.13	NA	2.78	0.61	NA	7.52	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
31541		A	Operative laryngoscopy	4.53	NA	3.15	0.75	NA	8.43	000
31560		A	Operative laryngoscopy	5.46	NA	3.57	0.51	NA	9.54	000
31561		A	Operative laryngoscopy	6.00	NA	4.13	1.08	NA	11.21	000
31570		A	Laryngoscopy with injection	3.87	2.38	2.77	0.60	6.85	7.24	000
31571		A	Laryngoscopy with injection	4.27	NA	2.98	0.69	NA	7.94	000
31575		A	Diagnostic laryngoscopy	1.10	1.37	0.65	0.17	2.64	1.92	000
31576		A	Laryngoscopy with biopsy	1.97	1.64	1.12	0.33	3.94	3.42	000
31577		A	Remove foreign body, larynx	2.47	1.97	1.22	0.37	4.81	4.06	000
31578		A	Removal of larynx lesion	2.84	2.17	1.35	0.48	5.49	4.67	000
31579		A	Diagnostic laryngoscopy	2.26	2.16	1.25	0.26	4.68	3.77	000
31580		A	Revision of larynx	12.38	NA	13.28	1.63	NA	27.29	090
31582		A	Revision of larynx	21.62	NA	19.49	1.94	NA	43.05	090
31584		A	Repair of larynx fracture	19.64	NA	17.42	1.34	NA	38.40	090
31585		A	Repair of larynx fracture	4.64	NA	6.56	0.40	NA	11.60	090
31586		A	Repair of larynx fracture	8.03	NA	9.67	0.71	NA	18.41	090
31587		A	Revision of larynx	11.99	NA	13.22	0.79	NA	26.00	090
31588		A	Revision of larynx	13.11	NA	14.51	1.16	NA	28.78	090
31590		A	Reinnervate larynx	6.97	NA	9.63	0.62	NA	17.22	090
31595		A	Larynx nerve surgery	8.34	NA	9.26	0.74	NA	18.34	090
31600		A	Incision of windpipe	3.62	NA	2.22	0.65	NA	6.49	000
31601		A	Incision of windpipe	4.45	NA	2.90	0.66	NA	8.01	000
31603		A	Incision of windpipe	4.15	NA	2.49	0.66	NA	7.30	000
31605		A	Incision of windpipe	3.58	NA	1.76	0.50	NA	5.84	000
31610		A	Incision of windpipe	8.76	NA	9.04	0.92	NA	18.72	090
31611		A	Surgery/speech prosthesis	5.64	NA	7.88	1.04	NA	14.56	090
31612		A	Puncture/clear windpipe	0.91	1.14	0.52	0.12	2.17	1.55	000
31613		A	Repair windpipe opening	4.59	NA	6.56	0.28	NA	11.43	090
31614		A	Repair windpipe opening	7.12	NA	9.23	0.73	NA	17.08	090
31615		A	Visualization of windpipe	2.09	4.04	1.44	0.22	6.35	3.75	000
31622		A	Diagnostic bronchoscopy	2.80	2.75	1.37	0.34	5.89	4.51	000
31625		A	Bronchoscopy with biopsy	3.37	2.79	1.50	0.35	6.51	5.22	000
31628		A	Bronchoscopy with biopsy	3.81	2.77	1.59	0.38	6.96	5.78	000
31629		A	Bronchoscopy with biopsy	3.37	NA	1.28	0.34	NA	4.99	000
31630		A	Bronchoscopy with repair	3.82	NA	2.03	0.50	NA	6.35	000
31631		A	Bronchoscopy with dilation	4.37	NA	2.10	0.48	NA	6.95	000
31635		A	Remove foreign body, airway	3.68	NA	1.72	0.53	NA	5.93	000
31640		A	Bronchoscopy & remove lesion	4.94	NA	2.38	0.67	NA	7.99	000
31641		A	Bronchoscopy, treat blockage	5.03	NA	2.10	0.85	NA	7.98	000
31645		A	Bronchoscopy, clear airways	3.16	NA	1.28	0.30	NA	4.74	000
31646		A	Bronchoscopy, reclear airways	2.72	NA	1.16	0.27	NA	4.15	000
31656		A	Bronchoscopy, inject for xray	2.17	NA	0.95	0.31	NA	3.43	000
31700		A	Insertion of airway catheter	1.34	1.85	0.64	0.17	3.36	2.15	000
31708		A	Instill airway contrast dye	1.41	NA	0.76	0.09	NA	2.26	000
31710		A	Insertion of airway catheter	1.30	NA	0.70	0.12	NA	2.12	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.57	0.04	NA	1.72	000
31717		A	Bronchial brush biopsy	2.12	2.11	0.87	0.06	4.29	3.05	000
31720		A	Clearance of airways	1.06	1.59	0.51	0.09	2.74	1.66	000
31725		A	Clearance of airways	1.96	NA	0.83	0.15	NA	2.94	000
31730		A	Intro windpipe wire/tube	2.85	1.76	1.06	0.23	4.84	4.14	000
31750		A	Repair of windpipe	13.02	NA	13.74	1.09	NA	27.85	090
31755		A	Repair of windpipe	15.93	NA	16.59	1.44	NA	33.96	090
31760		A	Repair of windpipe	22.35	NA	14.37	2.55	NA	39.27	090
31766		A	Reconstruction of windpipe	30.43	NA	19.67	1.12	NA	51.22	090
31770		A	Repair/graft of bronchus	22.51	NA	15.37	2.08	NA	39.96	090
31775		A	Reconstruct bronchus	23.54	NA	18.49	1.92	NA	43.95	090
31780		A	Reconstruct windpipe	17.72	NA	15.56	2.08	NA	35.36	090
31781		A	Reconstruct windpipe	23.53	NA	22.21	1.96	NA	47.70	090
31785		A	Remove windpipe lesion	17.23	NA	16.74	1.17	NA	35.14	090
31786		A	Remove windpipe lesion	23.98	NA	21.83	2.24	NA	48.05	090
31800		A	Repair of windpipe injury	7.43	NA	8.70	0.76	NA	16.89	090
31805		A	Repair of windpipe injury	13.13	NA	12.12	1.41	NA	26.66	090
31820		A	Closure of windpipe lesion	4.49	5.74	6.36	0.46	10.69	11.31	090
31825		A	Repair of windpipe defect	6.81	7.91	8.99	0.58	15.30	16.38	090
31830		A	Revise windpipe scar	4.50	5.74	6.40	0.42	10.66	11.32	090
32000		A	Drainage of chest	1.54	2.62	0.66	0.08	4.24	2.28	000
32002		A	Treatment of collapsed lung	2.19	NA	0.92	0.22	NA	3.33	000
32005		A	Treat lung lining chemically	2.19	NA	0.96	0.15	NA	3.30	000
32020		A	Insertion of chest tube	3.98	NA	1.61	0.43	NA	6.02	000
32035		A	Exploration of chest	8.67	NA	8.41	1.25	NA	18.33	090
32036		A	Exploration of chest	9.68	NA	8.84	1.32	NA	19.84	090
32095		A	Biopsy through chest wall	8.36	NA	8.11	1.45	NA	17.92	090
32100		A	Exploration/biopsy of chest	11.84	NA	9.52	2.10	NA	23.46	090
32110		A	Explore/repair chest	13.62	NA	11.93	2.01	NA	27.56	090
32120		A	Re-exploration of chest	11.54	NA	9.94	1.72	NA	23.20	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
32124		A	Explore chest, free adhesions	12.72	NA	10.22	2.21	NA	25.15	090
32140		A	Removal of lung lesion(s)	13.93	NA	10.82	2.42	NA	27.17	090
32141		A	Remove/treat lung lesions	14.00	NA	12.36	2.53	NA	28.89	090
32150		A	Removal of lung lesion(s)	14.15	NA	10.82	2.01	NA	26.98	090
32151		A	Remove lung foreign body	14.21	NA	10.55	1.37	NA	26.13	090
32160		A	Open chest heart massage	9.30	NA	8.36	1.52	NA	19.18	090
32200		A	Open drainage, lung lesion	15.29	NA	13.85	0.93	NA	30.07	090
32201		A	Percut drainage, lung lesion	4.00	NA	9.66	0.35	NA	14.01	000
32215		A	Treat chest lining	11.33	NA	8.92	1.28	NA	21.53	090
32220		A	Release of lung	19.27	NA	14.67	3.01	NA	36.95	090
32225		A	Partial release of lung	13.96	NA	12.42	2.28	NA	28.66	090
32310		A	Removal of chest lining	13.44	NA	12.07	2.10	NA	27.61	090
32320		A	Free/remove chest lining	20.54	NA	14.84	3.40	NA	38.78	090
32400		A	Needle biopsy chest lining	1.76	1.32	0.98	0.12	3.20	2.86	000
32402		A	Open biopsy chest lining	7.56	NA	6.91	1.34	NA	15.81	090
32405		A	Biopsy, lung or mediastinum	1.93	1.49	1.24	0.18	3.60	3.35	000
32420		A	Puncture/clear lung	2.18	NA	0.92	0.13	NA	3.23	000
32440		A	Removal of lung	21.02	NA	14.46	3.55	NA	39.03	090
32442		A	Sleeve pneumonectomy	26.24	NA	17.50	3.50	NA	47.24	090
32445		A	Removal of lung	25.09	NA	17.24	3.88	NA	46.21	090
32480		A	Partial removal of lung	18.32	NA	11.23	3.23	NA	32.78	090
32482		A	Bilobectomy	19.71	NA	12.90	3.23	NA	35.84	090
32484		A	Segmentectomy	20.69	NA	13.37	3.23	NA	37.29	090
32486		A	Sleeve lobectomy	23.92	NA	16.28	3.23	NA	43.43	090
32488		A	Completion pneumonectomy	25.71	NA	16.85	3.46	NA	46.02	090
32491		R	Lung volume reduction	21.25	NA	45.14	3.02	NA	69.41	090
32500		A	Partial removal of lung	14.30	NA	10.60	2.56	NA	27.46	090
32501		A	Repair bronchus (add-on)	4.69	NA	1.92	0.70	NA	7.31	ZZZ
32520		A	Remove lung & revise chest	21.68	NA	14.48	3.93	NA	40.09	090
32522		A	Remove lung & revise chest	24.20	NA	16.71	4.19	NA	45.10	090
32525		A	Remove lung & revise chest	26.50	NA	17.36	4.61	NA	48.47	090
32540		A	Removal of lung lesion	14.64	NA	12.62	2.05	NA	29.31	090
32601		A	Thoracoscopy, diagnostic	5.46	NA	4.37	0.57	NA	10.40	000
32602		A	Thoracoscopy, diagnostic	5.96	NA	4.59	0.64	NA	11.19	000
32603		A	Thoracoscopy, diagnostic	7.81	NA	5.71	0.57	NA	14.09	000
32604		A	Thoracoscopy, diagnostic	8.78	NA	5.85	0.64	NA	15.27	000
32605		A	Thoracoscopy, diagnostic	6.93	NA	4.86	0.57	NA	12.36	000
32606		A	Thoracoscopy, diagnostic	8.40	NA	5.59	0.64	NA	14.63	000
32650		A	Thoracoscopy, surgical	10.75	NA	9.05	1.28	NA	21.08	090
32651		A	Thoracoscopy, surgical	12.91	NA	10.09	2.28	NA	25.28	090
32652		A	Thoracoscopy, surgical	18.66	NA	13.47	3.01	NA	35.14	090
32653		A	Thoracoscopy, surgical	12.87	NA	11.02	2.01	NA	25.90	090
32654		A	Thoracoscopy, surgical	12.44	NA	11.35	2.01	NA	25.80	090
32655		A	Thoracoscopy, surgical	13.10	NA	11.32	2.53	NA	26.95	090
32656		A	Thoracoscopy, surgical	12.91	NA	9.83	2.36	NA	25.10	090
32657		A	Thoracoscopy, surgical	13.65	NA	10.22	2.56	NA	26.43	090
32658		A	Thoracoscopy, surgical	11.63	NA	9.63	2.52	NA	23.78	090
32659		A	Thoracoscopy, surgical	11.59	NA	9.64	2.61	NA	23.84	090
32660		A	Thoracoscopy, surgical	17.43	NA	12.53	3.56	NA	33.52	090
32661		A	Thoracoscopy, surgical	13.25	NA	9.98	1.47	NA	24.70	090
32662		A	Thoracoscopy, surgical	16.44	NA	10.82	2.74	NA	30.00	090
32663		A	Thoracoscopy, surgical	18.47	NA	12.95	3.23	NA	34.65	090
32664		A	Thoracoscopy, surgical	14.20	NA	9.81	2.04	NA	26.05	090
32665		A	Thoracoscopy, surgical	15.54	NA	10.92	2.64	NA	29.10	090
32800		A	Repair lung hernia	13.69	NA	9.95	1.58	NA	25.22	090
32810		A	Close chest after drainage	13.05	NA	10.62	1.19	NA	24.86	090
32815		A	Close bronchial fistula	23.15	NA	16.10	2.62	NA	41.87	090
32820		A	Reconstruct injured chest	21.48	NA	16.63	3.24	NA	41.35	090
32851		A	Lung transplant, single	38.63	NA	21.92	4.99	NA	65.54	090
32852		A	Lung transplant w/bypass	41.80	NA	24.20	5.41	NA	71.41	090
32853		A	Lung transplant, double	47.81	NA	27.72	6.24	NA	81.77	090
32854		A	Lung transplant w/bypass	50.98	NA	29.31	6.67	NA	86.96	090
32900		A	Removal of rib(s)	20.27	NA	13.27	1.63	NA	35.17	090
32905		A	Revise & repair chest wall	20.75	NA	13.80	2.60	NA	37.15	090
32906		A	Revise & repair chest wall	26.77	NA	18.37	2.92	NA	48.06	090
32940		A	Revision of lung	19.43	NA	12.97	1.75	NA	34.15	090
32960		A	Therapeutic pneumothorax	1.84	1.70	0.53	0.13	3.67	2.50	000
33010		A	Drainage of heart sac	2.24	NA	0.95	0.14	NA	3.33	000
33011		A	Repeat drainage of heart sac	2.24	NA	1.18	0.12	NA	3.54	000
33015		A	Incision of heart sac	6.80	NA	4.01	0.62	NA	11.43	090
33020		A	Incision of heart sac	12.61	NA	7.40	2.52	NA	22.53	090
33025		A	Incision of heart sac	12.09	NA	6.97	2.61	NA	21.67	090
33030		A	Partial removal of heart sac	18.71	NA	14.40	3.92	NA	37.03	090
33031		A	Partial removal of heart sac	21.79	NA	18.63	2.50	NA	42.92	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
33050		A	Removal of heart sac lesion	14.36	NA	10.51	1.47	NA	26.34	090
33120		A	Removal of heart lesion	24.56	NA	21.61	5.17	NA	51.34	090
33130		A	Removal of heart lesion	21.39	NA	14.67	2.22	NA	38.28	090
33200		A	Insertion of heart pacemaker	12.48	NA	9.41	1.90	NA	23.79	090
33201		A	Insertion of heart pacemaker	10.18	NA	7.50	1.67	NA	19.35	090
33206		A	Insertion of heart pacemaker	6.67	NA	5.04	1.34	NA	13.05	090
33207		A	Insertion of heart pacemaker	8.04	NA	5.67	1.33	NA	15.04	090
33208		A	Insertion of heart pacemaker	8.13	NA	5.92	1.54	NA	15.59	090
33210		A	Insertion of heart electrode	3.30	NA	1.64	0.27	NA	5.21	000
33211		A	Insertion of heart electrode	3.40	NA	1.80	0.27	NA	5.47	000
33212		A	Insertion of pulse generator	5.52	NA	4.00	0.88	NA	10.40	090
33213		A	Insertion of pulse generator	6.37	NA	4.52	0.88	NA	11.77	090
33214		A	Upgrade of pacemaker system	7.75	NA	5.62	1.06	NA	14.43	090
33216		A	Revision implanted electrode	5.39	NA	4.31	0.55	NA	10.25	090
33217		A	Insert/revise electrode	5.75	NA	4.80	0.55	NA	11.10	090
33218		A	Repair pacemaker electrodes	5.44	NA	4.09	0.62	NA	10.15	090
33220		A	Repair pacemaker electrode	5.52	NA	4.33	0.62	NA	10.47	090
33222		A	Pacemaker aicd pocket	4.96	NA	3.78	1.01	NA	9.75	090
33223		A	Pacemaker aicd pocket	6.46	NA	5.03	1.01	NA	12.50	090
33233		A	Removal of pacemaker system	3.29	NA	3.15	0.05	NA	6.49	090
33234		A	Removal of pacemaker system	7.82	NA	5.18	0.23	NA	13.23	090
33235		A	Removal pacemaker electrode	9.40	NA	5.96	0.33	NA	15.69	090
33236		A	Remove electrode/thoracotomy	12.60	NA	9.10	0.62	NA	22.32	090
33237		A	Remove electrode/thoracotomy	13.71	NA	9.86	1.13	NA	24.70	090
33238		A	Remove electrode/thoracotomy	15.22	NA	9.93	2.01	NA	27.16	090
33240		A	Insert/replace pulse gener	7.60	NA	5.48	0.88	NA	13.96	090
33241		A	Remove pulse generator only	3.24	NA	3.27	0.43	NA	6.94	090
33242		A	Repair pulse generator/leads	6.17	NA	5.28	1.54	NA	12.99	090
33243		A	Remove generator/thoracotomy	22.64	NA	12.43	1.54	NA	36.61	090
33244		A	Remove generator	8.97	NA	5.88	1.54	NA	16.39	090
33245		A	Implant heart defibrillator	14.30	NA	10.81	2.36	NA	27.47	090
33246		A	Implant heart defibrillator	20.71	NA	13.35	3.19	NA	37.25	090
33247		A	Insert/replace leads	10.21	NA	6.52	2.36	NA	19.09	090
33249		A	Insert/replace leads/gener	13.28	NA	8.88	3.19	NA	25.35	090
33250		A	Ablate heart dysrhythm focus	21.85	NA	21.85	0.86	NA	44.56	090
33251		A	Ablate heart dysrhythm focus	24.88	NA	19.99	3.21	NA	48.08	090
33253		A	Reconstruct atria	31.06	NA	22.52	4.26	NA	57.84	090
33261		A	Ablate heart dysrhythm focus	24.88	NA	20.05	2.73	NA	47.66	090
33300		A	Repair of heart wound	17.92	NA	13.72	2.60	NA	34.24	090
33305		A	Repair of heart wound	21.44	NA	18.22	3.07	NA	42.73	090
33310		A	Exploratory heart surgery	18.51	NA	13.81	1.93	NA	34.25	090
33315		A	Exploratory heart surgery	22.37	NA	18.11	2.57	NA	43.05	090
33320		A	Repair major blood vessel(s)	16.79	NA	13.37	2.51	NA	32.67	090
33321		A	Repair major vessel	20.20	NA	14.89	3.61	NA	38.70	090
33322		A	Repair major blood vessel(s)	20.62	NA	17.45	3.61	NA	41.68	090
33330		A	Insert major vessel graft	21.43	NA	16.43	1.93	NA	39.79	090
33332		A	Insert major vessel graft	23.96	NA	16.43	2.39	NA	42.78	090
33335		A	Insert major vessel graft	30.01	NA	22.99	2.39	NA	55.39	090
33400		A	Repair of aortic valve	25.34	NA	19.64	2.83	NA	47.81	090
33401		A	Valvuloplasty, open	23.91	NA	16.16	2.83	NA	42.90	090
33403		A	Valvuloplasty, w/cp bypass	24.89	NA	19.19	2.83	NA	46.91	090
33404		A	Prepare heart-aorta conduit	28.54	NA	21.32	5.59	NA	55.45	090
33405		A	Replacement of aortic valve	30.61	NA	22.26	5.33	NA	58.20	090
33406		A	Replacement, aortic valve	32.30	NA	23.15	7.45	NA	62.90	090
33411		A	Replacement of aortic valve	32.47	NA	23.68	7.45	NA	63.60	090
33412		A	Replacement of aortic valve	34.79	NA	26.42	7.45	NA	68.66	090
33413		A	Replacement, aortic valve	35.24	NA	26.89	7.23	NA	69.36	090
33414		A	Repair, aortic valve	30.35	NA	23.29	7.45	NA	61.09	090
33415		A	Revision, subvalvular tissue	27.15	NA	19.43	5.33	NA	51.91	090
33416		A	Revise ventricle muscle	30.35	NA	22.06	4.99	NA	57.40	090
33417		A	Repair of aortic valve	28.53	NA	20.93	6.18	NA	55.64	090
33420		A	Revision of mitral valve	22.70	NA	14.14	2.45	NA	39.29	090
33422		A	Revision of mitral valve	25.94	NA	19.49	6.45	NA	51.88	090
33425		A	Repair of mitral valve	27.00	NA	20.19	5.42	NA	52.61	090
33426		A	Repair of mitral valve	31.03	NA	22.99	5.80	NA	59.82	090
33427		A	Repair of mitral valve	33.72	NA	25.61	6.30	NA	65.63	090
33430		A	Replacement of mitral valve	31.43	NA	23.99	6.11	NA	61.53	090
33460		A	Revision of tricuspid valve	23.60	NA	18.79	4.73	NA	47.12	090
33463		A	Valvuloplasty, tricuspid	25.62	NA	19.35	5.95	NA	50.92	090
33464		A	Valvuloplasty, tricuspid	27.33	NA	20.43	5.95	NA	53.71	090
33465		A	Replace tricuspid valve	28.79	NA	21.25	5.95	NA	55.99	090
33468		A	Revision of tricuspid valve	30.12	NA	22.60	6.30	NA	59.02	090
33470		A	Revision of pulmonary valve	20.81	NA	21.86	2.45	NA	45.12	090
33471		A	Valvotomy, pulmonary valve	22.25	NA	16.00	2.83	NA	41.08	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
33472		A	Revision of pulmonary valve	22.25	NA	43.06	2.83	NA	68.14	090
33474		A	Revision of pulmonary valve	23.04	NA	17.82	2.83	NA	43.69	090
33475		A	Replacement, pulmonary valve	28.41	NA	21.61	6.11	NA	56.13	090
33476		A	Revision of heart chamber	25.77	NA	20.87	4.99	NA	51.63	090
33478		A	Revision of heart chamber	26.74	NA	19.25	5.42	NA	51.41	090
33496		A	Repair, prosth valve clot	27.25	NA	20.82	5.33	NA	53.40	090
33500		A	Repair heart vessel fistula	25.55	NA	17.29	5.20	NA	48.04	090
33501		A	Repair heart vessel fistula	17.78	NA	12.14	2.51	NA	32.43	090
33502		A	Coronary artery correction	21.04	NA	15.92	2.51	NA	39.47	090
33503		A	Coronary artery graft	21.78	NA	15.61	5.20	NA	42.59	090
33504		A	Coronary artery graft	24.66	NA	21.49	5.20	NA	51.35	090
33505		A	Repair artery w/tunnel	26.84	NA	21.99	6.03	NA	54.86	090
33506		A	Repair artery, translocation	26.71	NA	27.49	6.03	NA	60.23	090
33510		A	CABG, vein, single	25.12	NA	19.13	5.20	NA	49.45	090
33511		A	CABG, vein, two	27.40	NA	20.51	5.71	NA	53.62	090
33512		A	CABG, vein, three	29.67	NA	22.07	6.22	NA	57.96	090
33513		A	CABG, vein, four	31.95	NA	23.50	6.73	NA	62.18	090
33514		A	CABG, vein, five	35.00	NA	25.94	7.23	NA	68.17	090
33516		A	CABG, vein, six+	37.40	NA	27.00	7.74	NA	72.14	090
33517		A	CABG, artery-vein, single	2.57	NA	1.89	0.50	NA	4.96	090
33518		A	CABG, artery-vein, two	4.85	NA	3.38	1.02	NA	9.25	090
33519		A	CABG, artery-vein, three	7.12	NA	4.86	1.52	NA	13.50	090
33521		A	CABG, artery-vein, four	9.40	NA	6.34	2.03	NA	17.77	090
33522		A	CABG, artery-vein, five	11.67	NA	7.81	2.54	NA	22.02	090
33523		A	CABG, artery-vein, six+	13.95	NA	9.30	3.05	NA	26.30	090
33530		A	Coronary artery, bypass/reop	5.86	NA	12.93	2.18	NA	20.97	ZZZ
33533		A	CABG, arterial, single	25.83	NA	19.68	5.36	NA	50.87	090
33534		A	CABG, arterial, two	28.82	NA	21.60	6.03	NA	56.45	090
33535		A	CABG, arterial, three	31.81	NA	21.94	6.70	NA	60.45	090
33536		A	CABG, arterial, four+	34.79	NA	25.27	7.37	NA	67.43	090
33542		A	Removal of heart lesion	28.85	NA	23.04	5.53	NA	57.42	090
33545		A	Repair of heart damage	36.78	NA	28.76	6.28	NA	71.82	090
33572		A	Open coronary endarterectomy	4.45	NA	2.18	0.63	NA	7.26	ZZZ
33600		A	Closure of valve	29.51	NA	23.71	6.11	NA	59.33	090
33602		A	Closure of valve	28.54	NA	20.46	5.33	NA	54.33	090
33606		A	Anastomosis/artery-aorta	30.74	NA	26.86	7.45	NA	65.05	090
33608		A	Repair anomaly w/conduit	31.09	NA	22.38	7.45	NA	60.92	090
33610		A	Repair by enlargement	30.61	NA	24.18	7.45	NA	62.24	090
33611		A	Repair double ventricle	32.30	NA	22.97	7.45	NA	62.72	090
33612		A	Repair double ventricle	33.26	NA	25.25	7.45	NA	65.96	090
33615		A	Repair (simple fontan)	32.06	NA	23.68	7.45	NA	63.19	090
33617		A	Repair by modified fontan	34.03	NA	24.49	7.45	NA	65.97	090
33619		A	Repair single ventricle	37.57	NA	31.02	8.04	NA	76.63	090
33641		A	Repair heart septum defect	21.39	NA	16.49	4.87	NA	42.75	090
33645		A	Revision of heart veins	24.82	NA	17.60	4.87	NA	47.29	090
33647		A	Repair heart septum defects	28.73	NA	20.98	6.28	NA	55.99	090
33660		A	Repair of heart defects	25.54	NA	18.72	5.42	NA	49.68	090
33665		A	Repair of heart defects	28.60	NA	19.06	5.42	NA	53.08	090
33670		A	Repair of heart chambers	32.73	NA	20.41	7.45	NA	60.59	090
33681		A	Repair heart septum defect	27.67	NA	20.17	6.28	NA	54.12	090
33684		A	Repair heart septum defect	29.65	NA	23.79	6.28	NA	59.72	090
33688		A	Repair heart septum defect	30.62	NA	63.16	6.28	NA	100.06	090
33690		A	Reinforce pulmonary artery	19.55	NA	16.44	4.29	NA	40.28	090
33692		A	Repair of heart defects	30.75	NA	21.13	7.45	NA	59.33	090
33694		A	Repair of heart defects	31.73	NA	21.61	7.45	NA	60.79	090
33697		A	Repair of heart defects	33.71	NA	22.46	7.45	NA	63.62	090
33702		A	Repair of heart defects	26.54	NA	20.22	5.33	NA	52.09	090
33710		A	Repair of heart defects	29.71	NA	21.83	6.28	NA	57.82	090
33720		A	Repair of heart defect	26.56	NA	19.32	5.33	NA	51.21	090
33722		A	Repair of heart defect	28.41	NA	21.06	5.33	NA	54.80	090
33730		A	Repair heart-vein defect(s)	31.67	NA	22.08	7.45	NA	61.20	090
33732		A	Repair heart-vein defect	28.16	NA	23.01	5.42	NA	56.59	090
33735		A	Revision of heart chamber	21.39	NA	12.93	4.87	NA	39.19	090
33736		A	Revision of heart chamber	23.52	NA	19.80	4.87	NA	48.19	090
33737		A	Revision of heart chamber	21.76	NA	42.57	4.87	NA	69.20	090
33750		A	Major vessel shunt	21.41	NA	14.24	4.29	NA	39.94	090
33755		A	Major vessel shunt	21.79	NA	13.68	4.29	NA	39.76	090
33762		A	Major vessel shunt	21.79	NA	41.95	4.29	NA	68.03	090
33764		A	Major vessel shunt & graft	21.79	NA	16.45	4.29	NA	42.53	090
33766		A	Major vessel shunt	22.76	NA	15.04	4.29	NA	42.09	090
33767		A	Atrial septectomy/septostomy	24.50	NA	19.22	4.87	NA	48.59	090
33770		A	Repair great vessels defect	33.29	NA	24.12	7.45	NA	64.86	090
33771		A	Repair great vessels defect	34.65	NA	22.66	7.45	NA	64.76	090
33774		A	Repair great vessels defect	30.98	NA	22.61	5.42	NA	59.01	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
33775		A	Repair great vessels defect	32.20	NA	66.64	5.42	NA	104.26	090
33776		A	Repair great vessels defect	34.04	NA	69.46	6.28	NA	109.78	090
33777		A	Repair great vessels defect	33.46	NA	68.87	5.42	NA	107.75	090
33778		A	Repair great vessels defect	35.82	NA	26.25	7.37	NA	69.44	090
33779		A	Repair great vessels defect	36.21	NA	74.50	7.37	NA	118.08	090
33780		A	Repair great vessels defect	36.94	NA	21.44	7.37	NA	65.75	090
33781		A	Repair great vessels defect	36.45	NA	74.00	7.37	NA	117.82	090
33786		A	Repair arterial trunk	34.84	NA	25.43	7.45	NA	67.72	090
33788		A	Revision of pulmonary artery	26.62	NA	19.74	5.20	NA	51.56	090
33800		A	Aortic suspension	16.24	NA	12.22	2.51	NA	30.97	090
33802		A	Repair vessel defect	17.66	NA	12.54	4.29	NA	34.49	090
33803		A	Repair vessel defect	19.60	NA	13.73	4.29	NA	37.62	090
33813		A	Repair septal defect	20.65	NA	14.15	4.29	NA	39.09	090
33814		A	Repair septal defect	25.77	NA	20.07	5.33	NA	51.17	090
33820		A	Revise major vessel	16.29	NA	10.40	4.29	NA	30.98	090
33822		A	Revise major vessel	17.32	NA	11.47	4.29	NA	33.08	090
33824		A	Revise major vessel	19.52	NA	14.73	4.29	NA	38.54	090
33840		A	Remove aorta constriction	20.63	NA	14.20	5.59	NA	40.42	090
33845		A	Remove aorta constriction	22.12	NA	15.14	5.59	NA	42.85	090
33851		A	Remove aorta constriction	21.27	NA	38.59	5.59	NA	65.45	090
33852		A	Repair septal defect	23.71	NA	15.49	5.59	NA	44.79	090
33853		A	Repair septal defect	31.72	NA	22.13	7.45	NA	61.30	090
33860		A	Ascending aorta graft	33.96	NA	24.68	6.18	NA	64.82	090
33861		A	Ascending aorta graft	34.52	NA	25.56	6.18	NA	66.26	090
33863		A	Ascending aorta graft	36.47	NA	26.75	6.18	NA	69.40	090
33870		A	Transverse aortic arch graft	40.31	NA	28.86	8.04	NA	77.21	090
33875		A	Thoracic aorta graft	33.06	NA	24.29	5.59	NA	62.94	090
33877		A	Thoracoabdominal graft	42.60	NA	33.86	8.38	NA	84.84	090
33910		A	Remove lung artery emboli	24.59	NA	19.32	2.77	NA	46.68	090
33915		A	Remove lung artery emboli	21.02	NA	14.95	2.22	NA	38.19	090
33916		A	Surgery of great vessel	25.83	NA	21.82	3.43	NA	51.08	090
33917		A	Repair pulmonary artery	24.50	NA	18.33	6.30	NA	49.13	090
33918		A	Repair pulmonary atresia	26.45	NA	47.27	5.20	NA	78.92	090
33919		A	Repair pulmonary atresia	32.67	NA	70.82	7.45	NA	110.94	090
33920		A	Repair pulmonary atresia	31.95	NA	67.30	7.45	NA	106.70	090
33922		A	Transect pulmonary artery	23.52	NA	18.86	2.83	NA	45.21	090
33924		A	Remove pulmonary shunt	5.50	NA	6.42	0.78	NA	12.70	ZZZ
33935		R	Transplantation, heart/lung	60.96	NA	33.17	13.54	NA	107.67	090
33945		R	Transplantation of heart	42.10	NA	23.73	11.05	NA	76.88	090
33960		A	External circulation assist	19.36	NA	10.19	0.94	NA	30.49	XXX
33961		A	External circulation assist	10.93	NA	9.18	0.94	NA	21.05	XXX
33970		A	Aortic circulation assist	6.75	NA	6.02	1.00	NA	13.77	000
33971		A	Aortic circulation assist	9.69	NA	9.35	0.91	NA	19.95	090
33973		A	Insert balloon device	9.76	NA	4.53	1.00	NA	15.29	000
33974		A	Remove intra-aortic balloon	14.41	NA	12.17	0.91	NA	27.49	090
33975		A	Implant ventricular device	21.60	NA	27.04	2.77	NA	51.41	090
33976		A	Implant ventricular device	29.10	NA	30.12	3.78	NA	63.00	090
33977		A	Remove ventricular device	19.29	NA	15.19	2.43	NA	36.91	090
33978		A	Remove ventricular device	21.73	NA	15.83	2.77	NA	40.33	090
34001		A	Removal of artery clot	12.91	NA	6.63	1.87	NA	21.41	090
34051		A	Removal of artery clot	15.21	NA	8.32	1.59	NA	25.12	090
34101		A	Removal of artery clot	9.97	NA	5.11	1.71	NA	16.79	090
34111		A	Removal of arm artery clot	8.07	NA	4.24	1.59	NA	13.90	090
34151		A	Removal of artery clot	16.86	NA	8.78	2.39	NA	28.03	090
34201		A	Removal of artery clot	9.13	NA	5.06	1.78	NA	15.97	090
34203		A	Removal of leg artery clot	12.21	NA	6.50	1.72	NA	20.43	090
34401		A	Removal of vein clot	12.86	NA	6.97	1.39	NA	21.22	090
34421		A	Removal of vein clot	9.93	NA	5.53	1.51	NA	16.97	090
34451		A	Removal of vein clot	14.44	NA	7.56	2.14	NA	24.14	090
34471		A	Removal of vein clot	10.18	NA	5.99	0.55	NA	16.72	090
34490		A	Removal of vein clot	7.60	NA	4.44	1.54	NA	13.58	090
34501		A	Repair valve, femoral vein	10.93	NA	6.64	0.86	NA	18.43	090
34502		A	Reconstruct, vena cava	26.95	NA	13.27	3.64	NA	43.86	090
34510		A	Transposition of vein valve	13.25	NA	7.27	1.04	NA	21.56	090
34520		A	Cross-over vein graft	13.74	NA	7.82	1.09	NA	22.65	090
34530		A	Leg vein fusion	17.61	NA	8.53	1.44	NA	27.58	090
35001		A	Repair defect of artery	19.64	NA	9.74	3.18	NA	32.56	090
35002		A	Repair artery rupture, neck	21.00	NA	10.45	2.41	NA	33.86	090
35005		A	Repair defect of artery	18.12	NA	8.37	2.19	NA	28.68	090
35011		A	Repair defect of artery	11.65	NA	6.04	2.76	NA	20.45	090
35013		A	Repair artery rupture, arm	17.40	NA	8.36	3.03	NA	28.79	090
35021		A	Repair defect of artery	19.65	NA	10.62	3.06	NA	33.33	090
35022		A	Repair artery rupture, chest	23.18	NA	11.79	2.80	NA	37.77	090
35045		A	Repair defect of arm artery	11.26	NA	6.20	2.50	NA	19.96	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
35081		A	Repair defect of artery	28.01	NA	13.63	4.18	NA	45.82	090
35082		A	Repair artery rupture, aorta	36.35	NA	16.98	4.59	NA	57.92	090
35091		A	Repair defect of artery	35.40	NA	17.11	4.25	NA	56.76	090
35092		A	Repair artery rupture, aorta	38.39	NA	18.51	5.21	NA	62.11	090
35102		A	Repair defect of artery	30.76	NA	14.86	4.32	NA	49.94	090
35103		A	Repair artery rupture, groin	33.57	NA	16.03	5.21	NA	54.81	090
35111		A	Repair defect of artery	16.43	NA	8.76	3.70	NA	28.89	090
35112		A	Repair artery rupture, spleen	18.69	NA	9.51	2.22	NA	30.42	090
35121		A	Repair defect of artery	25.99	NA	13.06	3.66	NA	42.71	090
35122		A	Repair artery rupture, belly	33.45	NA	16.16	3.96	NA	53.57	090
35131		A	Repair defect of artery	18.55	NA	10.00	3.15	NA	31.70	090
35132		A	Repair artery rupture, groin	21.95	NA	11.46	3.58	NA	36.99	090
35141		A	Repair defect of artery	14.46	NA	7.74	2.88	NA	25.08	090
35142		A	Repair artery rupture, thigh	15.86	NA	8.30	3.24	NA	27.40	090
35151		A	Repair defect of artery	17.00	NA	9.27	2.94	NA	29.21	090
35152		A	Repair artery rupture, knee	16.70	NA	9.28	1.95	NA	27.93	090
35161		A	Repair defect of artery	18.76	NA	10.07	3.15	NA	31.98	090
35162		A	Repair artery rupture	19.78	NA	10.70	3.58	NA	34.06	090
35180		A	Repair blood vessel lesion	13.62	NA	6.71	1.48	NA	21.81	090
35182		A	Repair blood vessel lesion	17.74	NA	8.29	1.61	NA	27.64	090
35184		A	Repair blood vessel lesion	12.25	NA	6.82	1.96	NA	21.03	090
35188		A	Repair blood vessel lesion	14.28	NA	7.97	1.59	NA	23.84	090
35189		A	Repair blood vessel lesion	18.43	NA	9.60	2.21	NA	30.24	090
35190		A	Repair blood vessel lesion	12.75	NA	6.87	2.14	NA	21.76	090
35201		A	Repair blood vessel lesion	9.99	NA	5.50	1.94	NA	17.43	090
35206		A	Repair blood vessel lesion	9.25	NA	5.52	2.03	NA	16.80	090
35207		A	Repair blood vessel lesion	10.15	NA	8.47	1.93	NA	20.55	090
35211		A	Repair blood vessel lesion	22.12	NA	18.02	2.59	NA	42.73	090
35216		A	Repair blood vessel lesion	18.75	NA	17.42	2.08	NA	38.25	090
35221		A	Repair blood vessel lesion	16.42	NA	8.49	2.20	NA	27.11	090
35226		A	Repair blood vessel lesion	9.06	NA	5.51	1.95	NA	16.52	090
35231		A	Repair blood vessel lesion	12.00	NA	6.96	2.91	NA	21.87	090
35236		A	Repair blood vessel lesion	10.54	NA	6.24	2.56	NA	19.34	090
35241		A	Repair blood vessel lesion	23.12	NA	20.47	2.60	NA	46.19	090
35246		A	Repair blood vessel lesion	19.84	NA	19.39	2.15	NA	41.38	090
35251		A	Repair blood vessel lesion	17.49	NA	9.04	1.88	NA	28.41	090
35256		A	Repair blood vessel lesion	11.38	NA	6.68	2.39	NA	20.45	090
35261		A	Repair blood vessel lesion	11.63	NA	6.10	2.66	NA	20.39	090
35266		A	Repair blood vessel lesion	10.30	NA	5.93	2.41	NA	18.64	090
35271		A	Repair blood vessel lesion	22.12	NA	20.24	2.56	NA	44.92	090
35276		A	Repair blood vessel lesion	18.75	NA	17.51	2.26	NA	38.52	090
35281		A	Repair blood vessel lesion	16.48	NA	8.93	3.37	NA	28.78	090
35286		A	Repair blood vessel lesion	11.87	NA	6.88	2.33	NA	21.08	090
35301		A	Rechanneling of artery	18.70	NA	9.57	2.81	NA	31.08	090
35311		A	Rechanneling of artery	23.85	NA	12.29	4.61	NA	40.75	090
35321		A	Rechanneling of artery	11.97	NA	5.89	2.69	NA	20.55	090
35331		A	Rechanneling of artery	23.52	NA	11.84	2.66	NA	38.02	090
35341		A	Rechanneling of artery	25.11	NA	12.97	3.53	NA	41.61	090
35351		A	Rechanneling of artery	20.11	NA	10.51	2.97	NA	33.59	090
35355		A	Rechanneling of artery	16.09	NA	8.95	2.99	NA	28.03	090
35361		A	Rechanneling of artery	23.59	NA	11.90	3.88	NA	39.37	090
35363		A	Rechanneling of artery	24.66	NA	12.69	4.40	NA	41.75	090
35371		A	Rechanneling of artery	11.64	NA	6.48	2.50	NA	20.62	090
35372		A	Rechanneling of artery	13.56	NA	7.08	2.28	NA	22.92	090
35381		A	Rechanneling of artery	15.81	NA	8.02	2.71	NA	26.54	090
35390		A	Reoperation, carotid	3.19	NA	1.47	0.39	NA	5.05	ZZZ
35400		A	Angioscopy	3.00	NA	1.39	0.27	NA	4.66	ZZZ
35450		A	Repair arterial blockage	10.07	NA	5.11	1.38	NA	16.56	000
35452		A	Repair arterial blockage	6.91	NA	3.96	0.61	NA	11.48	000
35454		A	Repair arterial blockage	6.04	NA	3.32	1.53	NA	10.89	000
35456		A	Repair arterial blockage	7.35	NA	3.90	1.69	NA	12.94	000
35458		A	Repair arterial blockage	9.49	NA	4.81	1.83	NA	16.13	000
35459		A	Repair arterial blockage	8.63	NA	4.38	1.69	NA	14.70	000
35460		A	Repair venous blockage	6.04	NA	3.09	0.74	NA	9.87	000
35470		A	Repair arterial blockage	8.63	NA	4.92	1.69	NA	15.24	000
35471		A	Repair arterial blockage	10.07	NA	5.54	1.38	NA	16.99	000
35472		A	Repair arterial blockage	6.91	NA	4.11	0.85	NA	11.87	000
35473		A	Repair arterial blockage	6.04	NA	3.76	1.53	NA	11.33	000
35474		A	Repair arterial blockage	7.36	NA	4.17	1.69	NA	13.22	000
35475		R	Repair arterial blockage	9.49	NA	4.98	1.83	NA	16.30	000
35476		A	Repair venous blockage	6.04	NA	3.62	0.74	NA	10.40	000
35480		A	Atherectomy, open	11.08	NA	5.46	1.38	NA	17.92	000
35481		A	Atherectomy, open	7.61	NA	4.07	0.61	NA	12.29	000
35482		A	Atherectomy, open	6.65	NA	3.63	1.53	NA	11.81	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
35483		A	Atherectomy, open	8.10	NA	4.29	1.69	NA	14.08	000
35484		A	Atherectomy, open	10.44	NA	5.02	1.83	NA	17.29	000
35485		A	Atherectomy, open	9.49	NA	5.02	1.06	NA	15.57	000
35490		A	Atherectomy, percutaneous	11.08	NA	6.00	1.38	NA	18.46	000
35491		A	Atherectomy, percutaneous	7.61	NA	3.71	0.61	NA	11.93	000
35492		A	Atherectomy, percutaneous	6.65	NA	4.06	1.53	NA	12.24	000
35493		A	Atherectomy, percutaneous	8.10	NA	4.99	1.69	NA	14.78	000
35494		A	Atherectomy, percutaneous	10.44	NA	5.22	1.83	NA	17.49	000
35495		A	Atherectomy, percutaneous	9.49	NA	5.63	1.06	NA	16.18	000
35501		A	Artery bypass graft	19.19	NA	9.34	3.49	NA	32.02	090
35506		A	Artery bypass graft	19.67	NA	9.60	3.64	NA	32.91	090
35507		A	Artery bypass graft	19.67	NA	9.58	3.61	NA	32.86	090
35508		A	Artery bypass graft	18.65	NA	9.64	3.43	NA	31.72	090
35509		A	Artery bypass graft	18.07	NA	9.12	3.92	NA	31.11	090
35511		A	Artery bypass graft	16.83	NA	8.53	1.92	NA	27.28	090
35515		A	Artery bypass graft	18.65	NA	9.09	2.01	NA	29.75	090
35516		A	Artery bypass graft	16.32	NA	8.02	3.54	NA	27.88	090
35518		A	Artery bypass graft	15.42	NA	7.63	3.38	NA	26.43	090
35521		A	Artery bypass graft	16.17	NA	8.51	3.34	NA	28.02	090
35526		A	Artery bypass graft	20.00	NA	11.12	2.44	NA	33.56	090
35531		A	Artery bypass graft	25.61	NA	12.68	3.90	NA	42.19	090
35533		A	Artery bypass graft	20.52	NA	10.25	4.43	NA	35.20	090
35536		A	Artery bypass graft	23.11	NA	11.63	4.17	NA	38.91	090
35541		A	Artery bypass graft	25.80	NA	13.09	3.65	NA	42.54	090
35546		A	Artery bypass graft	25.54	NA	13.05	4.26	NA	42.85	090
35548		A	Artery bypass graft	21.57	NA	10.45	3.65	NA	35.67	090
35549		A	Artery bypass graft	23.35	NA	11.99	4.26	NA	39.60	090
35551		A	Artery bypass graft	26.67	NA	13.47	3.87	NA	44.01	090
35556		A	Artery bypass graft	21.76	NA	10.85	3.71	NA	36.32	090
35558		A	Artery bypass graft	14.04	NA	7.38	3.23	NA	24.65	090
35560		A	Artery bypass graft	23.56	NA	12.08	3.93	NA	39.57	090
35563		A	Artery bypass graft	15.14	NA	8.31	1.70	NA	25.15	090
35565		A	Artery bypass graft	15.14	NA	8.29	3.51	NA	26.94	090
35566		A	Artery bypass graft	26.92	NA	14.80	4.08	NA	45.80	090
35571		A	Artery bypass graft	18.58	NA	10.80	3.87	NA	33.25	090
35582		A	Vein bypass graft	27.13	NA	13.35	4.89	NA	45.37	090
35583		A	Vein bypass graft	22.37	NA	11.75	4.13	NA	38.25	090
35585		A	Vein bypass graft	28.39	NA	14.81	4.63	NA	47.83	090
35587		A	Vein bypass graft	19.05	NA	11.24	4.13	NA	34.42	090
35601		A	Artery bypass graft	17.50	NA	8.65	3.33	NA	29.48	090
35606		A	Artery bypass graft	18.71	NA	9.06	3.51	NA	31.28	090
35612		A	Artery bypass graft	15.76	NA	8.05	3.30	NA	27.11	090
35616		A	Artery bypass graft	15.70	NA	7.83	3.42	NA	26.95	090
35621		A	Artery bypass graft	14.54	NA	7.60	3.80	NA	25.94	090
35623		A	Bypass graft, not vein	16.62	NA	8.71	1.88	NA	27.21	090
35626		A	Artery bypass graft	23.63	NA	12.27	4.08	NA	39.98	090
35631		A	Artery bypass graft	24.60	NA	12.40	3.57	NA	40.57	090
35636		A	Artery bypass graft	22.46	NA	11.18	2.45	NA	36.09	090
35641		A	Artery bypass graft	24.57	NA	12.51	4.08	NA	41.16	090
35642		A	Artery bypass graft	17.98	NA	8.88	2.20	NA	29.06	090
35645		A	Artery bypass graft	17.47	NA	8.37	2.05	NA	27.89	090
35646		A	Artery bypass graft	25.81	NA	13.02	4.73	NA	43.56	090
35650		A	Artery bypass graft	14.36	NA	7.08	3.56	NA	25.00	090
35651		A	Artery bypass graft	25.04	NA	12.98	4.69	NA	42.71	090
35654		A	Artery bypass graft	18.61	NA	9.57	4.42	NA	32.60	090
35656		A	Artery bypass graft	19.53	NA	9.51	3.60	NA	32.64	090
35661		A	Artery bypass graft	13.18	NA	6.84	3.30	NA	23.32	090
35663		A	Artery bypass graft	14.17	NA	7.96	3.80	NA	25.93	090
35665		A	Artery bypass graft	15.40	NA	8.43	3.57	NA	27.40	090
35666		A	Artery bypass graft	19.19	NA	11.24	4.00	NA	34.43	090
35671		A	Artery bypass graft	14.80	NA	9.14	4.08	NA	28.02	090
35681		A	Artery bypass graft	8.05	NA	4.35	3.52	NA	15.92	ZZZ
35691		A	Arterial transposition	18.05	NA	8.66	3.81	NA	30.52	090
35693		A	Arterial transposition	15.36	NA	7.72	1.91	NA	24.99	090
35694		A	Arterial transposition	19.16	NA	9.16	2.17	NA	30.49	090
35695		A	Arterial transposition	19.16	NA	9.16	2.17	NA	30.49	090
35700		A	Reoperation, bypass graft	3.08	NA	2.49	0.38	NA	5.95	ZZZ
35701		A	Exploration, carotid artery	5.55	NA	3.90	1.25	NA	10.70	090
35721		A	Exploration, femoral artery	5.28	NA	3.58	1.11	NA	9.97	090
35741		A	Exploration popliteal artery	5.37	NA	3.66	1.15	NA	10.18	090
35761		A	Exploration of artery/vein	5.37	NA	3.77	1.14	NA	10.28	090
35800		A	Explore neck vessels	7.02	NA	4.07	0.97	NA	12.06	090
35820		A	Explore chest vessels	12.88	NA	8.88	1.43	NA	23.19	090
35840		A	Explore abdominal vessels	9.77	NA	5.99	1.44	NA	17.20	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
35860		A	Explore limb vessels	5.55	NA	3.64	1.15	NA	10.34	090
35870		A	Repair vessel graft defect	22.17	NA	12.13	2.47	NA	36.77	090
35875		A	Removal of clot in graft	10.01	NA	5.62	1.65	NA	17.28	090
35876		A	Removal of clot in graft	13.67	NA	7.42	1.65	NA	22.74	090
35901		A	Excision, graft, neck	8.19	NA	5.37	1.46	NA	15.02	090
35903		A	Excision, graft, extremity	9.39	NA	7.09	1.46	NA	17.94	090
35905		A	Excision, graft, thorax	18.19	NA	17.16	1.46	NA	36.81	090
35907		A	Excision, graft, abdomen	19.24	NA	11.58	1.46	NA	32.28	090
36000		A	Place needle in vein	0.18	0.31	0.05	0.04	0.53	0.27	XXX
36005		A	Injection, venography	0.95	11.83	0.31	0.04	12.82	1.30	000
36010		A	Place catheter in vein	2.43	NA	1.48	0.31	NA	4.22	XXX
36011		A	Place catheter in vein	3.14	NA	1.82	0.22	NA	5.18	XXX
36012		A	Place catheter in vein	3.52	NA	2.28	0.32	NA	6.12	XXX
36013		A	Place catheter in artery	2.52	NA	1.38	0.31	NA	4.21	XXX
36014		A	Place catheter in artery	3.02	NA	1.90	0.27	NA	5.19	XXX
36015		A	Place catheter in artery	3.52	NA	2.03	0.32	NA	5.87	XXX
36100		A	Establish access to artery	3.02	NA	1.98	0.32	NA	5.32	XXX
36120		A	Establish access to artery	2.01	NA	1.45	0.30	NA	3.76	XXX
36140		A	Establish access to artery	2.01	NA	1.45	0.24	NA	3.70	XXX
36145		A	Artery to vein shunt	2.01	NA	1.55	0.49	NA	4.05	XXX
36160		A	Establish access to aorta	2.52	NA	1.68	0.35	NA	4.55	XXX
36200		A	Place catheter in aorta	3.02	NA	1.94	0.28	NA	5.24	XXX
36215		A	Place catheter in artery	4.68	NA	2.50	0.23	NA	7.41	XXX
36216		A	Place catheter in artery	5.28	NA	2.88	0.27	NA	8.43	XXX
36217		A	Place catheter in artery	6.30	NA	3.27	0.32	NA	9.89	XXX
36218		A	Place catheter in artery	1.01	NA	1.48	0.05	NA	2.54	XXX
36245		A	Place catheter in artery	4.68	NA	2.57	0.26	NA	7.51	XXX
36246		A	Place catheter in artery	5.28	NA	2.93	0.27	NA	8.48	XXX
36247		A	Place catheter in artery	6.30	NA	3.23	0.32	NA	9.85	XXX
36248		A	Place catheter in artery	1.01	NA	1.47	0.05	NA	2.53	XXX
36260		A	Insertion of infusion pump	9.71	NA	5.54	1.41	NA	16.66	090
36261		A	Revision of infusion pump	5.45	NA	3.31	0.42	NA	9.18	090
36262		A	Removal of infusion pump	4.02	NA	2.77	0.40	NA	7.19	090
36400		A	Drawing blood	0.18	0.39	0.05	0.01	0.58	0.24	XXX
36405		A	Drawing blood	0.18	0.29	0.04	0.03	0.50	0.25	XXX
36406		A	Drawing blood	0.18	0.32	0.06	0.01	0.51	0.25	XXX
36410		A	Drawing blood	0.18	0.30	0.05	0.02	0.50	0.25	XXX
36420		A	Establish access to vein	1.01	NA	0.41	0.05	NA	1.47	XXX
36425		A	Establish access to vein	0.76	2.17	0.25	0.01	2.94	1.02	XXX
36430		A	Blood transfusion service	0.00	1.50	0.10	0.07	1.57	0.17	XXX
36440		A	Blood transfusion service	1.03	NA	0.37	0.07	NA	1.47	XXX
36450		A	Exchange transfusion service	2.23	NA	1.15	0.18	NA	3.56	XXX
36455		A	Exchange transfusion service	2.43	NA	0.92	0.22	NA	3.57	XXX
36460		A	Transfusion service, fetal	6.59	NA	2.91	1.09	NA	10.59	XXX
36470		A	Injection therapy of vein	1.09	1.89	0.44	0.04	3.02	1.57	010
36471		A	Injection therapy of veins	1.57	2.13	0.64	0.05	3.75	2.26	010
36481		A	Insertion of catheter, vein	6.99	NA	2.56	0.61	NA	10.16	000
36488		A	Insertion of catheter, vein	1.35	NA	0.54	0.14	NA	2.03	000
36489		A	Insertion of catheter, vein	1.22	2.72	0.45	0.17	4.11	1.84	000
36490		A	Insertion of catheter, vein	1.67	NA	0.65	0.20	NA	2.52	000
36491		A	Insertion of catheter, vein	1.43	NA	0.59	0.32	NA	2.34	000
36493		A	Repositioning of cvc	1.21	NA	0.59	0.16	NA	1.96	000
36500		A	Insertion of catheter, vein	3.52	NA	1.78	0.01	NA	5.31	000
36510		A	Insertion of catheter, vein	1.09	NA	0.72	0.02	NA	1.83	000
36520		A	Plasma and/or cell exchange	1.74	NA	0.82	0.12	NA	2.68	000
36522		A	Photopheresis	1.67	4.18	1.01	0.37	6.22	3.05	000
36530		R	Insertion of infusion pump	6.20	NA	3.34	1.02	NA	10.56	010
36531		R	Revision of infusion pump	4.87	NA	2.88	0.27	NA	8.02	010
36532		R	Removal of infusion pump	3.30	NA	1.64	0.37	NA	5.31	010
36533		A	Insertion of access port	5.32	3.02	3.92	0.85	9.19	10.09	010
36534		A	Revision of access port	2.80	NA	1.52	0.21	NA	4.53	010
36535		A	Removal of access port	2.27	1.92	1.99	0.38	4.57	4.64	010
36600		A	Withdrawal of arterial blood	0.32	0.27	0.08	0.02	0.61	0.42	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.38	0.14	NA	1.67	000
36625		A	Insertion catheter, artery	2.11	NA	0.59	0.18	NA	2.88	000
36640		A	Insertion catheter, artery	2.10	NA	1.06	0.40	NA	3.56	000
36660		A	Insertion catheter, artery	1.40	NA	0.72	0.04	NA	2.16	000
36680		A	Insert needle, bone cavity	1.20	NA	0.42	0.10	NA	1.72	000
36800		A	Insertion of cannula	2.43	NA	1.47	0.28	NA	4.18	000
36810		A	Insertion of cannula	3.97	NA	2.41	0.74	NA	7.12	000
36815		A	Insertion of cannula	2.62	NA	1.90	0.70	NA	5.22	000
36821		A	Artery-vein fusion	8.93	NA	4.71	1.46	NA	15.10	090
36822		A	Insertion of cannula(s)	5.42	NA	6.99	0.77	NA	13.18	090
36825		A	Artery-vein graft	9.84	NA	5.38	2.21	NA	17.43	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
36830		A	Artery-vein graft	12.00	NA	6.05	2.36	NA	20.41	090
36832		A	Revise artery-vein fistula	6.45	NA	3.82	2.38	NA	12.65	090
36834		A	Repair A–V aneurysm	9.93	NA	5.01	1.66	NA	16.60	090
36835		A	Artery to vein shunt	7.15	NA	4.03	0.79	NA	11.97	090
36860		A	Cannula declotting	2.01	2.05	3.31	0.43	4.49	5.75	000
36861		A	Cannula declotting	2.52	NA	1.52	1.01	NA	5.05	000
37140		A	Revision of circulation	23.60	NA	11.09	3.34	NA	38.03	090
37145		A	Revision of circulation	24.61	NA	13.07	1.72	NA	39.40	090
37160		A	Revision of circulation	21.60	NA	10.56	3.79	NA	35.95	090
37180		A	Revision of circulation	24.61	NA	11.66	2.76	NA	39.03	090
37181		A	Splice spleen/kidney veins	26.68	NA	12.36	3.52	NA	42.56	090
37195		A	Thrombolytic therapy, stroke	0.00	2.02	0.16	0.54	2.56	0.70	XXX
37200		A	Transcatheter biopsy	4.56	NA	3.39	0.13	NA	8.08	000
37201		A	Transcatheter therapy infuse	5.00	NA	2.97	0.64	NA	8.61	000
37202		A	Transcatheter therapy infuse	5.68	NA	3.78	0.50	NA	9.96	000
37203		A	Transcatheter retrieval	5.03	NA	2.93	0.45	NA	8.41	000
37204		A	Transcatheter occlusion	18.14	NA	7.97	1.60	NA	27.71	000
37205		A	Transcatheter stent	8.28	NA	4.71	0.42	NA	13.41	000
37206		A	Transcatheter stent	4.13	NA	2.40	0.21	NA	6.74	ZZZ
37207		A	Transcatheter stent	8.28	NA	4.34	0.42	NA	13.04	000
37208		A	Transcatheter stent	4.13	NA	1.94	0.21	NA	6.28	ZZZ
37209		A	Exchange arterial catheter	2.27	NA	1.64	0.11	NA	4.02	000
37250		A	Intravascular us	2.10	NA	3.83	0.13	NA	6.06	ZZZ
37251		A	Intravascular us	1.60	NA	3.33	0.10	NA	5.03	ZZZ
37565		A	Ligation of neck vein	4.44	NA	2.84	0.74	NA	8.02	090
37600		A	Ligation of neck artery	4.57	NA	3.45	0.80	NA	8.82	090
37605		A	Ligation of neck artery	6.19	NA	4.06	1.04	NA	11.29	090
37606		A	Ligation of neck artery	6.28	NA	4.94	0.72	NA	11.94	090
37607		A	Ligation of fistula	6.16	NA	3.24	0.71	NA	10.11	090
37609		A	Temporal artery procedure	2.30	4.20	1.94	0.38	6.88	4.62	010
37615		A	Ligation of neck artery	5.73	NA	3.99	1.11	NA	10.83	090
37616		A	Ligation of chest artery	16.49	NA	13.38	0.83	NA	30.70	090
37617		A	Ligation of abdomen artery	15.95	NA	8.73	1.54	NA	26.22	090
37618		A	Ligation of extremity artery	4.84	NA	3.33	1.06	NA	9.23	090
37620		A	Revision of major vein	10.56	NA	5.78	1.48	NA	17.82	090
37650		A	Revision of major vein	5.13	NA	3.12	0.52	NA	8.77	090
37660		A	Revision of major vein	10.61	NA	6.09	1.07	NA	17.77	090
37700		A	Revise leg vein	3.73	NA	2.49	0.73	NA	6.95	090
37720		A	Removal of leg vein	5.66	NA	3.17	1.04	NA	9.87	090
37730		A	Removal of leg veins	7.33	NA	4.19	1.40	NA	12.92	090
37735		A	Removal of leg veins/lesion	10.53	NA	6.07	1.68	NA	18.28	090
37760		A	Revision of leg veins	10.47	NA	6.21	1.52	NA	18.20	090
37780		A	Revision of leg vein	3.84	NA	2.51	0.35	NA	6.70	090
37785		A	Revise secondary varicosity	3.88	4.63	3.11	0.18	8.69	7.17	090
37788		A	Revascularization, penis	22.01	NA	11.57	1.48	NA	35.06	090
37790		A	Penile venous occlusion	8.34	NA	5.86	0.55	NA	14.75	090
38100		A	Removal of spleen, total	13.01	NA	6.41	1.81	NA	21.23	090
38101		A	Removal of spleen, partial	13.74	NA	6.94	1.51	NA	22.19	090
38102		A	Removal of spleen, total	4.80	NA	2.03	0.58	NA	7.41	ZZZ
38115		A	Repair of ruptured spleen	14.19	NA	6.91	1.49	NA	22.59	090
38200		A	Injection for spleen x-ray	2.64	NA	0.83	0.15	NA	3.62	000
38230		R	Bone marrow collection	4.54	NA	2.23	0.21	NA	6.98	010
38231		R	Stem cell collection	1.50	NA	0.58	0.08	NA	2.16	000
38240		R	Bone marrow/stem transplant	2.24	NA	1.20	0.14	NA	3.58	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.28	0.13	NA	3.65	XXX
38300		A	Drainage lymph node lesion	1.53	2.60	1.54	0.10	4.23	3.17	010
38305		A	Drainage lymph node lesion	4.61	5.06	4.08	0.36	10.03	9.05	090
38308		A	Incision of lymph channels	4.95	NA	3.75	0.45	NA	9.15	090
38380		A	Thoracic duct procedure	7.46	NA	5.68	0.76	NA	13.90	090
38381		A	Thoracic duct procedure	12.88	NA	10.21	1.50	NA	24.59	090
38382		A	Thoracic duct procedure	10.08	NA	9.37	1.13	NA	20.58	090
38500		A	Biopsy/removal, lymph node(s)	2.88	2.02	1.92	0.31	5.21	5.11	010
38505		A	Needle biopsy, lymph node(s)	1.14	1.98	1.04	0.17	3.29	2.35	000
38510		A	Biopsy/removal, lymph node(s)	4.14	NA	3.28	0.45	NA	7.87	090
38520		A	Biopsy/removal, lymph node(s)	5.12	NA	3.57	0.56	NA	9.25	090
38525		A	Biopsy/removal, lymph node(s)	4.66	NA	2.95	0.53	NA	8.14	090
38530		A	Biopsy/removal, lymph node(s)	6.13	NA	4.08	0.65	NA	10.86	090
38542		A	Explore deep node(s), neck	5.91	NA	4.90	0.59	NA	11.40	090
38550		A	Removal neck/armpit lesion	6.73	NA	4.15	0.63	NA	11.51	090
38555		A	Removal neck/armpit lesion	14.27	NA	8.94	1.38	NA	24.59	090
38562		A	Removal, pelvic lymph nodes	10.49	NA	6.35	1.20	NA	18.04	090
38564		A	Removal, abdomen lymph nodes	10.83	NA	6.15	1.51	NA	18.49	090
38700		A	Removal of lymph nodes, neck	8.24	NA	10.81	1.31	NA	20.36	090
38720		A	Removal of lymph nodes, neck	13.61	NA	13.91	2.04	NA	29.56	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
38724		A	Removal of lymph nodes, neck	14.54	NA	14.45	2.00	NA	30.99	090
38740		A	Remove armpit lymph nodes	6.77	NA	3.81	1.00	NA	11.58	090
38745		A	Remove armpits lymph nodes	8.84	NA	5.36	1.76	NA	15.96	090
38746		A	Remove thoracic lymph nodes	4.39	NA	2.29	0.53	NA	7.21	ZZZ
38747		A	Remove abdominal lymph nodes	4.89	NA	2.24	0.59	NA	7.72	ZZZ
38760		A	Remove groin lymph nodes	8.74	NA	4.84	1.35	NA	14.93	090
38765		A	Remove groin lymph nodes	16.06	NA	9.45	2.42	NA	27.93	090
38770		A	Remove pelvis lymph nodes	13.23	NA	7.39	1.73	NA	22.35	090
38780		A	Remove abdomen lymph nodes	16.59	NA	9.80	3.13	NA	29.52	090
38790		A	Injection for lymphatic xray	1.29	15.73	0.46	0.19	17.21	1.94	000
38794		A	Access thoracic lymph duct	4.45	NA	1.63	0.38	NA	6.46	090
39000		A	Exploration of chest	6.10	NA	7.52	1.08	NA	14.70	090
39010		A	Exploration of chest	11.79	NA	10.10	2.08	NA	23.97	090
39200		A	Removal chest lesion	13.62	NA	9.99	2.14	NA	25.75	090
39220		A	Removal chest lesion	17.42	NA	11.53	2.83	NA	31.78	090
39400		A	Visualization of chest	5.61	NA	5.83	0.95	NA	12.39	010
39501		A	Repair diaphragm laceration	13.19	NA	8.27	2.10	NA	23.56	090
39502		A	Repair paraesophageal hernia	16.33	NA	9.21	2.45	NA	27.99	090
39503		A	Repair of diaphragm hernia	34.85	NA	16.15	2.94	NA	53.94	090
39520		A	Repair of diaphragm hernia	16.10	NA	10.12	2.46	NA	28.68	090
39530		A	Repair of diaphragm hernia	15.41	NA	9.39	2.71	NA	27.51	090
39531		A	Repair of diaphragm hernia	16.42	NA	10.12	1.80	NA	28.34	090
39540		A	Repair of diaphragm hernia	13.32	NA	7.38	2.51	NA	23.21	090
39541		A	Repair of diaphragm hernia	14.41	NA	8.60	2.37	NA	25.38	090
39545		A	Revision of diaphragm	13.37	NA	8.87	1.31	NA	23.55	090
40490		A	Biopsy of lip	1.22	1.11	0.68	0.07	2.40	1.97	000
40500		A	Partial excision of lip	4.28	3.71	4.46	0.94	8.93	9.68	090
40510		A	Partial excision of lip	4.70	4.37	4.92	0.83	9.90	10.45	090
40520		A	Partial excision of lip	4.67	4.80	5.06	0.68	10.15	10.41	090
40525		A	Reconstruct lip with flap	7.55	NA	6.94	1.43	NA	15.92	090
40527		A	Reconstruct lip with flap	9.13	NA	8.05	1.65	NA	18.83	090
40530		A	Partial removal of lip	5.40	4.34	4.99	0.74	10.48	11.13	090
40650		A	Repair lip	3.64	3.35	3.03	0.65	7.64	7.32	090
40652		A	Repair lip	4.26	4.36	4.46	0.79	9.41	9.51	090
40654		A	Repair lip	5.31	4.81	5.43	1.00	11.12	11.74	090
40700		A	Repair cleft lip/nasal	12.79	NA	9.03	1.28	NA	23.10	090
40701		A	Repair cleft lip/nasal	15.85	NA	8.34	1.62	NA	25.81	090
40702		A	Repair cleft lip/nasal	13.04	NA	8.30	1.10	NA	22.44	090
40720		A	Repair cleft lip/nasal	13.55	NA	9.97	1.79	NA	25.31	090
40761		A	Repair cleft lip/nasal	14.72	NA	11.73	1.74	NA	28.19	090
40800		A	Drainage of mouth lesion	1.17	2.22	1.41	0.07	3.46	2.65	010
40801		A	Drainage of mouth lesion	2.53	1.94	1.90	0.16	4.63	4.59	010
40804		A	Removal foreign body, mouth	1.24	1.67	1.50	0.06	2.97	2.80	010
40805		A	Removal foreign body, mouth	2.69	2.40	2.50	0.30	5.39	5.49	010
40806		A	Incision of lip fold	0.31	0.58	0.60	0.03	0.92	0.94	000
40808		A	Biopsy of mouth lesion	0.96	1.32	1.60	0.08	2.36	2.64	010
40810		A	Excision of mouth lesion	1.31	1.76	1.85	0.11	3.18	3.27	010
40812		A	Excise/repair mouth lesion	2.31	2.16	2.45	0.14	4.61	4.90	010
40814		A	Excise/repair mouth lesion	3.42	3.08	3.61	0.32	6.82	7.35	090
40816		A	Excision of mouth lesion	3.67	3.32	3.85	0.33	7.32	7.85	090
40818		A	Excise oral mucosa for graft	2.41	2.76	4.56	0.20	5.37	7.17	090
40819		A	Excise lip or cheek fold	2.41	2.57	2.64	0.14	5.12	5.19	090
40820		A	Treatment of mouth lesion	1.28	1.54	1.80	0.06	2.88	3.14	010
40830		A	Repair mouth laceration	1.76	1.71	1.52	0.07	3.54	3.35	010
40831		A	Repair mouth laceration	2.46	2.11	2.14	0.21	4.78	4.81	010
40840		R	Reconstruction of mouth	8.73	5.13	6.14	0.73	14.59	15.60	090
40842		R	Reconstruction of mouth	8.73	5.21	6.40	0.73	14.67	15.86	090
40843		R	Reconstruction of mouth	12.10	6.00	8.99	1.03	19.13	22.12	090
40844		R	Reconstruction of mouth	16.01	8.17	8.59	1.36	25.54	25.96	090
40845		R	Reconstruction of mouth	18.58	9.57	10.76	1.93	30.08	31.27	090
41000		A	Drainage of mouth lesion	1.30	1.53	1.44	0.08	2.91	2.82	010
41005		A	Drainage of mouth lesion	1.26	1.50	1.28	0.07	2.83	2.61	010
41006		A	Drainage of mouth lesion	3.24	2.72	2.86	0.11	6.07	6.21	090
41007		A	Drainage of mouth lesion	3.10	2.67	2.82	0.30	6.07	6.22	090
41008		A	Drainage of mouth lesion	3.37	2.74	2.81	0.11	6.22	6.29	090
41009		A	Drainage of mouth lesion	3.59	2.82	2.85	0.34	6.75	6.78	090
41010		A	Incision of tongue fold	1.06	1.93	2.83	0.04	3.03	3.93	010
41015		A	Drainage of mouth lesion	3.96	3.03	3.07	0.10	7.09	7.13	090
41016		A	Drainage of mouth lesion	4.07	3.07	3.13	0.38	7.52	7.58	090
41017		A	Drainage of mouth lesion	4.07	3.10	3.12	0.14	7.31	7.33	090
41018		A	Drainage of mouth lesion	5.10	3.61	3.52	0.38	9.09	9.00	090
41100		A	Biopsy of tongue	1.63	1.76	2.03	0.08	3.47	3.74	010
41105		A	Biopsy of tongue	1.42	1.61	1.92	0.12	3.15	3.46	010
41108		A	Biopsy of floor of mouth	1.05	1.44	1.68	0.09	2.58	2.82	010

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
41110		A	Excision of tongue lesion	1.51	1.97	1.98	0.15	3.63	3.64	010
41112		A	Excision of tongue lesion	2.73	2.56	2.94	0.23	5.52	5.90	090
41113		A	Excision of tongue lesion	3.19	2.70	4.71	0.37	6.26	8.27	090
41114		A	Excision of tongue lesion	8.47	NA	6.15	0.73	NA	15.35	090
41115		A	Excision of tongue fold	1.74	1.85	2.00	0.17	3.76	3.91	010
41116		A	Excision of mouth lesion	2.44	2.42	2.78	0.27	5.13	5.49	090
41120		A	Partial removal of tongue	9.77	NA	7.88	0.88	NA	18.53	090
41130		A	Partial removal of tongue	11.15	NA	8.73	1.14	NA	21.02	090
41135		A	Tongue and neck surgery	23.09	NA	16.39	2.64	NA	42.12	090
41140		A	Removal of tongue	25.50	NA	17.08	2.45	NA	45.03	090
41145		A	Tongue removal; neck surgery	30.06	NA	20.79	2.95	NA	53.80	090
41150		A	Tongue, mouth, jaw surgery	23.04	NA	16.14	2.46	NA	41.64	090
41153		A	Tongue, mouth, neck surgery	23.77	NA	17.27	3.03	NA	44.07	090
41155		A	Tongue, jaw, & neck surgery	27.72	NA	19.93	3.75	NA	51.40	090
41250		A	Repair tongue laceration	1.91	1.89	1.50	0.11	3.91	3.52	010
41251		A	Repair tongue laceration	2.27	1.94	1.88	0.21	4.42	4.36	010
41252		A	Repair tongue laceration	2.97	2.48	2.21	0.26	5.71	5.44	010
41500		A	Fixation of tongue	3.71	NA	2.80	0.26	NA	6.77	090
41510		A	Tongue to lip surgery	3.42	NA	3.04	0.45	NA	6.91	090
41520		A	Reconstruction, tongue fold	2.73	2.31	2.90	0.28	5.32	5.91	090
41800		A	Drainage of gum lesion	1.17	1.35	1.12	0.07	2.59	2.36	010
41805		A	Removal foreign body, gum	1.24	1.36	1.78	0.08	2.68	3.10	010
41806		A	Removal foreign body, jawbone	2.69	2.00	2.33	0.15	4.84	5.17	010
41822		R	Excision of gum lesion	2.31	3.15	2.96	0.25	5.71	5.52	010
41823		R	Excision of gum lesion	3.30	2.76	2.83	0.34	6.40	6.47	090
41825		A	Excision of gum lesion	1.31	1.67	1.78	0.14	3.12	3.23	010
41826		A	Excision of gum lesion	2.31	2.05	2.24	0.18	4.54	4.73	010
41827		A	Excision of gum lesion	3.42	2.79	3.30	0.38	6.59	7.10	090
41828		R	Excision of gum lesion	3.09	2.44	2.33	0.33	5.86	5.75	010
41830		R	Removal of gum tissue	3.35	2.49	2.74	0.36	6.20	6.45	010
41872		R	Repair gum	2.59	2.40	2.44	0.27	5.26	5.30	090
41874		R	Repair tooth socket	3.09	2.27	2.26	0.32	5.68	5.67	090
42000		A	Drainage mouth roof lesion	1.23	1.65	1.41	0.06	2.94	2.70	010
42100		A	Biopsy roof of mouth	1.31	1.57	1.84	0.08	2.96	3.23	010
42104		A	Excision lesion, mouth roof	1.64	1.72	2.08	0.17	3.53	3.89	010
42106		A	Excision lesion, mouth roof	2.10	1.99	2.29	0.21	4.30	4.60	010
42107		A	Excision lesion, mouth roof	4.44	3.32	3.94	0.50	8.26	8.88	090
42120		A	Remove palate/lesion	6.17	NA	5.28	1.01	NA	12.46	090
42140		A	Excision of uvula	1.62	2.22	2.38	0.15	3.99	4.15	090
42145		A	Repair, palate, pharynx/uvula	8.05	NA	6.73	1.45	NA	16.23	090
42160		A	Treatment mouth roof lesion	1.80	2.02	2.10	0.16	3.98	4.06	010
42180		A	Repair palate	2.50	2.01	1.94	0.26	4.77	4.70	010
42182		A	Repair palate	3.83	2.77	3.02	0.38	6.98	7.23	010
42200		A	Reconstruct cleft palate	12.00	NA	9.19	0.85	NA	22.04	090
42205		A	Reconstruct cleft palate	9.59	NA	7.39	0.79	NA	17.77	090
42210		A	Reconstruct cleft palate	14.50	NA	9.13	0.95	NA	24.58	090
42215		A	Reconstruct cleft palate	8.82	NA	7.70	0.86	NA	17.38	090
42220		A	Reconstruct cleft palate	7.02	NA	5.37	0.81	NA	13.20	090
42225		A	Reconstruct cleft palate	9.54	NA	7.73	1.08	NA	18.35	090
42226		A	Lengthening of palate	10.01	NA	8.78	0.86	NA	19.65	090
42227		A	Lengthening of palate	9.52	NA	14.99	0.38	NA	24.89	090
42235		A	Repair palate	7.87	NA	5.57	0.49	NA	13.93	090
42260		A	Repair nose to lip fistula	9.80	5.49	7.44	0.44	15.73	17.68	090
42280		A	Preparation, palate mold	1.54	1.14	0.82	0.17	2.85	2.53	010
42281		A	Insertion, palate prosthesis	1.93	1.30	1.09	0.15	3.38	3.17	010
42300		A	Drainage of salivary gland	1.93	1.87	2.26	0.12	3.92	4.31	010
42305		A	Drainage of salivary gland	6.07	NA	5.09	0.27	NA	11.43	090
42310		A	Drainage of salivary gland	1.56	1.60	1.95	0.12	3.28	3.63	010
42320		A	Drainage of salivary gland	2.35	2.10	2.40	0.22	4.67	4.97	010
42325		A	Create salivary cyst drain	2.75	2.35	1.15	0.20	5.30	4.10	090
42326		A	Create salivary cyst drain	3.78	3.65	1.44	0.33	7.76	5.55	090
42330		A	Removal of salivary stone	2.21	2.04	1.27	0.12	4.37	3.60	010
42335		A	Removal of salivary stone	3.31	2.78	3.56	0.27	6.36	7.14	090
42340		A	Removal of salivary stone	4.60	3.74	4.38	0.45	8.79	9.43	090
42400		A	Biopsy of salivary gland	0.78	1.63	0.74	0.10	2.51	1.62	000
42405		A	Biopsy of salivary gland	3.29	2.54	3.25	0.19	6.02	6.73	010
42408		A	Excision of salivary cyst	4.54	3.45	4.37	0.38	8.37	9.29	090
42409		A	Drainage of salivary cyst	2.81	2.44	3.35	0.30	5.55	6.46	090
42410		A	Excise parotid gland/lesion	9.34	NA	6.83	0.92	NA	17.09	090
42415		A	Excise parotid gland/lesion	16.89	NA	12.33	1.68	NA	30.90	090
42420		A	Excise parotid gland/lesion	19.59	NA	14.21	1.87	NA	35.67	090
42425		A	Excise parotid gland/lesion	13.02	NA	10.06	1.43	NA	24.51	090
42426		A	Excise parotid gland/lesion	21.26	NA	15.55	3.21	NA	40.02	090
42440		A	Excision submaxillary gland	6.97	NA	5.73	0.99	NA	13.69	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
42450		A	Excision sublingual gland	4.62	3.71	4.47	0.35	8.68	9.44	090
42500		A	Repair salivary duct	4.30	3.70	4.34	0.50	8.50	9.14	090
42505		A	Repair salivary duct	6.18	4.43	5.38	0.86	11.47	12.42	090
42507		A	Parotid duct diversion	6.11	NA	5.22	0.67	NA	12.00	090
42508		A	Parotid duct diversion	9.10	NA	7.48	0.94	NA	17.52	090
42509		A	Parotid duct diversion	11.54	NA	9.89	1.23	NA	22.66	090
42510		A	Parotid duct diversion	8.15	NA	5.61	0.84	NA	14.60	090
42550		A	Injection for salivary x-ray	1.25	7.23	0.40	0.04	8.52	1.69	000
42600		A	Closure of salivary fistula	4.82	4.52	4.79	0.46	9.80	10.07	090
42650		A	Dilation of salivary duct	0.77	1.10	1.36	0.04	1.91	2.17	000
42660		A	Dilation of salivary duct	1.13	0.96	1.78	0.06	2.15	2.97	000
42665		A	Ligation of salivary duct	2.53	2.88	3.17	0.25	5.66	5.95	090
42700		A	Drainage of tonsil abscess	1.62	1.96	1.78	0.10	3.68	3.50	010
42720		A	Drainage of throat abscess	5.42	4.08	4.43	0.22	9.72	10.07	010
42725		A	Drainage of throat abscess	10.72	NA	7.89	0.53	NA	19.14	090
42800		A	Biopsy of throat	1.39	1.79	1.92	0.08	3.26	3.39	010
42802		A	Biopsy of throat	1.54	1.89	2.02	0.12	3.55	3.68	010
42804		A	Biopsy of upper nose/throat	1.24	1.71	1.85	0.13	3.08	3.22	010
42806		A	Biopsy of upper nose/throat	1.58	2.01	2.16	0.16	3.75	3.90	010
42808		A	Excise pharynx lesion	2.30	2.84	2.56	0.29	5.43	5.15	010
42809		A	Remove pharynx foreign body	1.81	2.09	1.45	0.08	3.98	3.34	010
42810		A	Excision of neck cyst	3.33	3.66	3.33	0.47	7.46	7.13	090
42815		A	Excision of neck cyst	7.23	NA	5.86	1.12	NA	14.21	090
42820		A	Remove tonsils and adenoids	3.91	NA	3.38	0.32	NA	7.61	090
42821		A	Remove tonsils and adenoids	4.29	NA	3.69	0.46	NA	8.44	090
42825		A	Removal of tonsils	3.42	NA	3.27	0.33	NA	7.02	090
42826		A	Removal of tonsils	3.38	NA	3.24	0.43	NA	7.05	090
42830		A	Removal of adenoids	2.57	NA	2.28	0.27	NA	5.12	090
42831		A	Removal of adenoids	2.71	NA	2.50	0.25	NA	5.46	090
42835		A	Removal of adenoids	2.30	NA	2.54	0.10	NA	4.94	090
42836		A	Removal of adenoids	3.18	NA	3.13	0.31	NA	6.62	090
42842		A	Extensive surgery of throat	8.76	NA	7.14	0.73	NA	16.63	090
42844		A	Extensive surgery of throat	14.31	NA	10.67	1.27	NA	26.25	090
42845		A	Extensive surgery of throat	24.29	NA	17.14	2.22	NA	43.65	090
42860		A	Excision of tonsil tags	2.22	NA	2.43	0.21	NA	4.86	090
42870		A	Excision of lingual tonsil	5.40	NA	5.08	0.26	NA	10.74	090
42890		A	Partial removal of pharynx	12.94	NA	10.10	1.03	NA	24.07	090
42892		A	Revision of pharyngeal walls	15.83	NA	12.11	1.27	NA	29.21	090
42894		A	Revision of pharyngeal walls	22.88	NA	16.72	1.83	NA	41.43	090
42900		A	Repair throat wound	5.25	NA	3.94	0.48	NA	9.67	010
42950		A	Reconstruction of throat	8.10	NA	6.76	1.10	NA	15.96	090
42953		A	Repair throat, esophagus	8.96	NA	7.93	0.93	NA	17.82	090
42955		A	Surgical opening of throat	7.39	NA	5.74	0.43	NA	13.56	090
42960		A	Control throat bleeding	2.33	NA	2.09	0.12	NA	4.54	010
42961		A	Control throat bleeding	5.59	NA	4.67	0.19	NA	10.45	090
42962		A	Control throat bleeding	7.14	NA	4.55	0.68	NA	12.37	090
42970		A	Control nose/throat bleeding	5.43	NA	3.46	0.10	NA	8.99	090
42971		A	Control nose/throat bleeding	6.21	NA	4.85	0.34	NA	11.40	090
42972		A	Control nose/throat bleeding	7.20	NA	5.58	0.73	NA	13.51	090
43020		A	Incision of esophagus	8.09	NA	5.75	0.71	NA	14.55	090
43030		A	Throat muscle surgery	7.69	NA	6.16	1.21	NA	15.06	090
43045		A	Incision of esophagus	20.12	NA	11.38	2.36	NA	33.86	090
43100		A	Excision of esophagus lesion	9.19	NA	7.68	0.95	NA	17.82	090
43101		A	Excision of esophagus lesion	16.24	NA	9.49	1.88	NA	27.61	090
43107		A	Removal of esophagus	28.79	NA	16.54	4.42	NA	49.75	090
43108		A	Removal of esophagus	34.19	NA	18.50	4.77	NA	57.46	090
43112		A	Removal of esophagus	31.22	NA	17.71	4.22	NA	53.15	090
43113		A	Removal of esophagus	35.27	NA	19.69	4.77	NA	59.73	090
43116		A	Partial removal of esophagus	31.22	NA	22.24	4.77	NA	58.23	090
43117		A	Partial removal of esophagus	30.02	NA	17.20	4.77	NA	51.99	090
43118		A	Partial removal of esophagus	33.20	NA	17.53	4.77	NA	55.50	090
43121		A	Partial removal of esophagus	29.19	NA	16.84	4.19	NA	50.22	090
43122		A	Parital removal of esophagus	29.11	NA	16.10	4.19	NA	49.40	090
43123		A	Partial removal of esophagus	33.20	NA	18.08	4.77	NA	56.05	090
43124		A	Removal of esophagus	27.32	NA	16.97	4.42	NA	48.71	090
43130		A	Removal of esophagus pouch	11.75	NA	9.35	1.60	NA	22.70	090
43135		A	Removal of esophagus pouch	16.10	NA	10.05	2.17	NA	28.32	090
43200		A	Esophagus endoscopy	1.59	3.93	1.00	0.26	5.78	2.85	000
43202		A	Esophagus endoscopy, biopsy	1.89	3.61	0.94	0.31	5.81	3.14	000
43204		A	Esophagus endoscopy & inject	3.77	NA	1.45	0.36	NA	5.58	000
43205		A	Esophagus endoscopy/ligation	3.79	NA	1.47	0.18	NA	5.44	000
43215		A	Esophagus endoscopy	2.60	NA	1.16	0.46	NA	4.22	000
43216		A	Esophagus endoscopy/lesion	2.40	NA	1.06	0.37	NA	3.83	000
43217		A	Esophagus endoscopy	2.90	NA	1.25	0.37	NA	4.52	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
43219		A	Esophagus endoscopy	2.80	NA	1.22	0.34	NA	4.36	000
43220		A	Esophagus endoscopy, dilation	2.10	NA	0.91	0.27	NA	3.28	000
43226		A	Esophagus endoscopy, dilation	2.34	NA	0.96	0.26	NA	3.56	000
43227		A	Esophagus endoscopy, repair	3.60	NA	1.41	0.34	NA	5.35	000
43228		A	Esophagus endoscopy, ablation	3.77	NA	1.56	0.38	NA	5.71	000
43234		A	Upper GI endoscopy, exam	2.01	2.35	0.86	0.30	4.66	3.17	000
43235		A	Upper gi endoscopy, diagnosis	2.39	3.80	0.98	0.29	6.48	3.66	000
43239		A	Upper GI endoscopy, biopsy	2.69	3.88	1.09	0.33	6.90	4.11	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.04	0.38	NA	4.01	000
43243		A	Upper GI endoscopy & inject.	4.57	NA	1.73	0.39	NA	6.69	000
43244		A	Upper GI endoscopy/ligation	4.59	NA	1.74	0.41	NA	6.74	000
43245		A	Operative upper GI endoscopy	3.39	NA	1.33	0.40	NA	5.12	000
43246		A	Place gastrostomy tube	4.33	NA	1.65	0.51	NA	6.49	000
43247		A	Operative upper GI endoscopy	3.39	NA	1.33	0.38	NA	5.10	000
43248		A	Upper GI endoscopy/guidewire	3.15	NA	1.23	0.35	NA	4.73	000
43249		A	Esophagus endoscopy, dilation	2.90	NA	1.15	0.30	NA	4.35	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.26	0.43	NA	4.89	000
43251		A	Operative upper GI endoscopy	3.70	NA	1.43	0.43	NA	5.56	000
43255		A	Operative upper GI endoscopy	4.40	NA	1.62	0.38	NA	6.40	000
43258		A	Operative upper GI endoscopy	4.55	NA	1.73	0.38	NA	6.66	000
43259		A	Endoscopic ultrasound exam	4.89	NA	1.88	0.35	NA	7.12	000
43260		A	Endoscopy, bile duct/pancreas	5.96	NA	2.21	0.39	NA	8.56	000
43261		A	Endoscopy, bile duct/pancreas	6.27	NA	2.33	0.39	NA	8.99	000
43262		A	Endoscopy, bile duct/pancreas	7.39	NA	2.72	0.58	NA	10.69	000
43263		A	Endoscopy, bile duct/pancreas	6.19	NA	2.31	0.38	NA	8.88	000
43264		A	Endoscopy, bile duct/pancreas	8.90	NA	3.26	0.61	NA	12.77	000
43265		A	Endoscopy, bile duct/pancreas	8.90	NA	3.27	0.49	NA	12.66	000
43267		A	Endoscopy, bile duct/pancreas	7.39	NA	2.72	0.48	NA	10.59	000
43268		A	Endoscopy, bile duct/pancreas	7.39	NA	2.72	0.56	NA	10.67	000
43269		A	Endoscopy, bile duct/pancreas	6.04	NA	2.25	0.51	NA	8.80	000
43271		A	Endoscopy, bile duct/pancreas	7.39	NA	2.72	0.50	NA	10.61	000
43272		A	Endoscopy, bile duct/pancreas	7.39	NA	2.74	0.42	NA	10.55	000
43300		A	Repair of esophagus	9.14	NA	6.70	1.70	NA	17.54	090
43305		A	Repair esophagus and fistula	17.15	NA	15.03	1.78	NA	33.96	090
43310		A	Repair of esophagus	25.39	NA	15.67	3.23	NA	44.29	090
43312		A	Repair esophagus and fistula	28.42	NA	18.88	2.30	NA	49.60	090
43320		A	Fuse esophagus & stomach	16.07	NA	10.25	2.05	NA	28.37	090
43324		A	Revise esophagus & stomach	16.58	NA	9.19	2.53	NA	28.30	090
43325		A	Revise esophagus & stomach	16.17	NA	9.81	2.29	NA	28.27	090
43326		A	Revise esophagus & stomach	15.91	NA	10.44	1.75	NA	28.10	090
43330		A	Repair of esophagus	15.94	NA	9.56	2.39	NA	27.89	090
43331		A	Repair of esophagus	16.23	NA	10.50	2.64	NA	29.37	090
43340		A	Fuse esophagus & intestine	15.81	NA	9.82	2.52	NA	28.15	090
43341		A	Fuse esophagus & intestine	16.81	NA	10.70	1.56	NA	29.07	090
43350		A	Surgical opening, esophagus	12.72	NA	10.38	1.15	NA	24.25	090
43351		A	Surgical opening, esophagus	14.79	NA	9.21	1.53	NA	25.53	090
43352		A	Surgical opening, esophagus	12.30	NA	9.19	1.47	NA	22.96	090
43360		A	Gastrointestinal repair	28.78	NA	16.01	4.19	NA	48.98	090
43361		A	Gastrointestinal repair	32.65	NA	18.33	4.77	NA	55.75	090
43400		A	Ligate esophagus veins	17.09	NA	9.76	1.63	NA	28.48	090
43401		A	Esophagus surgery for veins	17.81	NA	10.85	1.93	NA	30.59	090
43405		A	Ligate/staple esophagus	16.13	NA	10.21	2.64	NA	28.98	090
43410		A	Repair esophagus wound	10.86	NA	8.25	1.54	NA	20.65	090
43415		A	Repair esophagus wound	17.06	NA	10.46	2.52	NA	30.04	090
43420		A	Repair esophagus opening	11.57	NA	8.52	0.78	NA	20.87	090
43425		A	Repair esophagus opening	16.95	NA	10.15	1.71	NA	28.81	090
43450		A	Dilate esophagus	1.38	0.91	0.54	0.05	2.34	1.97	000
43453		A	Dilate esophagus	1.51	NA	0.58	0.11	NA	2.20	000
43456		A	Dilate esophagus	2.57	NA	0.97	0.24	NA	3.78	000
43458		A	Dilation of esophagus	3.06	NA	1.15	0.27	NA	4.48	000
43460		A	Pressure treatment esophagus	3.80	NA	1.74	0.15	NA	5.69	000
43500		A	Surgical opening of stomach	8.44	NA	4.35	1.20	NA	13.99	090
43501		A	Surgical repair of stomach	15.31	NA	7.45	1.83	NA	24.59	090
43502		A	Surgical repair of stomach	17.67	NA	8.37	1.83	NA	27.87	090
43510		A	Surgical opening of stomach	9.99	NA	5.88	0.94	NA	16.81	090
43520		A	Incision of pyloric muscle	7.63	NA	4.44	0.87	NA	12.94	090
43600		A	Biopsy of stomach	1.91	NA	0.80	0.05	NA	2.76	000
43605		A	Biopsy of stomach	9.15	NA	4.62	1.29	NA	15.06	090
43610		A	Excision of stomach lesion	11.15	NA	5.84	1.71	NA	18.70	090
43611		A	Excision of stomach lesion	13.63	NA	6.85	1.71	NA	22.19	090
43620		A	Removal of stomach	22.54	NA	11.01	3.19	NA	36.74	090
43621		A	Removal of stomach	23.06	NA	11.28	3.19	NA	37.53	090
43622		A	Removal of stomach	24.41	NA	11.86	3.19	NA	39.46	090
43631		A	Removal of stomach, partial	19.66	NA	9.48	2.66	NA	31.80	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
43632		A	Removal stomach, partial	19.66	NA	9.48	2.66	NA	31.80	090
43633		A	Removal stomach, partial	20.10	NA	9.74	2.66	NA	32.50	090
43634		A	Removal stomach, partial	21.86	NA	10.69	4.57	NA	37.12	090
43635		A	Partial removal of stomach	2.06	NA	0.89	0.26	NA	3.21	ZZZ
43638		A	Partial removal of stomach	21.76	NA	10.27	2.73	NA	34.76	090
43639		A	Removal stomach, partial	22.25	NA	10.59	2.73	NA	35.57	090
43640		A	Vagotomy & pylorus repair	14.81	NA	7.28	2.19	NA	24.28	090
43641		A	Vagotomy & pylorus repair	15.03	NA	7.36	2.18	NA	24.57	090
43750		A	Place gastrostomy tube	4.49	NA	2.33	0.56	NA	7.38	010
43760		A	Change gastrostomy tube	1.10	0.88	0.50	0.09	2.07	1.69	000
43761		A	Reposition gastrostomy tube	2.01	NA	0.71	0.25	NA	2.97	000
43800		A	Reconstruction of pylorus	10.46	NA	5.53	1.47	NA	17.46	090
43810		A	Fusion of stomach and bowel	11.19	NA	5.86	1.53	NA	18.58	090
43820		A	Fusion of stomach and bowel	11.74	NA	6.01	1.75	NA	19.50	090
43825		A	Fusion of stomach and bowel	14.68	NA	7.24	2.30	NA	24.22	090
43830		A	Place gastrostomy tube	7.28	NA	4.11	1.19	NA	12.58	090
43831		A	Place gastrostomy tube	7.33	NA	4.08	0.93	NA	12.34	090
43832		A	Place gastrostomy tube	11.92	NA	6.23	1.36	NA	19.51	090
43840		A	Repair of stomach lesion	11.89	NA	6.02	1.66	NA	19.57	090
43842		A	Gastroplasty for obesity	14.71	NA	8.34	2.93	NA	25.98	090
43843		A	Gastroplasty for obesity	14.85	NA	8.41	2.93	NA	26.19	090
43846		A	Gastric bypass for obesity	19.15	NA	10.32	3.30	NA	32.77	090
43847		A	Gastric bypass for obesity	21.44	NA	11.57	3.30	NA	36.31	090
43848		A	Revision gastroplasty	23.41	NA	12.70	3.30	NA	39.41	090
43850		A	Revise stomach-bowel fusion	19.69	NA	9.27	2.25	NA	31.21	090
43855		A	Revise stomach-bowel fusion	20.83	NA	9.71	2.28	NA	32.82	090
43860		A	Revise stomach-bowel fusion	19.91	NA	9.43	2.51	NA	31.85	090
43865		A	Revise stomach-bowel fusion	21.12	NA	9.97	2.98	NA	34.07	090
43870		A	Repair stomach opening	7.40	NA	4.13	1.14	NA	12.67	090
43880		A	Repair stomach-bowel fistula	19.63	NA	9.75	1.76	NA	31.14	090
44005		A	Freeing of bowel adhesion	13.84	NA	6.88	1.75	NA	22.47	090
44010		A	Incision of small bowel	10.68	NA	5.89	1.42	NA	17.99	090
44015		A	Insert needle catheter,bowel	2.62	NA	1.10	0.45	NA	4.17	ZZZ
44020		A	Exploration of small bowel	11.93	NA	6.06	1.65	NA	19.64	090
44021		A	Decompress small bowel	12.01	NA	6.30	1.48	NA	19.79	090
44025		A	Incision of large bowel	12.18	NA	6.03	1.61	NA	19.82	090
44050		A	Reduce bowel obstruction	11.40	NA	5.86	1.64	NA	18.90	090
44055		A	Correct malrotation of bowel	13.14	NA	6.56	1.60	NA	21.30	090
44100		A	Biopsy of bowel	2.01	NA	0.86	0.13	NA	3.00	000
44110		A	Excision of bowel lesion(s)	10.07	NA	5.42	1.58	NA	17.07	090
44111		A	Excision of bowel lesion(s)	12.19	NA	6.68	2.14	NA	21.01	090
44120		A	Removal of small intestine	14.50	NA	7.15	2.02	NA	23.67	090
44121		A	Removal of small intestine	4.45	NA	1.98	0.54	NA	6.97	ZZZ
44125		A	Removal of small intestine	14.96	NA	7.39	2.28	NA	24.63	090
44130		A	Bowel to bowel fusion	12.36	NA	6.29	1.86	NA	20.51	090
44139		A	Mobilization of colon	2.23	NA	0.98	0.27	NA	3.48	ZZZ
44140		A	Partial removal of colon	18.35	NA	8.86	2.40	NA	29.61	090
44141		A	Partial removal of colon	19.51	NA	11.52	2.55	NA	33.58	090
44143		A	Partial removal of colon	20.17	NA	11.83	2.62	NA	34.62	090
44144		A	Partial removal of colon	18.89	NA	10.76	2.53	NA	32.18	090
44145		A	Partial removal of colon	23.18	NA	11.32	2.78	NA	37.28	090
44146		A	Partial removal of colon	24.16	NA	13.56	3.14	NA	40.86	090
44147		A	Partial removal of colon	18.17	NA	9.40	3.30	NA	30.87	090
44150		A	Removal of colon	21.01	NA	12.18	3.17	NA	36.36	090
44151		A	Removal of colon/ileostomy	20.04	NA	12.76	2.22	NA	35.02	090
44152		A	Removal of colon/ileostomy	24.41	NA	15.25	3.36	NA	43.02	090
44153		A	Removal of colon/ileostomy	26.83	NA	15.26	3.63	NA	45.72	090
44155		A	Removal of colon	24.44	NA	13.46	3.50	NA	41.40	090
44156		A	Removal of colon/ileostomy	23.01	NA	13.26	2.52	NA	38.79	090
44160		A	Removal of colon	15.88	NA	7.85	2.68	NA	26.41	090
44300		A	Open bowel to skin	8.88	NA	5.32	1.29	NA	15.49	090
44310		A	Ileostomy/jejunostomy	11.70	NA	7.71	1.66	NA	21.07	090
44312		A	Revision of ileostomy	5.88	NA	4.12	0.45	NA	10.45	090
44314		A	Revision of ileostomy	11.04	NA	7.79	1.21	NA	20.04	090
44316		A	Devise bowel pouch	15.47	NA	11.49	1.43	NA	28.39	090
44320		A	Colostomy	12.94	NA	8.94	1.57	NA	23.45	090
44322		A	Colostomy with biopsies	11.98	NA	8.75	1.88	NA	22.61	090
44340		A	Revision of colostomy	5.66	NA	3.74	0.35	NA	9.75	090
44345		A	Revision of colostomy	11.32	NA	6.80	1.03	NA	19.15	090
44346		A	Revision of colostomy	12.46	NA	7.25	1.38	NA	21.09	090
44360		A	Small bowel endoscopy	2.92	NA	1.19	0.32	NA	4.43	000
44361		A	Small bowel endoscopy,biopsy	3.23	NA	1.29	0.34	NA	4.86	000
44363		A	Small bowel endoscopy	3.94	NA	1.52	0.36	NA	5.82	000
44364		A	Small bowel endoscopy	4.22	NA	1.67	0.72	NA	6.61	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
44365		A	Small bowel endoscopy	3.73	NA	1.50	0.72	NA	5.95	000
44366		A	Small bowel endoscopy	4.97	NA	1.90	0.45	NA	7.32	000
44369		A	Small bowel endoscopy	5.09	NA	1.96	0.50	NA	7.55	000
44372		A	Small bowel endoscopy	4.97	NA	1.96	0.67	NA	7.60	000
44373		A	Small bowel endoscopy	3.94	NA	1.57	0.50	NA	6.01	000
44376		A	Small bowel endoscopy	5.69	NA	2.19	0.26	NA	8.14	000
44377		A	Small bowel endoscopy	5.98	NA	2.27	0.28	NA	8.53	000
44378		A	Small bowel endoscopy	7.71	NA	2.90	0.35	NA	10.96	000
44380		A	Small bowel endoscopy	1.51	NA	0.70	0.22	NA	2.43	000
44382		A	Small bowel endoscopy	1.82	NA	0.81	0.29	NA	2.92	000
44385		A	Endoscopy of bowel pouch	1.82	2.87	0.90	0.34	5.03	3.06	000
44386		A	Endoscopy, bowel pouch, biopsy	2.12	3.78	1.04	0.15	6.05	3.31	000
44388		A	Colon endoscopy	2.82	3.48	1.30	0.50	6.80	4.62	000
44389		A	Colonoscopy with biopsy	3.13	4.09	1.41	0.45	7.67	4.99	000
44390		A	Colonoscopy for foreign body	3.83	4.31	1.71	0.28	8.42	5.82	000
44391		A	Colonoscopy for bleeding	4.32	3.79	1.81	0.53	8.64	6.66	000
44392		A	Colonoscopy & polypectomy	3.82	4.34	1.66	0.70	8.86	6.18	000
44393		A	Colonoscopy, lesion removal	4.84	4.39	2.01	0.70	9.93	7.55	000
44394		A	Colonoscopy w/snare	4.43	4.53	1.90	0.70	9.66	7.03	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.25	0.02	NA	0.76	000
44602		A	Suture, small intestine	10.61	NA	5.66	1.62	NA	17.89	090
44603		A	Suture, small intestine	14.00	NA	7.23	1.96	NA	23.19	090
44604		A	Suture, large intestine	14.28	NA	7.08	1.67	NA	23.03	090
44605		A	Repair of bowel lesion	15.37	NA	7.91	2.02	NA	25.30	090
44615		A	Intestinal stricturoplasty	14.19	NA	7.34	1.57	NA	23.10	090
44620		A	Repair bowel opening	10.87	NA	5.63	1.26	NA	17.76	090
44625		A	Repair bowel opening	13.41	NA	6.71	2.03	NA	22.15	090
44626		A	Repair bowel opening	22.59	NA	10.26	2.40	NA	35.25	090
44640		A	Repair bowel-skin fistula	14.83	NA	7.81	1.35	NA	23.99	090
44650		A	Repair bowel fistula	15.25	NA	7.97	1.46	NA	24.68	090
44660		A	Repair bowel-bladder fistula	14.63	NA	7.85	1.21	NA	23.69	090
44661		A	Repair bowel-bladder fistula	16.99	NA	8.69	2.52	NA	28.20	090
44680		A	Surgical revision, intestine	13.72	NA	7.51	2.14	NA	23.37	090
44700		A	Suspend bowel w/prosthesis	14.35	NA	7.86	2.40	NA	24.61	090
44800		A	Excision of bowel pouch	11.23	NA	5.71	1.08	NA	18.02	090
44820		A	Excision of mesentery lesion	10.31	NA	5.39	1.21	NA	16.91	090
44850		A	Repair of mesentery	9.57	NA	5.09	1.18	NA	15.84	090
44900		A	Drain, app abscess, open	8.82	NA	5.23	0.88	NA	14.93	090
44901		A	Drain, app abscess, perc	3.38	NA	3.15	0.30	NA	6.83	000
44950		A	Appendectomy	8.70	NA	4.46	1.01	NA	14.17	090
44955		A	Appendectomy	1.53	NA	0.68	0.60	NA	2.81	ZZZ
44960		A	Appendectomy	10.74	NA	5.72	1.24	NA	17.70	090
45000		A	Drainage of pelvic abscess	4.52	NA	3.28	0.24	NA	8.04	090
45005		A	Drainage of rectal abscess	1.99	2.91	1.24	0.21	5.11	3.44	010
45020		A	Drainage of rectal abscess	4.72	NA	3.18	0.51	NA	8.41	090
45100		A	Biopsy of rectum	3.68	3.40	1.91	0.35	7.43	5.94	090
45108		A	Removal of anorectal lesion	4.76	4.36	2.54	0.53	9.65	7.83	090
45110		A	Removal of rectum	23.80	NA	11.87	3.43	NA	39.10	090
45111		A	Partial removal of rectum	16.48	NA	8.73	2.49	NA	27.70	090
45112		A	Removal of rectum	25.96	NA	12.03	3.36	NA	41.35	090
45113		A	Partial proctectomy	25.99	NA	12.33	3.36	NA	41.68	090
45114		A	Partial removal of rectum	23.22	NA	11.45	3.24	NA	37.91	090
45116		A	Partial removal of rectum	20.89	NA	10.07	2.34	NA	33.30	090
45119		A	Remove, rectum w/reservoir	26.21	NA	12.12	3.36	NA	41.69	090
45120		A	Removal of rectum	24.60	NA	12.00	3.54	NA	40.14	090
45121		A	Removal of rectum and colon	27.04	NA	13.11	2.01	NA	42.16	090
45123		A	Partial proctectomy	14.20	NA	7.46	2.49	NA	24.15	090
45130		A	Excision of rectal prolapse	13.97	NA	6.51	1.79	NA	22.27	090
45135		A	Excision of rectal prolapse	16.39	NA	8.28	3.50	NA	28.17	090
45150		A	Excision of rectal stricture	5.67	4.05	2.84	0.63	10.35	9.14	090
45160		A	Excision of rectal lesion	13.02	NA	6.50	1.56	NA	21.08	090
45170		A	Excision of rectal lesion	9.77	NA	4.81	0.96	NA	15.54	090
45190		A	Destruction, rectal tumor	8.28	NA	4.15	1.06	NA	13.49	090
45300		A	Proctosigmoidoscopy	0.70	2.68	0.30	0.07	3.45	1.07	000
45303		A	Proctosigmoidoscopy	0.80	3.28	0.34	0.12	4.20	1.26	000
45305		A	Proctosigmoidoscopy; biopsy	1.01	2.65	0.42	0.14	3.80	1.57	000
45307		A	Proctosigmoidoscopy	1.71	3.54	0.60	0.18	5.43	2.49	000
45308		A	Proctosigmoidoscopy	1.51	2.24	0.62	0.20	3.95	2.33	000
45309		A	Proctosigmoidoscopy	2.01	3.03	0.81	0.20	5.24	3.02	000
45315		A	Proctosigmoidoscopy	2.54	3.79	1.00	0.18	6.51	3.72	000
45317		A	Proctosigmoidoscopy	2.73	2.62	1.06	0.19	5.54	3.98	000
45320		A	Proctosigmoidoscopy	2.88	2.85	1.13	0.34	6.07	4.35	000
45321		A	Proctosigmoidoscopy	2.12	NA	0.84	0.27	NA	3.23	000
45330		A	Sigmoidoscopy, diagnostic	0.96	3.42	0.38	0.12	4.50	1.46	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
45331		A	Sigmoidoscopy and biopsy	1.26	3.44	0.49	0.15	4.85	1.90	000
45332		A	Sigmoidoscopy	1.96	4.71	0.75	0.16	6.83	2.87	000
45333		A	Sigmoidoscopy & polypectomy	1.96	3.76	0.75	0.26	5.98	2.97	000
45334		A	Sigmoidoscopy for bleeding	2.99	NA	1.11	0.23	NA	4.33	000
45337		A	Sigmoidoscopy, decompression	2.36	NA	0.90	0.38	NA	3.64	000
45338		A	Sigmoidoscopy	2.57	4.21	0.97	0.26	7.04	3.80	000
45339		A	Sigmoidoscopy	3.14	3.94	1.16	0.31	7.39	4.61	000
45355		A	Surgical colonoscopy	3.52	NA	1.71	0.10	NA	5.33	000
45378		A	Diagnostic colonoscopy	3.70	4.29	1.97	0.39	8.38	6.06	000
45378	53	A	Diagnostic colonoscopy	0.96	1.28	0.59	0.12	2.36	1.67	000
45379		A	Colonoscopy	4.72	4.69	2.08	0.45	9.86	7.25	000
45380		A	Colonoscopy and biopsy	4.01	4.37	1.74	0.40	8.78	6.15	000
45382		A	Colonoscopy,control bleeding	5.73	5.11	2.33	0.41	11.25	8.47	000
45383		A	Colonoscopy, lesion removal	5.87	5.21	2.42	0.50	11.58	8.79	000
45384		A	Colonoscopy	4.70	4.73	2.01	0.58	10.01	7.29	000
45385		A	Colonoscopy, lesion removal	5.31	4.93	2.22	0.58	10.82	8.11	000
45500		A	Repair of rectum	7.29	NA	3.84	1.21	NA	12.34	090
45505		A	Repair of rectum	6.02	NA	3.05	1.23	NA	10.30	090
45520		A	Treatment of rectal prolapse	0.55	0.46	0.21	0.10	1.11	0.86	000
45540		A	Correct rectal prolapse	12.92	NA	6.63	2.10	NA	21.65	090
45541		A	Correct rectal prolapse	10.64	NA	5.55	2.04	NA	18.23	090
45550		A	Repair rectum; remove sigmoid	18.26	NA	8.85	2.38	NA	29.49	090
45560		A	Repair of rectocele	8.40	NA	4.94	0.98	NA	14.32	090
45562		A	Exploration/repair of rectum	12.21	NA	6.07	1.58	NA	19.86	090
45563		A	Exploration/repair of rectum	18.63	NA	9.55	2.49	NA	30.67	090
45800		A	Repair rectumbladder fistula	14.11	NA	6.95	1.45	NA	22.51	090
45805		A	Repair fistula; colostomy	16.50	NA	8.63	2.39	NA	27.52	090
45820		A	Repair rectourethral fistula	14.67	NA	7.07	1.23	NA	22.97	090
45825		A	Repair fistula; colostomy	16.87	NA	9.22	1.66	NA	27.75	090
45900		A	Reduction of rectal prolapse	1.83	NA	0.96	0.11	NA	2.90	010
45905		A	Dilation of anal sphincter	1.61	1.75	0.78	0.12	3.48	2.51	010
45910		A	Dilation of rectal narrowing	1.96	2.25	0.92	0.13	4.34	3.01	010
45915		A	Remove rectal obstruction	2.20	2.70	0.92	0.09	4.99	3.21	010
46030		A	Removal of rectal marker	1.23	1.57	0.93	0.07	2.87	2.23	010
46040		A	Incision of rectal abscess	4.96	3.80	2.63	0.34	9.10	7.93	090
46045		A	Incision of rectal abscess	4.32	NA	2.35	0.38	NA	7.05	090
46050		A	Incision of anal abscess	1.19	2.11	0.91	0.11	3.41	2.21	010
46060		A	Incision of rectal abscess	5.69	NA	3.10	1.12	NA	9.91	090
46070		A	Incision of anal septum	2.71	NA	5.74	0.33	NA	8.78	090
46080		A	Incision of anal sphincter	2.49	2.33	1.43	0.43	5.25	4.35	010
46083		A	Incise external hemorrhoid	1.40	2.90	0.98	0.08	4.38	2.46	010
46200		A	Removal of anal fissure	3.42	2.53	1.97	0.66	6.61	6.05	090
46210		A	Removal of anal crypt	2.67	3.28	1.65	0.14	6.09	4.46	090
46211		A	Removal of anal crypts	4.25	3.26	2.29	0.38	7.89	6.92	090
46220		A	Removal of anal tab	1.56	0.99	0.60	0.12	2.67	2.28	010
46221		A	Ligation of hemorrhoid(s)	1.43	1.81	0.55	0.14	3.38	2.12	010
46230		A	Removal of anal tabs	2.57	2.78	1.48	0.12	5.47	4.17	010
46250		A	Hemorrhoidectomy	4.53	3.80	2.48	0.52	8.85	7.53	090
46255		A	Hemorrhoidectomy	5.36	4.10	2.83	0.85	10.31	9.04	090
46257		A	Remove hemorrhoids & fissure	6.28	NA	3.16	1.08	NA	10.52	090
46258		A	Remove hemorrhoids & fistula	6.67	NA	3.35	1.22	NA	11.24	090
46260		A	Hemorrhoidectomy	7.42	NA	3.78	1.25	NA	12.45	090
46261		A	Remove hemorrhoids & fissure	8.24	NA	4.05	1.34	NA	13.63	090
46262		A	Remove hemorrhoids & fistula	8.73	NA	4.31	1.39	NA	14.43	090
46270		A	Removal of anal fistula	3.72	3.41	2.13	0.37	7.50	6.22	090
46275		A	Removal of anal fistula	4.56	3.52	2.42	1.13	9.21	8.11	090
46280		A	Removal of anal fistula	5.98	NA	3.23	1.24	NA	10.45	090
46285		A	Removal of anal fistula	4.09	2.52	2.21	0.43	7.04	6.73	090
46288		A	Repair anal fistula	7.13	NA	3.27	0.83	NA	11.23	090
46320		A	Removal of hemorrhoid clot	1.61	2.39	0.98	0.11	4.11	2.70	010
46500		A	Injection into hemorrhoids	1.61	1.56	0.60	0.06	3.23	2.27	010
46600		A	Diagnostic anoscopy	0.50	0.56	0.14	0.03	1.09	0.67	000
46604		A	Anoscopy and dilation	1.31	0.77	0.49	0.06	2.14	1.86	000
46606		A	Anoscopy and biopsy	0.81	0.64	0.31	0.06	1.51	1.18	000
46608		A	Anoscopy; remove foreign body	1.51	1.34	0.39	0.12	2.97	2.02	000
46610		A	Anoscopy; remove lesion	1.32	1.12	0.51	0.15	2.59	1.98	000
46611		A	Anoscopy	1.81	1.45	0.70	0.15	3.41	2.66	000
46612		A	Anoscopy; remove lesions	2.34	1.66	0.87	0.20	4.20	3.41	000
46614		A	Anoscopy; control bleeding	2.01	1.26	0.73	0.25	3.52	2.99	000
46615		A	Anoscopy	2.68	1.47	1.03	0.25	4.40	3.96	000
46700		A	Repair of anal stricture	7.25	NA	3.64	1.24	NA	12.13	090
46705		A	Repair of anal stricture	7.17	NA	3.84	0.77	NA	11.78	090
46715		A	Repair of anovaginal fistula	7.46	NA	5.30	0.82	NA	13.58	090
46716		A	Repair of anovaginal fistula	12.15	NA	18.73	1.40	NA	32.28	090

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
46730		A	Construction of absent anus	21.57	NA	10.64	2.50	NA	34.71	090
46735		A	Construction of absent anus	25.94	NA	12.05	3.04	NA	41.03	090
46740		A	Construction of absent anus	23.11	NA	10.68	2.68	NA	36.47	090
46742		A	Repair, imperforated anus	29.67	NA	40.97	1.93	NA	72.57	090
46744		A	Repair, cloacal anomaly	33.21	NA	15.40	2.17	NA	50.78	090
46746		A	Repair, cloacal anomaly	36.74	NA	16.73	2.37	NA	55.84	090
46748		A	Repair, cloacal anomaly	40.52	NA	53.98	2.64	NA	97.14	090
46750		A	Repair of anal sphincter	8.14	NA	4.39	1.22	NA	13.75	090
46751		A	Repair of anal sphincter	8.56	NA	13.65	0.95	NA	23.16	090
46753		A	Reconstruction of anus	6.58	NA	3.24	1.02	NA	10.84	090
46754		A	Removal of suture from anus	1.54	2.74	1.09	0.30	4.58	2.93	010
46760		A	Repair of anal sphincter	11.46	NA	6.44	1.41	NA	19.31	090
46761		A	Repair of anal sphincter	10.99	NA	5.26	1.35	NA	17.60	090
46762		A	Implant artificial sphincter	10.09	NA	5.03	1.21	NA	16.33	090
46900		A	Destruction, anal lesion(s)	1.91	2.68	1.27	0.06	4.65	3.24	010
46910		A	Destruction, anal lesion(s)	1.86	2.22	1.27	0.08	4.16	3.21	010
46916		A	Cryosurgery, anal lesion(s)	1.86	2.01	1.33	0.06	3.93	3.25	010
46917		A	Laser surgery,anal lesion(s)	1.86	2.27	1.37	0.31	4.44	3.54	010
46922		A	Excision of anal lesion(s)	1.86	2.25	1.26	0.23	4.34	3.35	010
46924		A	Destruction, anal lesion(s)	2.76	2.99	1.63	0.46	6.21	4.85	010
46934		A	Destruction of hemorrhoids	4.08	3.64	2.61	0.17	7.89	6.86	090
46935		A	Destruction of hemorrhoids	2.43	4.73	1.60	0.22	7.38	4.25	010
46936		A	Destruction of hemorrhoids	4.30	3.45	2.70	0.24	7.99	7.24	090
46937		A	Cryotherapy of rectal lesion	2.69	2.73	1.54	0.45	5.87	4.68	010
46938		A	Cryotherapy of rectal lesion	4.66	4.51	2.99	0.52	9.69	8.17	090
46940		A	Treatment of anal fissure	2.32	2.58	1.20	0.09	4.99	3.61	010
46942		A	Treatment of anal fissure	2.04	2.01	1.19	0.08	4.13	3.31	010
46945		A	Ligation of hemorrhoids	2.14	2.53	1.51	0.12	4.79	3.77	090
46946		A	Ligation of hemorrhoids	3.00	2.59	1.88	0.17	5.76	5.05	090
47000		A	Needle biopsy of liver	1.90	5.71	1.13	0.13	7.74	3.16	000
47001		A	Needle biopsy, liver	1.90	NA	0.83	0.13	NA	2.86	ZZZ
47010		A	Open drainage, liver lesion	10.28	NA	7.53	1.13	NA	18.94	090
47011		A	Percut drain, liver lesion	3.70	NA	5.32	0.33	NA	9.35	000
47015		A	Inject/aspirate liver cyst	9.70	NA	5.97	1.13	NA	16.80	090
47100		A	Wedge biopsy of liver	7.49	NA	4.54	0.67	NA	12.70	090
47120		A	Partial removal of liver	22.79	NA	12.14	2.48	NA	37.41	090
47122		A	Extensive removal of liver	35.39	NA	18.09	3.59	NA	57.07	090
47125		A	Partial removal of liver	31.58	NA	15.94	3.61	NA	51.13	090
47130		A	Partial removal of liver	34.25	NA	17.15	3.89	NA	55.29	090
47134		R	Partial removal, donor liver	39.15	NA	16.42	4.77	NA	60.34	XXX
47135		R	Transplantation of liver	81.52	NA	42.58	8.49	NA	132.59	090
47136		R	Transplantation of liver	68.60	NA	114.97	7.79	NA	191.36	090
47300		A	Surgery for liver lesion	9.68	NA	5.76	1.59	NA	17.03	090
47350		A	Repair liver wound	12.56	NA	6.72	1.49	NA	20.77	090
47360		A	Repair liver wound	17.28	NA	9.73	2.18	NA	29.19	090
47361		A	Repair liver wound	30.25	NA	14.34	3.41	NA	48.00	090
47362		A	Repair liver wound	11.88	NA	7.38	1.22	NA	20.48	090
47400		A	Incision of liver duct	20.86	NA	10.76	1.36	NA	32.98	090
47420		A	Incision of bile duct	16.72	NA	8.61	1.99	NA	27.32	090
47425		A	Incision of bile duct	16.68	NA	8.96	2.45	NA	28.09	090
47460		A	Incise bile duct sphincter	15.17	NA	8.18	1.82	NA	25.17	090
47480		A	Incision of gallbladder	9.10	NA	5.82	1.59	NA	16.51	090
47490		A	Incision of gallbladder	7.23	NA	6.73	0.38	NA	14.34	090
47500		A	Injection for liver x-rays	1.96	NA	0.62	0.14	NA	2.72	000
47505		A	Injection for liver x-rays	0.76	7.82	0.24	0.14	8.72	1.14	000
47510		A	Insert catheter, bile duct	7.83	NA	22.22	0.25	NA	30.30	090
47511		A	Insert bile duct drain	10.50	NA	23.45	0.25	NA	34.20	090
47525		A	Change bile duct catheter	5.55	NA	3.18	0.16	NA	8.89	010
47530		A	Revise, reinsert bile tube	5.85	NA	4.65	0.19	NA	10.69	090
47550		A	Bile duct endoscopy	3.02	NA	1.28	0.35	NA	4.65	000
47552		A	Biliary endoscopy, thru skin	6.04	NA	2.34	0.21	NA	8.59	000
47553		A	Biliary endoscopy, thru skin	6.35	NA	2.27	0.62	NA	9.24	000
47554		A	Biliary endoscopy, thru skin	9.06	NA	3.49	0.67	NA	13.22	000
47555		A	Biliary endoscopy, thru skin	7.56	NA	2.65	0.30	NA	10.51	000
47556		A	Biliary endoscopy, thru skin	8.56	NA	2.96	0.30	NA	11.82	000
47600		A	Removal of gallbladder	11.42	NA	6.00	1.58	NA	19.00	090
47605		A	Removal of gallbladder	12.36	NA	6.40	1.75	NA	20.51	090
47610		A	Removal of gallbladder	15.83	NA	8.09	2.00	NA	25.92	090
47612		A	Removal of gallbladder	15.80	NA	8.17	3.05	NA	27.02	090
47620		A	Removal of gallbladder	17.36	NA	8.97	2.36	NA	28.69	090
47630		A	Remove bile duct stone	9.11	NA	3.49	0.40	NA	13.00	090
47700		A	Exploration of bile ducts	14.93	NA	8.10	1.58	NA	24.61	090
47701		A	Bile duct revision	27.81	NA	13.96	1.90	NA	43.67	090
47711		A	Excision of bile duct tumor	19.37	NA	10.08	2.46	NA	31.91	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
47712		A	Excision of bile duct tumor	25.44	NA	12.63	2.46	NA	40.53	090
47715		A	Excision of bile duct cyst	15.81	NA	8.45	1.71	NA	25.97	090
47716		A	Fusion of bile duct cyst	13.83	NA	7.61	1.53	NA	22.97	090
47720		A	Fuse gallbladder & bowel	13.38	NA	7.30	1.93	NA	22.61	090
47721		A	Fuse upper gi structures	16.08	NA	8.50	2.47	NA	27.05	090
47740		A	Fuse gallbladder & bowel	15.54	NA	8.29	2.14	NA	25.97	090
47741		A	Fuse gallbladder & bowel	17.95	NA	9.30	3.02	NA	30.27	090
47760		A	Fuse bile ducts and bowel	21.74	NA	10.76	2.53	NA	35.03	090
47765		A	Fuse liver ducts & bowel	20.93	NA	11.52	2.97	NA	35.42	090
47780		A	Fuse bile ducts and bowel	22.29	NA	11.27	2.73	NA	36.29	090
47785		A	Fuse bile ducts and bowel	26.23	NA	13.50	2.73	NA	42.46	090
47800		A	Reconstruction of bile ducts	19.60	NA	10.14	2.43	NA	32.17	090
47801		A	Placement, bile duct support	12.76	NA	8.03	0.81	NA	21.60	090
47802		A	Fuse liver duct & intestine	18.13	NA	9.88	1.75	NA	29.76	090
47900		A	Suture bile duct injury	16.74	NA	8.87	2.43	NA	28.04	090
48000		A	Drainage of abdomen	14.91	NA	8.86	1.40	NA	25.17	090
48001		A	Placement of drain, pancreas	18.83	NA	10.21	1.89	NA	30.93	090
48005		A	Resect/debride pancreas	22.40	NA	11.28	2.14	NA	35.82	090
48020		A	Removal of pancreatic stone	14.22	NA	7.80	1.57	NA	23.59	090
48100		A	Biopsy of pancreas	11.08	NA	6.06	0.79	NA	17.93	090
48102		A	Needle biopsy, pancreas	4.68	5.97	2.73	0.25	10.90	7.66	010
48120		A	Removal of pancreas lesion	14.36	NA	7.39	2.07	NA	23.82	090
48140		A	Partial removal of pancreas	20.78	NA	10.31	2.83	NA	33.92	090
48145		A	Partial removal of pancreas	21.76	NA	11.16	3.16	NA	36.08	090
48146		A	Pancreatectomy	23.91	NA	12.87	1.92	NA	38.70	090
48148		A	Removal of pancreatic duct	15.71	NA	8.32	1.68	NA	25.71	090
48150		A	Partial removal of pancreas	43.48	NA	21.74	4.75	NA	69.97	090
48152		A	Pancreatectomy	39.63	NA	19.76	4.75	NA	64.14	090
48153		A	Pancreatectomy	43.38	NA	21.70	4.75	NA	69.83	090
48154		A	Pancreatectomy	39.95	NA	20.03	4.75	NA	64.73	090
48155		A	Removal of pancreas	22.32	NA	13.03	4.26	NA	39.61	090
48180		A	Fuse pancreas and bowel	22.39	NA	11.09	2.63	NA	36.11	090
48400		A	Injection, intraoperative	1.95	NA	0.77	0.24	NA	2.96	ZZZ
48500		A	Surgery of pancreas cyst	13.84	NA	7.20	1.66	NA	22.70	090
48510		A	Drain pancreatic pseudocyst	12.96	NA	7.51	1.44	NA	21.91	090
48511		A	Drain pancreatic pseudocyst	4.00	NA	4.36	0.35	NA	8.71	000
48520		A	Fuse pancreas cyst and bowel	14.12	NA	7.23	2.43	NA	23.78	090
48540		A	Fuse pancreas cyst and bowel	17.86	NA	8.85	2.65	NA	29.36	090
48545		A	Pancreatorrhaphy	16.47	NA	8.38	1.79	NA	26.64	090
48547		A	Duodenal exclusion	23.40	NA	11.06	2.58	NA	37.04	090
48554		N	Transplantallograft pancreas	+34.17	NA	57.19	4.16	NA	95.52	XXX
48556		A	Removal, allograft pancreas	15.71	NA	8.69	1.69	NA	26.09	090
49000		A	Exploration of abdomen	11.68	NA	5.90	1.40	NA	18.98	090
49002		A	Reopening of abdomen	10.49	NA	5.84	1.21	NA	17.54	090
49010		A	Exploration behind abdomen	12.28	NA	6.40	1.31	NA	19.99	090
49020		A	Drain abdominal abscess	16.79	NA	9.55	0.91	NA	27.25	090
49021		A	Drain abdominal abscess	3.38	NA	4.88	0.91	NA	9.17	000
49040		A	Open drainage abdom abscess	9.94	NA	6.91	1.27	NA	18.12	090
49041		A	Percut drain abdom abscess	4.00	NA	4.79	0.35	NA	9.14	000
49060		A	Open drain retroper abscess	11.66	NA	7.71	1.01	NA	20.38	090
49061		A	Percutdrain retroper abscess	3.70	NA	5.01	0.33	NA	9.04	000
49062		A	Drain to peritoneal cavity	11.36	NA	6.59	0.79	NA	18.74	090
49080		A	Puncture, peritoneal cavity	1.35	1.86	0.65	0.08	3.29	2.08	000
49081		A	Removal of abdominal fluid	1.26	2.12	0.61	0.07	3.45	1.94	000
49085		A	Remove abdomen foreign body	8.93	NA	5.02	0.67	NA	14.62	090
49180		A	Biopsy, abdominal mass	1.73	4.35	1.34	0.20	6.28	3.27	000
49200		A	Removal of abdominal lesion	10.25	NA	5.98	1.70	NA	17.93	090
49201		A	Removal of abdominal lesion	14.84	NA	8.52	2.50	NA	25.86	090
49215		A	Excise sacral spine tumor	22.36	NA	11.08	1.59	NA	35.03	090
49220		A	Multiple surgery, abdomen	14.88	NA	7.86	2.53	NA	25.27	090
49250		A	Excision of umbilicus	8.35	NA	4.41	0.96	NA	13.72	090
49255		A	Removal of omentum	11.14	NA	6.40	1.15	NA	18.69	090
49400		A	Air injection into abdomen	1.88	NA	0.87	0.17	NA	2.92	000
49420		A	Insert abdominal drain	2.22	NA	1.20	0.20	NA	3.62	000
49421		A	Insert abdominal drain	5.54	NA	3.52	0.81	NA	9.87	090
49422		A	Remove perm cannula/catheter	6.25	NA	3.03	0.81	NA	10.09	010
49423		A	Exchange drainage cath	1.46	NA	2.00	0.13	NA	3.59	000
49424		A	Assess cyst, contrast inj	0.76	NA	1.30	0.07	NA	2.13	000
49425		A	Insert abdomen-venous drain	11.37	NA	6.08	1.78	NA	19.23	090
49426		A	Revise abdomen-venous shunt	9.63	NA	5.42	1.07	NA	16.12	090
49427		A	Injection, abdominal shunt	0.89	NA	0.56	0.03	NA	1.48	000
49428		A	Ligation of shunt	2.38	NA	1.42	0.24	NA	4.04	010
49429		A	Removal of shunt	7.40	NA	4.02	0.77	NA	12.19	010
49495		A	Repair inguinal hernia, init	5.89	NA	3.06	0.95	NA	9.90	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
49496		A	Repair inguinal hernia, init	8.79	NA	5.33	1.08	NA	15.20	090
49500		A	Repair inguinal hernia	4.68	NA	2.69	0.95	NA	8.32	090
49501		A	Repair inguinal hernia, init	7.58	NA	3.84	1.08	NA	12.50	090
49505		A	Repair inguinal hernia	6.49	3.34	4.15	0.94	10.77	11.58	090
49507		A	Repair, inguinal hernia	8.17	NA	4.80	1.08	NA	14.05	090
49520		A	Rerepair inguinal hernia	8.22	NA	4.39	1.11	NA	13.72	090
49521		A	Repair inguinal hernia, rec	10.22	NA	5.10	1.08	NA	16.40	090
49525		A	Repair inguinal hernia	7.32	NA	3.91	1.16	NA	12.39	090
49540		A	Repair lumbar hernia	8.87	NA	4.66	1.12	NA	14.65	090
49550		A	Repair femoral hernia	7.37	NA	3.70	0.97	NA	12.04	090
49553		A	Repair femoral hernia, init	8.06	NA	4.29	0.97	NA	13.32	090
49555		A	Repair femoral hernia	7.71	NA	4.25	1.26	NA	13.22	090
49557		A	Repair femoral hernia, recur	9.52	NA	4.85	1.26	NA	15.63	090
49560		A	Repair abdominal hernia	9.88	NA	5.05	1.19	NA	16.12	090
49561		A	Repair incisional hernia	12.17	NA	5.94	1.19	NA	19.30	090
49565		A	Rerepair abdominal hernia	9.88	NA	5.28	1.35	NA	16.51	090
49566		A	Repair incisional hernia	12.30	NA	6.02	1.35	NA	19.67	090
49568		A	Hernia repair w/mesh	4.89	NA	2.07	0.59	NA	7.55	ZZZ
49570		A	Repair epigastric hernia	4.86	NA	2.74	0.91	NA	8.51	090
49572		A	Repair, epigastric hernia	5.75	NA	3.43	1.18	NA	10.36	090
49580		A	Repair umbilical hernia	3.51	NA	2.17	0.94	NA	6.62	090
49582		A	Repair umbilical hernia	5.68	NA	3.63	0.94	NA	10.25	090
49585		A	Repair umbilical hernia	5.32	NA	3.10	0.91	NA	9.33	090
49587		A	Repair umbilical hernia	6.46	NA	3.65	0.91	NA	11.02	090
49590		A	Repair abdominal hernia	7.29	NA	3.84	1.22	NA	12.35	090
49600		A	Repair umbilical lesion	10.35	NA	5.21	0.77	NA	16.33	090
49605		A	Repair umbilical lesion	22.66	NA	11.17	1.77	NA	35.60	090
49606		A	Repair umbilical lesion	18.60	NA	9.65	0.96	NA	29.21	090
49610		A	Repair umbilical lesion	10.50	NA	6.60	1.27	NA	18.37	090
49611		A	Repair umbilical lesion	8.92	NA	16.34	0.58	NA	25.84	090
49900		A	Repair of abdominal wall	12.28	NA	6.58	0.75	NA	19.61	090
49905		A	Omental flap	6.55	NA	3.08	0.80	NA	10.43	ZZZ
50010		A	Exploration of kidney	10.98	NA	6.07	1.13	NA	18.18	090
50020		A	Open drain renal abscess	14.66	NA	9.96	0.85	NA	25.47	090
50021		A	Percut drain renal abscess	3.38	NA	6.17	0.30	NA	9.85	000
50040		A	Drainage of kidney	14.94	NA	9.11	0.62	NA	24.67	090
50045		A	Exploration of kidney	15.46	NA	7.78	0.89	NA	24.13	090
50060		A	Removal of kidney stone	19.30	NA	9.20	1.21	NA	29.71	090
50065		A	Incision of kidney	20.79	NA	9.81	1.35	NA	31.95	090
50070		A	Incision of kidney	20.32	NA	9.58	1.35	NA	31.25	090
50075		A	Removal of kidney stone	25.34	NA	11.74	1.62	NA	38.70	090
50080		A	Removal of kidney stone	14.71	NA	9.10	1.15	NA	24.96	090
50081		A	Removal of kidney stone	21.80	NA	11.69	1.44	NA	34.93	090
50100		A	Revise kidney blood vessels	16.09	NA	8.58	1.35	NA	26.02	090
50120		A	Exploration of kidney	15.91	NA	8.00	1.24	NA	25.15	090
50125		A	Explore and drain kidney	16.52	NA	8.02	1.06	NA	25.60	090
50130		A	Removal of kidney stone	17.29	NA	8.46	1.26	NA	27.01	090
50135		A	Exploration of kidney	19.18	NA	9.18	1.63	NA	29.99	090
50200		A	Biopsy of kidney	2.63	NA	1.25	0.22	NA	4.10	000
50205		A	Biopsy of kidney	11.31	NA	5.98	0.69	NA	17.98	090
50220		A	Removal of kidney	17.15	NA	8.40	1.43	NA	26.98	090
50225		A	Removal of kidney	20.23	NA	9.58	1.70	NA	31.51	090
50230		A	Removal of kidney	22.07	NA	10.27	1.84	NA	34.18	090
50234		A	Removal of kidney & ureter	22.40	NA	10.39	1.65	NA	34.44	090
50236		A	Removal of kidney & ureter	24.86	NA	12.78	1.74	NA	39.38	090
50240		A	Partial removal of kidney	22.00	NA	11.71	1.70	NA	35.41	090
50280		A	Removal of kidney lesion	15.67	NA	7.84	1.16	NA	24.67	090
50290		A	Removal of kidney lesion	14.73	NA	7.26	1.19	NA	23.18	090
50320		A	Removal of donor kidney	22.21	NA	10.23	2.40	NA	34.84	090
50340		A	Removal of kidney	12.15	NA	5.67	2.24	NA	20.06	090
50360		A	Transplantation of kidney	31.53	NA	16.90	4.24	NA	52.67	090
50365		A	Transplantation of kidney	36.81	NA	19.94	3.89	NA	60.64	090
50370		A	Remove transplanted kidney	13.72	NA	8.02	1.92	NA	23.66	090
50380		A	Reimplantation of kidney	20.76	NA	12.25	1.71	NA	34.72	090
50390		A	Drainage of kidney lesion	1.96	NA	1.18	0.15	NA	3.29	000
50392		A	Insert kidney drain	3.38	NA	1.63	0.20	NA	5.21	000
50393		A	Insert ureteral tube	4.16	NA	1.87	0.26	NA	6.29	000
50394		A	Injection for kidney x-ray	0.76	10.57	0.24	0.05	11.38	1.05	000
50395		A	Create passage to kidney	3.38	NA	1.61	0.29	NA	5.28	000
50396		A	Measure kidney pressure	2.09	NA	0.76	0.05	NA	2.90	000
50398		A	Change kidney tube	1.46	0.79	1.66	0.05	2.30	3.17	000
50400		A	Revision of kidney/ureter	19.50	NA	9.32	1.36	NA	30.18	090
50405		A	Revision of kidney/ureter	23.93	NA	12.08	1.74	NA	37.75	090
50500		A	Repair of kidney wound	19.57	NA	9.85	1.64	NA	31.06	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
50520		A	Close kidney-skin fistula	17.23	NA	9.54	1.50	NA	28.27	090
50525		A	Repair renal-abdomen fistula	22.27	NA	11.53	1.99	NA	35.79	090
50526		A	Repair renal-abdomen fistula	24.02	NA	19.58	2.32	NA	45.92	090
50540		A	Revision of horseshoe kidney	19.93	NA	8.91	1.54	NA	30.38	090
50551		A	Kidney endoscopy	5.60	3.89	2.30	0.21	9.70	8.11	000
50553		A	Kidney endoscopy	5.99	13.31	2.48	0.17	19.47	8.64	000
50555		A	Kidney endoscopy & biopsy	6.53	14.10	2.65	0.45	21.08	9.63	000
50557		A	Kidney endoscopy & treatment	6.62	14.38	2.68	0.49	21.49	9.79	000
50559		A	Renal endoscopy; radiotracer	6.78	NA	2.74	0.14	NA	9.66	000
50561		A	Kidney endoscopy & treatment	7.59	12.38	3.03	0.49	20.46	11.11	000
50570		A	Kidney endoscopy	9.54	NA	3.77	0.14	NA	13.45	000
50572		A	Kidney endoscopy	10.35	NA	4.03	0.75	NA	15.13	000
50574		A	Kidney endoscopy & biopsy	11.02	NA	4.36	0.64	NA	16.02	000
50575		A	Kidney endoscopy	13.98	NA	5.42	0.97	NA	20.37	000
50576		A	Kidney endoscopy & treatment	10.99	NA	4.32	0.77	NA	16.08	000
50578		A	Renal endoscopy; radiotracer	11.35	NA	4.44	1.19	NA	16.98	000
50580		A	Kidney endoscopy & treatment	11.86	NA	4.62	0.35	NA	16.83	000
50590		A	Fragmenting of kidney stone	9.09	4.97	6.03	0.97	15.03	16.09	090
50600		A	Exploration of ureter	15.84	NA	7.94	1.01	NA	24.79	090
50605		A	Insert ureteral support	15.46	NA	7.72	0.60	NA	23.78	090
50610		A	Removal of ureter stone	15.92	NA	8.07	1.17	NA	25.16	090
50620		A	Removal of ureter stone	15.16	NA	7.61	1.16	NA	23.93	090
50630		A	Removal of ureter stone	14.94	NA	7.56	1.25	NA	23.75	090
50650		A	Removal of ureter	17.41	NA	8.64	1.21	NA	27.26	090
50660		A	Removal of ureter	19.55	NA	9.48	1.53	NA	30.56	090
50684		A	Injection for ureter x-ray	0.76	10.95	0.27	0.05	11.76	1.08	000
50686		A	Measure ureter pressure	1.51	3.50	0.58	0.04	5.05	2.13	000
50688		A	Change of ureter tube	1.17	NA	1.59	0.04	NA	2.80	010
50690		A	Injection for ureter x-ray	1.16	12.38	0.38	0.03	13.57	1.57	000
50700		A	Revision of ureter	15.21	NA	7.72	1.29	NA	24.22	090
50715		A	Release of ureter	18.90	NA	10.01	1.49	NA	30.40	090
50722		A	Release of ureter	16.35	NA	8.95	1.97	NA	27.27	090
50725		A	Release/revise ureter	18.49	NA	9.15	1.75	NA	29.39	090
50727		A	Revise ureter	8.18	NA	5.20	0.51	NA	13.89	090
50728		A	Revise ureter	12.02	NA	6.78	0.77	NA	19.57	090
50740		A	Fusion of ureter & kidney	18.42	NA	8.77	1.88	NA	29.07	090
50750		A	Fusion of ureter & kidney	19.51	NA	9.57	1.26	NA	30.34	090
50760		A	Fusion of ureters	18.42	NA	9.00	1.48	NA	28.90	090
50770		A	Splicing of ureters	19.51	NA	9.41	1.53	NA	30.45	090
50780		A	Reimplant ureter in bladder	18.36	NA	9.00	1.46	NA	28.82	090
50782		A	Reimplant ureter in bladder	19.54	NA	9.60	1.46	NA	30.60	090
50783		A	Reimplant ureter in bladder	20.55	NA	10.09	1.46	NA	32.10	090
50785		A	Reimplant ureter in bladder	20.52	NA	9.83	1.80	NA	32.15	090
50800		A	Implant ureter in bowel	14.52	NA	8.21	1.51	NA	24.24	090
50810		A	Fusion of ureter & bowel	20.05	NA	10.52	1.75	NA	32.32	090
50815		A	Urine shunt to bowel	19.93	NA	10.42	2.75	NA	33.10	090
50820		A	Construct bowel bladder	21.89	NA	10.95	2.50	NA	35.34	090
50825		A	Construct bowel bladder	28.18	NA	13.66	3.33	NA	45.17	090
50830		A	Revise urine flow	31.28	NA	14.49	2.27	NA	48.04	090
50840		A	Replace ureter by bowel	20.00	NA	10.26	1.35	NA	31.61	090
50845		A	Appendico-vesicostomy	20.89	NA	10.44	1.35	NA	32.68	090
50860		A	Transplant ureter to skin	15.36	NA	7.87	1.16	NA	24.39	090
50900		A	Repair of ureter	13.62	NA	6.95	1.15	NA	21.72	090
50920		A	Closure ureter/skin fistula	14.33	NA	7.26	0.99	NA	22.58	090
50930		A	Closure ureter/bowel fistula	18.72	NA	8.90	1.22	NA	28.84	090
50940		A	Release of ureter	14.51	NA	7.41	0.95	NA	22.87	090
50951		A	Endoscopy of ureter	5.84	4.15	2.39	0.17	10.16	8.40	000
50953		A	Endoscopy of ureter	6.24	13.47	2.55	0.16	19.87	8.95	000
50955		A	Ureter endoscopy & biopsy	6.75	14.05	2.72	0.25	21.05	9.72	000
50957		A	Ureter endoscopy & treatment	6.79	10.33	2.92	0.25	17.37	9.96	000
50959		A	Ureter endoscopy & tracer	4.40	NA	1.85	0.29	NA	6.54	000
50961		A	Ureter endoscopy & treatment	6.05	16.81	2.43	0.26	23.12	8.74	000
50970		A	Ureter endoscopy	7.14	NA	2.87	0.52	NA	10.53	000
50972		A	Ureter endoscopy & catheter	6.89	NA	2.81	0.16	NA	9.86	000
50974		A	Ureter endoscopy & biopsy	9.17	NA	3.62	0.65	NA	13.44	000
50976		A	Ureter endoscopy & treatment	9.04	NA	3.60	0.62	NA	13.26	000
50978		A	Ureter endoscopy & tracer	5.10	NA	2.26	0.48	NA	7.84	000
50980		A	Ureter endoscopy & treatment	6.85	NA	2.77	0.30	NA	9.92	000
51000		A	Drainage of bladder	0.78	1.24	0.53	0.05	2.07	1.36	000
51005		A	Drainage of bladder	1.02	2.05	0.58	0.04	3.11	1.64	000
51010		A	Drainage of bladder	3.53	5.13	1.95	0.11	8.77	5.59	010
51020		A	Incise & treat bladder	6.71	NA	4.46	0.71	NA	11.88	090
51030		A	Incise & treat bladder	6.77	NA	4.77	0.43	NA	11.97	090
51040		A	Incise & drain bladder	4.40	NA	3.41	0.75	NA	8.56	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
51045		A	Incise bladder, drain ureter	6.77	NA	4.53	0.50	NA	11.80	090
51050		A	Removal of bladder stone	6.92	NA	4.31	0.70	NA	11.93	090
51060		A	Removal of ureter stone	8.85	NA	5.28	1.19	NA	15.32	090
51065		A	Removal of ureter stone	8.85	NA	5.25	0.71	NA	14.81	090
51080		A	Drainage of bladder abscess	5.96	NA	4.24	0.57	NA	10.77	090
51500		A	Removal of bladder cyst	10.14	NA	4.05	1.21	NA	15.40	090
51520		A	Removal of bladder lesion	9.29	NA	5.41	0.87	NA	15.57	090
51525		A	Removal of bladder lesion	13.97	NA	7.17	1.06	NA	22.20	090
51530		A	Removal of bladder lesion	12.38	NA	6.59	1.02	NA	19.99	090
51535		A	Repair of ureter lesion	12.57	NA	6.99	1.14	NA	20.70	090
51550		A	Partial removal of bladder	15.66	NA	7.75	1.17	NA	24.58	090
51555		A	Partial removal of bladder	21.23	NA	10.07	1.31	NA	32.61	090
51565		A	Revise bladder & ureter(s)	21.62	NA	10.46	1.67	NA	33.75	090
51570		A	Removal of bladder	24.24	NA	11.63	1.62	NA	37.49	090
51575		A	Removal of bladder & nodes	30.45	NA	14.31	2.25	NA	47.01	090
51580		A	Remove bladder; revise tract	31.08	NA	14.70	2.04	NA	47.82	090
51585		A	Removal of bladder & nodes	35.23	NA	16.24	2.42	NA	53.89	090
51590		A	Remove bladder; revise tract	32.66	NA	15.03	2.56	NA	50.25	090
51595		A	Remove bladder; revise tract	37.14	NA	16.73	3.34	NA	57.21	090
51596		A	Remove bladder, create pouch	39.52	NA	17.86	3.45	NA	60.83	090
51597		A	Removal of pelvic structures	38.35	NA	17.46	4.31	NA	60.12	090
51600		A	Injection for bladder x-ray	0.88	11.09	0.29	0.03	12.00	1.20	000
51605		A	Preparation for bladder xray	0.64	11.15	0.22	0.03	11.82	0.89	000
51610		A	Injection for bladder x-ray	1.05	11.29	0.36	0.02	12.36	1.43	000
51700		A	Irrigation of bladder	0.88	2.77	0.34	0.02	3.67	1.24	000
51705		A	Change of bladder tube	1.02	1.84	1.16	0.04	2.90	2.22	010
51710		A	Change of bladder tube	1.49	3.52	1.40	0.06	5.07	2.95	010
51715		A	Endoscopic injection/implant	3.74	3.30	1.62	0.27	7.31	5.63	000
51720		A	Treatment of bladder lesion	1.96	2.97	0.99	0.05	4.98	3.00	000
51725		A	Simple cystometrogram	1.51	3.96	3.96	0.11	5.58	5.58	000
51725	26	A	Simple cystometrogram	1.51	0.59	0.59	0.07	2.17	2.17	000
51725	TC	A	Simple cystometrogram	0.00	3.37	3.37	0.04	3.41	3.41	000
51726		A	Complex cystometrogram	1.71	3.15	3.15	0.13	4.99	4.99	000
51726	26	A	Complex cystometrogram	1.71	0.64	0.64	0.08	2.43	2.43	000
51726	TC	A	Complex cystometrogram	0.00	2.51	2.51	0.05	2.56	2.56	000
51736		A	Urine flow measurement	0.61	0.63	0.63	0.04	1.28	1.28	000
51736	26	A	Urine flow measurement	0.61	0.24	0.24	0.03	0.88	0.88	000
51736	TC	A	Urine flow measurement	0.00	0.39	0.39	0.01	0.40	0.40	000
51741		A	Electro-uroflowmetry, first	1.14	1.20	1.20	0.06	2.40	2.40	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.43	0.43	0.04	1.61	1.61	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.77	0.77	0.02	0.79	0.79	000
51772		A	Urethra pressure profile	1.61	3.20	3.20	0.11	4.92	4.92	000
51772	26	A	Urethra pressure profile	1.61	0.61	0.61	0.06	2.28	2.28	000
51772	TC	A	Urethra pressure profile	0.00	2.59	2.59	0.05	2.64	2.64	000
51784		A	Anal/urinary muscle study	1.53	2.13	2.13	0.11	3.77	3.77	000
51784	26	A	Anal/urinary muscle study	1.53	0.78	0.78	0.07	2.38	2.38	000
51784	TC	A	Anal/urinary muscle study	0.00	1.35	1.35	0.04	1.39	1.39	000
51785		A	Anal/urinary muscle study	1.53	2.25	2.25	0.11	3.89	3.89	000
51785	26	A	Anal/urinary muscle study	1.53	0.58	0.58	0.07	2.18	2.18	000
51785	TC	A	Anal/urinary muscle study	0.00	1.67	1.67	0.04	1.71	1.71	000
51792		A	Urinary reflex study	1.10	2.34	2.34	0.20	3.64	3.64	000
51792	26	A	Urinary reflex study	1.10	0.25	0.25	0.06	1.41	1.41	000
51792	TC	A	Urinary reflex study	0.00	2.09	2.09	0.14	2.23	2.23	000
51795		A	Urine voiding pressure study	1.53	3.21	3.21	0.16	4.90	4.90	000
51795	26	A	Urine voiding pressure study	1.53	0.57	0.57	0.06	2.16	2.16	000
51795	TC	A	Urine voiding pressure study	0.00	2.64	2.64	0.10	2.74	2.74	000
51797		A	Intraabdominal pressure test	1.60	3.27	3.27	0.10	4.97	4.97	000
51797	26	A	Intraabdominal pressure test	1.60	0.61	0.61	0.05	2.26	2.26	000
51797	TC	A	Intraabdominal pressure test	0.00	2.66	2.66	0.05	2.71	2.71	000
51800		A	Revision of bladder/urethra	17.42	NA	8.68	1.47	NA	27.57	090
51820		A	Revision of urinary tract	17.89	NA	9.48	1.32	NA	28.69	090
51840		A	Attach bladder/urethra	10.71	NA	5.93	1.26	NA	17.90	090
51841		A	Attach bladder/urethra	13.03	NA	7.26	1.48	NA	21.77	090
51845		A	Repair bladder neck	9.73	NA	5.72	1.09	NA	16.54	090
51860		A	Repair of bladder wound	12.02	NA	6.57	0.91	NA	19.50	090
51865		A	Repair of bladder wound	15.04	NA	7.78	1.27	NA	24.09	090
51880		A	Repair of bladder opening	7.66	NA	4.65	0.52	NA	12.83	090
51900		A	Repair bladder/vagina lesion	12.97	NA	6.95	1.41	NA	21.33	090
51920		A	Close bladder-uterus fistula	11.81	NA	6.38	0.73	NA	18.92	090
51925		A	Hysterectomy/bladder repair	15.58	NA	8.45	2.33	NA	26.36	090
51940		A	Correction of bladder defect	26.81	NA	13.08	2.22	NA	42.11	090
51960		A	Revision of bladder & bowel	23.01	NA	11.75	2.27	NA	37.03	090
51980		A	Construct bladder opening	11.36	NA	6.25	0.75	NA	18.36	090
52000		A	Cystoscopy	2.01	2.44	0.96	0.14	4.59	3.11	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
52005		A	Cystoscopy & ureter catheter	2.37	3.76	1.09	0.22	6.35	3.68	000
52007		A	Cystoscopy and biopsy	3.02	NA	1.33	0.28	NA	4.63	000
52010		A	Cystoscopy & duct catheter	3.02	4.04	1.35	0.20	7.26	4.57	000
52204		A	Cystoscopy	2.37	4.32	1.09	0.24	6.93	3.70	000
52214		A	Cystoscopy and treatment	3.71	4.76	1.59	0.28	8.75	5.58	000
52224		A	Cystoscopy and treatment	3.14	4.59	1.38	0.29	8.02	4.81	000
52234		A	Cystoscopy and treatment	4.63	5.41	1.94	0.45	10.49	7.02	000
52235		A	Cystoscopy and treatment	5.45	5.72	2.24	0.81	11.98	8.50	000
52240		A	Cystoscopy and treatment	9.72	7.33	4.04	1.04	18.09	14.80	000
52250		A	Cystoscopy & radiotracer	4.50	NA	1.88	0.29	NA	6.67	000
52260		A	Cystoscopy & treatment	3.92	NA	1.72	0.22	NA	5.86	000
52265		A	Cystoscopy & treatment	2.94	2.84	1.30	0.14	5.92	4.38	000
52270		A	Cystoscopy & revise urethra	3.37	4.97	1.50	0.35	8.69	5.22	000
52275		A	Cystoscopy & revise urethra	4.70	5.52	2.00	0.34	10.56	7.04	000
52276		A	Cystoscopy and treatment	5.00	5.63	2.34	0.45	11.08	7.79	000
52277		A	Cystoscopy and treatment	6.17	NA	2.54	0.47	NA	9.18	000
52281		A	Cystoscopy and treatment	2.80	2.82	1.25	0.23	5.85	4.28	000
52282		A	Cystoscopy, implant stent	6.40	5.98	2.83	0.45	12.83	9.68	000
52283		A	Cystoscopy and treatment	3.74	4.95	1.60	0.15	8.84	5.49	000
52285		A	Cystoscopy and treatment	3.61	5.10	1.55	0.30	9.01	5.46	000
52290		A	Cystoscopy and treatment	4.59	NA	1.92	0.24	NA	6.75	000
52300		A	Cystoscopy and treatment	5.31	NA	2.19	0.36	NA	7.86	000
52301		A	Cystoscopy and treatment	5.51	NA	2.26	0.36	NA	8.13	000
52305		A	Cystoscopy and treatment	5.31	NA	2.19	0.35	NA	7.85	000
52310		A	Cystoscopy and treatment	2.81	10.72	1.26	0.30	13.83	4.37	000
52315		A	Cystoscopy and treatment	5.21	11.74	2.13	0.40	17.35	7.74	000
52317		A	Remove bladder stone	6.72	17.78	2.72	0.59	25.09	10.03	000
52318		A	Remove bladder stone	9.19	NA	3.64	0.77	NA	13.60	000
52320		A	Cystoscopy and treatment	4.70	NA	1.96	0.47	NA	7.13	000
52325		A	Cystoscopy, stone removal	6.16	NA	2.50	0.68	NA	9.34	000
52327		A	Cystoscopy, inject material	5.19	NA	2.15	0.36	NA	7.70	000
52330		A	Cystoscopy and treatment	5.04	14.55	2.09	0.35	19.94	7.48	000
52332		A	Cystoscopy and treatment	2.83	20.61	1.26	0.32	23.76	4.41	000
52334		A	Create passage to kidney	4.83	NA	2.00	0.34	NA	7.17	000
52335		A	Endoscopy of urinary tract	5.86	NA	2.40	0.45	NA	8.71	000
52336		A	Cystoscopy, stone removal	6.88	NA	2.78	0.99	NA	10.65	000
52337		A	Cystoscopy, stone removal	7.97	NA	3.18	1.08	NA	12.23	000
52338		A	Cystoscopy and treatment	7.34	NA	2.94	0.57	NA	10.85	000
52339		A	Cystoscopy and treatment	8.82	NA	3.39	0.57	NA	12.78	000
52340		A	Cystoscopy and treatment	9.68	NA	5.05	0.50	NA	15.23	090
52450		A	Incision of prostate	7.64	NA	5.33	0.49	NA	13.46	090
52500		A	Revision of bladder neck	8.47	NA	5.64	0.72	NA	14.83	090
52510		A	Dilation prostatic urethra	6.72	NA	4.75	0.74	NA	12.21	090
52601		A	Prostatectomy (TURP)	12.37	NA	7.09	1.16	NA	20.62	090
52606		A	Control postop bleeding	8.13	NA	5.25	0.33	NA	13.71	090
52612		A	Prostatectomy, first stage	7.98	NA	5.46	0.99	NA	14.43	090
52614		A	Prostatectomy, second stage	6.84	NA	5.02	0.68	NA	12.54	090
52620		A	Remove residual prostate	6.61	NA	4.94	0.51	NA	12.06	090
52630		A	Remove prostate regrowth	7.26	NA	5.19	1.13	NA	13.58	090
52640		A	Relieve bladder contracture	6.62	NA	4.70	0.62	NA	11.94	090
52647		A	Laser surgery of prostate	10.36	NA	6.35	1.16	NA	17.87	090
52648		A	Laser surgery of prostate	11.21	NA	6.62	1.16	NA	18.99	090
52700		A	Drainage of prostate abscess	6.80	NA	5.00	0.34	NA	12.14	090
53000		A	Incision of urethra	2.28	4.63	2.02	0.17	7.08	4.47	010
53010		A	Incision of urethra	3.64	NA	3.23	0.37	NA	7.24	090
53020		A	Incision of urethra	1.77	3.07	0.69	0.09	4.93	2.55	000
53025		A	Incision of urethra	1.13	3.25	0.45	0.08	4.46	1.66	000
53040		A	Drainage of urethra abscess	6.40	7.08	8.13	0.19	13.67	14.72	090
53060		A	Drainage of urethra abscess	2.63	4.88	2.02	0.07	7.58	4.72	010
53080		A	Drainage of urinary leakage	6.29	NA	6.39	0.45	NA	13.13	090
53085		A	Drainage of urinary leakage	10.27	NA	7.98	0.70	NA	18.95	090
53200		A	Biopsy of urethra	2.59	3.96	1.01	0.12	6.67	3.72	000
53210		A	Removal of urethra	12.57	NA	6.79	0.67	NA	20.03	090
53215		A	Removal of urethra	15.58	NA	7.84	0.96	NA	24.38	090
53220		A	Treatment of urethra lesion	7.00	NA	4.47	0.49	NA	11.96	090
53230		A	Removal of urethra lesion	9.58	NA	5.50	0.79	NA	15.87	090
53235		A	Removal of urethra lesion	10.14	NA	5.52	0.49	NA	16.15	090
53240		A	Surgery for urethra pouch	6.45	NA	4.14	0.45	NA	11.04	090
53250		A	Removal of urethra gland	5.89	NA	3.63	0.40	NA	9.92	090
53260		A	Treatment of urethra lesion	2.98	4.34	1.93	0.16	7.48	5.07	010
53265		A	Treatment of urethra lesion	3.12	4.79	1.93	0.22	8.13	5.27	010
53270		A	Removal of urethra gland	3.09	4.35	2.03	0.18	7.62	5.30	010
53275		A	Repair of urethra defect	4.53	NA	2.98	0.25	NA	7.76	010
53400		A	Revise urethra, 1st stage	12.77	NA	6.89	0.76	NA	20.42	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
53405	.....	A	Revise urethra, 2nd stage	14.48	NA	7.42	1.21	NA	23.11	090
53410	.....	A	Reconstruction of urethra	16.44	NA	8.19	0.84	NA	25.47	090
53415	.....	A	Reconstruction of urethra	19.41	NA	9.33	1.15	NA	29.89	090
53420	.....	A	Reconstruct urethra, stage 1	14.08	NA	7.15	1.05	NA	22.28	090
53425	.....	A	Reconstruct urethra, stage 2	15.98	NA	7.99	0.88	NA	24.85	090
53430	.....	A	Reconstruction of urethra	16.34	NA	8.23	0.76	NA	25.33	090
53440	.....	A	Correct bladder function	12.34	NA	6.87	1.39	NA	20.60	090
53442	.....	A	Remove perineal prosthesis	8.27	NA	5.01	0.67	NA	13.95	090
53443	.....	A	Reconstruction of urethra	19.89	NA	9.15	1.07	NA	30.11	090
53445	.....	A	Correct urine flow control	14.06	NA	7.48	2.03	NA	23.57	090
53447	.....	A	Remove artificial sphincter	13.17	NA	6.93	0.89	NA	20.99	090
53449	.....	A	Correct artificial sphincter	9.70	NA	5.63	0.82	NA	16.15	090
53450	.....	A	Revision of urethra	6.14	NA	4.08	0.27	NA	10.49	090
53460	.....	A	Revision of urethra	7.12	NA	4.45	0.25	NA	11.82	090
53502	.....	A	Repair of urethra injury	7.63	NA	4.76	0.56	NA	12.95	090
53505	.....	A	Repair of urethra injury	7.63	NA	4.63	0.51	NA	12.77	090
53510	.....	A	Repair of urethra injury	10.11	NA	5.90	0.66	NA	16.67	090
53515	.....	A	Repair of urethra injury	13.31	NA	6.76	0.88	NA	20.95	090
53520	.....	A	Repair of urethra defect	8.68	NA	4.96	0.56	NA	14.20	090
53600	.....	A	Dilate urethra stricture	1.21	2.94	0.50	0.03	4.18	1.74	000
53601	.....	A	Dilate urethra stricture	0.98	2.86	0.42	0.03	3.87	1.43	000
53605	.....	A	Dilate urethra stricture	1.28	NA	0.69	0.05	NA	2.02	000
53620	.....	A	Dilate urethra stricture	1.62	4.35	0.81	0.05	6.02	2.48	000
53621	.....	A	Dilate urethra stricture	1.35	4.31	0.71	0.04	5.70	2.10	000
53660	.....	A	Dilation of urethra	0.71	2.68	0.32	0.03	3.42	1.06	000
53661	.....	A	Dilation of urethra	0.72	2.74	0.27	0.03	3.49	1.02	000
53665	.....	A	Dilation of urethra	0.76	NA	0.56	0.04	NA	1.36	000
53670	.....	A	Insert urinary catheter	0.50	2.57	0.15	0.02	3.09	0.67	000
53675	.....	A	Insert urinary catheter	1.47	3.45	0.71	0.05	4.97	2.23	000
53850	.....	A	Prostatic microwave thermotx	9.45	NA	6.00	0.66	NA	16.11	090
53852	.....	A	Prostatic rf thermotx	9.88	NA	6.16	0.69	NA	16.73	090
54000	.....	A	Slitting of prepuce	1.54	3.93	1.19	0.07	5.54	2.80	010
54001	.....	A	Slitting of prepuce	2.19	4.35	1.66	0.09	6.63	3.94	010
54015	.....	A	Drain penis lesion	5.32	5.33	2.84	0.09	10.74	8.25	010
54050	.....	A	Destruction, penis lesion(s)	1.24	4.80	1.12	0.03	6.07	2.39	010
54055	.....	A	Destruction, penis lesion(s)	1.22	4.14	1.08	0.06	5.42	2.36	010
54056	.....	A	Cryosurgery, penis lesion(s)	1.24	3.11	1.18	0.04	4.39	2.46	010
54057	.....	A	Laser surg, penis lesion(s)	1.24	1.62	1.10	0.21	3.07	2.55	010
54060	.....	A	Excision of penis lesion(s)	1.93	3.63	1.34	0.12	5.68	3.39	010
54065	.....	A	Destruction, penis lesion(s)	2.42	3.40	1.74	0.25	6.07	4.41	010
54100	.....	A	Biopsy of penis	1.90	2.41	0.77	0.07	4.38	2.74	000
54105	.....	A	Biopsy of penis	3.50	4.58	1.94	0.11	8.19	5.55	010
54110	.....	A	Treatment of penis lesion	10.13	NA	6.85	0.61	NA	17.59	090
54111	.....	A	Treat penis lesion, graft	13.57	NA	8.25	0.97	NA	22.79	090
54112	.....	A	Treat penis lesion, graft	15.86	NA	9.29	1.14	NA	26.29	090
54115	.....	A	Treatment of penis lesion	6.15	7.66	5.34	0.44	14.25	11.93	090
54120	.....	A	Partial removal of penis	9.97	NA	6.87	0.62	NA	17.46	090
54125	.....	A	Removal of penis	13.53	NA	8.24	1.17	NA	22.94	090
54130	.....	A	Remove penis & nodes	20.14	NA	10.87	1.32	NA	32.33	090
54135	.....	A	Remove penis & nodes	26.36	NA	13.23	1.74	NA	41.33	090
54150	.....	A	Circumcision	1.81	3.25	1.48	0.05	5.11	3.34	010
54152	.....	A	Circumcision	2.31	NA	1.47	0.20	NA	3.98	010
54160	.....	A	Circumcision	2.48	3.66	1.54	0.21	6.35	4.23	010
54161	.....	A	Circumcision	3.27	NA	1.85	0.23	NA	5.35	010
54200	.....	A	Treatment of penis lesion	1.06	1.79	0.40	0.03	2.88	1.49	010
54205	.....	A	Treatment of penis lesion	7.93	NA	6.08	0.50	NA	14.51	090
54220	.....	A	Treatment of penis lesion	2.42	1.72	0.99	0.17	4.31	3.58	000
54230	.....	A	Prepare penis study	1.34	NA	0.49	0.13	NA	1.96	000
54231	.....	A	Dynamic cavernosometry	2.04	1.56	0.81	0.14	3.74	2.99	000
54235	.....	A	Penile injection	1.19	0.85	0.44	0.04	2.08	1.67	000
54240	.....	A	Penis study	1.31	1.16	1.16	0.12	2.59	2.59	000
54240	26	A	Penis study	1.31	0.38	0.38	0.06	1.75	1.75	000
54240	TC	A	Penis study	0.00	0.78	0.78	0.06	0.84	0.84	000
54250	.....	A	Penis study	2.22	2.00	2.00	0.08	4.30	4.30	000
54250	26	A	Penis study	2.22	0.77	0.77	0.05	3.04	3.04	000
54250	TC	A	Penis study	0.00	1.23	1.23	0.03	1.26	1.26	000
54300	.....	A	Revision of penis	10.41	NA	7.30	0.87	NA	18.58	090
54304	.....	A	Revision of penis	12.49	NA	8.54	0.90	NA	21.93	090
54308	.....	A	Reconstruction of urethra	11.83	NA	8.36	0.74	NA	20.93	090
54312	.....	A	Reconstruction of urethra	13.57	NA	9.92	0.91	NA	24.40	090
54316	.....	A	Reconstruction of urethra	16.82	NA	6.95	1.12	NA	24.89	090
54318	.....	A	Reconstruction of urethra	11.25	NA	19.72	1.11	NA	32.08	090
54322	.....	A	Reconstruction of urethra	13.01	NA	7.94	0.74	NA	21.69	090
54324	.....	A	Reconstruction of urethra	16.31	NA	9.76	1.08	NA	27.15	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
54326		A	Reconstruction of urethra	15.72	NA	9.17	1.03	NA	25.92	090
54328		A	Revise penis, urethra	15.65	NA	9.45	1.24	NA	26.34	090
54332		A	Revise penis, urethra	17.08	NA	10.05	1.13	NA	28.26	090
54336		A	Revise penis, urethra	20.04	NA	11.41	1.40	NA	32.85	090
54340		A	Secondary urethral surgery	8.91	NA	6.44	0.59	NA	15.94	090
54344		A	Secondary urethral surgery	15.94	NA	11.37	1.10	NA	28.41	090
54348		A	Secondary urethral surgery	17.15	NA	14.36	1.14	NA	32.65	090
54352		A	Reconstruct urethra, penis	24.74	NA	13.56	1.49	NA	39.79	090
54360		A	Penis plastic surgery	11.93	NA	7.60	0.73	NA	20.26	090
54380		A	Repair penis	13.18	NA	8.00	0.75	NA	21.93	090
54385		A	Repair penis	15.39	NA	9.03	0.89	NA	25.31	090
54390		A	Repair penis and bladder	21.61	NA	30.09	1.58	NA	53.28	090
54400		A	Insert semi-rigid prosthesis	8.99	NA	5.39	1.27	NA	15.65	090
54401		A	Insert self-contd prosthesis	10.28	NA	6.08	1.73	NA	18.09	090
54402		A	Remove penis prosthesis	9.21	NA	5.44	0.58	NA	15.23	090
54405		A	Insert multi-comp prosthesis	13.43	NA	7.25	2.10	NA	22.78	090
54407		A	Remove multi-comp prosthesis	13.34	NA	7.00	1.10	NA	21.44	090
54409		A	Revise penis prosthesis	12.20	NA	6.59	0.87	NA	19.66	090
54420		A	Revision of penis	11.42	NA	7.23	0.87	NA	19.52	090
54430		A	Revision of penis	10.15	NA	6.87	0.69	NA	17.71	090
54435		A	Revision of penis	6.12	NA	5.12	0.39	NA	11.63	090
54450		A	Preputial stretching	1.12	0.85	0.46	0.07	2.04	1.65	000
54500		A	Biopsy of testis	1.31	4.14	0.74	0.05	5.50	2.10	000
54505		A	Biopsy of testis	3.46	NA	2.32	0.22	NA	6.00	010
54510		A	Removal of testis lesion	5.45	NA	3.16	0.38	NA	8.99	090
54520		A	Removal of testis	5.23	NA	3.22	0.52	NA	8.97	090
54530		A	Removal of testis	8.58	NA	4.78	0.77	NA	14.13	090
54535		A	Extensive testis surgery	12.16	NA	6.30	1.02	NA	19.48	090
54550		A	Exploration for testis	7.78	NA	4.37	0.61	NA	12.76	090
54560		A	Exploration for testis	11.13	NA	6.09	0.81	NA	18.03	090
54600		A	Reduce testis torsion	7.01	NA	3.90	0.48	NA	11.39	090
54620		A	Suspension of testis	4.90	NA	2.88	0.33	NA	8.11	010
54640		A	Suspension of testis	6.90	NA	3.90	0.91	NA	11.71	090
54650		A	Orchiopexy (Fowler-Stephens)	11.45	NA	6.05	0.91	NA	18.41	090
54660		A	Revision of testis	5.11	NA	3.20	0.34	NA	8.65	090
54670		A	Repair testis injury	6.41	NA	3.71	0.43	NA	10.55	090
54680		A	Relocation of testis(es)	12.65	NA	6.61	0.80	NA	20.06	090
54700		A	Drainage of scrotum	3.43	6.31	2.81	0.11	9.85	6.35	010
54800		A	Biopsy of epididymis	2.33	3.92	1.15	0.19	6.44	3.67	000
54820		A	Exploration of epididymis	5.14	NA	3.21	0.29	NA	8.64	090
54830		A	Remove epididymis lesion	5.38	NA	3.28	0.39	NA	9.05	090
54840		A	Remove epididymis lesion	5.20	NA	3.25	0.48	NA	8.93	090
54860		A	Removal of epididymis	6.32	NA	3.81	0.50	NA	10.63	090
54861		A	Removal of epididymis	8.90	NA	4.83	0.72	NA	14.45	090
54900		A	Fusion of spermatic ducts	13.20	NA	6.55	0.87	NA	20.62	090
54901		A	Fusion of spermatic ducts	17.94	NA	8.55	1.20	NA	27.69	090
55000		A	Drainage of hydrocele	1.43	1.36	0.76	0.04	2.83	2.23	000
55040		A	Removal of hydrocele	5.36	NA	3.12	0.55	NA	9.03	090
55041		A	Removal of hydroceles	7.74	NA	4.21	0.81	NA	12.76	090
55060		A	Repair of hydrocele	5.52	NA	3.19	0.50	NA	9.21	090
55100		A	Drainage of scrotum abscess	2.13	7.25	2.72	0.07	9.45	4.92	010
55110		A	Explore scrotum	5.70	NA	3.04	0.37	NA	9.11	090
55120		A	Removal of scrotum lesion	5.09	NA	3.07	0.21	NA	8.37	090
55150		A	Removal of scrotum	7.22	NA	4.20	0.57	NA	11.99	090
55175		A	Revision of scrotum	5.24	NA	3.32	0.48	NA	9.04	090
55180		A	Revision of scrotum	10.72	NA	5.79	0.82	NA	17.33	090
55200		A	Incision of sperm duct	4.24	NA	2.77	0.20	NA	7.21	090
55250		A	Removal of sperm duct(s)	3.29	6.89	2.51	0.28	10.46	6.08	090
55300		A	Preparation, sperm duct x-ray	3.51	NA	1.50	0.27	NA	5.28	000
55400		A	Repair of sperm duct	8.49	NA	4.85	0.62	NA	13.96	090
55450		A	Ligation of sperm duct	4.12	6.35	2.47	0.32	10.79	6.91	010
55500		A	Removal of hydrocele	5.59	NA	3.04	0.50	NA	9.13	090
55520		A	Removal of sperm cord lesion	6.03	NA	3.27	0.51	NA	9.81	090
55530		A	Revise spermatic cord veins	5.66	NA	3.39	0.60	NA	9.65	090
55535		A	Revise spermatic cord veins	6.56	NA	3.78	0.45	NA	10.79	090
55540		A	Revise hernia & sperm veins	7.67	NA	3.90	0.91	NA	12.48	090
55600		A	Incise sperm duct pouch	6.38	NA	3.93	0.55	NA	10.86	090
55605		A	Incise sperm duct pouch	7.96	NA	4.56	0.59	NA	13.11	090
55650		A	Remove sperm duct pouch	11.80	NA	6.04	0.76	NA	18.60	090
55680		A	Remove sperm pouch lesion	5.19	NA	3.35	0.38	NA	8.92	090
55700		A	Biopsy of prostate	1.57	2.69	0.82	0.15	4.41	2.54	000
55705		A	Biopsy of prostate	4.57	NA	3.16	0.34	NA	8.07	010
55720		A	Drainage of prostate abscess	7.64	NA	4.80	0.37	NA	12.81	090
55725		A	Drainage of prostate abscess	8.68	NA	5.32	0.54	NA	14.54	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
55801		A	Removal of prostate	17.80	NA	8.82	1.44	NA	28.06	090
55810		A	Extensive prostate surgery	22.58	NA	10.82	1.77	NA	35.17	090
55812		A	Extensive prostate surgery	27.51	NA	12.82	1.94	NA	42.27	090
55815		A	Extensive prostate surgery	30.46	NA	13.64	2.42	NA	46.52	090
55821		A	Removal of prostate	14.25	NA	7.29	1.35	NA	22.89	090
55831		A	Removal of prostate	15.62	NA	7.82	1.44	NA	24.88	090
55840		A	Extensive prostate surgery	22.69	NA	11.10	1.61	NA	35.40	090
55842		A	Extensive prostate surgery	24.38	NA	11.72	1.88	NA	37.98	090
55845		A	Extensive prostate surgery	28.55	NA	13.27	2.44	NA	44.26	090
55859		A	Percut/needle insert, pros	12.52	NA	6.62	0.58	NA	19.72	090
55860		A	Surgical exposure, prostate	14.45	NA	7.42	0.70	NA	22.57	090
55862		A	Extensive prostate surgery	18.39	NA	8.86	1.20	NA	28.45	090
55865		A	Extensive prostate surgery	22.87	NA	10.69	2.39	NA	35.95	090
55870		A	Electroejaculation	2.58	1.52	0.99	0.18	4.28	3.75	000
56300		A	Laparoscopy; diagnostic	5.10	NA	2.79	0.93	NA	8.82	010
56301		A	Laparoscopy; tubal cautery	5.60	NA	3.48	1.28	NA	10.36	010
56302		A	Laparoscopy; tubal block	5.60	NA	3.49	1.32	NA	10.41	010
56303		A	Laparoscopy; excise lesions	11.79	NA	5.25	1.16	NA	18.20	090
56304		A	Laparoscopy; lysis	11.29	NA	5.20	1.20	NA	17.69	090
56305		A	Laparoscopy; biopsy	5.40	NA	2.87	0.79	NA	9.06	010
56306		A	Laparoscopy; aspiration	5.70	NA	3.28	1.18	NA	10.16	010
56307		A	Laparoscopy; remove adnexa	11.05	NA	5.11	1.60	NA	17.76	010
56308		A	Laparoscopy; hysterectomy	14.19	NA	6.56	2.07	NA	22.82	010
56309		A	Laparoscopy; remove myoma	14.21	NA	6.53	1.03	NA	21.77	010
56310		A	Laparoscopic enterolysis	14.44	NA	7.11	1.75	NA	23.30	090
56311		A	Laparoscopic lymph node biop	9.25	NA	4.59	1.47	NA	15.31	010
56312		A	Laparoscopic lymphadenectomy	12.38	NA	5.86	0.84	NA	19.08	010
56313		A	Laparoscopic lymphadenectomy	14.32	NA	6.96	2.31	NA	23.59	010
56314		A	Lapar; drain lymphocele	9.48	NA	4.66	0.66	NA	14.80	090
56315		A	Laparoscopic appendectomy	8.70	NA	4.28	1.01	NA	13.99	090
56316		A	Laparoscopic hernia repair	6.27	NA	3.23	0.94	NA	10.44	090
56317		A	Laparoscopic hernia repair	8.24	NA	4.20	1.11	NA	13.55	090
56318		A	Laparoscopic orchiectomy	10.96	NA	6.02	0.81	NA	17.79	090
56320		A	Laparoscopy, spermatic veins	6.57	NA	3.54	0.45	NA	10.56	090
56322		A	Laparoscopy, vagus nerves	10.15	NA	4.84	1.18	NA	16.17	090
56323		A	Laparoscopy, vagus nerves	12.15	NA	5.91	1.41	NA	19.47	090
56324		A	Laparoscopy, cholecystoenter	12.58	NA	6.23	1.93	NA	20.74	090
56340		A	Laparoscopic cholecystectomy	11.09	NA	5.25	1.74	NA	18.08	090
56341		A	Laparoscopic cholecystectomy	11.94	NA	5.68	1.84	NA	19.46	090
56342		A	Laparoscopic cholecystectomy	14.23	NA	7.04	2.00	NA	23.27	090
56343		A	Laparoscopic salpingostomy	13.74	NA	6.70	1.11	NA	21.55	090
56344		A	Laparoscopic fimbrioplasty	12.88	NA	5.77	1.19	NA	19.84	090
56346		A	Laparoscopic gastrostomy	7.73	NA	4.29	1.19	NA	13.21	090
56348		A	Laparo; resect intestine	22.04	NA	10.28	2.78	NA	35.10	090
56349		A	Laparoscopy; fundoplasty	17.25	NA	9.46	2.53	NA	29.24	090
56350		A	Hysteroscopy; diagnostic	3.33	2.58	1.44	0.44	6.35	5.21	000
56351		A	Hysteroscopy; biopsy	4.75	3.17	2.03	0.44	8.36	7.22	000
56352		A	Hysteroscopy; lysis	6.17	NA	2.59	0.85	NA	9.61	000
56353		A	Hysteroscopy; resect septum	7.00	NA	2.98	0.85	NA	10.83	000
56354		A	Hysteroscopy; remove myoma	10.00	NA	4.19	1.30	NA	15.49	000
56355		A	Hysteroscopy; remove impact	5.21	NA	2.19	0.44	NA	7.84	000
56356		A	Hysteroscopy; ablation	6.17	NA	2.61	1.49	NA	10.27	000
56362		A	Laparoscopy w/cholangio	4.89	NA	2.29	0.19	NA	7.37	000
56363		A	Laparoscopy w/biopsy	5.18	NA	2.50	0.45	NA	8.13	000
56405		A	I & D of vulva/perineum	1.44	1.88	1.01	0.15	3.47	2.60	010
56420		A	Drainage of gland abscess	1.39	1.86	0.88	0.13	3.38	2.40	010
56440		A	Surgery for vulva lesion	2.84	2.83	2.05	0.52	6.19	5.41	010
56441		A	Lysis of labial lesion(s)	1.97	2.15	1.80	0.30	4.42	4.07	010
56501		A	Destruction, vulva lesion(s)	1.53	1.85	1.18	0.11	3.49	2.82	010
56515		A	Destruction, vulva lesion(s)	1.88	2.17	1.67	0.66	4.71	4.21	010
56605		A	Biopsy of vulva/perineum	1.10	1.44	0.47	0.15	2.69	1.72	000
56606		A	Biopsy of vulva/perineum	0.55	1.21	0.25	0.08	1.84	0.88	000
56620		A	Partial removal of vulva	7.47	NA	4.32	1.40	NA	13.19	090
56625		A	Complete removal of vulva	8.40	NA	4.96	2.13	NA	15.49	090
56630		A	Extensive vulva surgery	12.36	NA	6.83	3.28	NA	22.47	090
56631		A	Extensive vulva surgery	16.20	NA	8.96	4.51	NA	29.67	090
56632		A	Extensive vulva surgery	20.29	NA	10.64	4.51	NA	35.44	090
56633		A	Extensive vulva surgery	16.47	NA	8.54	3.28	NA	28.29	090
56634		A	Extensive vulva surgery	17.88	NA	9.67	4.51	NA	32.06	090
56637		A	Extensive vulva surgery	21.97	NA	11.32	4.51	NA	37.80	090
56640		A	Extensive vulva surgery	22.17	NA	11.23	4.36	NA	37.76	090
56700		A	Partial removal of hymen	2.52	2.45	1.78	0.35	5.32	4.65	010
56720		A	Incision of hymen	0.68	1.32	0.61	0.11	2.11	1.40	000
56740		A	Remove vagina gland lesion	3.76	2.82	2.37	0.55	7.13	6.68	010

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
56800		A	Repair of vagina	3.89	NA	2.54	0.57	NA	7.00	010
56805		A	Repair clitoris	18.86	NA	9.03	1.37	NA	29.26	090
56810		A	Repair of perineum	4.13	NA	2.57	0.51	NA	7.21	010
57000		A	Exploration of vagina	2.97	NA	2.08	0.35	NA	5.40	010
57010		A	Drainage of pelvic abscess	6.03	NA	3.54	0.51	NA	10.08	090
57020		A	Drainage of pelvic fluid	1.50	1.24	0.60	0.14	2.88	2.24	000
57061		A	Destruction vagina lesion(s)	1.25	1.77	1.06	0.17	3.19	2.48	010
57065		A	Destruction vagina lesion(s)	2.61	2.42	1.96	0.74	5.77	5.31	010
57100		A	Biopsy of vagina	0.97	1.14	0.41	0.13	2.24	1.51	000
57105		A	Biopsy of vagina	1.69	1.99	1.57	0.33	4.01	3.59	010
57108		A	Partial removal of vagina	6.36	NA	3.73	1.10	NA	11.19	090
57110		A	Removal of vagina	14.29	NA	6.92	1.76	NA	22.97	090
57120		A	Closure of vagina	7.41	NA	4.33	1.51	NA	13.25	090
57130		A	Remove vagina lesion	2.43	NA	1.85	0.55	NA	4.83	010
57135		A	Remove vagina lesion	2.67	2.39	1.97	0.38	5.44	5.02	010
57150		A	Treat vagina infection	0.55	0.81	0.22	0.04	1.40	0.81	000
57160		A	Insertion of pessary/device	0.89	1.07	0.36	0.05	2.01	1.30	000
57170		A	Fitting of diaphragm/cap	0.91	1.07	0.35	0.06	2.04	1.32	000
57180		A	Treat vaginal bleeding	1.58	1.78	1.19	0.11	3.47	2.88	010
57200		A	Repair of vagina	3.94	NA	2.66	0.60	NA	7.20	090
57210		A	Repair vagina/perineum	5.17	NA	3.20	0.65	NA	9.02	090
57220		A	Revision of urethra	4.31	NA	3.05	0.80	NA	8.16	090
57230		A	Repair of urethral lesion	5.64	NA	3.76	0.64	NA	10.04	090
57240		A	Repair bladder & vagina	6.07	NA	3.92	1.60	NA	11.59	090
57250		A	Repair rectum & vagina	5.53	NA	3.53	1.69	NA	10.75	090
57260		A	Repair of vagina	8.27	NA	4.66	1.88	NA	14.81	090
57265		A	Extensive repair of vagina	11.34	NA	6.28	2.11	NA	19.73	090
57268		A	Repair of bowel bulge	6.76	NA	4.03	1.50	NA	12.29	090
57270		A	Repair of bowel pouch	12.11	NA	6.08	1.44	NA	19.63	090
57280		A	Suspension of vagina	15.04	NA	7.27	1.85	NA	24.16	090
57282		A	Repair of vaginal prolapse	8.86	NA	4.91	1.89	NA	15.66	090
57284		A	Repair paravaginal defect	12.70	NA	6.67	0.84	NA	20.21	090
57288		A	Repair bladder defect	13.02	NA	6.65	1.36	NA	21.03	090
57289		A	Repair bladder & vagina	11.58	NA	6.21	1.13	NA	18.92	090
57291		A	Construction of vagina	7.95	NA	5.76	1.19	NA	14.90	090
57292		A	Construct vagina with graft	13.09	NA	6.89	1.38	NA	21.36	090
57300		A	Repair rectum-vagina fistula	7.61	NA	4.30	1.66	NA	13.57	090
57305		A	Repair rectum-vagina fistula	13.77	NA	7.02	1.56	NA	22.35	090
57307		A	Fistula repair & colostomy	15.93	NA	7.93	1.28	NA	25.14	090
57308		A	Fistula repair, transperine	9.94	NA	4.76	1.41	NA	16.11	090
57310		A	Repair urethrovaginal lesion	6.78	NA	4.22	0.48	NA	11.48	090
57311		A	Repair urethrovaginal lesion	7.98	NA	4.74	0.41	NA	13.13	090
57320		A	Repair bladder-vagina lesion	8.01	NA	4.77	1.35	NA	14.13	090
57330		A	Repair bladder-vagina lesion	12.35	NA	6.21	0.81	NA	19.37	090
57335		A	Repair vagina	18.73	NA	9.14	0.81	NA	28.68	090
57400		A	Dilation of vagina	2.27	NA	1.22	0.06	NA	3.55	000
57410		A	Pelvic examination	1.75	1.93	1.01	0.05	3.73	2.81	000
57415		A	Removal vaginal foreign body	2.17	2.75	1.78	0.05	4.97	4.00	010
57452		A	Examination of vagina	0.99	1.30	0.39	0.14	2.43	1.52	000
57454		A	Vagina examination & biopsy	1.27	1.42	0.51	0.26	2.95	2.04	000
57460		A	Cervix excision	2.83	1.83	1.16	0.46	5.12	4.45	000
57500		A	Biopsy of cervix	0.97	1.17	0.42	0.12	2.26	1.51	000
57505		A	Endocervical curettage	1.14	1.54	1.07	0.13	2.81	2.34	010
57510		A	Cauterization of cervix	1.90	2.45	1.38	0.09	4.44	3.37	010
57511		A	Cryocautery of cervix	1.90	1.99	0.75	0.17	4.06	2.82	010
57513		A	Laser surgery of cervix	1.90	2.06	1.35	0.67	4.63	3.92	010
57520		A	Conization of cervix	4.04	3.50	2.56	0.73	8.27	7.33	090
57522		A	Conization of cervix	3.36	3.16	2.30	0.73	7.25	6.39	090
57530		A	Removal of cervix	4.79	NA	3.23	0.78	NA	8.80	090
57531		A	Removal of cervix, radical	28.00	NA	12.75	3.87	NA	44.62	090
57540		A	Removal of residual cervix	12.22	NA	5.99	1.51	NA	19.72	090
57545		A	Remove cervix, repair pelvis	13.03	NA	6.53	1.03	NA	20.59	090
57550		A	Removal of residual cervix	5.53	NA	3.52	1.54	NA	10.59	090
57555		A	Remove cervix, repair vagina	8.95	NA	5.09	2.17	NA	16.21	090
57556		A	Remove cervix, repair bowel	8.37	NA	4.64	1.92	NA	14.93	090
57700		A	Revision of cervix	3.55	NA	2.27	0.34	NA	6.16	090
57720		A	Revision of cervix	4.13	NA	2.97	0.50	NA	7.60	090
57800		A	Dilation of cervical canal	0.77	0.94	0.33	0.10	1.81	1.20	000
57820		A	D&C of residual cervix	1.67	2.07	1.86	0.46	4.20	3.99	010
58100		A	Biopsy of uterus lining	0.71	0.92	0.29	0.14	1.77	1.14	000
58120		A	Dilation and curettage (D&C)	3.27	3.12	2.22	0.56	6.95	6.05	010
58140		A	Removal of uterus lesion	14.60	NA	6.98	1.71	NA	23.29	090
58145		A	Removal of uterus lesion	8.04	NA	4.57	1.54	NA	14.15	090
58150		A	Total hysterectomy	15.24	NA	7.32	2.08	NA	24.64	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
58152		A	Total hysterectomy	15.09	NA	7.28	2.59	NA	24.96	090
58180		A	Partial hysterectomy	15.29	NA	7.27	2.11	NA	24.67	090
58200		A	Extensive hysterectomy	21.59	NA	10.57	2.80	NA	34.96	090
58210		A	Extensive hysterectomy	28.85	NA	13.49	3.87	NA	46.21	090
58240		A	Removal of pelvis contents	38.39	NA	17.76	6.15	NA	62.30	090
58260		A	Vaginal hysterectomy	12.20	NA	5.84	2.07	NA	20.11	090
58262		A	Vaginal hysterectomy	13.99	NA	6.57	2.07	NA	22.63	090
58263		A	Vaginal hysterectomy	15.28	NA	6.88	2.22	NA	24.38	090
58267		A	Hysterectomy & vagina repair	15.00	NA	6.93	2.46	NA	24.39	090
58270		A	Hysterectomy & vagina repair	13.48	NA	6.37	2.22	NA	22.07	090
58275		A	Hysterectomy, revise vagina	14.98	NA	6.95	2.32	NA	24.25	090
58280		A	Hysterectomy, revise vagina	15.41	NA	7.10	2.30	NA	24.81	090
58285		A	Extensive hysterectomy	18.57	NA	9.55	2.70	NA	30.82	090
58300		N	Insert intrauterine device	+1.01	2.37	1.01	0.13	3.51	2.15	XXX
58301		A	Remove intrauterine device	1.27	1.20	0.49	0.08	2.55	1.84	000
58321		A	Artificial insemination	0.92	0.86	0.34	0.15	1.93	1.41	000
58322		A	Artificial insemination	1.10	0.90	0.42	0.15	2.15	1.67	000
58323		A	Sperm washing	0.23	0.37	0.10	0.04	0.64	0.37	000
58340		A	Catheter for hysterography	0.88	9.69	0.32	0.08	10.65	1.28	000
58345		A	Reopen fallopian tube	4.66	NA	1.74	0.41	NA	6.81	010
58350		A	Reopen fallopian tube	1.01	1.58	0.98	0.16	2.75	2.15	010
58400		A	Suspension of uterus	6.36	NA	3.70	1.16	NA	11.22	090
58410		A	Suspension of uterus	12.73	NA	6.19	0.84	NA	19.76	090
58520		A	Repair of ruptured uterus	11.92	NA	5.74	0.99	NA	18.65	090
58540		A	Revision of uterus	14.64	NA	6.89	1.42	NA	22.95	090
58600		A	Division of fallopian tube	3.84	NA	2.46	1.38	NA	7.68	090
58605		A	Division of fallopian tube	3.34	NA	2.26	1.01	NA	6.61	090
58611		A	Ligate oviduct(s)	0.63	NA	0.40	0.10	NA	1.13	ZZZ
58615		A	Occlude fallopian tube(s)	3.90	NA	5.53	0.35	NA	9.78	010
58700		A	Removal of fallopian tube	6.49	NA	3.56	1.31	NA	11.36	090
58720		A	Removal of ovary/tube(s)	11.36	NA	5.58	1.63	NA	18.57	090
58740		A	Revise fallopian tube(s)	5.83	NA	3.47	1.88	NA	11.18	090
58750		A	Repair oviduct	14.84	NA	7.09	1.46	NA	23.39	090
58752		A	Revise ovarian tube(s)	14.84	NA	7.36	0.93	NA	23.13	090
58760		A	Remove tubal obstruction	13.13	NA	6.43	1.19	NA	20.75	090
58770		A	Create new tubal opening	13.97	NA	6.88	1.11	NA	21.96	090
58800		A	Drainage of ovarian cyst(s)	4.14	3.67	3.33	0.53	8.34	8.00	090
58805		A	Drainage of ovarian cyst(s)	5.88	NA	3.27	1.36	NA	10.51	090
58820		A	Open drain ovary abscess	4.22	NA	2.85	0.49	NA	7.56	090
58822		A	Percut drain ovary abscess	10.13	NA	4.89	0.81	NA	15.83	090
58823		A	Percut drain pelvic abscess	3.38	NA	2.46	0.30	NA	6.14	000
58825		A	Transposition, ovary(s)	6.13	NA	3.69	0.93	NA	10.75	090
58900		A	Biopsy of ovary(s)	5.99	NA	3.29	1.07	NA	10.35	090
58920		A	Partial removal of ovary(s)	6.78	NA	3.66	1.41	NA	11.85	090
58925		A	Removal of ovarian cyst(s)	11.36	NA	5.46	1.38	NA	18.20	090
58940		A	Removal of ovary(s)	7.29	NA	3.76	1.33	NA	12.38	090
58943		A	Removal of ovary(s)	18.43	NA	9.07	2.63	NA	30.13	090
58950		A	Resect ovarian malignancy	15.27	NA	7.83	2.38	NA	25.48	090
58951		A	Resect ovarian malignancy	21.81	NA	10.61	3.93	NA	36.35	090
58952		A	Resect ovarian malignancy	25.01	NA	11.86	3.92	NA	40.79	090
58960		A	Exploration of abdomen	14.65	NA	7.59	2.95	NA	25.19	090
58970		A	Retrieval of oocyte	3.53	6.04	1.90	0.58	10.15	6.01	000
58976		A	Transfer of embryo	3.83	4.93	4.62	0.63	9.39	9.08	000
59000		A	Amniocentesis	1.30	1.36	0.53	0.18	2.84	2.01	000
59012		A	Fetal cord puncture, prenatal	3.45	NA	1.53	0.31	NA	5.29	000
59015		A	Chorion biopsy	2.20	1.25	0.91	0.10	3.55	3.21	000
59020		A	Fetal contract stress test	0.66	1.15	1.15	0.29	2.10	2.10	000
59020	26	A	Fetal contract stress test	0.66	NA	0.21	0.19	NA	1.06	000
59020	TC	A	Fetal contract stress test	0.00	0.94	0.94	0.10	1.04	1.04	000
59025		A	Fetal non-stress test	0.53	0.61	0.61	0.12	1.26	1.26	000
59025	26	A	Fetal non-stress test	0.53	NA	0.21	0.08	NA	0.82	000
59025	TC	A	Fetal non-stress test	0.00	0.40	0.40	0.04	0.44	0.44	000
59030		A	Fetal scalp blood sample	1.99	NA	1.00	0.21	NA	3.20	000
59050		A	Fetal monitor w/report	0.89	NA	0.37	0.15	NA	1.41	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.31	0.15	NA	1.20	XXX
59100		A	Remove uterus lesion	12.35	NA	6.27	0.96	NA	19.58	090
59120		A	Treat ectopic pregnancy	11.49	NA	5.88	1.50	NA	18.87	090
59121		A	Treat ectopic pregnancy	11.67	NA	5.63	1.07	NA	18.37	090
59130		A	Treat ectopic pregnancy	14.22	NA	16.39	0.70	NA	31.31	090
59135		A	Treat ectopic pregnancy	13.88	NA	6.08	1.15	NA	21.11	090
59136		A	Treat ectopic pregnancy	13.18	NA	6.67	1.44	NA	21.29	090
59140		A	Treat ectopic pregnancy	5.46	NA	2.97	0.29	NA	8.72	090
59150		A	Treat ectopic pregnancy	6.89	NA	4.30	1.05	NA	12.24	090
59151		A	Treat ectopic pregnancy	7.86	NA	4.21	0.64	NA	12.71	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
59160		A	D&C after delivery	2.71	2.93	1.99	0.52	6.16	5.22	010
59200		A	Insert cervical dilator	0.79	1.03	0.31	0.11	1.93	1.21	000
59300		A	Episiotomy or vaginal repair	2.41	1.54	0.97	0.10	4.05	3.48	000
59320		A	Revision of cervix	2.48	NA	1.36	0.41	NA	4.25	000
59325		A	Revision of cervix	4.07	NA	2.35	0.29	NA	6.71	000
59350		A	Repair of uterus	4.95	NA	2.11	0.82	NA	7.88	000
59400		A	Obstetrical care	23.06	NA	12.94	3.47	NA	39.47	MMM
59409		A	Obstetrical care	13.50	NA	5.47	2.20	NA	21.17	MMM
59410		A	Obstetrical care	14.78	NA	6.52	2.39	NA	23.69	MMM
59412		A	Antepartum manipulation	1.71	1.29	0.70	0.29	3.29	2.70	MMM
59414		A	Deliver placenta	1.61	NA	1.07	0.27	NA	2.95	MMM
59425		A	Antepartum care only	4.81	4.02	4.05	0.66	9.49	9.52	MMM
59426		A	Antepartum care only	8.28	6.86	6.89	1.14	16.28	16.31	MMM
59430		A	Care after delivery	2.13	1.11	1.10	0.07	3.31	3.30	MMM
59510		A	Cesarean delivery	26.22	NA	14.88	3.92	NA	45.02	MMM
59514		A	Cesarean delivery only	15.97	NA	6.48	2.55	NA	25.00	MMM
59515		A	Cesarean delivery	17.37	NA	7.92	2.73	NA	28.02	MMM
59525		A	Remove uterus after cesarean	8.54	NA	3.67	0.88	NA	13.09	MMM
59610		A	Vbac delivery	24.62	NA	10.06	3.47	NA	38.15	MMM
59612		A	Vbac delivery only	15.06	NA	6.06	2.20	NA	23.32	MMM
59614		A	Vbac care after delivery	16.34	NA	6.41	2.39	NA	25.14	MMM
59618		A	Attempted vbac delivery	27.78	NA	11.13	3.92	NA	42.83	MMM
59620		A	Attempted vbac delivery only	17.53	NA	17.55	2.55	NA	37.63	MMM
59622		A	Attempted vbac after care	18.93	NA	7.86	2.73	NA	29.52	MMM
59812		A	Treatment of miscarriage	3.25	3.59	2.21	0.77	7.61	6.23	090
59820		A	Care of miscarriage	4.01	3.93	2.50	0.77	8.71	7.28	090
59821		A	Treatment of miscarriage	4.47	4.13	2.67	0.62	9.22	7.76	090
59830		A	Treat uterus infection	6.11	NA	3.64	0.52	NA	10.27	090
59840		A	Abortion	3.01	3.85	2.08	0.69	7.55	5.78	010
59841		A	Abortion	5.24	5.30	3.28	0.76	11.30	9.28	010
59850		A	Abortion	5.91	NA	2.77	0.85	NA	9.53	090
59851		A	Abortion	5.93	NA	3.07	0.88	NA	9.88	090
59852		A	Abortion	8.24	NA	4.05	1.27	NA	13.56	090
59855		A	Abortion	6.12	NA	3.12	0.96	NA	10.20	090
59856		A	Abortion	7.48	NA	3.75	1.19	NA	12.42	090
59857		A	Abortion	9.29	NA	10.55	1.44	NA	21.28	090
59866		A	Abortion	4.00	NA	4.69	0.66	NA	9.35	000
59870		A	Evacuate mole of uterus	4.28	NA	2.99	0.67	NA	7.94	090
59871		A	Remove cerclage suture	2.13	3.59	2.17	0.41	6.13	4.71	000
60000		A	Drain thyroid/tongue cyst	1.76	1.56	1.65	0.09	3.41	3.50	010
60001		A	Aspirate/inject thyriod cyst	0.97	1.47	0.36	0.12	2.56	1.45	000
60100		A	Biopsy of thyroid	0.97	1.88	0.72	0.12	2.97	1.81	000
60200		A	Remove thyroid lesion	9.55	NA	6.23	1.04	NA	16.82	090
60210		A	Partial excision thyroid	10.88	NA	6.20	1.65	NA	18.73	090
60212		A	Parital thyroid excision	16.03	NA	8.19	1.74	NA	25.96	090
60220		A	Partial removal of thyroid	10.53	NA	6.31	1.61	NA	18.45	090
60225		A	Partial removal of thyroid	14.19	NA	8.08	1.92	NA	24.19	090
60240		A	Removal of thyroid	16.06	NA	9.13	1.96	NA	27.15	090
60252		A	Removal of thyroid	18.20	NA	10.75	2.55	NA	31.50	090
60254		A	Extensive thyroid surgery	23.88	NA	14.70	3.08	NA	41.66	090
60260		A	Repeat thyroid surgery	15.46	NA	9.42	0.34	NA	25.22	090
60270		A	Removal of thyroid	17.94	NA	10.61	2.54	NA	31.09	090
60271		A	Removal of thyroid	14.89	NA	8.98	2.25	NA	26.12	090
60280		A	Remove thyroid duct lesion	6.08	NA	4.89	1.11	NA	12.08	090
60281		A	Remove thyroid duct lesion	8.53	NA	5.94	0.95	NA	15.42	090
60500		A	Explore parathyroid glands	16.23	NA	8.14	2.31	NA	26.68	090
60502		A	Re-explore parathyroids	20.35	NA	10.27	2.33	NA	32.95	090
60505		A	Explore parathyroid glands	21.49	NA	11.63	2.56	NA	35.68	090
60512		A	Autotransplant, parathyroid	4.45	NA	2.04	0.54	NA	7.03	ZZZ
60520		A	Removal of thymus gland	16.81	NA	9.26	2.46	NA	28.53	090
60521		A	Removal thymus gland	18.87	NA	10.85	2.46	NA	32.18	090
60522		A	Removal of thymus gland	23.09	NA	12.72	2.46	NA	38.27	090
60540		A	Explore adrenal gland	17.03	NA	8.46	2.08	NA	27.57	090
60545		A	Explore adrenal gland	19.88	NA	9.89	2.34	NA	32.11	090
60600		A	Remove carotid body lesion	17.93	NA	12.24	1.88	NA	32.05	090
60605		A	Remove carotid body lesion	20.24	NA	17.68	2.21	NA	40.13	090
61000		A	Remove cranial cavity fluid	1.58	1.26	1.30	0.17	3.01	3.05	000
61001		A	Remove cranial cavity fluid	1.49	1.24	1.27	0.17	2.90	2.93	000
61020		A	Remove brain cavity fluid	1.51	1.30	1.23	0.20	3.01	2.94	000
61026		A	Injection into brain canal	1.69	1.33	1.28	0.22	3.24	3.19	000
61050		A	Remove brain canal fluid	1.51	NA	1.34	0.15	NA	3.00	000
61055		A	Injection into brain canal	2.10	NA	1.45	0.19	NA	3.74	000
61070		A	Brain canal shunt procedure	0.89	3.37	0.84	0.03	4.29	1.76	000
61105		A	Drill skull for examination	5.14	NA	3.51	1.24	NA	9.89	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
61106		A	Drill skull for exam/surgery	4.62	NA	2.67	1.15	NA	8.44	ZZZ
61107		A	Drill skull for implantation	5.00	NA	3.13	1.26	NA	9.39	000
61108		A	Drill skull for drainage	10.19	NA	6.82	2.22	NA	19.23	090
61120		A	Pierce skull for examination	8.76	NA	5.73	1.08	NA	15.57	090
61130		A	Pierce skull, exam/surgery	6.37	NA	3.71	0.96	NA	11.04	ZZZ
61140		A	Pierce skull for biopsy	15.90	NA	10.04	2.56	NA	28.50	090
61150		A	Pierce skull for drainage	17.57	NA	10.62	2.63	NA	30.82	090
61151		A	Pierce skull for drainage	12.42	NA	8.03	0.37	NA	20.82	090
61154		A	Pierce skull, remove clot	14.99	NA	9.45	3.27	NA	27.71	090
61156		A	Pierce skull for drainage	16.32	NA	10.26	3.05	NA	29.63	090
61210		A	Pierce skull; implant device	5.84	NA	3.67	1.53	NA	11.04	000
61215		A	Insert brain-fluid device	4.89	NA	3.87	1.63	NA	10.39	090
61250		A	Pierce skull & explore	10.42	NA	6.74	1.44	NA	18.60	090
61253		A	Pierce skull & explore	12.36	NA	7.87	1.69	NA	21.92	090
61304		A	Open skull for exploration	21.96	NA	13.26	4.78	NA	40.00	090
61305		A	Open skull for exploration	26.61	NA	15.78	5.05	NA	47.44	090
61312		A	Open skull for drainage	24.57	NA	14.75	4.46	NA	43.78	090
61313		A	Open skull for drainage	24.93	NA	15.30	4.38	NA	44.61	090
61314		A	Open skull for drainage	24.23	NA	14.74	4.68	NA	43.65	090
61315		A	Open skull for drainage	27.68	NA	17.03	4.47	NA	49.18	090
61320		A	Open skull for drainage	25.62	NA	15.91	3.41	NA	44.94	090
61321		A	Open skull for drainage	28.50	NA	17.28	3.54	NA	49.32	090
61330		A	Decompress eye socket	23.32	NA	18.40	1.22	NA	42.94	090
61332		A	Explore/biopsy eye socket	27.28	NA	20.32	2.76	NA	50.36	090
61333		A	Explore orbit; remove lesion	27.95	NA	19.48	3.26	NA	50.69	090
61334		A	Explore orbit; remove object	18.27	NA	11.98	1.82	NA	32.07	090
61340		A	Relieve cranial pressure	18.66	NA	11.75	2.54	NA	32.95	090
61343		A	Incise skull, pressure relief	29.77	NA	18.69	5.28	NA	53.74	090
61345		A	Relieve cranial pressure	27.20	NA	16.48	3.45	NA	47.13	090
61440		A	Incise skull for surgery	26.63	NA	14.53	3.00	NA	44.16	090
61450		A	Incise skull for surgery	25.95	NA	15.66	3.43	NA	45.04	090
61458		A	Incise skull for brain wound	27.29	NA	16.70	4.87	NA	48.86	090
61460		A	Incise skull for surgery	28.39	NA	17.74	3.98	NA	50.11	090
61470		A	Incise skull for surgery	26.06	NA	16.40	2.53	NA	44.99	090
61480		A	Incise skull for surgery	26.49	NA	32.47	1.78	NA	60.74	090
61490		A	Incise skull for surgery	25.66	NA	15.39	2.16	NA	43.21	090
61500		A	Removal of skull lesion	17.92	NA	11.45	3.58	NA	32.95	090
61501		A	Remove infected skull bone	14.84	NA	9.58	3.33	NA	27.75	090
61510		A	Removal of brain lesion	28.45	NA	17.40	4.90	NA	50.75	090
61512		A	Remove brain lining lesion	35.09	NA	21.10	5.28	NA	61.47	090
61514		A	Removal of brain abscess	25.26	NA	15.37	4.74	NA	45.37	090
61516		A	Removal of brain lesion	24.61	NA	15.37	4.57	NA	44.55	090
61518		A	Removal of brain lesion	37.32	NA	23.03	5.46	NA	65.81	090
61519		A	Remove brain lining lesion	41.39	NA	25.28	5.77	NA	72.44	090
61520		A	Removal of brain lesion	54.84	NA	33.94	5.89	NA	94.67	090
61521		A	Removal of brain lesion	44.48	NA	27.27	5.85	NA	77.60	090
61522		A	Removal of brain abscess	29.45	NA	19.01	3.79	NA	52.25	090
61524		A	Removal of brain lesion	27.86	NA	17.28	5.15	NA	50.29	090
61526		A	Removal of brain lesion	52.17	NA	33.40	4.79	NA	90.36	090
61530		A	Removal of brain lesion	43.86	NA	29.39	4.79	NA	78.04	090
61531		A	Implant brain electrodes	14.63	NA	9.56	1.75	NA	25.94	090
61533		A	Implant brain electrodes	19.71	NA	12.33	3.33	NA	35.37	090
61534		A	Removal of brain lesion	20.97	NA	13.26	2.01	NA	36.24	090
61535		A	Remove brain electrodes	11.63	NA	8.05	1.25	NA	20.93	090
61536		A	Removal of brain lesion	35.52	NA	21.77	3.99	NA	61.28	090
61538		A	Removal of brain tissue	26.81	NA	17.07	4.97	NA	48.85	090
61539		A	Removal of brain tissue	32.08	NA	18.98	4.07	NA	55.13	090
61541		A	Incision of brain tissue	28.85	NA	18.26	3.78	NA	50.89	090
61542		A	Removal of brain tissue	31.02	NA	17.53	3.90	NA	52.45	090
61543		A	Removal of brain tissue	29.22	NA	18.17	2.49	NA	49.88	090
61544		A	Remove & treat brain lesion	25.50	NA	16.41	2.11	NA	44.02	090
61545		A	Excision of brain tumor	43.80	NA	26.55	4.80	NA	75.15	090
61546		A	Removal of pituitary gland	31.30	NA	19.32	4.78	NA	55.40	090
61548		A	Removal of pituitary gland	21.53	NA	14.40	4.03	NA	39.96	090
61550		A	Release of skull seams	14.65	NA	6.61	1.11	NA	22.37	090
61552		A	Release of skull seams	19.56	NA	10.26	2.70	NA	32.52	090
61556		A	Incise skull/sutures	22.26	NA	11.78	3.04	NA	37.08	090
61557		A	Incise skull/sutures	22.38	NA	11.40	3.05	NA	36.83	090
61558		A	Excision of skull/sutures	25.58	NA	16.83	3.47	NA	45.88	090
61559		A	Excision of skull/sutures	32.79	NA	21.49	4.50	NA	58.78	090
61563		A	Excision of skull tumor	26.83	NA	17.62	3.68	NA	48.13	090
61564		A	Excision of skull tumor	33.83	NA	22.16	4.64	NA	60.63	090
61570		A	Remove brain foreign body	24.60	NA	14.66	3.06	NA	42.32	090
61571		A	Incise skull for brain wound	26.39	NA	16.46	3.21	NA	46.06	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
61575		A	Skull base/brainstem surgery	34.36	NA	23.04	5.05	NA	62.45	090
61576		A	Skull base/brainstem surgery	52.43	NA	36.28	3.91	NA	92.62	090
61580		A	Craniofacial approach, skull	30.35	NA	20.42	4.10	NA	54.87	090
61581		A	Craniofacial approach, skull	34.60	NA	23.59	4.66	NA	62.85	090
61582		A	Craniofacial approach, skull	31.66	NA	19.47	4.22	NA	55.35	090
61583		A	Craniofacial approach, skull	36.21	NA	22.95	4.83	NA	63.99	090
61584		A	Orbitocranial approach/skull	34.65	NA	21.45	4.68	NA	60.78	090
61585		A	Orbitocranial approach/skull	38.61	NA	25.32	5.23	NA	69.16	090
61586		A	Resect nasopharynx, skull	25.10	NA	18.73	2.32	NA	46.15	090
61590		A	Infratemporal approach/skull	41.78	NA	28.03	5.68	NA	75.49	090
61591		A	Infratemporal approach/skull	43.68	NA	29.19	5.96	NA	78.83	090
61592		A	Orbitocranial approach/skull	39.64	NA	24.66	5.41	NA	69.71	090
61595		A	Transtemporal approach/skull	29.57	NA	20.52	4.00	NA	54.09	090
61596		A	Transcochlear approach/skull	35.63	NA	24.72	4.86	NA	65.21	090
61597		A	Transcondylar approach/skull	37.96	NA	22.85	5.13	NA	65.94	090
61598		A	Transpetrosal approach/skull	33.41	NA	22.09	4.52	NA	60.02	090
61600		A	Resect/excise cranial lesion	25.85	NA	18.10	3.46	NA	47.41	090
61601		A	Resect/excise cranial lesion	27.89	NA	17.64	3.72	NA	49.25	090
61605		A	Resect/excise cranial lesion	29.33	NA	19.91	3.93	NA	53.17	090
61606		A	Resect/excise cranial lesion	38.83	NA	23.98	5.25	NA	68.06	090
61607		A	Resect/excise cranial lesion	36.27	NA	22.45	4.91	NA	63.63	090
61608		A	Resect/excise cranial lesion	42.10	NA	25.98	5.71	NA	73.79	090
61609		A	Transect, artery, sinus	9.89	NA	5.36	1.40	NA	16.65	ZZZ
61610		A	Transect, artery, sinus	29.67	NA	16.40	4.21	NA	50.28	ZZZ
61611		A	Transect, artery, sinus	7.42	NA	8.99	1.06	NA	17.47	ZZZ
61612		A	Transect, artery, sinus	27.88	NA	15.35	3.96	NA	47.19	ZZZ
61613		A	Remove aneurysm, sinus	40.86	NA	24.84	5.61	NA	71.31	090
61615		A	Resect/excise lesion, skull	32.07	NA	21.56	4.31	NA	57.94	090
61616		A	Resect/excise lesion, skull	43.33	NA	27.06	5.86	NA	76.25	090
61618		A	Repair dura	16.99	NA	11.54	2.22	NA	30.75	090
61619		A	Repair dura	20.71	NA	14.37	2.77	NA	37.85	090
61624		A	Occlusion/embolization cath	20.15	NA	12.30	1.79	NA	34.24	000
61626		A	Occlusion/embolization cath	16.62	NA	9.57	1.47	NA	27.66	000
61680		A	Intracranial vessel surgery	30.71	NA	18.58	5.79	NA	55.08	090
61682		A	Intracranial vessel surgery	61.57	NA	36.19	6.36	NA	104.12	090
61684		A	Intracranial vessel surgery	39.81	NA	24.39	3.47	NA	67.67	090
61686		A	Intracranial vessel surgery	64.49	NA	36.48	4.20	NA	105.17	090
61690		A	Intracranial vessel surgery	29.31	NA	18.15	4.09	NA	51.55	090
61692		A	Intracranial vessel surgery	51.87	NA	31.20	3.36	NA	86.43	090
61700		A	Inner skull vessel surgery	50.52	NA	29.37	5.67	NA	85.56	090
61702		A	Inner skull vessel surgery	48.41	NA	28.26	6.61	NA	83.28	090
61703		A	Clamp neck artery	17.47	NA	11.29	2.24	NA	31.00	090
61705		A	Revise circulation to head	36.20	NA	20.67	5.25	NA	62.12	090
61708		A	Revise circulation to head	35.30	NA	15.87	2.32	NA	53.49	090
61710		A	Revise circulation to head	29.67	NA	14.80	1.75	NA	46.22	090
61711		A	Fusion of skull arteries	36.33	NA	21.45	6.20	NA	63.98	090
61712		A	Skull or spine microsurgery	3.49	NA	2.21	0.93	NA	6.63	ZZZ
61720		A	Incise skull/brain surgery	16.77	NA	10.55	4.05	NA	31.37	090
61735		A	Incise skull/brain surgery	20.43	NA	12.95	1.51	NA	34.89	090
61750		A	Incise skull; brain biopsy	18.20	NA	11.26	4.31	NA	33.77	090
61751		A	Brain biopsy with cat scan	17.62	NA	10.82	4.44	NA	32.88	090
61760		A	Implant brain electrodes	22.27	NA	13.31	1.75	NA	37.33	090
61770		A	Incise skull for treatment	21.44	NA	13.67	3.43	NA	38.54	090
61790		A	Treat trigeminal nerve	10.86	NA	6.57	3.03	NA	20.46	090
61791		A	Treat trigeminal tract	14.61	NA	9.51	3.16	NA	27.28	090
61793		A	Focus radiation beam	17.24	NA	11.21	1.96	NA	30.41	090
61795		A	Brain surgery using computer	4.04	NA	2.61	1.55	NA	8.20	000
61850		A	Implant neuroelectrodes	12.39	NA	8.25	2.26	NA	22.90	090
61855		A	Implant neuroelectrodes	13.39	NA	8.95	1.47	NA	23.81	090
61860		A	Implant neuroelectrodes	20.87	NA	13.11	1.59	NA	35.57	090
61865		A	Implant neuroelectrodes	22.97	NA	13.68	3.09	NA	39.74	090
61870		A	Implant neuroelectrodes	14.94	NA	10.21	0.82	NA	25.97	090
61875		A	Implant neuroelectrodes	15.06	NA	21.03	1.31	NA	37.40	090
61880		A	Revise/remove neuroelectrode	6.29	NA	4.64	0.66	NA	11.59	090
61885		A	Implant neuroreceiver	5.85	NA	4.42	0.29	NA	10.56	090
61888		A	Revise/remove neuroreceiver	5.07	NA	3.60	0.44	NA	9.11	010
62000		A	Repair of skull fracture	12.53	NA	6.11	0.95	NA	19.59	090
62005		A	Repair of skull fracture	16.17	NA	9.71	1.97	NA	27.85	090
62010		A	Treatment of head injury	19.81	NA	12.24	3.39	NA	35.44	090
62100		A	Repair brain fluid leakage	22.03	NA	14.47	3.72	NA	40.22	090
62115		A	Reduction of skull defect	21.66	NA	13.85	1.82	NA	37.33	090
62116		A	Reduction of skull defect	23.59	NA	15.13	1.99	NA	40.71	090
62117		A	Reduction of skull defect	26.60	NA	16.82	2.25	NA	45.67	090
62120		A	Repair skull cavity lesion	23.35	NA	16.32	1.98	NA	41.65	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
62121		A	Incise skull repair	21.58	NA	14.65	3.41	NA	39.64	090
62140		A	Repair of skull defect	13.51	NA	8.88	2.39	NA	24.78	090
62141		A	Repair of skull defect	14.91	NA	9.90	3.28	NA	28.09	090
62142		A	Remove skull plate/flap	10.79	NA	7.19	2.64	NA	20.62	090
62143		A	Replace skull plate/flap	13.05	NA	8.77	1.65	NA	23.47	090
62145		A	Repair of skull & brain	18.82	NA	12.41	2.29	NA	33.52	090
62146		A	Repair of skull with graft	16.12	NA	10.41	2.15	NA	28.68	090
62147		A	Repair of skull with graft	19.34	NA	12.51	2.57	NA	34.42	090
62180		A	Establish brain cavity shunt	21.06	NA	13.51	2.70	NA	37.27	090
62190		A	Establish brain cavity shunt	11.07	NA	7.75	3.21	NA	22.03	090
62192		A	Establish brain cavity shunt	12.25	NA	8.28	2.74	NA	23.27	090
62194		A	Replace/irrigate catheter	5.03	NA	2.49	0.29	NA	7.81	010
62200		A	Establish brain cavity shunt	18.32	NA	11.85	3.09	NA	33.26	090
62201		A	Establish brain cavity shunt	14.86	NA	10.10	1.72	NA	26.68	090
62220		A	Establish brain cavity shunt	13.00	NA	8.29	3.12	NA	24.41	090
62223		A	Establish brain cavity shunt	12.87	NA	8.36	3.02	NA	24.25	090
62225		A	Replace/irrigate catheter	5.41	NA	3.93	0.58	NA	9.92	090
62230		A	Replace/revise brain shunt	10.54	NA	6.77	1.82	NA	19.13	090
62256		A	Remove brain cavity shunt	6.60	NA	4.90	1.17	NA	12.67	090
62258		A	Replace brain cavity shunt	14.54	NA	9.12	2.55	NA	26.21	090
62268		A	Drain spinal cord cyst	4.74	NA	2.47	0.36	NA	7.57	000
62269		A	Needle biopsy spinal cord	5.02	NA	2.43	0.28	NA	7.73	000
62270		A	Spinal fluid tap, diagnostic	1.13	0.64	0.40	0.06	1.83	1.59	000
62272		A	Drain spinal fluid	1.35	0.79	0.58	0.12	2.26	2.05	000
62273		A	Treat lumbar spine lesion	2.15	1.24	0.82	0.26	3.65	3.23	000
62274		A	Inject spinal anesthetic	1.78	2.37	1.22	0.17	4.32	3.17	000
62275		A	Inject spinal anesthetic	1.79	2.14	1.21	0.19	4.12	3.19	000
62276		A	Inject spinal anesthetic	2.04	1.89	1.46	0.23	4.16	3.73	000
62277		A	Inject spinal anesthetic	2.15	3.63	1.26	0.23	6.01	3.64	000
62278		A	Inject spinal anesthetic	1.51	1.52	2.16	0.26	3.29	3.93	000
62279		A	Inject spinal anesthetic	1.58	1.80	1.13	0.24	3.62	2.95	000
62280		A	Treat spinal cord lesion	2.63	2.29	1.49	0.14	5.06	4.26	010
62281		A	Treat spinal cord lesion	2.66	2.36	1.39	0.28	5.30	4.33	010
62282		A	Treat spinal canal lesion	2.33	3.74	1.41	0.40	6.47	4.14	010
62284		A	Injection for myelogram	1.54	2.27	0.78	0.34	4.15	2.66	000
62287		A	Percutaneous diskectomy	8.08	NA	4.98	2.65	NA	15.71	090
62288		A	Injection into spinal canal	1.74	2.48	1.36	0.24	4.46	3.34	000
62289		A	Injection into spinal canal	1.64	2.43	1.19	0.29	4.36	3.12	000
62290		A	Inject for spine disk x-ray	3.00	2.84	1.48	0.24	6.08	4.72	000
62291		A	Inject for spine disk x-ray	2.91	2.96	1.17	0.39	6.26	4.47	000
62292		A	Injection into disk lesion	7.86	NA	4.91	2.13	NA	14.90	090
62294		A	Injection into spinal artery	11.83	NA	6.64	0.68	NA	19.15	090
62298		A	Injection into spinal canal	2.20	2.45	1.25	0.13	4.78	3.58	000
62350		A	Implant spinal catheter	6.87	NA	3.29	1.02	NA	11.18	090
62351		A	Implant spinal catheter	10.00	NA	6.04	1.50	NA	17.54	090
62355		A	Remove spinal canal catheter	5.45	NA	2.26	0.68	NA	8.39	090
62360		A	Insert spine infusion device	2.62	NA	2.18	0.33	NA	5.13	090
62361		A	Implant spine infusion pump	5.42	NA	2.63	0.78	NA	8.83	090
62362		A	Implant spine infusion pump	7.04	NA	3.87	1.02	NA	11.93	090
62365		A	Remove spine infusion device	5.42	NA	2.88	0.68	NA	8.98	090
62367	26	A	Analyze spine infusion pump	0.48	0.10	0.10	0.07	0.65	0.65	XXX
62368	26	A	Analyze spine infusion pump	0.75	0.16	0.16	0.11	1.02	1.02	XXX
63001		A	Removal of spinal lamina	15.82	NA	10.73	3.42	NA	29.97	090
63003		A	Removal of spinal lamina	15.95	NA	10.73	3.23	NA	29.91	090
63005		A	Removal of spinal lamina	14.92	NA	10.60	3.10	NA	28.62	090
63011		A	Removal of spinal lamina	14.52	NA	10.02	1.87	NA	26.41	090
63012		A	Removal of spinal lamina	15.40	NA	10.51	3.15	NA	29.06	090
63015		A	Removal of spinal lamina	19.35	NA	12.63	4.18	NA	36.16	090
63016		A	Removal of spinal lamina	19.20	NA	12.90	4.11	NA	36.21	090
63017		A	Removal of spinal lamina	15.94	NA	11.18	4.00	NA	31.12	090
63020		A	Neck spine disk surgery	14.81	NA	10.25	3.38	NA	28.44	090
63030		A	Low back disk surgery	12.00	NA	8.73	2.81	NA	23.54	090
63035		A	Added spinal disk surgery	3.15	NA	2.10	0.76	NA	6.01	ZZZ
63040		A	Neck spine disk surgery	18.81	NA	12.81	4.30	NA	35.92	090
63042		A	Low back disk surgery	17.47	NA	11.99	4.38	NA	33.84	090
63045		A	Removal of spinal lamina	16.50	NA	11.21	4.38	NA	32.09	090
63046		A	Removal of spinal lamina	15.80	NA	10.99	4.58	NA	31.37	090
63047		A	Removal of spinal lamina	14.61	NA	10.46	4.48	NA	29.55	090
63048		A	Removal of spinal lamina	3.26	NA	2.23	1.03	NA	6.52	ZZZ
63055		A	Decompress spinal cord	21.99	NA	14.35	4.18	NA	40.52	090
63056		A	Decompress spinal cord	20.36	NA	13.92	3.76	NA	38.04	090
63057		A	Decompress spinal cord	5.26	NA	3.19	0.85	NA	9.30	ZZZ
63064		A	Decompress spinal cord	24.61	NA	16.30	4.09	NA	45.00	090
63066		A	Decompress spinal cord	3.26	NA	2.18	0.45	NA	5.89	ZZZ

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
63075		A	Neck spine disk surgery	19.41	NA	12.78	3.21	NA	35.40	090
63076		A	Neck spine disk surgery	4.05	NA	2.73	0.97	NA	7.75	ZZZ
63077		A	Spine disk surgery, thorax	21.44	NA	14.91	3.17	NA	39.52	090
63078		A	Spine disk surgery, thorax	3.28	NA	2.34	0.45	NA	6.07	ZZZ
63081		A	Removal of vertebral body	23.73	NA	15.84	4.50	NA	44.07	090
63082		A	Removal of vertebral body	4.37	NA	2.96	1.22	NA	8.55	ZZZ
63085		A	Removal of vertebral body	26.92	NA	17.86	4.69	NA	49.47	090
63086		A	Removal of vertebral body	3.19	NA	1.35	1.07	NA	5.61	ZZZ
63087		A	Removal of vertebral body	35.57	NA	22.64	4.85	NA	63.06	090
63088		A	Removal of vertebral body	4.33	NA	2.98	1.18	NA	8.49	ZZZ
63090		A	Removal of vertebral body	28.16	NA	18.37	4.92	NA	51.45	090
63091		A	Removal of vertebral body	3.03	NA	2.10	0.46	NA	5.59	ZZZ
63170		A	Incise spinal cord tract(s)	19.83	NA	13.17	3.28	NA	36.28	090
63172		A	Drainage of spinal cyst	17.66	NA	12.04	4.26	NA	33.96	090
63173		A	Drainage of spinal cyst	21.99	NA	14.50	1.81	NA	38.30	090
63180		A	Revise spinal cord ligaments	18.27	NA	11.80	2.05	NA	32.12	090
63182		A	Revise spinal cord ligaments	20.50	NA	13.00	2.21	NA	35.71	090
63185		A	Incise spinal column/nerves	15.04	NA	9.89	2.93	NA	27.86	090
63190		A	Incise spinal column/nerves	17.45	NA	11.57	3.91	NA	32.93	090
63191		A	Incise spinal column/nerves	17.54	NA	12.16	2.21	NA	31.91	090
63194		A	Incise spinal column & cord	19.19	NA	13.04	2.33	NA	34.56	090
63195		A	Incise spinal column & cord	18.84	NA	12.24	2.11	NA	33.19	090
63196		A	Incise spinal column & cord	22.30	NA	12.39	1.83	NA	36.52	090
63197		A	Incise spinal column & cord	21.11	NA	13.78	2.62	NA	37.51	090
63198		A	Incise spinal column & cord	25.38	NA	33.47	3.19	NA	62.04	090
63199		A	Incise spinal column & cord	26.89	NA	12.16	2.61	NA	41.66	090
63200		A	Release of spinal cord	19.18	NA	12.21	1.83	NA	33.22	090
63250		A	Revise spinal cord vessels	40.76	NA	23.31	5.22	NA	69.29	090
63251		A	Revise spinal cord vessels	41.20	NA	24.91	4.32	NA	70.43	090
63252		A	Revise spinal cord vessels	41.19	NA	22.74	5.52	NA	69.45	090
63265		A	Excise intraspinal lesion	21.56	NA	13.88	3.90	NA	39.34	090
63266		A	Excise intraspinal lesion	22.30	NA	14.16	4.43	NA	40.89	090
63267		A	Excise intraspinal lesion	17.95	NA	11.93	4.20	NA	34.08	090
63268		A	Excise intraspinal lesion	18.52	NA	11.63	2.46	NA	32.61	090
63270		A	Excise intraspinal lesion	26.80	NA	16.57	3.42	NA	46.79	090
63271		A	Excise intraspinal lesion	26.92	NA	16.80	4.79	NA	48.51	090
63272		A	Excise intraspinal lesion	25.32	NA	15.72	4.26	NA	45.30	090
63273		A	Excise intraspinal lesion	24.29	NA	15.41	3.12	NA	42.82	090
63275		A	Biopsy/excise spinal tumor	23.68	NA	14.78	5.09	NA	43.55	090
63276		A	Biopsy/excise spinal tumor	23.45	NA	14.78	4.62	NA	42.85	090
63277		A	Biopsy/excise spinal tumor	20.83	NA	13.44	4.25	NA	38.52	090
63278		A	Biopsy/excise spinal tumor	20.56	NA	13.18	4.32	NA	38.06	090
63280		A	Biopsy/excise spinal tumor	28.35	NA	17.77	4.99	NA	51.11	090
63281		A	Biopsy/excise spinal tumor	28.05	NA	17.40	4.96	NA	50.41	090
63282		A	Biopsy/excise spinal tumor	26.39	NA	16.53	4.44	NA	47.36	090
63283		A	Biopsy/excise spinal tumor	25.00	NA	15.98	3.44	NA	44.42	090
63285		A	Biopsy/excise spinal tumor	36.00	NA	21.55	4.49	NA	62.04	090
63286		A	Biopsy/excise spinal tumor	35.63	NA	21.97	4.92	NA	62.52	090
63287		A	Biopsy/excise spinal tumor	36.70	NA	22.55	4.53	NA	63.78	090
63290		A	Biopsy/excise spinal tumor	37.38	NA	22.74	4.65	NA	64.77	090
63300		A	Removal of vertebral body	24.43	NA	15.51	2.02	NA	41.96	090
63301		A	Removal of vertebral body	27.60	NA	17.36	3.58	NA	48.54	090
63302		A	Removal of vertebral body	27.81	NA	18.00	3.02	NA	48.83	090
63303		A	Removal of vertebral body	30.50	NA	18.91	3.39	NA	52.80	090
63304		A	Removal of vertebral body	30.33	NA	18.67	2.49	NA	51.49	090
63305		A	Removal of vertebral body	32.03	NA	19.28	3.75	NA	55.06	090
63306		A	Removal of vertebral body	32.22	NA	19.95	2.65	NA	54.82	090
63307		A	Removal of vertebral body	31.63	NA	17.92	2.98	NA	52.53	090
63308		A	Removal of vertebral body	5.25	NA	3.17	0.73	NA	9.15	ZZZ
63600		A	Remove spinal cord lesion	14.02	NA	5.15	2.63	NA	21.80	090
63610		A	Stimulation of spinal cord	8.73	NA	2.31	2.06	NA	13.10	000
63615		A	Remove lesion of spinal cord	16.28	NA	10.48	2.03	NA	28.79	090
63650		A	Implant neuroelectrodes	6.74	NA	2.48	2.13	NA	11.35	090
63655		A	Implant neuroelectrodes	10.29	NA	7.28	3.64	NA	21.21	090
63660		A	Revise/remove neuroelectrode	6.16	NA	3.22	1.56	NA	10.94	090
63685		A	Implant neuroreceiver	7.04	NA	3.67	1.46	NA	12.17	090
63688		A	Revise/remove neuroreceiver	5.39	NA	3.27	1.26	NA	9.92	090
63690		A	Analysis of neuroreceiver	0.45	0.31	0.24	0.12	0.88	0.81	XXX
63691		A	Analysis of neuroreceiver	0.65	0.41	0.35	0.11	1.17	1.11	XXX
63700		A	Repair of spinal herniation	16.53	NA	10.92	2.22	NA	29.67	090
63702		A	Repair of spinal herniation	18.48	NA	11.93	2.49	NA	32.90	090
63704		A	Repair of spinal herniation	21.18	NA	14.82	2.77	NA	38.77	090
63706		A	Repair of spinal herniation	24.11	NA	15.25	3.18	NA	42.54	090
63707		A	Repair spinal fluid leakage	11.26	NA	8.05	2.56	NA	21.87	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
63709		A	Repair spinal fluid leakage	14.32	NA	10.23	3.30	NA	27.85	090
63710		A	Graft repair of spine defect	14.07	NA	9.67	1.58	NA	25.32	090
63740		A	Install spinal shunt	11.36	NA	7.83	2.99	NA	22.18	090
63741		A	Install spinal shunt	8.25	NA	4.93	2.39	NA	15.57	090
63744		A	Revision of spinal shunt	8.10	NA	4.95	1.68	NA	14.73	090
63746		A	Removal of spinal shunt	6.43	NA	3.39	1.08	NA	10.90	090
64400		A	Injection for nerve block	1.11	1.44	1.03	0.05	2.60	2.19	000
64402		A	Injection for nerve block	1.25	2.85	1.19	0.09	4.19	2.53	000
64405		A	Injection for nerve block	1.32	1.49	0.99	0.07	2.88	2.38	000
64408		A	Injection for nerve block	1.41	1.68	1.36	0.11	3.20	2.88	000
64410		A	Injection for nerve block	1.43	1.56	1.12	0.15	3.14	2.70	000
64412		A	Injection for nerve block	1.18	1.52	0.96	0.08	2.78	2.22	000
64413		A	Injection for nerve block	1.40	1.74	1.17	0.08	3.22	2.65	000
64415		A	Injection for nerve block	1.48	1.52	1.12	0.07	3.07	2.67	000
64417		A	Injection for nerve block	1.44	1.44	1.09	0.15	3.03	2.68	000
64418		A	Injection for nerve block	1.32	1.42	0.98	0.10	2.84	2.40	000
64420		A	Injection for nerve block	1.18	1.47	0.98	0.07	2.72	2.23	000
64421		A	Injection for nerve block	1.68	1.62	1.16	0.17	3.47	3.01	000
64425		A	Injection for nerve block	1.75	1.43	1.07	0.10	3.28	2.92	000
64430		A	Injection for nerve block	1.46	2.10	1.16	0.12	3.68	2.74	000
64435		A	Injection for nerve block	1.45	2.24	1.58	0.09	3.78	3.12	000
64440		A	Injection for nerve block	1.34	2.16	1.20	0.09	3.59	2.63	000
64441		A	Injection for nerve block	1.79	2.29	1.25	0.12	4.20	3.16	000
64442		A	Injection for nerve block	1.41	2.40	1.33	0.16	3.97	2.90	000
64443		A	Injection for nerve block	0.98	2.18	1.34	0.12	3.28	2.44	ZZZ
64445		A	Injection for nerve block	1.48	2.00	1.19	0.06	3.54	2.73	000
64450		A	Injection for nerve block	1.27	1.00	1.00	0.05	2.32	2.32	000
64505		A	Injection for nerve block	1.36	1.57	1.14	0.06	2.99	2.56	000
64508		A	Injection for nerve block	1.12	1.69	1.42	0.08	2.89	2.62	000
64510		A	Injection for nerve block	1.22	1.43	1.05	0.18	2.83	2.45	000
64520		A	Injection for nerve block	1.35	2.03	1.10	0.17	3.55	2.62	000
64530		A	Injection for nerve block	1.58	3.11	1.30	0.28	4.97	3.16	000
64550		A	Apply neurostimulator	0.18	0.25	0.04	0.04	0.47	0.26	000
64553		A	Implant neuroelectrodes	2.31	1.19	1.50	0.10	3.60	3.91	010
64555		A	Implant neuroelectrodes	2.27	1.75	0.91	0.10	4.12	3.28	010
64560		A	Implant neuroelectrodes	2.36	1.13	1.05	0.24	3.73	3.65	010
64565		A	Implant neuroelectrodes	1.76	1.77	0.73	0.08	3.61	2.57	010
64573		A	Implant neuroelectrodes	4.43	NA	2.77	0.61	NA	7.81	090
64575		A	Implant neuroelectrodes	4.35	NA	3.07	0.40	NA	7.82	090
64577		A	Implant neuroelectrodes	4.62	NA	3.02	0.45	NA	8.09	090
64580		A	Implant neuroelectrodes	4.12	NA	2.55	0.20	NA	6.87	090
64585		A	Revise/remove neuroelectrode	2.06	1.66	1.54	0.09	3.81	3.69	010
64590		A	Implant neuroreceiver	2.40	NA	2.18	0.35	NA	4.93	010
64595		A	Revise/remove neuroreceiver	1.73	NA	1.55	0.21	NA	3.49	010
64600		A	Injection treatment of nerve	3.45	2.22	1.88	0.17	5.84	5.50	010
64605		A	Injection treatment of nerve	5.61	4.38	2.31	0.33	10.32	8.25	010
64610		A	Injection treatment of nerve	7.16	NA	4.22	1.35	NA	12.73	010
64612		A	Destroy nerve, face muscle	1.96	2.41	2.10	0.17	4.54	4.23	010
64613		A	Destroy nerve, spine muscle	1.96	1.23	1.18	0.17	3.36	3.31	010
64620		A	Injection treatment of nerve	2.84	1.87	1.47	0.19	4.90	4.50	010
64622		A	Injection treatment of nerve	3.00	3.33	1.56	0.35	6.68	4.91	010
64623		A	Injection treatment of nerve	0.99	2.08	1.13	0.17	3.24	2.29	ZZZ
64630		A	Injection treatment of nerve	3.00	2.29	1.43	0.38	5.67	4.81	010
64640		A	Injection treatment of nerve	2.76	2.52	1.94	0.09	5.37	4.79	010
64680		A	Injection treatment of nerve	2.62	1.56	1.55	0.41	4.59	4.58	010
64702		A	Revise finger/toe nerve	4.23	NA	3.52	0.70	NA	8.45	090
64704		A	Revise hand/foot nerve	4.57	NA	2.92	0.74	NA	8.23	090
64708		A	Revise arm/leg nerve	6.12	NA	4.82	1.26	NA	12.20	090
64712		A	Revision of sciatic nerve	7.75	NA	4.87	1.68	NA	14.30	090
64713		A	Revision of arm nerve(s)	11.00	NA	6.33	1.72	NA	19.05	090
64714		A	Revise low back nerve(s)	10.33	NA	4.61	1.41	NA	16.35	090
64716		A	Revision of cranial nerve	6.31	NA	4.82	0.67	NA	11.80	090
64718		A	Revise ulnar nerve at elbow	5.99	NA	4.90	1.13	NA	12.02	090
64719		A	Revise ulnar nerve at wrist	4.85	NA	4.10	0.85	NA	9.80	090
64721		A	Carpal tunnel surgery	4.29	4.68	6.98	0.83	9.80	12.10	090
64722		A	Relieve pressure on nerve(s)	4.70	NA	3.06	1.11	NA	8.87	090
64726		A	Release foot/toe nerve	4.18	NA	2.49	0.07	NA	6.74	090
64727		A	Internal nerve revision	3.10	NA	2.10	0.55	NA	5.75	ZZZ
64732		A	Incision of brow nerve	4.41	NA	3.16	0.72	NA	8.29	090
64734		A	Incision of cheek nerve	4.92	NA	3.23	0.67	NA	8.82	090
64736		A	Incision of chin nerve	4.60	NA	2.70	0.42	NA	7.72	090
64738		A	Incision of jaw nerve	5.73	NA	3.22	0.61	NA	9.56	090
64740		A	Incision of tongue nerve	5.59	NA	3.55	0.62	NA	9.76	090
64742		A	Incision of facial nerve	6.22	NA	4.72	0.44	NA	11.38	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
64744		A	Incise nerve, back of head	5.24	NA	3.43	1.10	NA	9.77	090
64746		A	Incise diaphragm nerve	5.93	NA	3.88	0.77	NA	10.58	090
64752		A	Incision of vagus nerve	7.06	NA	4.07	0.85	NA	11.98	090
64755		A	Incision of stomach nerves	13.52	NA	6.43	2.27	NA	22.22	090
64760		A	Incision of vagus nerve	6.96	NA	3.72	1.50	NA	12.18	090
64761		A	Incision of pelvis nerve	6.41	NA	3.66	0.50	NA	10.57	090
64763		A	Incise hip/thigh nerve	6.93	NA	5.70	0.92	NA	13.55	090
64766		A	Incise hip/thigh nerve	8.67	NA	4.91	1.20	NA	14.78	090
64771		A	Sever cranial nerve	7.35	NA	5.16	0.73	NA	13.24	090
64772		A	Incision of spinal nerve	7.21	NA	4.03	1.30	NA	12.54	090
64774		A	Remove skin nerve lesion	5.17	NA	3.43	0.45	NA	9.05	090
64776		A	Remove digit nerve lesion	5.12	NA	3.59	0.41	NA	9.12	090
64778		A	Added digit nerve surgery	3.11	NA	1.95	0.43	NA	5.49	ZZZ
64782		A	Remove limb nerve lesion	6.23	NA	3.40	0.46	NA	10.09	090
64783		A	Added limb nerve surgery	3.72	NA	2.42	0.47	NA	6.61	ZZZ
64784		A	Remove nerve lesion	9.82	NA	6.55	0.96	NA	17.33	090
64786		A	Remove sciatic nerve lesion	15.46	NA	10.12	2.14	NA	27.72	090
64787		A	Implant nerve end	4.30	NA	2.51	0.60	NA	7.41	ZZZ
64788		A	Remove skin nerve lesion	4.61	NA	2.99	0.50	NA	8.10	090
64790		A	Removal of nerve lesion	11.31	NA	7.35	1.22	NA	19.88	090
64792		A	Removal of nerve lesion	14.92	NA	9.11	1.66	NA	25.69	090
64795		A	Biopsy of nerve	3.01	NA	1.73	0.39	NA	5.13	000
64802		A	Remove sympathetic nerves	9.15	NA	5.06	1.10	NA	15.31	090
64804		A	Remove sympathetic nerves	14.64	NA	8.06	2.44	NA	25.14	090
64809		A	Remove sympathetic nerves	13.67	NA	6.18	2.04	NA	21.89	090
64818		A	Remove sympathetic nerves	10.30	NA	5.49	1.72	NA	17.51	090
64820		A	Remove sympathetic nerves	10.37	NA	7.87	1.42	NA	19.66	090
64830		A	Microrepair of nerve	3.10	NA	2.09	0.38	NA	5.57	ZZZ
64831		A	Repair of digit nerve	9.44	NA	6.91	0.56	NA	16.91	090
64832		A	Repair additional nerve	5.66	NA	3.63	0.24	NA	9.53	ZZZ
64834		A	Repair of hand or foot nerve	10.19	NA	7.05	0.56	NA	17.80	090
64835		A	Repair of hand or foot nerve	10.94	NA	7.57	1.03	NA	19.54	090
64836		A	Repair of hand or foot nerve	10.94	NA	7.50	1.22	NA	19.66	090
64837		A	Repair additional nerve	6.26	NA	3.93	0.85	NA	11.04	ZZZ
64840		A	Repair of leg nerve	13.02	NA	9.09	0.53	NA	22.64	090
64856		A	Repair/transpose nerve	13.80	NA	9.82	1.46	NA	25.08	090
64857		A	Repair arm/leg nerve	14.49	NA	10.20	1.54	NA	26.23	090
64858		A	Repair sciatic nerve	16.49	NA	10.05	2.11	NA	28.65	090
64859		A	Additional nerve surgery	4.26	NA	2.55	0.58	NA	7.39	ZZZ
64861		A	Repair of arm nerves	19.24	NA	14.22	1.38	NA	34.84	090
64862		A	Repair of low back nerves	19.44	NA	8.00	1.61	NA	29.05	090
64864		A	Repair of facial nerve	12.55	NA	8.83	1.16	NA	22.54	090
64865		A	Repair of facial nerve	15.24	NA	10.67	1.50	NA	27.41	090
64866		A	Fusion of facial/other nerve	15.74	NA	10.75	1.84	NA	28.33	090
64868		A	Fusion of facial/other nerve	14.04	NA	9.67	1.47	NA	25.18	090
64870		A	Fusion of facial/other nerve	15.99	NA	20.77	1.70	NA	38.46	090
64872		A	Subsequent repair of nerve	1.99	NA	1.29	0.29	NA	3.57	ZZZ
64874		A	Repair & revise nerve	2.98	NA	1.80	0.43	NA	5.21	ZZZ
64876		A	Repair nerve; shorten bone	3.38	NA	2.25	0.48	NA	6.11	ZZZ
64885		A	Nerve graft, head or neck	17.53	NA	11.64	1.48	NA	30.65	090
64886		A	Nerve graft, head or neck	20.75	NA	13.57	1.77	NA	36.09	090
64890		A	Nerve graft, hand or foot	15.15	NA	10.74	2.12	NA	28.01	090
64891		A	Nerve graft, hand or foot	16.14	NA	11.69	1.73	NA	29.56	090
64892		A	Nerve graft, arm or leg	14.65	NA	10.55	1.69	NA	26.89	090
64893		A	Nerve graft, arm or leg	15.60	NA	10.68	2.27	NA	28.55	090
64895		A	Nerve graft, hand or foot	19.25	NA	11.82	2.55	NA	33.62	090
64896		A	Nerve graft, hand or foot	20.49	NA	14.75	1.90	NA	37.14	090
64897		A	Nerve graft, arm or leg	18.24	NA	11.06	2.47	NA	31.77	090
64898		A	Nerve graft, arm or leg	19.50	NA	13.66	2.35	NA	35.51	090
64901		A	Additional nerve graft	10.22	NA	6.60	0.87	NA	17.69	ZZZ
64902		A	Additional nerve graft	11.83	NA	8.07	0.99	NA	20.89	ZZZ
64905		A	Nerve pedicle transfer	14.02	NA	10.13	0.70	NA	24.85	090
64907		A	Nerve pedicle transfer	18.83	NA	13.77	2.55	NA	35.15	090
65091		A	Revise eye	6.46	NA	8.43	0.45	NA	15.34	090
65093		A	Revise eye with implant	6.87	NA	9.14	0.52	NA	16.53	090
65101		A	Removal of eye	7.03	NA	9.28	0.47	NA	16.78	090
65103		A	Remove eye/insert implant	7.57	NA	9.63	0.50	NA	17.70	090
65105		A	Remove eye/attach implant	8.49	NA	10.38	0.55	NA	19.42	090
65110		A	Removal of eye	13.95	NA	13.66	1.14	NA	28.75	090
65112		A	Remove eye, revise socket	16.38	NA	15.14	1.09	NA	32.61	090
65114		A	Remove eye, revise socket	17.53	NA	16.81	1.65	NA	35.99	090
65125		A	Revise ocular implant	3.12	4.05	1.78	0.13	7.30	5.03	090
65130		A	Insert ocular implant	7.15	NA	8.87	0.50	NA	16.52	090
65135		A	Insert ocular implant	7.33	NA	9.07	0.35	NA	16.75	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
65140		A	Attach ocular implant	8.02	NA	9.49	0.33	NA	17.84	090
65150		A	Revise ocular implant	6.26	NA	8.41	0.56	NA	15.23	090
65155		A	Reinsert ocular implant	8.66	NA	10.02	0.90	NA	19.58	090
65175		A	Removal of ocular implant	6.28	NA	8.25	0.40	NA	14.93	090
65205		A	Remove foreign body from eye	0.71	3.17	0.23	0.02	3.90	0.96	000
65210		A	Remove foreign body from eye	0.84	3.18	0.26	0.03	4.05	1.13	000
65220		A	Remove foreign body from eye	0.71	4.56	0.22	0.04	5.31	0.97	000
65222		A	Remove foreign body from eye	0.93	3.17	0.23	0.03	4.13	1.19	000
65235		A	Remove foreign body from eye	7.57	NA	7.08	0.30	NA	14.95	090
65260		A	Remove foreign body from eye	10.96	NA	11.16	0.45	NA	22.57	090
65265		A	Remove foreign body from eye	12.59	NA	13.18	0.51	NA	26.28	090
65270		A	Repair of eye wound	1.90	2.72	2.29	0.07	4.69	4.26	010
65272		A	Repair of eye wound	3.82	4.32	4.04	0.10	8.24	7.96	090
65273		A	Repair of eye wound	4.36	NA	4.39	0.21	NA	8.96	090
65275		A	Repair of eye wound	5.34	4.47	4.28	0.04	9.85	9.66	090
65280		A	Repair of eye wound	7.66	NA	8.10	0.49	NA	16.25	090
65285		A	Repair of eye wound	12.90	NA	14.06	0.64	NA	27.60	090
65286		A	Repair of eye wound	5.51	6.60	6.30	0.25	12.36	12.06	090
65290		A	Repair of eye socket wound	5.41	NA	6.59	0.37	NA	12.37	090
65400		A	Removal of eye lesion	6.06	7.42	6.99	0.35	13.83	13.40	090
65410		A	Biopsy of cornea	1.47	1.50	1.16	0.11	3.08	2.74	000
65420		A	Removal of eye lesion	4.17	5.78	5.53	0.23	10.18	9.93	090
65426		A	Removal of eye lesion	5.25	6.83	6.54	0.38	12.46	12.17	090
65430		A	Corneal smear	1.47	3.62	1.03	0.03	5.12	2.53	000
65435		A	Curette/treat cornea	0.92	1.16	0.48	0.04	2.12	1.44	000
65436		A	Curette/treat cornea	4.19	4.51	4.25	0.08	8.78	8.52	090
65450		A	Treatment of corneal lesion	3.27	5.32	5.02	0.17	8.76	8.46	090
65600		A	Revision of cornea	3.40	4.03	1.45	0.14	7.57	4.99	090
65710		A	Corneal transplant	12.35	NA	13.50	1.13	NA	26.98	090
65730		A	Corneal transplant	14.25	NA	14.30	1.29	NA	29.84	090
65750		A	Corneal transplant	15.00	NA	14.90	1.33	NA	31.23	090
65755		A	Corneal transplant	14.89	NA	14.73	1.39	NA	31.01	090
65770		A	Revise cornea with implant	17.56	NA	16.78	0.71	NA	35.05	090
65772		A	Correction of astigmatism	4.29	5.25	4.98	0.31	9.85	9.58	090
65775		A	Correction of astigmatism	5.79	NA	7.85	0.50	NA	14.14	090
65800		A	Drainage of eye	1.91	1.98	1.73	0.10	3.99	3.74	000
65805		A	Drainage of eye	1.91	1.99	1.74	0.10	4.00	3.75	000
65810		A	Drainage of eye	4.87	NA	6.59	0.30	NA	11.76	090
65815		A	Drainage of eye	5.05	6.67	6.36	0.24	11.96	11.65	090
65820		A	Relieve inner eye pressure	8.13	NA	8.81	0.51	NA	17.45	090
65850		A	Incision of eye	10.52	NA	9.81	0.69	NA	21.02	090
65855		A	Laser surgery of eye	4.30	4.61	3.88	0.52	9.43	8.70	090
65860		A	Incise inner eye adhesions	3.55	3.56	2.91	0.37	7.48	6.83	090
65865		A	Incise inner eye adhesions	5.60	NA	6.64	0.41	NA	12.65	090
65870		A	Incise inner eye adhesions	6.27	NA	7.02	0.31	NA	13.60	090
65875		A	Incise inner eye adhesions	6.54	NA	7.18	0.34	NA	14.06	090
65880		A	Incise inner eye adhesions	7.09	NA	7.56	0.37	NA	15.02	090
65900		A	Remove eye lesion	10.93	NA	11.93	0.92	NA	23.78	090
65920		A	Remove implant from eye	8.40	NA	8.40	0.44	NA	17.24	090
65930		A	Remove blood clot from eye	7.44	NA	8.40	0.41	NA	16.25	090
66020		A	Injection treatment of eye	1.59	1.98	1.72	0.14	3.71	3.45	010
66030		A	Injection treatment of eye	1.25	1.77	1.32	0.03	3.05	2.60	010
66130		A	Remove eye lesion	7.69	6.54	6.27	0.28	14.51	14.24	090
66150		A	Glaucoma surgery	8.30	NA	9.01	0.59	NA	17.90	090
66155		A	Glaucoma surgery	8.29	NA	9.00	0.50	NA	17.79	090
66160		A	Glaucoma surgery	10.17	NA	10.01	0.55	NA	20.73	090
66165		A	Glaucoma surgery	8.01	NA	8.86	0.57	NA	17.44	090
66170		A	Glaucoma surgery	12.16	10.57	15.51	0.63	23.36	28.30	090
66172		A	Incision of eye	15.04	NA	12.81	0.63	NA	28.48	090
66180		A	Implant eye shunt	14.55	NA	13.02	1.03	NA	28.60	090
66185		A	Revise eye shunt	8.14	NA	9.00	0.58	NA	17.72	090
66220		A	Repair eye lesion	7.77	NA	9.21	0.34	NA	17.32	090
66225		A	Repair/graft eye lesion	11.05	NA	10.47	0.86	NA	22.38	090
66250		A	Follow-up surgery of eye	5.98	7.38	6.96	0.38	13.74	13.32	090
66500		A	Incision of iris	3.71	NA	4.02	0.27	NA	8.00	090
66505		A	Incision of iris	4.08	NA	4.20	0.17	NA	8.45	090
66600		A	Remove iris and lesion	8.68	NA	8.72	0.51	NA	17.91	090
66605		A	Removal of iris	12.79	NA	13.29	0.67	NA	26.75	090
66625		A	Removal of iris	5.13	6.70	6.41	0.48	12.31	12.02	090
66630		A	Removal of iris	6.16	NA	7.33	0.45	NA	13.94	090
66635		A	Removal of iris	6.25	NA	7.04	0.49	NA	13.78	090
66680		A	Repair iris & ciliary body	5.44	NA	6.63	0.35	NA	12.42	090
66682		A	Repair iris and ciliary body	6.21	NA	7.35	0.38	NA	13.94	090
66700		A	Destruction, ciliary body	4.78	6.17	5.89	0.35	11.30	11.02	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
66710		A	Destruction, ciliary body	4.78	6.36	5.87	0.41	11.55	11.06	090
66720		A	Destruction, ciliary body	4.78	6.07	5.85	0.38	11.23	11.01	090
66740		A	Destruction, ciliary body	4.78	NA	6.35	0.39	NA	11.52	090
66761		A	Revision of iris	4.07	3.83	3.19	0.47	8.37	7.73	090
66762		A	Revision of iris	4.58	4.11	3.47	0.55	9.24	8.60	090
66770		A	Removal of inner eye lesion	5.18	4.46	3.81	0.45	10.09	9.44	090
66820		A	Incision, secondary cataract	3.89	NA	6.03	0.29	NA	10.21	090
66821		A	After cataract laser surgery	2.35	2.80	2.56	0.37	5.52	5.28	090
66825		A	Reposition intraocular lens	8.23	NA	8.49	0.38	NA	17.10	090
66830		A	Removal of lens lesion	8.20	8.47	13.09	0.40	17.07	21.69	090
66840		A	Removal of lens material	7.91	NA	7.95	0.54	NA	16.40	090
66850		A	Removal of lens material	9.11	NA	8.58	0.70	NA	18.39	090
66852		A	Removal of lens material	9.97	NA	9.18	0.90	NA	20.05	090
66920		A	Extraction of lens	8.86	NA	8.48	0.60	NA	17.94	090
66930		A	Extraction of lens	10.18	NA	9.27	0.57	NA	20.02	090
66940		A	Extraction of lens	8.93	NA	8.54	0.62	NA	18.09	090
66983		A	Remove cataract, insert lens	8.99	NA	5.94	0.95	NA	15.88	090
66984		A	Remove cataract, insert lens	10.28	NA	8.36	0.94	NA	19.58	090
66985		A	Insert lens prosthesis	8.39	NA	7.24	0.63	NA	16.26	090
66986		A	Exchange lens prosthesis	12.28	NA	10.45	0.63	NA	23.36	090
67005		A	Partial removal of eye fluid	5.70	NA	3.42	1.13	NA	10.25	090
67010		A	Partial removal of eye fluid	6.87	NA	4.34	1.04	NA	12.25	090
67015		A	Release of eye fluid	6.92	NA	7.55	0.35	NA	14.82	090
67025		A	Replace eye fluid	6.84	10.75	7.07	0.36	17.95	14.27	090
67027		A	Implant eye drug system	10.85	24.75	15.60	0.47	36.07	26.92	090
67028		A	Injection eye drug	2.52	5.37	1.68	0.18	8.07	4.38	000
67030		A	Incise inner eye strands	4.84	NA	5.99	0.50	NA	11.33	090
67031		A	Laser surgery, eye strands	3.67	3.63	2.98	0.75	8.05	7.40	090
67036		A	Removal of inner eye fluid	11.89	NA	9.91	1.49	NA	23.29	090
67038		A	Strip retinal membrane	21.24	NA	17.55	1.80	NA	40.59	090
67039		A	Laser treatment of retina	14.52	NA	12.59	1.68	NA	28.79	090
67040		A	Laser treatment of retina	17.23	NA	14.64	1.75	NA	33.62	090
67101		A	Repair, detached retina	7.53	9.23	8.73	0.66	17.42	16.92	090
67105		A	Repair, detached retina	7.41	7.17	5.67	0.80	15.38	13.88	090
67107		A	Repair detached retina	14.84	NA	13.64	1.10	NA	29.58	090
67108		A	Repair detached retina	20.82	NA	18.57	1.76	NA	41.15	090
67110		A	Repair detached retina	8.81	13.73	10.00	0.97	23.51	19.78	090
67112		A	Re-repair detached retina	16.86	NA	15.75	0.86	NA	33.47	090
67115		A	Release, encircling material	4.99	NA	5.99	0.44	NA	11.42	090
67120		A	Remove eye implant material	5.98	10.12	6.53	0.38	16.48	12.89	090
67121		A	Remove eye implant material	10.67	NA	11.52	0.49	NA	22.68	090
67141		A	Treatment of retina	5.20	6.47	6.18	0.48	12.15	11.86	090
67145		A	Treatment of retina	5.37	5.01	4.15	0.49	10.87	10.01	090
67208		A	Treatment of retinal lesion	6.70	7.13	6.73	0.52	14.35	13.95	090
67210		A	Treatment of retinal lesion	10.05	7.98	6.80	0.47	18.50	17.32	090
67218		A	Treatment of retinal lesion	13.52	NA	13.52	0.70	NA	27.74	090
67227		A	Treatment of retinal lesion	6.58	7.23	6.94	0.51	14.32	14.03	090
67228		A	Treatment of retinal lesion	12.74	10.02	8.11	0.48	23.24	21.33	090
67250		A	Reinforce eye wall	8.66	NA	9.58	0.40	NA	18.64	090
67255		A	Reinforce/graft eye wall	8.90	NA	9.96	0.87	NA	19.73	090
67311		A	Revise eye muscle	6.65	NA	6.99	0.47	NA	14.11	090
67312		A	Revise two eye muscles	8.54	NA	8.28	0.53	NA	17.35	090
67314		A	Revise eye muscle	7.52	NA	7.48	0.58	NA	15.58	090
67316		A	Revise two eye muscles	9.66	NA	8.78	0.67	NA	19.11	090
67318		A	Revise eye muscle(s)	7.85	NA	7.92	0.33	NA	16.10	090
67320		A	Revise eye muscle(s)	8.66	NA	9.44	0.69	NA	18.79	090
67331		A	Eye surgery follow-up	8.12	NA	8.00	0.54	NA	16.66	090
67332		A	Rerevise eye muscles	8.99	NA	9.20	0.58	NA	18.77	090
67334		A	Revise eye muscle w/suture	7.96	NA	7.99	0.33	NA	16.28	090
67335		A	Eye suture during surgery	2.49	NA	3.31	0.43	NA	6.23	ZZZ
67340		A	Revise eye muscle	9.85	NA	10.06	0.41	NA	20.32	090
67343		A	Release eye tissue	7.35	NA	7.65	0.31	NA	15.31	090
67345		A	Destroy nerve of eye muscle	2.96	3.29	1.51	0.26	6.51	4.73	010
67350		A	Biopsy eye muscle	2.87	NA	3.23	0.13	NA	6.23	000
67400		A	Explore/biopsy eye socket	9.76	NA	10.78	0.62	NA	21.16	090
67405		A	Explore/drain eye socket	7.93	NA	9.75	0.67	NA	18.35	090
67412		A	Explore/treat eye socket	9.50	NA	12.50	0.67	NA	22.67	090
67413		A	Explore/treat eye socket	10.00	NA	11.17	0.57	NA	21.74	090
67414		A	Explore/decompress eye socket	11.13	NA	13.33	0.44	NA	24.90	090
67415		A	Aspiration orbital contents	1.76	NA	1.52	0.12	NA	3.40	000
67420		A	Explore/treat eye socket	20.06	NA	18.62	1.11	NA	39.79	090
67430		A	Explore/treat eye socket	13.39	NA	14.77	0.54	NA	28.70	090
67440		A	Explore/drain eye socket	13.09	NA	14.66	0.97	NA	28.72	090
67445		A	Explore/decompress eye socket	14.42	NA	15.53	0.57	NA	30.52	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
67450		A	Explore/biopsy eye socket	13.51	NA	14.67	0.87	NA	29.05	090
67500		A	Inject/treat eye socket	0.79	4.27	0.82	0.06	5.12	1.67	000
67505		A	Inject/treat eye socket	0.82	3.21	0.32	0.06	4.09	1.20	000
67515		A	Inject/treat eye socket	0.61	3.07	0.56	0.03	3.71	1.20	000
67550		A	Insert eye socket implant	10.19	NA	10.57	0.70	NA	21.46	090
67560		A	Revise eye socket implant	10.60	NA	10.68	0.48	NA	21.76	090
67570		A	Decompress optic nerve	13.58	NA	14.66	0.39	NA	28.63	090
67700		A	Drainage of eyelid abscess	1.35	4.33	0.65	0.03	5.71	2.03	010
67710		A	Incision of eyelid	1.02	4.42	1.59	0.06	5.50	2.67	010
67715		A	Incision of eyelid fold	1.22	NA	1.74	0.09	NA	3.05	010
67800		A	Remove eyelid lesion	1.38	4.52	0.78	0.05	5.95	2.21	010
67801		A	Remove eyelid lesions	1.88	2.96	2.30	0.08	4.92	4.26	010
67805		A	Remove eyelid lesions	2.22	6.30	2.60	0.08	8.60	4.90	010
67808		A	Remove eyelid lesion(s)	3.80	NA	4.12	0.13	NA	8.05	090
67810		A	Biopsy of eyelid	1.48	3.62	0.84	0.05	5.15	2.37	000
67820		A	Revise eyelashes	0.89	3.26	0.49	0.02	4.17	1.40	000
67825		A	Revise eyelashes	1.38	4.39	1.78	0.05	5.82	3.21	010
67830		A	Revise eyelashes	1.70	5.26	2.16	0.17	7.13	4.03	010
67835		A	Revise eyelashes	5.56	NA	5.13	0.45	NA	11.14	090
67840		A	Remove eyelid lesion	2.04	5.86	2.80	0.07	7.97	4.91	010
67850		A	Treat eyelid lesion	1.69	4.51	2.12	0.05	6.25	3.86	010
67875		A	Closure of eyelid by suture	1.35	5.70	2.47	0.13	7.18	3.95	000
67880		A	Revision of eyelid	3.80	7.02	3.83	0.23	11.05	7.86	090
67882		A	Revision of eyelid	5.07	8.66	4.86	0.37	14.10	10.30	090
67900		A	Repair brow defect	6.14	8.06	6.72	0.20	14.40	13.06	090
67901		A	Repair eyelid defect	6.97	NA	7.07	0.64	NA	14.68	090
67902		A	Repair eyelid defect	7.03	NA	7.32	0.72	NA	15.07	090
67903		A	Repair eyelid defect	6.37	7.89	6.78	0.73	14.99	13.88	090
67904		A	Repair eyelid defect	6.26	10.24	7.81	0.71	17.21	14.78	090
67906		A	Repair eyelid defect	6.79	8.01	7.07	0.36	15.16	14.22	090
67908		A	Repair eyelid defect	5.13	7.35	6.24	0.54	13.02	11.91	090
67909		A	Revise eyelid defect	5.40	7.53	6.35	0.48	13.41	12.23	090
67911		A	Revise eyelid defect	5.27	NA	6.44	0.79	NA	12.50	090
67914		A	Repair eyelid defect	3.68	7.24	4.03	0.39	11.31	8.10	090
67915		A	Repair eyelid defect	3.18	9.88	3.11	0.07	13.13	6.36	090
67916		A	Repair eyelid defect	5.31	9.05	5.26	0.38	14.74	10.95	090
67917		A	Repair eyelid defect	6.02	8.08	6.91	0.47	14.57	13.40	090
67921		A	Repair eyelid defect	3.40	7.03	3.86	0.20	10.63	7.46	090
67922		A	Repair eyelid defect	3.06	5.76	3.05	0.07	8.89	6.18	090
67923		A	Repair eyelid defect	5.88	9.31	5.60	0.38	15.57	11.86	090
67924		A	Repair eyelid defect	5.79	7.64	6.50	0.43	13.86	12.72	090
67930		A	Repair eyelid wound	3.61	7.30	3.72	0.08	10.99	7.41	010
67935		A	Repair eyelid wound	6.22	9.27	5.41	0.24	15.73	11.87	090
67938		A	Remove eyelid foreign body	1.33	4.21	0.52	0.03	5.57	1.88	010
67950		A	Revision of eyelid	5.82	6.42	9.88	0.45	12.69	16.15	090
67961		A	Revision of eyelid	5.69	6.37	6.29	0.50	12.56	12.48	090
67966		A	Revision of eyelid	6.57	6.92	9.56	0.66	14.15	16.79	090
67971		A	Reconstruction of eyelid	9.79	NA	8.88	0.64	NA	19.31	090
67973		A	Reconstruction of eyelid	12.87	NA	10.87	0.91	NA	24.65	090
67974		A	Reconstruction of eyelid	12.84	NA	10.76	0.87	NA	24.47	090
67975		A	Reconstruction of eyelid	9.13	NA	8.31	0.24	NA	17.68	090
68020		A	Incise/drain eyelid lining	1.37	4.39	0.77	0.03	5.79	2.17	010
68040		A	Treatment of eyelid lesions	0.85	3.48	0.47	0.02	4.35	1.34	000
68100		A	Biopsy of eyelid lining	1.35	4.02	1.09	0.06	5.43	2.50	000
68110		A	Remove eyelid lining lesion	1.77	4.74	2.01	0.07	6.58	3.85	010
68115		A	Remove eyelid lining lesion	2.36	5.69	2.53	0.11	8.16	5.00	010
68130		A	Remove eyelid lining lesion	4.93	NA	5.74	0.22	NA	10.89	090
68135		A	Remove eyelid lining lesion	1.84	4.77	2.06	0.04	6.65	3.94	010
68200		A	Treat eyelid by injection	0.49	3.00	0.49	0.03	3.52	1.01	000
68320		A	Revise/graft eyelid lining	5.37	4.91	5.81	0.42	10.70	11.60	090
68325		A	Revise/graft eyelid lining	7.36	NA	6.86	0.62	NA	14.84	090
68326		A	Revise/graft eyelid lining	7.15	NA	6.88	0.49	NA	14.52	090
68328		A	Revise/graft eyelid lining	8.18	NA	7.39	0.82	NA	16.39	090
68330		A	Revise eyelid lining	4.83	6.09	5.65	0.35	11.27	10.83	090
68335		A	Revise/graft eyelid lining	7.19	NA	5.70	0.68	NA	13.57	090
68340		A	Separate eyelid adhesions	4.17	8.46	4.33	0.17	12.80	8.67	090
68360		A	Revise eyelid lining	4.37	5.79	5.39	0.33	10.49	10.09	090
68362		A	Revise eyelid lining	7.34	NA	7.77	0.42	NA	15.53	090
68400		A	Incise/drain tear gland	1.69	5.80	2.63	0.06	7.55	4.38	010
68420		A	Incise/drain tear sac	2.30	6.09	2.95	0.06	8.45	5.31	010
68440		A	Incise tear duct opening	0.94	4.28	1.55	0.04	5.26	2.53	010
68500		A	Removal of tear gland	11.02	NA	9.77	0.75	NA	21.54	090
68505		A	Partial removal tear gland	10.94	NA	10.06	0.49	NA	21.49	090
68510		A	Biopsy of tear gland	4.61	7.41	3.32	0.28	12.30	8.21	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
68520		A	Removal of tear sac	7.51	NA	7.37	0.51	NA	15.39	090
68525		A	Biopsy of tear sac	4.43	NA	3.24	0.23	NA	7.90	000
68530		A	Clearance of tear duct	3.66	7.39	3.45	0.17	11.22	7.28	010
68540		A	Remove tear gland lesion	10.60	NA	9.51	0.50	NA	20.61	090
68550		A	Remove tear gland lesion	13.26	NA	11.83	0.74	NA	25.83	090
68700		A	Repair tear ducts	6.60	NA	6.79	0.15	NA	13.54	090
68705		A	Revise tear duct opening	2.06	4.94	2.18	0.05	7.05	4.29	010
68720		A	Create tear sac drain	8.96	NA	8.39	0.74	NA	18.09	090
68745		A	Create tear duct drain	8.63	NA	7.87	0.45	NA	16.95	090
68750		A	Create tear duct drain	8.66	NA	8.38	0.83	NA	17.87	090
68760		A	Close tear duct opening	1.73	4.63	0.98	0.04	6.40	2.75	010
68761		A	Close tear duct opening	1.36	3.31	0.76	0.04	4.71	2.16	010
68770		A	Close tear system fistula	7.02	10.08	6.07	0.23	17.33	13.32	090
68801		A	Dilate tear duct opening	0.94	3.99	0.51	0.02	4.95	1.47	010
68810		A	Probe nasolacrimal duct	1.90	5.34	2.26	0.03	7.27	4.19	010
68811		A	Probe nasolacrimal duct	2.35	NA	2.51	0.09	NA	4.95	010
68815		A	Probe nasolacrimal duct	3.20	6.01	3.16	0.10	9.31	6.46	010
68840		A	Explore/irrigate tear ducts	1.25	4.43	0.69	0.03	5.71	1.97	010
68850		A	Injection for tear sac x-ray	0.80	8.95	0.33	0.04	9.79	1.17	000
69000		A	Drain external ear lesion	1.45	1.35	0.59	0.03	2.83	2.07	010
69005		A	Drain external ear lesion	2.11	1.83	1.62	0.13	4.07	3.86	010
69020		A	Drain outer ear canal lesion	1.48	1.48	0.71	0.04	3.00	2.23	010
69100		A	Biopsy of external ear	0.81	0.92	0.45	0.07	1.80	1.33	000
69105		A	Biopsy of external ear canal	0.85	0.95	0.71	0.09	1.89	1.65	000
69110		A	Partial removal external ear	3.44	2.58	2.33	0.37	6.39	6.14	090
69120		A	Removal of external ear	4.05	NA	4.35	0.07	NA	8.47	090
69140		A	Remove ear canal lesion(s)	7.97	NA	7.56	0.88	NA	16.41	090
69145		A	Remove ear canal lesion(s)	2.62	2.43	2.01	0.28	5.33	4.91	090
69150		A	Extensive ear canal surgery	13.43	NA	10.95	1.25	NA	25.63	090
69155		A	Extensive ear/neck surgery	20.80	NA	14.75	1.61	NA	37.16	090
69200		A	Clear outer ear canal	0.77	0.89	0.34	0.04	1.70	1.15	000
69205		A	Clear outer ear canal	1.20	NA	1.03	0.11	NA	2.34	010
69210		A	Remove impacted ear wax	0.61	0.79	0.22	0.02	1.42	0.85	000
69220		A	Clean out mastoid cavity	0.83	0.95	0.52	0.05	1.83	1.40	000
69222		A	Clean out mastoid cavity	1.40	1.45	1.20	0.08	2.93	2.68	010
69300		R	Revise external ear	6.36	NA	5.44	0.28	NA	12.08	YYY
69310		A	Rebuild outer ear canal	10.79	NA	9.33	1.08	NA	21.20	090
69320		A	Rebuild outer ear canal	16.96	NA	13.20	1.66	NA	31.82	090
69400		A	Inflate middle ear canal	0.83	0.94	0.38	0.05	1.82	1.26	000
69401		A	Inflate middle ear canal	0.63	0.82	0.39	0.03	1.48	1.05	000
69405		A	Catheterize middle ear canal	2.63	2.26	1.19	0.04	4.93	3.86	010
69410		A	Inset middle ear baffle	0.33	0.66	0.19	0.07	1.06	0.59	000
69420		A	Incision of eardrum	1.33	1.44	0.79	0.08	2.85	2.20	010
69421		A	Incision of eardrum	1.73	1.68	1.43	0.13	3.54	3.29	010
69424		A	Remove ventilating tube	0.85	1.00	0.59	0.06	1.91	1.50	000
69433		A	Create eardrum opening	1.52	1.53	0.96	0.15	3.20	2.63	010
69436		A	Create eardrum opening	1.96	NA	1.56	0.23	NA	3.75	010
69440		A	Exploration of middle ear	7.57	NA	7.13	0.93	NA	15.63	090
69450		A	Eardrum revision	5.57	NA	5.87	1.15	NA	12.59	090
69501		A	Mastoidectomy	9.07	NA	8.01	1.17	NA	18.25	090
69502		A	Mastoidectomy	12.38	NA	10.43	1.45	NA	24.26	090
69505		A	Remove mastoid structures	12.99	NA	10.68	1.79	NA	25.46	090
69511		A	Extensive mastoid surgery	13.52	NA	11.17	1.84	NA	26.53	090
69530		A	Extensive mastoid surgery	19.19	NA	14.85	1.72	NA	35.76	090
69535		A	Remove part of temporal bone	36.14	NA	25.22	2.85	NA	64.21	090
69540		A	Remove ear lesion	1.20	1.35	1.07	0.14	2.69	2.41	010
69550		A	Remove ear lesion	10.99	NA	9.30	2.00	NA	22.29	090
69552		A	Remove ear lesion	19.46	NA	14.98	1.86	NA	36.30	090
69554		A	Remove ear lesion	33.16	NA	23.94	2.63	NA	59.73	090
69601		A	Mastoid surgery revision	13.24	NA	11.10	1.55	NA	25.89	090
69602		A	Mastoid surgery revision	13.58	NA	11.23	1.75	NA	26.56	090
69603		A	Mastoid surgery revision	14.02	NA	11.38	1.88	NA	27.28	090
69604		A	Mastoid surgery revision	14.02	NA	11.25	2.70	NA	27.97	090
69605		A	Mastoid surgery revision	18.49	NA	14.22	1.86	NA	34.57	090
69610		A	Repair of eardrum	4.43	3.46	3.10	0.10	7.99	7.63	010
69620		A	Repair of eardrum	5.89	5.11	3.79	1.16	12.16	10.84	090
69631		A	Repair eardrum structures	9.86	NA	8.81	1.61	NA	20.28	090
69632		A	Rebuild eardrum structures	12.75	NA	10.85	1.73	NA	25.33	090
69633		A	Rebuild eardrum structures	12.10	NA	10.47	1.78	NA	24.35	090
69635		A	Repair eardrum structures	13.33	NA	11.05	1.91	NA	26.29	090
69636		A	Rebuild eardrum structures	15.22	NA	12.59	2.11	NA	29.92	090
69637		A	Rebuild eardrum structures	15.11	NA	12.49	2.22	NA	29.82	090
69641		A	Revise middle ear & mastoid	12.71	NA	10.64	1.87	NA	25.22	090
69642		A	Revise middle ear & mastoid	16.84	NA	13.41	2.21	NA	32.46	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
69643	.....	A	Revise middle ear & mastoid	15.32	NA	12.50	2.51	NA	30.33	090
69644	.....	A	Revise middle ear & mastoid	16.97	NA	13.65	2.70	NA	33.32	090
69645	.....	A	Revise middle ear & mastoid	16.38	NA	13.21	2.51	NA	32.10	090
69646	.....	A	Revise middle ear & mastoid	17.99	NA	14.31	2.40	NA	34.70	090
69650	.....	A	Release middle ear bone	9.66	NA	8.44	1.33	NA	19.43	090
69660	.....	A	Revise middle ear bone	11.90	NA	9.85	1.82	NA	23.57	090
69661	.....	A	Revise middle ear bone	15.74	NA	12.46	1.93	NA	30.13	090
69662	.....	A	Revise middle ear bone	15.44	NA	12.39	1.94	NA	29.77	090
69666	.....	A	Repair middle ear structures	9.75	NA	8.52	1.77	NA	20.04	090
69667	.....	A	Repair middle ear structures	9.76	NA	8.54	1.66	NA	19.96	090
69670	.....	A	Remove mastoid air cells	11.51	NA	9.98	1.08	NA	22.57	090
69676	.....	A	Remove middle ear nerve	9.52	NA	8.60	0.86	NA	18.98	090
69700	.....	A	Close mastoid fistula	8.23	NA	5.34	0.84	NA	14.41	090
69711	.....	A	Remove/repair hearing aid	10.44	NA	9.25	0.44	NA	20.13	090
69720	.....	A	Release facial nerve	14.38	NA	11.86	2.27	NA	28.51	090
69725	.....	A	Release facial nerve	25.38	NA	18.41	1.51	NA	45.30	090
69740	.....	A	Repair facial nerve	15.96	NA	11.67	1.69	NA	29.32	090
69745	.....	A	Repair facial nerve	16.69	NA	13.17	1.53	NA	31.39	090
69801	.....	A	Incise inner ear	8.56	NA	7.69	1.84	NA	18.09	090
69802	.....	A	Incise inner ear	13.10	NA	10.98	1.22	NA	25.30	090
69805	.....	A	Explore inner ear	13.82	NA	11.15	2.00	NA	26.97	090
69806	.....	A	Explore inner ear	12.35	NA	10.47	2.54	NA	25.36	090
69820	.....	A	Establish inner ear window	10.34	NA	8.82	1.00	NA	20.16	090
69840	.....	A	Revise inner ear window	10.26	NA	12.01	0.51	NA	22.78	090
69905	.....	A	Remove inner ear	11.10	NA	9.53	2.07	NA	22.70	090
69910	.....	A	Remove inner ear & mastoid	13.63	NA	11.12	2.34	NA	27.09	090
69915	.....	A	Incise inner ear nerve	21.23	NA	16.10	2.02	NA	39.35	090
69930	.....	A	Implant cochlear device	16.81	NA	12.89	3.34	NA	33.04	090
69950	.....	A	Incise inner ear nerve	25.64	NA	17.75	2.31	NA	45.70	090
69955	.....	A	Release facial nerve	27.04	NA	20.01	2.25	NA	49.30	090
69960	.....	A	Release inner ear canal	27.04	NA	18.59	1.93	NA	47.56	090
69970	.....	A	Remove inner ear lesion	30.04	NA	21.22	2.26	NA	53.52	090
70010	.....	A	Contrast x-ray of brain	1.19	3.46	3.46	0.34	4.99	4.99	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.08	1.66	1.66	XXX
70010	TC	A	Contrast x-ray of brain	0.00	3.07	3.07	0.26	3.33	3.33	XXX
70015	.....	A	Contrast x-ray of brain	1.19	1.35	1.35	0.17	2.71	2.71	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.08	1.66	1.66	XXX
70015	TC	A	Contrast x-ray of brain	0.00	0.96	0.96	0.09	1.05	1.05	XXX
70030	.....	A	X-ray eye for foreign body	0.17	0.36	0.36	0.04	0.57	0.57	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.30	0.30	0.03	0.33	0.33	XXX
70100	.....	A	X-ray exam of jaw	0.18	0.44	0.44	0.04	0.66	0.66	XXX
70100	26	A	X-ray exam of jaw	0.18	0.07	0.07	0.01	0.26	0.26	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.37	0.37	0.03	0.40	0.40	XXX
70110	.....	A	X-ray exam of jaw	0.25	0.53	0.53	0.06	0.84	0.84	XXX
70110	26	A	X-ray exam of jaw	0.25	0.09	0.09	0.02	0.36	0.36	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70120	.....	A	X-ray exam of mastoids	0.18	0.51	0.51	0.05	0.74	0.74	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.07	0.07	0.01	0.26	0.26	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70130	.....	A	X-ray exam of mastoids	0.34	0.68	0.68	0.07	1.09	1.09	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.12	0.12	0.02	0.48	0.48	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.56	0.56	0.05	0.61	0.61	XXX
70134	.....	A	X-ray exam of middle ear	0.34	0.64	0.64	0.07	1.05	1.05	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.12	0.12	0.02	0.48	0.48	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.52	0.52	0.05	0.57	0.57	XXX
70140	.....	A	X-ray exam of facial bones	0.19	0.51	0.51	0.05	0.75	0.75	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.07	0.07	0.01	0.27	0.27	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70150	.....	A	X-ray exam of facial bones	0.26	0.65	0.65	0.07	0.98	0.98	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.09	0.09	0.02	0.37	0.37	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.56	0.56	0.05	0.61	0.61	XXX
70160	.....	A	X-ray exam of nasal bones	0.17	0.43	0.43	0.04	0.64	0.64	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.37	0.37	0.03	0.40	0.40	XXX
70170	.....	A	X-ray exam of tear duct	0.30	0.77	0.77	0.08	1.15	1.15	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.02	0.42	0.42	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.67	0.67	0.06	0.73	0.73	XXX
70190	.....	A	X-ray exam of eye sockets	0.21	0.51	0.51	0.05	0.77	0.77	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70200	.....	A	X-ray exam of eye sockets	0.28	0.65	0.65	0.07	1.00	1.00	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.10	0.10	0.02	0.40	0.40	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.56	0.56	0.05	0.61	0.61	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
70210	.....	A	X-ray exam of sinuses	0.17	0.50	0.50	0.05	0.72	0.72	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70220	.....	A	X-ray exam of sinuses	0.25	0.65	0.65	0.07	0.97	0.97	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.09	0.09	0.02	0.36	0.36	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.56	0.56	0.05	0.61	0.61	XXX
70240	.....	A	X-ray exam pituitary saddle	0.19	0.36	0.36	0.04	0.59	0.59	XXX
70240	26	A	X-ray exam pituitary saddle	0.19	0.07	0.07	0.01	0.27	0.27	XXX
70240	TC	A	X-ray exam pituitary saddle	0.00	0.30	0.30	0.03	0.33	0.33	XXX
70250	.....	A	X-ray exam of skull	0.24	0.52	0.52	0.06	0.82	0.82	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.02	0.34	0.34	XXX
70250	TC	A	X-ray exam of skull	0.00	0.44	0.44	0.04	0.48	0.48	XXX
70260	.....	A	X-ray exam of skull	0.34	0.75	0.75	0.08	1.17	1.17	XXX
70260	26	A	X-ray exam of skull	0.34	0.12	0.12	0.02	0.48	0.48	XXX
70260	TC	A	X-ray exam of skull	0.00	0.63	0.63	0.06	0.69	0.69	XXX
70300	.....	A	X-ray exam of teeth	0.10	0.22	0.22	0.03	0.35	0.35	XXX
70300	26	A	X-ray exam of teeth	0.10	0.04	0.04	0.01	0.15	0.15	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.19	0.19	0.02	0.21	0.21	XXX
70310	.....	A	X-ray exam of teeth	0.16	0.35	0.35	0.04	0.55	0.55	XXX
70310	26	A	X-ray exam of teeth	0.16	0.05	0.05	0.01	0.22	0.22	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.30	0.30	0.03	0.33	0.33	XXX
70320	.....	A	Full mouth x-ray of teeth	0.22	0.63	0.63	0.07	0.92	0.92	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.07	0.07	0.02	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.56	0.56	0.05	0.61	0.61	XXX
70328	.....	A	X-ray exam of jaw joint	0.18	0.42	0.42	0.04	0.64	0.64	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.07	0.07	0.01	0.26	0.26	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.35	0.35	0.03	0.38	0.38	XXX
70330	.....	A	X-ray exam of jaw joints	0.24	0.68	0.68	0.07	0.99	0.99	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.02	0.34	0.34	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.60	0.60	0.05	0.65	0.65	XXX
70332	.....	A	X-ray exam of jaw joint	0.54	1.67	1.67	0.17	2.38	2.38	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.19	0.19	0.04	0.77	0.77	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.49	1.49	0.13	1.62	1.62	XXX
70336	.....	A	Magnetic image jaw joint	1.48	8.27	8.27	0.73	10.48	10.48	XXX
70336	26	A	Magnetic image jaw joint	1.48	0.32	0.32	0.06	1.86	1.86	XXX
70336	TC	A	Magnetic image jaw joint	0.00	7.95	7.95	0.67	8.62	8.62	XXX
70350	.....	A	X-ray head for orthodontia	0.17	0.33	0.33	0.03	0.53	0.53	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.27	0.27	0.02	0.29	0.29	XXX
70355	.....	A	Panoramic x-ray of jaws	0.20	0.47	0.47	0.05	0.72	0.72	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.01	0.28	0.28	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.40	0.40	0.04	0.44	0.44	XXX
70360	.....	A	X-ray exam of neck	0.17	0.36	0.36	0.04	0.57	0.57	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.30	0.30	0.03	0.33	0.33	XXX
70370	.....	A	Throat x-ray & fluoroscopy	0.32	1.03	1.03	0.10	1.45	1.45	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.02	0.45	0.45	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	0.92	0.92	0.08	1.00	1.00	XXX
70371	.....	A	Speech evaluation, complex	0.84	1.77	1.77	0.19	2.80	2.80	XXX
70371	26	A	Speech evaluation, complex	0.84	0.28	0.28	0.06	1.18	1.18	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.49	1.49	0.13	1.62	1.62	XXX
70373	.....	A	Contrast x-ray of larynx	0.44	1.41	1.41	0.14	1.99	1.99	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.15	0.15	0.03	0.62	0.62	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.27	1.27	0.11	1.38	1.38	XXX
70380	.....	A	X-ray exam of salivary gland	0.17	0.54	0.54	0.05	0.76	0.76	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.48	0.48	0.04	0.52	0.52	XXX
70390	.....	A	X-ray exam of salivary duct	0.38	1.39	1.39	0.14	1.91	1.91	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.13	0.13	0.03	0.54	0.54	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.27	1.27	0.11	1.38	1.38	XXX
70450	.....	A	CAT scan of head or brain	0.85	3.63	3.63	0.35	4.83	4.83	XXX
70450	26	A	CAT scan of head or brain	0.85	0.28	0.28	0.06	1.19	1.19	XXX
70450	TC	A	CAT scan of head or brain	0.00	3.35	3.35	0.29	3.64	3.64	XXX
70460	.....	A	Contrast CAT scan of head	1.13	4.38	4.38	0.43	5.94	5.94	XXX
70460	26	A	Contrast CAT scan of head	1.13	0.37	0.37	0.08	1.58	1.58	XXX
70460	TC	A	Contrast CAT scan of head	0.00	4.01	4.01	0.35	4.36	4.36	XXX
70470	.....	A	Contrast CAT scans of head	1.27	5.43	5.43	0.52	7.22	7.22	XXX
70470	26	A	Contrast CAT scans of head	1.27	0.42	0.42	0.09	1.78	1.78	XXX
70470	TC	A	Contrast CAT scans of head	0.00	5.02	5.02	0.43	5.45	5.45	XXX
70480	.....	A	CAT scan of skull	1.28	3.77	3.77	0.38	5.43	5.43	XXX
70480	26	A	CAT scan of skull	1.28	0.42	0.42	0.09	1.79	1.79	XXX
70480	TC	A	CAT scan of skull	0.00	3.35	3.35	0.29	3.64	3.64	XXX
70481	.....	A	Contrast CAT scan of skull	1.38	4.47	4.47	0.44	6.29	6.29	XXX
70481	26	A	Contrast CAT scan of skull	1.38	0.45	0.45	0.09	1.92	1.92	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
70481	TC	A	Contrast CAT scan of skull	0.00	4.01	4.01	0.35	4.36	4.36	XXX
70482		A	Contrast CAT scans of skull	1.45	5.49	5.49	0.53	7.47	7.47	XXX
70482	26	A	Contrast CAT scans of skull	1.45	0.48	0.48	0.10	2.03	2.03	XXX
70482	TC	A	Contrast CAT scans of skull	0.00	5.02	5.02	0.43	5.45	5.45	XXX
70486		A	CAT scan of face, jaw	1.14	3.72	3.72	0.37	5.23	5.23	XXX
70486	26	A	CAT scan of face, jaw	1.14	0.37	0.37	0.08	1.59	1.59	XXX
70486	TC	A	CAT scan of face, jaw	0.00	3.35	3.35	0.29	3.64	3.64	XXX
70487		A	Contrast CAT scan, face/jaw	1.30	4.44	4.44	0.44	6.18	6.18	XXX
70487	26	A	Contrast CAT scan, face/jaw	1.30	0.42	0.42	0.09	1.81	1.81	XXX
70487	TC	A	Contrast CAT scan, face/jaw	0.00	4.01	4.01	0.35	4.36	4.36	XXX
70488		A	Contrast CAT scans face/jaw	1.42	5.49	5.49	0.53	7.44	7.44	XXX
70488	26	A	Contrast CAT scans face/jaw	1.42	0.47	0.47	0.10	1.99	1.99	XXX
70488	TC	A	Contrast CAT scans face/jaw	0.00	5.02	5.02	0.43	5.45	5.45	XXX
70490		A	CAT scan of neck tissue	1.28	3.77	3.77	0.38	5.43	5.43	XXX
70490	26	A	CAT scan of neck tissue	1.28	0.42	0.42	0.09	1.79	1.79	XXX
70490	TC	A	CAT scan of neck tissue	0.00	3.35	3.35	0.29	3.64	3.64	XXX
70491		A	Contrast CAT of neck tissue	1.38	4.47	4.47	0.44	6.29	6.29	XXX
70491	26	A	Contrast CAT of neck tissue	1.38	0.45	0.45	0.09	1.92	1.92	XXX
70491	TC	A	Contrast CAT of neck tissue	0.00	4.01	4.01	0.35	4.36	4.36	XXX
70492		A	Contrast CAT of neck tissue	1.45	5.49	5.49	0.53	7.47	7.47	XXX
70492	26	A	Contrast CAT of neck tissue	1.45	0.48	0.48	0.10	2.03	2.03	XXX
70492	TC	A	Contrast CAT of neck tissue	0.00	5.02	5.02	0.43	5.45	5.45	XXX
70540		A	Magnetic image, face, neck	1.48	8.44	8.44	0.77	10.69	10.69	XXX
70540	26	A	Magnetic image, face, neck	1.48	0.49	0.49	0.10	2.07	2.07	XXX
70540	TC	A	Magnetic image, face, neck	0.00	7.95	7.95	0.67	8.62	8.62	XXX
70541		R	Magnetic image, head (MRA)	1.81	8.44	8.44	0.77	11.02	11.02	XXX
70541	26	R	Magnetic image, head (MRA)	1.81	0.49	0.49	0.10	2.40	2.40	XXX
70541	TC	R	Magnetic image, head (MRA)	0.00	7.95	7.95	0.67	8.62	8.62	XXX
70551		A	Magnetic image, brain (MRI)	1.48	8.44	8.44	0.77	10.69	10.69	XXX
70551	26	A	Magnetic image, brain (MRI)	1.48	0.49	0.49	0.10	2.07	2.07	XXX
70551	TC	A	Magnetic image, brain (MRI)	0.00	7.95	7.95	0.67	8.62	8.62	XXX
70552		A	Magnetic image, brain (MRI)	1.78	10.13	10.13	0.93	12.84	12.84	XXX
70552	26	A	Magnetic image, brain (MRI)	1.78	0.60	0.60	0.12	2.50	2.50	XXX
70552	TC	A	Magnetic image, brain (MRI)	0.00	9.53	9.53	0.81	10.34	10.34	XXX
70553		A	Magnetic image, brain	2.36	18.45	18.45	1.65	22.46	22.46	XXX
70553	26	A	Magnetic image, brain	2.36	0.80	0.80	0.16	3.32	3.32	XXX
70553	TC	A	Magnetic image, brain	0.00	17.65	17.65	1.49	19.14	19.14	XXX
71010		A	Chest x-ray	0.18	0.39	0.39	0.04	0.61	0.61	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.33	0.33	0.03	0.36	0.36	XXX
71015		A	X-ray exam of chest	0.21	0.45	0.45	0.04	0.70	0.70	XXX
71015	26	A	X-ray exam of chest	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	X-ray exam of chest	0.00	0.37	0.37	0.03	0.40	0.40	XXX
71020		A	Chest x-ray	0.22	0.51	0.51	0.05	0.78	0.78	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.44	0.44	0.04	0.48	0.48	XXX
71021		A	Chest x-ray	0.27	0.61	0.61	0.07	0.95	0.95	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.02	0.38	0.38	XXX
71021	TC	A	Chest x-ray	0.00	0.52	0.52	0.05	0.57	0.57	XXX
71022		A	Chest x-ray	0.31	0.63	0.63	0.07	1.01	1.01	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.02	0.43	0.43	XXX
71022	TC	A	Chest x-ray	0.00	0.52	0.52	0.05	0.57	0.57	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	0.68	0.68	0.08	1.14	1.14	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.03	0.54	0.54	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.56	0.56	0.05	0.61	0.61	XXX
71030		A	Chest x-ray	0.31	0.66	0.66	0.07	1.04	1.04	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.02	0.43	0.43	XXX
71030	TC	A	Chest x-ray	0.00	0.56	0.56	0.05	0.61	0.61	XXX
71034		A	Chest x-ray & fluoroscopy	0.46	1.18	1.18	0.12	1.76	1.76	XXX
71034	26	A	Chest x-ray & fluoroscopy	0.46	0.16	0.16	0.03	0.65	0.65	XXX
71034	TC	A	Chest x-ray & fluoroscopy	0.00	1.02	1.02	0.09	1.11	1.11	XXX
71035		A	Chest x-ray	0.18	0.43	0.43	0.04	0.65	0.65	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.37	0.37	0.03	0.40	0.40	XXX
71036		A	X-ray guidance for biopsy	0.54	1.30	1.30	0.14	1.98	1.98	XXX
71036	26	A	X-ray guidance for biopsy	0.54	0.19	0.19	0.04	0.77	0.77	XXX
71036	TC	A	X-ray guidance for biopsy	0.00	1.12	1.12	0.10	1.22	1.22	XXX
71038		A	X-ray guidance for biopsy	0.54	1.38	1.38	0.15	2.07	2.07	XXX
71038	26	A	X-ray guidance for biopsy	0.54	0.19	0.19	0.04	0.77	0.77	XXX
71038	TC	A	X-ray guidance for biopsy	0.00	1.19	1.19	0.11	1.30	1.30	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.24	1.24	0.13	1.95	1.95	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.20	0.20	0.04	0.82	0.82	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.03	1.03	0.09	1.12	1.12	XXX
71060		A	Contrast x-ray of bronchi	0.74	1.82	1.82	0.19	2.75	2.75	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
71060	26	A	Contrast x-ray of bronchi	0.74	0.25	0.25	0.05	1.04	1.04	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	1.56	1.56	0.14	1.70	1.70	XXX
71090		A	X-ray & pacemaker insertion	0.54	1.38	1.38	0.15	2.07	2.07	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.19	0.19	0.04	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.19	1.19	0.11	1.30	1.30	XXX
71100		A	X-ray exam of ribs	0.22	0.48	0.48	0.06	0.76	0.76	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.02	0.31	0.31	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.40	0.40	0.04	0.44	0.44	XXX
71101		A	X-ray exam of ribs, chest	0.27	0.57	0.57	0.06	0.90	0.90	XXX
71101	26	A	X-ray exam of ribs, chest	0.27	0.10	0.10	0.02	0.39	0.39	XXX
71101	TC	A	X-ray exam of ribs, chest	0.00	0.48	0.48	0.04	0.52	0.52	XXX
71110		A	X-ray exam of ribs	0.27	0.65	0.65	0.07	0.99	0.99	XXX
71110	26	A	X-ray exam of ribs	0.27	0.10	0.10	0.02	0.39	0.39	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.56	0.56	0.05	0.61	0.61	XXX
71111		A	X-ray exam of ribs, chest	0.32	0.74	0.74	0.08	1.14	1.14	XXX
71111	26	A	X-ray exam of ribs, chest	0.32	0.11	0.11	0.02	0.45	0.45	XXX
71111	TC	A	X-ray exam of ribs, chest	0.00	0.63	0.63	0.06	0.69	0.69	XXX
71120		A	X-ray exam of breastbone	0.20	0.53	0.53	0.05	0.78	0.78	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.46	0.46	0.04	0.50	0.50	XXX
71130		A	X-ray exam of breastbone	0.22	0.57	0.57	0.05	0.84	0.84	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.50	0.50	0.04	0.54	0.54	XXX
71250		A	Cat scan of chest	1.16	4.57	4.57	0.44	6.17	6.17	XXX
71250	26	A	Cat scan of chest	1.16	0.38	0.38	0.08	1.62	1.62	XXX
71250	TC	A	Cat scan of chest	0.00	4.19	4.19	0.36	4.55	4.55	XXX
71260		A	Contrast CAT scan of chest	1.24	5.43	5.43	0.51	7.18	7.18	XXX
71260	26	A	Contrast CAT scan of chest	1.24	0.41	0.41	0.08	1.73	1.73	XXX
71260	TC	A	Contrast CAT scan of chest	0.00	5.02	5.02	0.43	5.45	5.45	XXX
71270		A	Contrast CAT scans of chest	1.38	6.73	6.73	0.61	8.72	8.72	XXX
71270	26	A	Contrast CAT scans of chest	1.38	0.45	0.45	0.09	1.92	1.92	XXX
71270	TC	A	Contrast CAT scans of chest	0.00	6.27	6.27	0.52	6.79	6.79	XXX
71550		A	Magnetic image, chest	1.60	8.48	8.48	0.78	10.86	10.86	XXX
71550	26	A	Magnetic image, chest	1.60	0.54	0.54	0.11	2.25	2.25	XXX
71550	TC	A	Magnetic image, chest	0.00	7.95	7.95	0.67	8.62	8.62	XXX
71555		N	Magnetic imaging/chest (MRA)	+1.81	8.48	8.48	0.78	11.07	11.07	XXX
71555	26	N	Magnetic imaging/chest (MRA)	+1.81	0.54	0.54	0.11	2.46	2.46	XXX
71555	TC	N	Magnetic imaging/chest (MRA)	+0.00	7.95	7.95	0.67	8.62	8.62	XXX
72010		A	X-ray exam of spine	0.45	0.88	0.88	0.09	1.42	1.42	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.03	0.63	0.63	XXX
72010	TC	A	X-ray exam of spine	0.00	0.73	0.73	0.06	0.79	0.79	XXX
72020		A	X-ray exam of spine	0.15	0.35	0.35	0.04	0.54	0.54	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.30	0.30	0.03	0.33	0.33	XXX
72040		A	X-ray exam of neck spine	0.22	0.50	0.50	0.05	0.77	0.77	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.42	0.42	0.04	0.46	0.46	XXX
72050		A	X-ray exam of neck spine	0.31	0.74	0.74	0.08	1.13	1.13	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.02	0.43	0.43	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.63	0.63	0.06	0.69	0.69	XXX
72052		A	X-ray exam of neck spine	0.36	0.93	0.93	0.09	1.38	1.38	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.13	0.13	0.02	0.51	0.51	XXX
72052	TC	A	X-ray exam of neck spine	0.00	0.80	0.80	0.07	0.87	0.87	XXX
72069		A	X-ray exam of trunk spine	0.22	0.42	0.42	0.04	0.68	0.68	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.35	0.35	0.03	0.38	0.38	XXX
72070		A	X-ray exam of thorax spine	0.22	0.54	0.54	0.05	0.81	0.81	XXX
72070	26	A	X-ray exam of thorax spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thorax spine	0.00	0.46	0.46	0.04	0.50	0.50	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.60	0.60	0.06	0.88	0.88	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.52	0.52	0.05	0.57	0.57	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.72	0.72	0.07	1.01	1.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.65	0.65	0.06	0.71	0.71	XXX
72080		A	X-ray exam of trunk spine	0.22	0.55	0.55	0.05	0.82	0.82	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.48	0.48	0.04	0.52	0.52	XXX
72090		A	X-ray exam of trunk spine	0.28	0.57	0.57	0.06	0.91	0.91	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.10	0.02	0.40	0.40	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.48	0.48	0.04	0.52	0.52	XXX
72100		A	X-ray exam of lower spine	0.22	0.55	0.55	0.05	0.82	0.82	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.48	0.48	0.04	0.52	0.52	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
72110	.....	A	X-ray exam of lower spine	0.31	0.75	0.75	0.08	1.14	1.14	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.02	0.43	0.43	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.65	0.65	0.06	0.71	0.71	XXX
72114	.....	A	X-ray exam of lower spine	0.36	0.97	0.97	0.09	1.42	1.42	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.02	0.51	0.51	XXX
72114	TC	A	X-ray exam of lower spine	0.00	0.84	0.84	0.07	0.91	0.91	XXX
72120	.....	A	X-ray exam of lower spine	0.22	0.71	0.71	0.07	1.00	1.00	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.63	0.63	0.06	0.69	0.69	XXX
72125	.....	A	CAT scan of neck spine	1.16	4.57	4.57	0.44	6.17	6.17	XXX
72125	26	A	CAT scan of neck spine	1.16	0.38	0.38	0.08	1.62	1.62	XXX
72125	TC	A	CAT scan of neck spine	0.00	4.19	4.19	0.36	4.55	4.55	XXX
72126	.....	A	Contrast CAT scan of neck	1.22	5.41	5.41	0.51	7.14	7.14	XXX
72126	26	A	Contrast CAT scan of neck	1.22	0.39	0.39	0.08	1.69	1.69	XXX
72126	TC	A	Contrast CAT scan of neck	0.00	5.02	5.02	0.43	5.45	5.45	XXX
72127	.....	A	Contrast CAT scans of neck	1.27	6.69	6.69	0.61	8.57	8.57	XXX
72127	26	A	Contrast CAT scans of neck	1.27	0.42	0.42	0.09	1.78	1.78	XXX
72127	TC	A	Contrast CAT scans of neck	0.00	6.27	6.27	0.52	6.79	6.79	XXX
72128	.....	A	CAT scan of thorax spine	1.16	4.57	4.57	0.44	6.17	6.17	XXX
72128	26	A	CAT scan of thorax spine	1.16	0.38	0.38	0.08	1.62	1.62	XXX
72128	TC	A	CAT scan of thorax spine	0.00	4.19	4.19	0.36	4.55	4.55	XXX
72129	.....	A	Contrast CAT scan of thorax	1.22	5.41	5.41	0.51	7.14	7.14	XXX
72129	26	A	Contrast CAT scan of thorax	1.22	0.39	0.39	0.08	1.69	1.69	XXX
72129	TC	A	Contrast CAT scan of thorax	0.00	5.02	5.02	0.43	5.45	5.45	XXX
72130	.....	A	Contrast CAT scans of thorax	1.27	6.69	6.69	0.61	8.57	8.57	XXX
72130	26	A	Contrast CAT scans of thorax	1.27	0.42	0.42	0.09	1.78	1.78	XXX
72130	TC	A	Contrast CAT scans of thorax	0.00	6.27	6.27	0.52	6.79	6.79	XXX
72131	.....	A	CAT scan of lower spine	1.16	4.57	4.57	0.44	6.17	6.17	XXX
72131	26	A	CAT scan of lower spine	1.16	0.38	0.38	0.08	1.62	1.62	XXX
72131	TC	A	CAT scan of lower spine	0.00	4.19	4.19	0.36	4.55	4.55	XXX
72132	.....	A	Contrast CAT of lower spine	1.22	5.41	5.41	0.51	7.14	7.14	XXX
72132	26	A	Contrast CAT of lower spine	1.22	0.39	0.39	0.08	1.69	1.69	XXX
72132	TC	A	Contrast CAT of lower spine	0.00	5.02	5.02	0.43	5.45	5.45	XXX
72133	.....	A	Contrast CAT scans, low spine	1.27	6.69	6.69	0.61	8.57	8.57	XXX
72133	26	A	Contrast CAT scans, low spine	1.27	0.42	0.42	0.09	1.78	1.78	XXX
72133	TC	A	Contrast CAT scans, low spine	0.00	6.27	6.27	0.52	6.79	6.79	XXX
72141	.....	A	Magnetic image, neck spine	1.60	8.48	8.48	0.78	10.86	10.86	XXX
72141	26	A	Magnetic image, neck spine	1.60	0.54	0.54	0.11	2.25	2.25	XXX
72141	TC	A	Magnetic image, neck spine	0.00	7.95	7.95	0.67	8.62	8.62	XXX
72142	.....	A	Magnetic image, neck spine	1.92	10.17	10.17	0.94	13.03	13.03	XXX
72142	26	A	Magnetic image, neck spine	1.92	0.64	0.64	0.13	2.69	2.69	XXX
72142	TC	A	Magnetic image, neck spine	0.00	9.53	9.53	0.81	10.34	10.34	XXX
72146	.....	A	Magnetic image, chest spine	1.60	9.36	9.36	0.85	11.81	11.81	XXX
72146	26	A	Magnetic image, chest spine	1.60	0.54	0.54	0.11	2.25	2.25	XXX
72146	TC	A	Magnetic image, chest spine	0.00	8.83	8.83	0.74	9.57	9.57	XXX
72147	.....	A	Magnetic image, chest spine	1.92	10.17	10.17	0.94	13.03	13.03	XXX
72147	26	A	Magnetic image, chest spine	1.92	0.64	0.64	0.13	2.69	2.69	XXX
72147	TC	A	Magnetic image, chest spine	0.00	9.53	9.53	0.81	10.34	10.34	XXX
72148	.....	A	Magnetic image, lumbar spine	1.48	9.32	9.32	0.84	11.64	11.64	XXX
72148	26	A	Magnetic image, lumbar spine	1.48	0.49	0.49	0.10	2.07	2.07	XXX
72148	TC	A	Magnetic image, lumbar spine	0.00	8.83	8.83	0.74	9.57	9.57	XXX
72149	.....	A	Magnetic image, lumbar spine	1.78	10.13	10.13	0.93	12.84	12.84	XXX
72149	26	A	Magnetic image, lumbar spine	1.78	0.60	0.60	0.12	2.50	2.50	XXX
72149	TC	A	Magnetic image, lumbar spine	0.00	9.53	9.53	0.81	10.34	10.34	XXX
72156	.....	A	Magnetic image, neck spine	2.57	18.51	18.51	1.66	22.74	22.74	XXX
72156	26	A	Magnetic image, neck spine	2.57	0.86	0.86	0.17	3.60	3.60	XXX
72156	TC	A	Magnetic image, neck spine	0.00	17.65	17.65	1.49	19.14	19.14	XXX
72157	.....	A	Magnetic image, chest spine	2.57	18.51	18.51	1.66	22.74	22.74	XXX
72157	26	A	Magnetic image, chest spine	2.57	0.86	0.86	0.17	3.60	3.60	XXX
72157	TC	A	Magnetic image, chest spine	0.00	17.65	17.65	1.49	19.14	19.14	XXX
72158	.....	A	Magnetic image, lumbar spine	2.36	18.45	18.45	1.65	22.46	22.46	XXX
72158	26	A	Magnetic image, lumbar spine	2.36	0.80	0.80	0.16	3.32	3.32	XXX
72158	TC	A	Magnetic image, lumbar spine	0.00	17.65	17.65	1.49	19.14	19.14	XXX
72159	.....	N	Magnetic imaging/spine (MRA)	+1.80	9.32	9.32	0.84	11.96	11.96	XXX
72159	26	N	Magnetic imaging/spine (MRA)	+1.80	0.49	0.49	0.10	2.39	2.39	XXX
72159	TC	N	Magnetic imaging/spine (MRA)	+0.00	8.83	8.83	0.74	9.57	9.57	XXX
72170	.....	A	X-ray exam of pelvis	0.17	0.42	0.42	0.04	0.63	0.63	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.05	0.05	0.01	0.23	0.23	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.37	0.37	0.03	0.40	0.40	XXX
72190	.....	A	X-ray exam of pelvis	0.21	0.55	0.55	0.05	0.81	0.81	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.48	0.48	0.04	0.52	0.52	XXX
72192	.....	A	CAT scan of pelvis	1.09	4.55	4.55	0.43	6.07	6.07	XXX
72192	26	A	CAT scan of pelvis	1.09	0.36	0.36	0.07	1.52	1.52	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
72192	TC	A	CAT scan of pelvis	0.00	4.19	4.19	0.36	4.55	4.55	XXX
72193		A	Contrast CAT scan of pelvis	1.16	5.23	5.23	0.49	6.88	6.88	XXX
72193	26	A	Contrast CAT scan of pelvis	1.16	0.38	0.38	0.08	1.62	1.62	XXX
72193	TC	A	Contrast CAT scan of pelvis	0.00	4.85	4.85	0.41	5.26	5.26	XXX
72194		A	Contrast CAT scans of pelvis	1.22	6.42	6.42	0.58	8.22	8.22	XXX
72194	26	A	Contrast CAT scans of pelvis	1.22	0.39	0.39	0.08	1.69	1.69	XXX
72194	TC	A	Contrast CAT scans of pelvis	0.00	6.02	6.02	0.50	6.52	6.52	XXX
72196		A	Magnetic image, pelvis	1.60	8.48	8.48	0.78	10.86	10.86	XXX
72196	26	A	Magnetic image, pelvis	1.60	0.54	0.54	0.11	2.25	2.25	XXX
72196	TC	A	Magnetic image, pelvis	0.00	7.95	7.95	0.67	8.62	8.62	XXX
72198		N	Magnetic imaging/pelvis (MRA)	+1.80	8.48	8.48	0.78	11.06	11.06	XXX
72198	26	N	Magnetic imaging/pelvis (MRA)	+1.80	0.54	0.54	0.11	2.45	2.45	XXX
72198	TC	N	Magnetic imaging/pelvis (MRA)	+0.00	7.95	7.95	0.67	8.62	8.62	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.43	0.43	0.04	0.64	0.64	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.37	0.37	0.03	0.40	0.40	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.51	0.51	0.05	0.75	0.75	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.07	0.01	0.27	0.27	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.44	0.44	0.04	0.48	0.48	XXX
72220		A	X-ray exam of tailbone	0.17	0.46	0.46	0.05	0.68	0.68	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.40	0.40	0.04	0.44	0.44	XXX
72240		A	Contrast x-ray of neck spine	0.91	3.67	3.67	0.35	4.93	4.93	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.31	0.31	0.06	1.28	1.28	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	3.36	3.36	0.29	3.65	3.65	XXX
72255		A	Contrast x-ray thorax spine	0.91	3.38	3.38	0.32	4.61	4.61	XXX
72255	26	A	Contrast x-ray thorax spine	0.91	0.31	0.31	0.06	1.28	1.28	XXX
72255	TC	A	Contrast x-ray thorax spine	0.00	3.07	3.07	0.26	3.33	3.33	XXX
72265		A	Contrast x-ray lower spine	0.83	3.17	3.17	0.31	4.31	4.31	XXX
72265	26	A	Contrast x-ray lower spine	0.83	0.28	0.28	0.06	1.17	1.17	XXX
72265	TC	A	Contrast x-ray lower spine	0.00	2.89	2.89	0.25	3.14	3.14	XXX
72270		A	Contrast x-ray of spine	1.33	4.76	4.76	0.46	6.55	6.55	XXX
72270	26	A	Contrast x-ray of spine	1.33	0.44	0.44	0.09	1.86	1.86	XXX
72270	TC	A	Contrast x-ray of spine	0.00	4.32	4.32	0.37	4.69	4.69	XXX
72285		A	X-ray of neck spine disk	0.83	6.23	6.23	0.56	7.62	7.62	XXX
72285	26	A	X-ray of neck spine disk	0.83	0.28	0.28	0.06	1.17	1.17	XXX
72285	TC	A	X-ray of neck spine disk	0.00	5.95	5.95	0.50	6.45	6.45	XXX
72295		A	X-ray of lower spine disk	0.83	5.86	5.86	0.52	7.21	7.21	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.28	0.28	0.06	1.17	1.17	XXX
72295	TC	A	X-ray of lower spine disk	0.00	5.57	5.57	0.46	6.03	6.03	XXX
73000		A	X-ray exam of collarbone	0.16	0.42	0.42	0.04	0.62	0.62	XXX
73000	26	A	X-ray exam of collarbone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collarbone	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.43	0.43	0.04	0.64	0.64	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73020		A	X-ray exam of shoulder	0.15	0.39	0.39	0.04	0.58	0.58	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.33	0.33	0.03	0.36	0.36	XXX
73030		A	X-ray exam of shoulder	0.18	0.46	0.46	0.05	0.69	0.69	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73040		A	Contrast x-ray of shoulder	0.54	1.67	1.67	0.17	2.38	2.38	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	1.49	1.49	0.13	1.62	1.62	XXX
73050		A	X-ray exam of shoulders	0.20	0.54	0.54	0.05	0.79	0.79	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.48	0.48	0.04	0.52	0.52	XXX
73060		A	X-ray exam of humerus	0.17	0.46	0.46	0.05	0.68	0.68	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73070		A	X-ray exam of elbow	0.15	0.42	0.42	0.04	0.61	0.61	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73080		A	X-ray exam of elbow	0.17	0.46	0.46	0.05	0.68	0.68	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73085		A	Contrast x-ray of elbow	0.54	1.67	1.67	0.17	2.38	2.38	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.49	1.49	0.13	1.62	1.62	XXX
73090		A	X-ray exam of forearm	0.16	0.42	0.42	0.04	0.62	0.62	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73092		A	X-ray exam of arm, infant	0.16	0.40	0.40	0.04	0.60	0.60	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73100		A	X-ray exam of wrist	0.16	0.40	0.40	0.04	0.60	0.60	XXX
73100	26	A	X-ray exam of wrist	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73110		A	X-ray exam of wrist	0.17	0.44	0.44	0.04	0.65	0.65	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.38	0.38	0.03	0.41	0.41	XXX
73115		A	Contrast x-ray of wrist	0.54	1.30	1.30	0.14	1.98	1.98	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.12	1.12	0.10	1.22	1.22	XXX
73120		A	X-ray exam of hand	0.16	0.40	0.40	0.04	0.60	0.60	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73130		A	X-ray exam of hand	0.17	0.44	0.44	0.04	0.65	0.65	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.38	0.38	0.03	0.41	0.41	XXX
73140		A	X-ray exam of finger(s)	0.13	0.34	0.34	0.04	0.51	0.51	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.30	0.30	0.03	0.33	0.33	XXX
73200		A	CAT scan of arm	1.09	3.88	3.88	0.37	5.34	5.34	XXX
73200	26	A	CAT scan of arm	1.09	0.36	0.36	0.07	1.52	1.52	XXX
73200	TC	A	CAT scan of arm	0.00	3.52	3.52	0.30	3.82	3.82	XXX
73201		A	Contrast CAT scan of arm	1.16	4.57	4.57	0.44	6.17	6.17	XXX
73201	26	A	Contrast CAT scan of arm	1.16	0.38	0.38	0.08	1.62	1.62	XXX
73201	TC	A	Contrast CAT scan of arm	0.00	4.19	4.19	0.36	4.55	4.55	XXX
73202		A	Contrast CAT scans of arm	1.22	5.66	5.66	0.53	7.41	7.41	XXX
73202	26	A	Contrast CAT scans of arm	1.22	0.39	0.39	0.08	1.69	1.69	XXX
73202	TC	A	Contrast CAT scans of arm	0.00	5.27	5.27	0.45	5.72	5.72	XXX
73220		A	Magnetic image, arm, hand	1.48	8.44	8.44	0.77	10.69	10.69	XXX
73220	26	A	Magnetic image, arm, hand	1.48	0.49	0.49	0.10	2.07	2.07	XXX
73220	TC	A	Magnetic image, arm, hand	0.00	7.95	7.95	0.67	8.62	8.62	XXX
73221		A	Magnetic image, joint of arm	1.48	8.27	8.27	0.73	10.48	10.48	XXX
73221	26	A	Magnetic image, joint of arm	1.48	0.32	0.32	0.06	1.86	1.86	XXX
73221	TC	A	Magnetic image, joint of arm	0.00	7.95	7.95	0.67	8.62	8.62	XXX
73225		N	Magnetic imaging/upper (MRA)	+1.73	8.44	8.44	0.77	10.94	10.94	XXX
73225	26	N	Magnetic imaging/upper (MRA)	+1.73	0.49	0.49	0.10	2.32	2.32	XXX
73225	TC	N	Magnetic imaging/upper (MRA)	+0.00	7.95	7.95	0.67	8.62	8.62	XXX
73500		A	X-ray exam of hip	0.17	0.39	0.39	0.04	0.60	0.60	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.33	0.33	0.03	0.36	0.36	XXX
73510		A	X-ray exam of hip	0.21	0.48	0.48	0.05	0.74	0.74	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.01	0.29	0.29	XXX
73510	TC	A	X-ray exam of hip	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73520		A	X-ray exam of hips	0.26	0.57	0.57	0.06	0.89	0.89	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.02	0.37	0.37	XXX
73520	TC	A	X-ray exam of hips	0.00	0.48	0.48	0.04	0.52	0.52	XXX
73525		A	Contrast x-ray of hip	0.54	1.67	1.67	0.17	2.38	2.38	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.49	1.49	0.13	1.62	1.62	XXX
73530		A	X-ray exam of hip	0.29	0.47	0.47	0.05	0.81	0.81	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.02	0.41	0.41	XXX
73530	TC	A	X-ray exam of hip	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.48	0.48	0.05	0.73	0.73	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73550		A	X-ray exam of thigh	0.17	0.46	0.46	0.05	0.68	0.68	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73560		A	X-ray exam of knee	0.17	0.42	0.42	0.04	0.63	0.63	XXX
73560	26	A	X-ray exam of knee	0.17	0.05	0.05	0.01	0.23	0.23	XXX
73560	TC	A	X-ray exam of knee	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73562		A	X-ray exam of knee	0.18	0.47	0.47	0.05	0.70	0.70	XXX
73562	26	A	X-ray exam of knee	0.18	0.07	0.07	0.01	0.26	0.26	XXX
73562	TC	A	X-ray exam of knee	0.00	0.40	0.40	0.04	0.44	0.44	XXX
73564		A	X-ray exam of knee	0.22	0.51	0.51	0.06	0.79	0.79	XXX
73564	26	A	X-ray exam of knee	0.22	0.07	0.07	0.02	0.31	0.31	XXX
73564	TC	A	X-ray exam of knee	0.00	0.44	0.44	0.04	0.48	0.48	XXX
73565		A	X-ray exam of knee	0.17	0.40	0.40	0.04	0.61	0.61	XXX
73565	26	A	X-ray exam of knee	0.17	0.05	0.05	0.01	0.23	0.23	XXX
73565	TC	A	X-ray exam of knee	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.05	2.05	0.21	2.80	2.80	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	1.86	1.86	0.17	2.03	2.03	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
73590	.....	A	X-ray exam of lower leg	0.17	0.42	0.42	0.04	0.63	0.63	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.05	0.05	0.01	0.23	0.23	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.37	0.37	0.03	0.40	0.40	XXX
73592	.....	A	X-ray exam of leg, infant	0.16	0.40	0.40	0.04	0.60	0.60	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73600	.....	A	X-ray exam of ankle	0.16	0.40	0.40	0.04	0.60	0.60	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73610	.....	A	X-ray exam of ankle	0.17	0.44	0.44	0.04	0.65	0.65	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.38	0.38	0.03	0.41	0.41	XXX
73615	.....	A	Contrast x-ray of ankle	0.54	1.67	1.67	0.17	2.38	2.38	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.49	1.49	0.13	1.62	1.62	XXX
73620	.....	A	X-ray exam of foot	0.16	0.40	0.40	0.04	0.60	0.60	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.35	0.35	0.03	0.38	0.38	XXX
73630	.....	A	X-ray exam of foot	0.17	0.44	0.44	0.04	0.65	0.65	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.38	0.38	0.03	0.41	0.41	XXX
73650	.....	A	X-ray exam of heel	0.16	0.39	0.39	0.04	0.59	0.59	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.33	0.33	0.03	0.36	0.36	XXX
73660	.....	A	X-ray exam of toe(s)	0.13	0.34	0.34	0.04	0.51	0.51	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.30	0.30	0.03	0.33	0.33	XXX
73700	.....	A	CAT scan of leg	1.09	3.88	3.88	0.37	5.34	5.34	XXX
73700	26	A	CAT scan of leg	1.09	0.36	0.36	0.07	1.52	1.52	XXX
73700	TC	A	CAT scan of leg	0.00	3.52	3.52	0.30	3.82	3.82	XXX
73701	.....	A	Contrast CAT scan of leg	1.16	4.57	4.57	0.44	6.17	6.17	XXX
73701	26	A	Contrast CAT scan of leg	1.16	0.38	0.38	0.08	1.62	1.62	XXX
73701	TC	A	Contrast CAT scan of leg	0.00	4.19	4.19	0.36	4.55	4.55	XXX
73702	.....	A	Contrast CAT scans of leg	1.22	5.66	5.66	0.53	7.41	7.41	XXX
73702	26	A	Contrast CAT scans of leg	1.22	0.39	0.39	0.08	1.69	1.69	XXX
73702	TC	A	Contrast CAT scans of leg	0.00	5.27	5.27	0.45	5.72	5.72	XXX
73720	.....	A	Magnetic image, leg, foot	1.48	8.44	8.44	0.77	10.69	10.69	XXX
73720	26	A	Magnetic image, leg, foot	1.48	0.49	0.49	0.10	2.07	2.07	XXX
73720	TC	A	Magnetic image, leg, foot	0.00	7.95	7.95	0.67	8.62	8.62	XXX
73721	.....	A	Magnetic image, joint of leg	1.48	8.27	8.27	0.73	10.48	10.48	XXX
73721	26	A	Magnetic image, joint of leg	1.48	0.32	0.32	0.06	1.86	1.86	XXX
73721	TC	A	Magnetic image, joint of leg	0.00	7.95	7.95	0.67	8.62	8.62	XXX
73725	.....	R	Magnetic imaging/lower (MRA)	1.82	8.44	8.44	0.77	11.03	11.03	XXX
73725	26	R	Magnetic imaging/lower (MRA)	1.82	0.49	0.49	0.10	2.41	2.41	XXX
73725	TC	R	Magnetic imaging/lower (MRA)	0.00	7.95	7.95	0.67	8.62	8.62	XXX
74000	.....	A	X-ray exam of abdomen	0.18	0.43	0.43	0.04	0.65	0.65	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.37	0.37	0.03	0.40	0.40	XXX
74010	.....	A	X-ray exam of abdomen	0.23	0.48	0.48	0.06	0.77	0.77	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.02	0.33	0.33	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.40	0.40	0.04	0.44	0.44	XXX
74020	.....	A	X-ray exam of abdomen	0.27	0.54	0.54	0.06	0.87	0.87	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.10	0.10	0.02	0.39	0.39	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.44	0.44	0.04	0.48	0.48	XXX
74022	.....	A	X-ray exam series, abdomen	0.32	0.63	0.63	0.07	1.02	1.02	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.11	0.11	0.02	0.45	0.45	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.52	0.52	0.05	0.57	0.57	XXX
74150	.....	A	CAT scan of abdomen	1.19	4.40	4.40	0.43	6.02	6.02	XXX
74150	26	A	CAT scan of abdomen	1.19	0.39	0.39	0.08	1.66	1.66	XXX
74150	TC	A	CAT scan of abdomen	0.00	4.01	4.01	0.35	4.36	4.36	XXX
74160	.....	A	Contrast CAT scan of abdomen	1.27	5.27	5.27	0.50	7.04	7.04	XXX
74160	26	A	Contrast CAT scan of abdomen	1.27	0.42	0.42	0.09	1.78	1.78	XXX
74160	TC	A	Contrast CAT scan of abdomen	0.00	4.85	4.85	0.41	5.26	5.26	XXX
74170	.....	A	Contrast CAT scans, abdomen	1.40	6.48	6.48	0.60	8.48	8.48	XXX
74170	26	A	Contrast CAT scans, abdomen	1.40	0.46	0.46	0.10	1.96	1.96	XXX
74170	TC	A	Contrast CAT scans, abdomen	0.00	6.02	6.02	0.50	6.52	6.52	XXX
74181	.....	A	Magnetic image, abdomen (MRI)	1.60	8.48	8.48	0.78	10.86	10.86	XXX
74181	26	A	Magnetic image, abdomen (MRI)	1.60	0.54	0.54	0.11	2.25	2.25	XXX
74181	TC	A	Magnetic image, abdomen (MRI)	0.00	7.95	7.95	0.67	8.62	8.62	XXX
74185	.....	N	Magnetic image/abdomen (MRA)	+1.80	8.48	8.48	0.78	11.06	11.06	XXX
74185	26	N	Magnetic image/abdomen (MRA)	+1.80	0.54	0.54	0.11	2.45	2.45	XXX
74185	TC	N	Magnetic image/abdomen (MRA)	+0.00	7.95	7.95	0.67	8.62	8.62	XXX
74190	.....	A	X-ray exam of peritoneum	0.48	1.02	1.02	0.10	1.60	1.60	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.10	0.10	0.02	0.60	0.60	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
74190	TC	A	X-ray exam of peritoneum	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74210		A	Contrast xray exam of throat	0.36	0.96	0.96	0.09	1.41	1.41	XXX
74210	26	A	Contrast xray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrast xray exam of throat	0.00	0.84	0.84	0.07	0.91	0.91	XXX
74220		A	Contrast xray exam, esophagus	0.46	1.00	1.00	0.10	1.56	1.56	XXX
74220	26	A	Contrast xray exam, esophagus	0.46	0.16	0.16	0.03	0.65	0.65	XXX
74220	TC	A	Contrast xray exam, esophagus	0.00	0.84	0.84	0.07	0.91	0.91	XXX
74230		A	Cinema xray throat/esophagus	0.53	1.11	1.11	0.12	1.76	1.76	XXX
74230	26	A	Cinema xray throat/esophagus	0.53	0.19	0.19	0.04	0.76	0.76	XXX
74230	TC	A	Cinema xray throat/esophagus	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74235		A	Remove esophagus obstruction	1.19	2.25	2.25	0.25	3.69	3.69	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.39	0.39	0.08	1.66	1.66	XXX
74235	TC	A	Remove esophagus obstruction	0.00	1.86	1.86	0.17	2.03	2.03	XXX
74240		A	X-ray exam upper GI tract	0.69	1.27	1.27	0.14	2.10	2.10	XXX
74240	26	A	X-ray exam upper GI tract	0.69	0.24	0.24	0.05	0.98	0.98	XXX
74240	TC	A	X-ray exam upper GI tract	0.00	1.03	1.03	0.09	1.12	1.12	XXX
74241		A	X-ray exam upper GI tract	0.69	1.30	1.30	0.14	2.13	2.13	XXX
74241	26	A	X-ray exam upper GI tract	0.69	0.24	0.24	0.05	0.98	0.98	XXX
74241	TC	A	X-ray exam upper GI tract	0.00	1.06	1.06	0.09	1.15	1.15	XXX
74245		A	X-ray exam upper GI tract	0.91	1.99	1.99	0.21	3.11	3.11	XXX
74245	26	A	X-ray exam upper GI tract	0.91	0.31	0.31	0.06	1.28	1.28	XXX
74245	TC	A	X-ray exam upper GI tract	0.00	1.69	1.69	0.15	1.84	1.84	XXX
74246		A	Contrast xray upper GI tract	0.69	1.41	1.41	0.15	2.25	2.25	XXX
74246	26	A	Contrast xray upper GI tract	0.69	0.24	0.24	0.05	0.98	0.98	XXX
74246	TC	A	Contrast xray upper GI tract	0.00	1.17	1.17	0.10	1.27	1.27	XXX
74247		A	Contrast xray upper GI tract	0.69	1.43	1.43	0.16	2.28	2.28	XXX
74247	26	A	Contrast xray upper GI tract	0.69	0.24	0.24	0.05	0.98	0.98	XXX
74247	TC	A	Contrast xray upper GI tract	0.00	1.19	1.19	0.11	1.30	1.30	XXX
74249		A	Contrast xray upper GI tract	0.91	2.13	2.13	0.22	3.26	3.26	XXX
74249	26	A	Contrast xray upper GI tract	0.91	0.31	0.31	0.06	1.28	1.28	XXX
74249	TC	A	Contrast xray upper GI tract	0.00	1.82	1.82	0.16	1.98	1.98	XXX
74250		A	X-ray exam of small bowel	0.47	1.08	1.08	0.11	1.66	1.66	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.16	0.16	0.03	0.66	0.66	XXX
74250	TC	A	X-ray exam of small bowel	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74251		A	X-ray exam of small bowel	0.69	1.08	1.08	0.11	1.88	1.88	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.16	0.16	0.03	0.88	0.88	XXX
74251	TC	A	X-ray exam of small bowel	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74260		A	X-ray exam of small bowel	0.50	1.23	1.23	0.12	1.85	1.85	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.17	0.17	0.03	0.70	0.70	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.06	1.06	0.09	1.15	1.15	XXX
74270		A	Contrast x-ray exam of colon	0.69	1.44	1.44	0.16	2.29	2.29	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.24	0.24	0.05	0.98	0.98	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.21	1.21	0.11	1.32	1.32	XXX
74280		A	Contrast x-ray exam of colon	0.99	1.92	1.92	0.21	3.12	3.12	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.33	0.33	0.07	1.39	1.39	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	1.59	1.59	0.14	1.73	1.73	XXX
74283		A	Contrast x-ray exam of colon	2.02	2.49	2.49	0.30	4.81	4.81	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.67	0.67	0.14	2.83	2.83	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	1.82	1.82	0.16	1.98	1.98	XXX
74290		A	Contrast x-ray, gallbladder	0.32	0.63	0.63	0.07	1.02	1.02	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.11	0.11	0.02	0.45	0.45	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.52	0.52	0.05	0.57	0.57	XXX
74291		A	Contrast x-rays, gallbladder	0.20	0.36	0.36	0.04	0.60	0.60	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.30	0.30	0.03	0.33	0.33	XXX
74300	26	A	X-ray bile ducts, pancreas	0.36	0.13	0.13	0.02	0.51	0.51	XXX
74301	26	A	Additional x-rays at surgery	0.21	0.07	0.07	0.01	0.29	0.29	XXX
74305		A	X-ray bile ducts, pancreas	0.42	0.70	0.70	0.08	1.20	1.20	XXX
74305	26	A	X-ray bile ducts, pancreas	0.42	0.14	0.14	0.03	0.59	0.59	XXX
74305	TC	A	X-ray bile ducts, pancreas	0.00	0.56	0.56	0.05	0.61	0.61	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.42	2.42	0.23	3.19	3.19	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74327		A	X-ray for bile stone removal	0.70	1.49	1.49	0.16	2.35	2.35	XXX
74327	26	A	X-ray for bile stone removal	0.70	0.24	0.24	0.05	0.99	0.99	XXX
74327	TC	A	X-ray for bile stone removal	0.00	1.25	1.25	0.11	1.36	1.36	XXX
74328		A	X-ray for bile duct endoscopy	0.70	2.47	2.47	0.24	3.41	3.41	XXX
74328	26	A	X-ray for bile duct endoscopy	0.70	0.24	0.24	0.05	0.99	0.99	XXX
74328	TC	A	X-ray for bile duct endoscopy	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74329		A	X-ray for pancreas endoscopy	0.70	2.47	2.47	0.24	3.41	3.41	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.24	0.24	0.05	0.99	0.99	XXX
74329	TC	A	X-ray for pancreas endoscopy	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74330		A	Xray, bile/pancreas endoscopy	0.90	2.47	2.47	0.24	3.61	3.61	XXX
74330	26	A	Xray, bile/pancreas endoscopy	0.90	0.24	0.24	0.05	1.19	1.19	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
74330	TC	A	Xray, bile/pancreas endoscopy	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74340		A	X-ray guide for GI tube	0.54	2.05	2.05	0.21	2.80	2.80	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74340	TC	A	X-ray guide for GI tube	0.00	1.86	1.86	0.17	2.03	2.03	XXX
74350		A	X-ray guide, stomach tube	0.76	2.49	2.49	0.24	3.49	3.49	XXX
74350	26	A	X-ray guide, stomach tube	0.76	0.26	0.26	0.05	1.07	1.07	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74355		A	X-ray guide, intestinal tube	0.76	2.12	2.12	0.22	3.10	3.10	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.26	0.26	0.05	1.07	1.07	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	1.86	1.86	0.17	2.03	2.03	XXX
74360		A	X-ray guide, GI dilation	0.54	2.42	2.42	0.23	3.19	3.19	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74363		A	X-ray, bile duct dilation	0.88	4.62	4.62	0.43	5.93	5.93	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.30	0.30	0.06	1.24	1.24	XXX
74363	TC	A	X-ray, bile duct dilation	0.00	4.32	4.32	0.37	4.69	4.69	XXX
74400		A	Contrast x-ray urinary tract	0.49	1.35	1.35	0.14	1.98	1.98	XXX
74400	26	A	Contrast x-ray urinary tract	0.49	0.16	0.16	0.03	0.68	0.68	XXX
74400	TC	A	Contrast x-ray urinary tract	0.00	1.19	1.19	0.11	1.30	1.30	XXX
74405		A	Contrast x-ray urinary tract	0.49	1.57	1.57	0.16	2.22	2.22	XXX
74405	26	A	Contrast x-ray urinary tract	0.49	0.16	0.16	0.03	0.68	0.68	XXX
74405	TC	A	Contrast x-ray urinary tract	0.00	1.41	1.41	0.13	1.54	1.54	XXX
74410		A	Contrast x-ray urinary tract	0.49	1.55	1.55	0.15	2.19	2.19	XXX
74410	26	A	Contrast x-ray urinary tract	0.49	0.16	0.16	0.03	0.68	0.68	XXX
74410	TC	A	Contrast x-ray urinary tract	0.00	1.38	1.38	0.12	1.50	1.50	XXX
74415		A	Contrast x-ray urinary tract	0.49	1.67	1.67	0.16	2.32	2.32	XXX
74415	26	A	Contrast x-ray urinary tract	0.49	0.16	0.16	0.03	0.68	0.68	XXX
74415	TC	A	Contrast x-ray urinary tract	0.00	1.50	1.50	0.13	1.63	1.63	XXX
74420		A	Contrast x-ray urinary tract	0.36	1.98	1.98	0.19	2.53	2.53	XXX
74420	26	A	Contrast x-ray urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrast x-ray urinary tract	0.00	1.86	1.86	0.17	2.03	2.03	XXX
74425		A	Contrast x-ray urinary tract	0.36	1.04	1.04	0.10	1.50	1.50	XXX
74425	26	A	Contrast x-ray urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrast x-ray urinary tract	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74430		A	Contrast x-ray of bladder	0.32	0.86	0.86	0.09	1.27	1.27	XXX
74430	26	A	Contrast x-ray of bladder	0.32	0.11	0.11	0.02	0.45	0.45	XXX
74430	TC	A	Contrast x-ray of bladder	0.00	0.74	0.74	0.07	0.81	0.81	XXX
74440		A	X-ray exam male genital tract	0.38	0.93	0.93	0.10	1.41	1.41	XXX
74440	26	A	X-ray exam male genital tract	0.38	0.13	0.13	0.03	0.54	0.54	XXX
74440	TC	A	X-ray exam male genital tract	0.00	0.80	0.80	0.07	0.87	0.87	XXX
74445		A	X-ray exam of penis	1.14	1.18	1.18	0.15	2.47	2.47	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.08	1.59	1.59	XXX
74445	TC	A	X-ray exam of penis	0.00	0.80	0.80	0.07	0.87	0.87	XXX
74450		A	X-ray exam urethra/bladder	0.33	1.15	1.15	0.11	1.59	1.59	XXX
74450	26	A	X-ray exam urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74450	TC	A	X-ray exam urethra/bladder	0.00	1.03	1.03	0.09	1.12	1.12	XXX
74455		A	X-ray exam urethra/bladder	0.33	1.23	1.23	0.12	1.68	1.68	XXX
74455	26	A	X-ray exam urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray exam urethra/bladder	0.00	1.12	1.12	0.10	1.22	1.22	XXX
74470		A	X-ray exam of kidney lesion	0.54	1.07	1.07	0.12	1.73	1.73	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	0.89	0.89	0.08	0.97	0.97	XXX
74475		A	X-ray control catheter insert	0.54	3.07	3.07	0.29	3.90	3.90	XXX
74475	26	A	X-ray control catheter insert	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74475	TC	A	X-ray control catheter insert	0.00	2.89	2.89	0.25	3.14	3.14	XXX
74480		A	X-ray control catheter insert	0.54	3.07	3.07	0.29	3.90	3.90	XXX
74480	26	A	X-ray control catheter insert	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74480	TC	A	X-ray control catheter insert	0.00	2.89	2.89	0.25	3.14	3.14	XXX
74485		A	X-ray guide, GU dilation	0.54	2.42	2.42	0.23	3.19	3.19	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.19	0.19	0.04	0.77	0.77	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74710		A	X-ray measurement of pelvis	0.34	0.86	0.86	0.09	1.29	1.29	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.12	0.12	0.02	0.48	0.48	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.74	0.74	0.07	0.81	0.81	XXX
74740		A	X-ray female genital tract	0.38	1.05	1.05	0.11	1.54	1.54	XXX
74740	26	A	X-ray female genital tract	0.38	0.13	0.13	0.03	0.54	0.54	XXX
74740	TC	A	X-ray female genital tract	0.00	0.92	0.92	0.08	1.00	1.00	XXX
74742		A	X-ray fallopian tube	0.61	2.42	2.42	0.23	3.26	3.26	XXX
74742	26	A	X-ray fallopian tube	0.61	0.19	0.19	0.04	0.84	0.84	XXX
74742	TC	A	X-ray fallopian tube	0.00	2.23	2.23	0.19	2.42	2.42	XXX
74775		A	X-ray exam of perineum	0.62	1.25	1.25	0.13	2.00	2.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.22	0.22	0.04	0.88	0.88	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.03	1.03	0.09	1.12	1.12	XXX
75552		A	Magnetic image, myocardium	1.60	8.48	8.48	0.78	10.86	10.86	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
75552	26	A	Magnetic image, myocardium	1.60	0.54	0.54	0.11	2.25	2.25	XXX
75552	TC	A	Magnetic image, myocardium	0.00	7.95	7.95	0.67	8.62	8.62	XXX
75553		A	Magnetic image, myocardium	2.00	8.48	8.48	0.78	11.26	11.26	XXX
75553	26	A	Magnetic image, myocardium	2.00	0.54	0.54	0.11	2.65	2.65	XXX
75553	TC	A	Magnetic image, myocardium	0.00	7.95	7.95	0.67	8.62	8.62	XXX
75554		A	Cardiac MRI/function	1.83	8.48	8.48	0.78	11.09	11.09	XXX
75554	26	A	Cardiac MRI/function	1.83	0.54	0.54	0.11	2.48	2.48	XXX
75554	TC	A	Cardiac MRI/function	0.00	7.95	7.95	0.67	8.62	8.62	XXX
75555		A	Cardiac MRI/limited study	1.74	8.48	8.48	0.78	11.00	11.00	XXX
75555	26	A	Cardiac MRI/limited study	1.74	0.54	0.54	0.11	2.39	2.39	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	7.95	7.95	0.67	8.62	8.62	XXX
75600		A	Contrast x-ray exam of aorta	0.49	9.10	9.10	0.78	10.37	10.37	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.16	0.16	0.03	0.68	0.68	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75605		A	Contrast x-ray exam of aorta	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75625		A	Contrast x-ray exam of aorta	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75630		A	X-ray aorta, leg arteries	1.79	9.74	9.74	0.88	12.41	12.41	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.43	0.43	0.09	2.31	2.31	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	9.31	9.31	0.79	10.10	10.10	XXX
75650		A	Artery x-rays, head & neck	1.49	9.43	9.43	0.85	11.77	11.77	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.49	0.49	0.10	2.08	2.08	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75658		A	X-ray exam of arm arteries	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75658	26	A	X-ray exam of arm arteries	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75658	TC	A	X-ray exam of arm arteries	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75660		A	Artery x-rays, head & neck	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75662		A	Artery x-rays, head & neck	1.66	9.49	9.49	0.86	12.01	12.01	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.11	2.32	2.32	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75665		A	Artery x-rays, head & neck	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75671		A	Artery x-rays, head & neck	1.66	9.49	9.49	0.86	12.01	12.01	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.11	2.32	2.32	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75676		A	Artery x-rays, neck	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75676	26	A	Artery x-rays, neck	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75676	TC	A	Artery x-rays, neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75680		A	Artery x-rays, neck	1.66	9.49	9.49	0.86	12.01	12.01	XXX
75680	26	A	Artery x-rays, neck	1.66	0.55	0.55	0.11	2.32	2.32	XXX
75680	TC	A	Artery x-rays, neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75685		A	Artery x-rays, spine	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75685	TC	A	Artery x-rays, spine	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75705		A	Artery x-rays, spine	2.18	9.67	9.67	0.90	12.75	12.75	XXX
75705	26	A	Artery x-rays, spine	2.18	0.73	0.73	0.15	3.06	3.06	XXX
75705	TC	A	Artery x-rays, spine	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75710		A	Artery x-rays, arm/leg	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75716		A	Artery x-rays, arms/legs	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75722		A	Artery x-rays, kidney	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75722	TC	A	Artery x-rays, kidney	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75724		A	Artery x-rays, kidneys	1.49	9.43	9.43	0.85	11.77	11.77	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.49	0.49	0.10	2.08	2.08	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75726		A	Artery x-rays, abdomen	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75731		A	Artery x-rays, adrenal gland	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75733		A	Artery x-rays, adrenal glands	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75733	26	A	Artery x-rays, adrenal glands	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75733	TC	A	Artery x-rays, adrenal glands	0.00	8.94	8.94	0.75	9.69	9.69	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
75736	.....	A	Artery x-rays, pelvis	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75741	.....	A	Artery x-rays, lung	1.31	9.37	9.37	0.84	11.52	11.52	XXX
75741	26	A	Artery x-rays, lung	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75741	TC	A	Artery x-rays, lung	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75743	.....	A	Artery x-rays, lungs	1.66	9.49	9.49	0.86	12.01	12.01	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.55	0.55	0.11	2.32	2.32	XXX
75743	TC	A	Artery x-rays, lungs	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75746	.....	A	Artery x-rays, lung	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75746	26	A	Artery x-rays, lung	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75746	TC	A	Artery x-rays, lung	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75756	.....	A	Artery x-rays, chest	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75756	26	A	Artery x-rays, chest	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75756	TC	A	Artery x-rays, chest	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75774	.....	A	Artery x-ray, each vessel	0.36	9.06	9.06	0.77	10.19	10.19	XXX
75774	26	A	Artery x-ray, each vessel	0.36	0.12	0.12	0.02	0.50	0.50	XXX
75774	TC	A	Artery x-ray, each vessel	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75790	.....	A	Visualize A–V shunt	1.84	1.58	1.58	0.21	3.63	3.63	XXX
75790	26	A	Visualize A–V shunt	1.84	0.62	0.62	0.12	2.58	2.58	XXX
75790	TC	A	Visualize A–V shunt	0.00	0.96	0.96	0.09	1.05	1.05	XXX
75801	.....	A	Lymph vessel x-ray, arm/leg	0.81	4.12	4.12	0.38	5.31	5.31	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.28	0.28	0.05	1.14	1.14	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	3.84	3.84	0.33	4.17	4.17	XXX
75803	.....	A	Lymph vessel x-ray, arms/legs	1.17	4.22	4.22	0.41	5.80	5.80	XXX
75803	26	A	Lymph vessel x-ray, arms/legs	1.17	0.38	0.38	0.08	1.63	1.63	XXX
75803	TC	A	Lymph vessel x-ray, arms/legs	0.00	3.84	3.84	0.33	4.17	4.17	XXX
75805	.....	A	Lymph vessel x-ray, trunk	0.81	4.60	4.60	0.42	5.83	5.83	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.28	0.28	0.05	1.14	1.14	XXX
75805	TC	A	Lymph vessel x-ray, trunk	0.00	4.32	4.32	0.37	4.69	4.69	XXX
75807	.....	A	Lymph vessel x-ray, trunk	1.17	4.70	4.70	0.45	6.32	6.32	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.38	0.38	0.08	1.63	1.63	XXX
75807	TC	A	Lymph vessel x-ray, trunk	0.00	4.32	4.32	0.37	4.69	4.69	XXX
75809	.....	A	Nonvascular shunt, x-ray	0.47	0.70	0.70	0.08	1.25	1.25	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.14	0.14	0.03	0.64	0.64	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.56	0.56	0.05	0.61	0.61	XXX
75810	.....	A	Vein x-ray, spleen/liver	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75820	.....	A	Vein x-ray, arm/leg	0.70	0.91	0.91	0.11	1.72	1.72	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.24	0.24	0.05	0.99	0.99	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	0.67	0.67	0.06	0.73	0.73	XXX
75822	.....	A	Vein x-ray, arms/legs	1.06	1.40	1.40	0.16	2.62	2.62	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.35	0.35	0.07	1.48	1.48	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.05	1.05	0.09	1.14	1.14	XXX
75825	.....	A	Vein x-ray, trunk	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75825	TC	A	Vein x-ray, trunk	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75827	.....	A	Vein x-ray, chest	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75827	TC	A	Vein x-ray, chest	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75831	.....	A	Vein x-ray, kidney	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75831	TC	A	Vein x-ray, kidney	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75833	.....	A	Vein x-ray, kidneys	1.49	9.43	9.43	0.85	11.77	11.77	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.49	0.49	0.10	2.08	2.08	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75840	.....	A	Vein x-ray, adrenal gland	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75842	.....	A	Vein x-ray, adrenal glands	1.49	9.43	9.43	0.85	11.77	11.77	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.49	0.49	0.10	2.08	2.08	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75860	.....	A	Vein x-ray, neck	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75860	26	A	Vein x-ray, neck	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75860	TC	A	Vein x-ray, neck	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75870	.....	A	Vein x-ray, skull	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75870	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75870	TC	A	Vein x-ray, skull	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75872	.....	A	Vein x-ray, skull	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75872	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75872	TC	A	Vein x-ray, skull	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75880	.....	A	Vein x-ray, eye socket	0.70	0.91	0.91	0.11	1.72	1.72	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.24	0.24	0.05	0.99	0.99	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
75880	TC	A	Vein x-ray, eye socket	0.00	0.67	0.67	0.06	0.73	0.73	XXX
75885		A	Vein x-ray, liver	1.44	9.42	9.42	0.85	11.71	11.71	XXX
75885	26	A	Vein x-ray, liver	1.44	0.48	0.48	0.10	2.02	2.02	XXX
75885	TC	A	Vein x-ray, liver	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75887		A	Vein x-ray, liver	1.44	9.42	9.42	0.85	11.71	11.71	XXX
75887	26	A	Vein x-ray, liver	1.44	0.48	0.48	0.10	2.02	2.02	XXX
75887	TC	A	Vein x-ray, liver	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75889		A	Vein x-ray, liver	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75889	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75889	TC	A	Vein x-ray, liver	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75891		A	Vein x-ray, liver	1.14	9.31	9.31	0.83	11.28	11.28	XXX
75891	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.08	1.59	1.59	XXX
75891	TC	A	Vein x-ray, liver	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75893		A	Venous sampling by catheter	0.54	9.12	9.12	0.79	10.45	10.45	XXX
75893	26	A	Venous sampling by catheter	0.54	0.19	0.19	0.04	0.77	0.77	XXX
75893	TC	A	Venous sampling by catheter	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75894		A	X-rays, transcatheter therapy	1.31	17.55	17.55	1.53	20.39	20.39	XXX
75894	26	A	X-rays, transcatheter therapy	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75894	TC	A	X-rays, transcatheter therapy	0.00	17.12	17.12	1.44	18.56	18.56	XXX
75896		A	X-rays, transcatheter therapy	1.31	15.32	15.32	1.34	17.97	17.97	XXX
75896	26	A	X-rays, transcatheter therapy	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75896	TC	A	X-rays, transcatheter therapy	0.00	14.89	14.89	1.25	16.14	16.14	XXX
75898		A	Follow-up angiogram	1.65	1.30	1.30	0.18	3.13	3.13	XXX
75898	26	A	Follow-up angiogram	1.65	0.55	0.55	0.11	2.31	2.31	XXX
75898	TC	A	Follow-up angiogram	0.00	0.74	0.74	0.07	0.81	0.81	XXX
75900		A	Arterial catheter exchange	0.49	15.05	15.05	1.29	16.83	16.83	XXX
75900	26	A	Arterial catheter exchange	0.49	0.17	0.17	0.03	0.69	0.69	XXX
75900	TC	A	Arterial catheter exchange	0.00	14.88	14.88	1.26	16.14	16.14	XXX
75940		A	X-ray placement, vein filter	0.54	9.12	9.12	0.79	10.45	10.45	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.19	0.19	0.04	0.77	0.77	XXX
75940	TC	A	X-ray placement, vein filter	0.00	8.94	8.94	0.75	9.69	9.69	XXX
75945		A	Intravascular us	0.40	NA	3.40	0.31	NA	4.11	XXX
75945	26	A	Intravascular us	0.40	NA	0.16	0.03	NA	0.59	XXX
75945	TC	A	Intravascular us	0.00	NA	3.24	0.28	NA	3.52	XXX
75946		A	Intravascular us	0.40	NA	1.79	0.17	NA	2.36	XXX
75946	26	A	Intravascular us	0.40	NA	0.16	0.03	NA	0.59	XXX
75946	TC	A	Intravascular us	0.00	NA	1.62	0.14	NA	1.76	XXX
75960		A	Transcatheter intro, stent	0.82	10.84	10.84	0.94	12.60	12.60	XXX
75960	26	A	Transcatheter intro, stent	0.82	0.28	0.28	0.06	1.16	1.16	XXX
75960	TC	A	Transcatheter intro, stent	0.00	10.57	10.57	0.88	11.45	11.45	XXX
75961		A	Retrieval, broken catheter	4.25	8.86	8.86	0.90	14.01	14.01	XXX
75961	26	A	Retrieval, broken catheter	4.25	1.41	1.41	0.28	5.94	5.94	XXX
75961	TC	A	Retrieval, broken catheter	0.00	7.45	7.45	0.62	8.07	8.07	XXX
75962		A	Repair arterial blockage	0.54	11.35	11.35	0.98	12.87	12.87	XXX
75962	26	A	Repair arterial blockage	0.54	0.19	0.19	0.04	0.77	0.77	XXX
75962	TC	A	Repair arterial blockage	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75964		A	Repair artery blockage, each	0.36	6.07	6.07	0.52	6.95	6.95	XXX
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.02	0.50	0.50	XXX
75964	TC	A	Repair artery blockage, each	0.00	5.95	5.95	0.50	6.45	6.45	XXX
75966		A	Repair arterial blockage	1.31	11.60	11.60	1.03	13.94	13.94	XXX
75966	26	A	Repair arterial blockage	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75966	TC	A	Repair arterial blockage	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75968		A	Repair artery blockage, each	0.36	6.07	6.07	0.52	6.95	6.95	XXX
75968	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.02	0.50	0.50	XXX
75968	TC	A	Repair artery blockage, each	0.00	5.95	5.95	0.50	6.45	6.45	XXX
75970		A	Vascular biopsy	0.83	8.47	8.47	0.75	10.05	10.05	XXX
75970	26	A	Vascular biopsy	0.83	0.28	0.28	0.06	1.17	1.17	XXX
75970	TC	A	Vascular biopsy	0.00	8.19	8.19	0.69	8.88	8.88	XXX
75978		A	Repair venous blockage	0.54	11.52	11.52	0.98	13.04	13.04	XXX
75978	26	A	Repair venous blockage	0.54	0.36	0.36	0.04	0.94	0.94	XXX
75978	TC	A	Repair venous blockage	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75980		A	Contrast xray exam bile duct	1.44	4.32	4.32	0.43	6.19	6.19	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.48	0.48	0.10	2.02	2.02	XXX
75980	TC	A	Contrast xray exam bile duct	0.00	3.84	3.84	0.33	4.17	4.17	XXX
75982		A	Contrast xray exam bile duct	1.44	4.80	4.80	0.47	6.71	6.71	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.48	0.48	0.10	2.02	2.02	XXX
75982	TC	A	Contrast xray exam bile duct	0.00	4.32	4.32	0.37	4.69	4.69	XXX
75984		A	X-ray control catheter change	0.72	1.63	1.63	0.17	2.52	2.52	XXX
75984	26	A	X-ray control catheter change	0.72	0.25	0.25	0.05	1.02	1.02	XXX
75984	TC	A	X-ray control catheter change	0.00	1.38	1.38	0.12	1.50	1.50	XXX
75989		A	Abscess drainage under x-ray	1.19	2.62	2.62	0.27	4.08	4.08	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.39	0.39	0.08	1.66	1.66	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	2.23	2.23	0.19	2.42	2.42	XXX
75992		A	Atherectomy, x-ray exam	0.54	11.35	11.35	0.98	12.87	12.87	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.04	0.77	0.77	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75993		A	Atherectomy, x-ray exam	0.36	6.07	6.07	0.52	6.95	6.95	XXX
75993	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.02	0.50	0.50	XXX
75993	TC	A	Atherectomy, x-ray exam	0.00	5.95	5.95	0.50	6.45	6.45	XXX
75994		A	Atherectomy, x-ray exam	1.31	11.60	11.60	1.03	13.94	13.94	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75994	TC	A	Atherectomy, x-ray exam	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75995		A	Atherectomy, x-ray exam	1.31	11.60	11.60	1.03	13.94	13.94	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.43	0.43	0.09	1.83	1.83	XXX
75995	TC	A	Atherectomy, x-ray exam	0.00	11.16	11.16	0.94	12.10	12.10	XXX
75996		A	Atherectomy, x-ray exam	0.36	6.07	6.07	0.52	6.95	6.95	XXX
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.02	0.50	0.50	XXX
75996	TC	A	Atherectomy, x-ray exam	0.00	5.95	5.95	0.50	6.45	6.45	XXX
76000		A	Fluoroscope examination	0.17	0.98	0.98	0.09	1.24	1.24	XXX
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76001		A	Fluoroscope exam, extensive	0.67	2.09	2.09	0.22	2.98	2.98	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	1.86	1.86	0.17	2.03	2.03	XXX
76003		A	Needle localization by x-ray	0.54	1.11	1.11	0.12	1.77	1.77	XXX
76003	26	A	Needle localization by x-ray	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76003	TC	A	Needle localization by x-ray	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76010		A	X-ray, nose to rectum	0.18	0.43	0.43	0.04	0.65	0.65	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.37	0.37	0.03	0.40	0.40	XXX
76020		A	X-rays for bone age	0.19	0.44	0.44	0.04	0.67	0.67	XXX
76020	26	A	X-rays for bone age	0.19	0.07	0.07	0.01	0.27	0.27	XXX
76020	TC	A	X-rays for bone age	0.00	0.37	0.37	0.03	0.40	0.40	XXX
76040		A	X-rays, bone evaluation	0.27	0.65	0.65	0.07	0.99	0.99	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.10	0.10	0.02	0.39	0.39	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.56	0.56	0.05	0.61	0.61	XXX
76061		A	X-rays, bone survey	0.45	0.86	0.86	0.09	1.40	1.40	XXX
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.03	0.63	0.63	XXX
76061	TC	A	X-rays, bone survey	0.00	0.71	0.71	0.06	0.77	0.77	XXX
76062		A	X-rays, bone survey	0.54	1.21	1.21	0.13	1.88	1.88	XXX
76062	26	A	X-rays, bone survey	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76062	TC	A	X-rays, bone survey	0.00	1.02	1.02	0.09	1.11	1.11	XXX
76065		A	X-rays, bone evaluation	0.28	0.62	0.62	0.07	0.97	0.97	XXX
76065	26	A	X-rays, bone evaluation	0.28	0.10	0.10	0.02	0.40	0.40	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.52	0.52	0.05	0.57	0.57	XXX
76066		A	Joint(s) survey, single film	0.31	0.89	0.89	0.09	1.29	1.29	XXX
76066	26	A	Joint(s) survey, single film	0.31	0.10	0.10	0.02	0.43	0.43	XXX
76066	TC	A	Joint(s) survey, single film	0.00	0.79	0.79	0.07	0.86	0.86	XXX
76070		A	CT scan, bone density study	0.25	2.18	2.18	0.20	2.63	2.63	XXX
76070	26	A	CT scan, bone density study	0.25	0.09	0.09	0.02	0.36	0.36	XXX
76070	TC	A	CT scan, bone density study	0.00	2.09	2.09	0.18	2.27	2.27	XXX
76075		A	Dual energy x-ray study	0.30	2.28	2.28	0.21	2.79	2.79	XXX
76075	26	A	Dual energy x-ray study	0.30	0.09	0.09	0.02	0.41	0.41	XXX
76075	TC	A	Dual energy x-ray study	0.00	2.20	2.20	0.19	2.39	2.39	XXX
76076		A	Dual energy x-ray study	0.22	0.61	0.61	0.07	0.90	0.90	XXX
76076	26	A	Dual energy x-ray study	0.22	0.07	0.07	0.02	0.31	0.31	XXX
76076	TC	A	Dual energy x-ray study	0.00	0.54	0.54	0.05	0.59	0.59	XXX
76078		A	Photodensitometry	0.20	0.61	0.61	0.07	0.88	0.88	XXX
76078	26	A	Photodensitometry	0.20	0.07	0.07	0.02	0.29	0.29	XXX
76078	TC	A	Photodensitometry	0.00	0.54	0.54	0.05	0.59	0.59	XXX
76080		A	X-ray exam of fistula	0.54	0.93	0.93	0.11	1.58	1.58	XXX
76080	26	A	X-ray exam of fistula	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76086		A	X-ray of mammary duct	0.36	1.99	1.99	0.19	2.54	2.54	XXX
76086	26	A	X-ray of mammary duct	0.36	0.13	0.13	0.02	0.51	0.51	XXX
76086	TC	A	X-ray of mammary duct	0.00	1.86	1.86	0.17	2.03	2.03	XXX
76088		A	X-ray of mammary ducts	0.45	2.75	2.75	0.25	3.45	3.45	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.03	0.63	0.63	XXX
76088	TC	A	X-ray of mammary ducts	0.00	2.60	2.60	0.22	2.82	2.82	XXX
76090		A	Mammogram, one breast	0.58	0.83	0.83	0.09	1.50	1.50	XXX
76090	26	A	Mammogram, one breast	0.58	0.09	0.09	0.02	0.69	0.69	XXX
76090	TC	A	Mammogram, one breast	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76091		A	Mammogram, both breasts	0.69	1.06	1.06	0.11	1.86	1.86	XXX
76091	26	A	Mammogram, both breasts	0.69	0.13	0.13	0.03	0.85	0.85	XXX
76091	TC	A	Mammogram, both breasts	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76093		A	Magnetic image, breast	1.63	13.04	13.04	1.16	15.83	15.83	XXX
76093	26	A	Magnetic image, breast	1.63	0.54	0.54	0.11	2.28	2.28	XXX
76093	TC	A	Magnetic image, breast	0.00	12.50	12.50	1.05	13.55	13.55	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
76094	.....	A	Magnetic image, both breasts	1.63	17.50	17.50	1.53	20.66	20.66	XXX
76094	26	A	Magnetic image, both breasts	1.63	0.54	0.54	0.11	2.28	2.28	XXX
76094	TC	A	Magnetic image, both breasts	0.00	16.96	16.96	1.42	18.38	18.38	XXX
76095	.....	A	Stereotactic breast biopsy	1.59	5.61	5.61	0.54	7.74	7.74	XXX
76095	26	A	Stereotactic breast biopsy	1.59	0.53	0.53	0.11	2.23	2.23	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	5.08	5.08	0.43	5.51	5.51	XXX
76096	.....	A	X-ray of needle wire, breast	0.56	1.12	1.12	0.12	1.80	1.80	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.19	0.19	0.04	0.79	0.79	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76098	.....	A	X-ray exam, breast specimen	0.16	0.35	0.35	0.04	0.55	0.55	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.30	0.30	0.03	0.33	0.33	XXX
76100	.....	A	X-ray exam of body section	0.58	1.09	1.09	0.12	1.79	1.79	XXX
76100	26	A	X-ray exam of body section	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76100	TC	A	X-ray exam of body section	0.00	0.89	0.89	0.08	0.97	0.97	XXX
76101	.....	A	Complex body section x-ray	0.58	1.21	1.21	0.13	1.92	1.92	XXX
76101	26	A	Complex body section x-ray	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76101	TC	A	Complex body section x-ray	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76102	.....	A	Complex body section x-rays	0.58	1.43	1.43	0.15	2.16	2.16	XXX
76102	26	A	Complex body section x-rays	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76102	TC	A	Complex body section x-rays	0.00	1.23	1.23	0.11	1.34	1.34	XXX
76120	.....	A	Cinematic x-rays	0.38	0.87	0.87	0.10	1.35	1.35	XXX
76120	26	A	Cinematic x-rays	0.38	0.13	0.13	0.03	0.54	0.54	XXX
76120	TC	A	Cinematic x-rays	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76125	.....	A	Cinematic x-rays	0.27	0.65	0.65	0.07	0.99	0.99	XXX
76125	26	A	Cinematic x-rays	0.27	0.09	0.09	0.02	0.38	0.38	XXX
76125	TC	A	Cinematic x-rays	0.00	0.56	0.56	0.05	0.61	0.61	XXX
76150	.....	A	X-ray exam, dry process	0.00	0.30	0.30	0.03	0.33	0.33	XXX
76355	.....	A	CAT scan for localization	1.21	6.25	6.25	0.57	8.03	8.03	XXX
76355	26	A	CAT scan for localization	1.21	0.39	0.39	0.08	1.68	1.68	XXX
76355	TC	A	CAT scan for localization	0.00	5.86	5.86	0.49	6.35	6.35	XXX
76360	.....	A	CAT scan for needle biopsy	1.16	6.23	6.23	0.57	7.96	7.96	XXX
76360	26	A	CAT scan for needle biopsy	1.16	0.37	0.37	0.08	1.61	1.61	XXX
76360	TC	A	CAT scan for needle biopsy	0.00	5.86	5.86	0.49	6.35	6.35	XXX
76365	.....	A	CAT scan for cyst aspiration	1.16	6.23	6.23	0.57	7.96	7.96	XXX
76365	26	A	CAT scan for cyst aspiration	1.16	0.37	0.37	0.08	1.61	1.61	XXX
76365	TC	A	CAT scan for cyst aspiration	0.00	5.86	5.86	0.49	6.35	6.35	XXX
76370	.....	A	CAT scan for therapy guide	0.85	2.37	2.37	0.24	3.46	3.46	XXX
76370	26	A	CAT scan for therapy guide	0.85	0.28	0.28	0.06	1.19	1.19	XXX
76370	TC	A	CAT scan for therapy guide	0.00	2.09	2.09	0.18	2.27	2.27	XXX
76375	.....	A	3d/holograph reconstr add-on	0.16	2.56	2.56	0.22	2.94	2.94	XXX
76375	26	A	3d/holograph reconstr add-on	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76375	TC	A	3d/holograph reconstr add-on	0.00	2.51	2.51	0.21	2.72	2.72	XXX
76380	.....	A	CAT scan follow-up study	0.98	2.81	2.81	0.28	4.07	4.07	XXX
76380	26	A	CAT scan follow-up study	0.98	0.33	0.33	0.07	1.38	1.38	XXX
76380	TC	A	CAT scan follow-up study	0.00	2.49	2.49	0.21	2.70	2.70	XXX
76390	.....	A	Mr spectroscopy	1.40	8.44	8.44	0.77	10.61	10.61	XXX
76390	26	A	Mr spectroscopy	1.40	0.49	0.49	0.10	1.99	1.99	XXX
76390	TC	A	Mr spectroscopy	0.00	7.95	7.95	0.67	8.62	8.62	XXX
76400	.....	A	Magnetic image, bone marrow	1.60	8.48	8.48	0.78	10.86	10.86	XXX
76400	26	A	Magnetic image, bone marrow	1.60	0.54	0.54	0.11	2.25	2.25	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	7.95	7.95	0.67	8.62	8.62	XXX
76506	.....	A	Echo exam of head	0.63	1.22	1.22	0.13	1.98	1.98	XXX
76506	26	A	Echo exam of head	0.63	0.22	0.22	0.04	0.89	0.89	XXX
76506	TC	A	Echo exam of head	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76511	.....	A	Echo exam of eye	0.94	1.07	1.07	0.12	2.13	2.13	XXX
76511	26	A	Echo exam of eye	0.94	0.19	0.19	0.04	1.17	1.17	XXX
76511	TC	A	Echo exam of eye	0.00	0.89	0.89	0.08	0.97	0.97	XXX
76512	.....	A	Echo exam of eye	0.66	1.30	1.30	0.15	2.11	2.11	XXX
76512	26	A	Echo exam of eye	0.66	0.22	0.22	0.05	0.93	0.93	XXX
76512	TC	A	Echo exam of eye	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76513	.....	A	Echo exam of eye, water bath	0.66	1.30	1.30	0.15	2.11	2.11	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.22	0.22	0.05	0.93	0.93	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76516	.....	A	Echo exam of eye	0.54	1.07	1.07	0.12	1.73	1.73	XXX
76516	26	A	Echo exam of eye	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76516	TC	A	Echo exam of eye	0.00	0.89	0.89	0.08	0.97	0.97	XXX
76519	.....	A	Echo exam of eye	0.54	1.07	1.07	0.12	1.73	1.73	XXX
76519	26	A	Echo exam of eye	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76519	TC	A	Echo exam of eye	0.00	0.89	0.89	0.08	0.97	0.97	XXX
76529	.....	A	Echo exam of eye	0.57	1.16	1.16	0.13	1.86	1.86	XXX
76529	26	A	Echo exam of eye	0.57	0.19	0.19	0.04	0.80	0.80	XXX
76529	TC	A	Echo exam of eye	0.00	0.97	0.97	0.09	1.06	1.06	XXX
76536	.....	A	Echo exam of head and neck	0.56	1.20	1.20	0.13	1.89	1.89	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
76536	26	A	Echo exam of head and neck	0.56	0.19	0.19	0.04	0.79	0.79	XXX
76536	TC	A	Echo exam of head and neck	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76604		A	Echo exam of chest	0.55	1.12	1.12	0.12	1.79	1.79	XXX
76604	26	A	Echo exam of chest	0.55	0.19	0.19	0.04	0.78	0.78	XXX
76604	TC	A	Echo exam of chest	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76645		A	Echo exam of breast	0.54	0.93	0.93	0.11	1.58	1.58	XXX
76645	26	A	Echo exam of breast	0.54	0.19	0.19	0.04	0.77	0.77	XXX
76645	TC	A	Echo exam of breast	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76700		A	Echo exam of abdomen	0.81	1.67	1.67	0.17	2.65	2.65	XXX
76700	26	A	Echo exam of abdomen	0.81	0.28	0.28	0.05	1.14	1.14	XXX
76700	TC	A	Echo exam of abdomen	0.00	1.40	1.40	0.12	1.52	1.52	XXX
76705		A	Echo exam of abdomen	0.59	1.21	1.21	0.13	1.93	1.93	XXX
76705	26	A	Echo exam of abdomen	0.59	0.20	0.20	0.04	0.83	0.83	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76770		A	Echo exam abdomen back wall	0.74	1.65	1.65	0.17	2.56	2.56	XXX
76770	26	A	Echo exam abdomen back wall	0.74	0.25	0.25	0.05	1.04	1.04	XXX
76770	TC	A	Echo exam abdomen back wall	0.00	1.40	1.40	0.12	1.52	1.52	XXX
76775		A	Echo exam abdomen back wall	0.58	1.21	1.21	0.13	1.92	1.92	XXX
76775	26	A	Echo exam abdomen back wall	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76775	TC	A	Echo exam abdomen back wall	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76778		A	Echo exam kidney transplant	0.74	1.65	1.65	0.17	2.56	2.56	XXX
76778	26	A	Echo exam kidney transplant	0.74	0.25	0.25	0.05	1.04	1.04	XXX
76778	TC	A	Echo exam kidney transplant	0.00	1.40	1.40	0.12	1.52	1.52	XXX
76800		A	Echo exam spinal canal	1.13	1.38	1.38	0.17	2.68	2.68	XXX
76800	26	A	Echo exam spinal canal	1.13	0.37	0.37	0.08	1.58	1.58	XXX
76800	TC	A	Echo exam spinal canal	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76805		A	Echo exam of pregnant uterus	0.99	1.82	1.82	0.20	3.01	3.01	XXX
76805	26	A	Echo exam of pregnant uterus	0.99	0.33	0.33	0.07	1.39	1.39	XXX
76805	TC	A	Echo exam of pregnant uterus	0.00	1.49	1.49	0.13	1.62	1.62	XXX
76810		A	Echo exam of pregnant uterus	1.97	3.63	3.63	0.38	5.98	5.98	XXX
76810	26	A	Echo exam of pregnant uterus	1.97	0.65	0.65	0.13	2.75	2.75	XXX
76810	TC	A	Echo exam of pregnant uterus	0.00	2.98	2.98	0.25	3.23	3.23	XXX
76815		A	Echo exam of pregnant uterus	0.65	1.23	1.23	0.13	2.01	2.01	XXX
76815	26	A	Echo exam of pregnant uterus	0.65	0.22	0.22	0.04	0.91	0.91	XXX
76815	TC	A	Echo exam of pregnant uterus	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76816		A	Echo exam followup or repeat	0.57	0.98	0.98	0.11	1.66	1.66	XXX
76816	26	A	Echo exam followup or repeat	0.57	0.19	0.19	0.04	0.80	0.80	XXX
76816	TC	A	Echo exam followup or repeat	0.00	0.79	0.79	0.07	0.86	0.86	XXX
76818		A	Fetal biophysical profile	0.77	1.41	1.41	0.15	2.33	2.33	XXX
76818	26	A	Fetal biophysical profile	0.77	0.26	0.26	0.05	1.08	1.08	XXX
76818	TC	A	Fetal biophysical profile	0.00	1.15	1.15	0.10	1.25	1.25	XXX
76825		A	Echo exam of fetal heart	1.67	1.66	1.66	0.17	3.50	3.50	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.26	0.26	0.05	1.98	1.98	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.40	1.40	0.12	1.52	1.52	XXX
76826		A	Echo exam of fetal heart	0.83	1.00	1.00	0.10	1.93	1.93	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.51	0.51	0.05	1.39	1.39	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.50	0.50	0.05	0.55	0.55	XXX
76827		A	Echo exam of fetal heart	0.58	1.70	1.70	0.18	2.46	2.46	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.48	0.48	0.05	1.11	1.11	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.22	1.22	0.13	1.35	1.35	XXX
76828		A	Echo exam of fetal heart	0.56	1.00	1.00	0.11	1.67	1.67	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.21	0.02	0.79	0.79	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.79	0.79	0.09	0.88	0.88	XXX
76830		A	Echo exam, transvaginal	0.69	1.32	1.32	0.15	2.16	2.16	XXX
76830	26	A	Echo exam, transvaginal	0.69	0.24	0.24	0.05	0.98	0.98	XXX
76830	TC	A	Echo exam, transvaginal	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76831		A	Echo exam, uterus	0.72	1.32	1.32	0.15	2.19	2.19	XXX
76831	26	A	Echo exam, uterus	0.72	0.24	0.24	0.05	1.01	1.01	XXX
76831	TC	A	Echo exam, uterus	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76856		A	Echo exam of pelvis	0.69	1.32	1.32	0.15	2.16	2.16	XXX
76856	26	A	Echo exam of pelvis	0.69	0.24	0.24	0.05	0.98	0.98	XXX
76856	TC	A	Echo exam of pelvis	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76857		A	Echo exam of pelvis	0.38	0.87	0.87	0.10	1.35	1.35	XXX
76857	26	A	Echo exam of pelvis	0.38	0.13	0.13	0.03	0.54	0.54	XXX
76857	TC	A	Echo exam of pelvis	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76870		A	Echo exam of scrotum	0.64	1.30	1.30	0.14	2.08	2.08	XXX
76870	26	A	Echo exam of scrotum	0.64	0.22	0.22	0.04	0.90	0.90	XXX
76870	TC	A	Echo exam of scrotum	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76872		A	Echo exam, transrectal	0.69	1.32	1.32	0.15	2.16	2.16	XXX
76872	26	A	Echo exam, transrectal	0.69	0.24	0.24	0.05	0.98	0.98	XXX
76872	TC	A	Echo exam, transrectal	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76880		A	Echo exam of extremity	0.59	1.21	1.21	0.13	1.93	1.93	XXX
76880	26	A	Echo exam of extremity	0.59	0.20	0.20	0.04	0.83	0.83	XXX
76880	TC	A	Echo exam of extremity	0.00	1.00	1.00	0.09	1.09	1.09	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
76885	.....	A	Echo exam, infant hips	0.74	1.32	1.32	0.15	2.21	2.21	XXX
76885	26	A	Echo exam, infant hips	0.74	0.24	0.24	0.05	1.03	1.03	XXX
76885	TC	A	Echo exam, infant hips	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76886	.....	A	Echo exam, infant hips	0.62	1.21	1.21	0.13	1.96	1.96	XXX
76886	26	A	Echo exam, infant hips	0.62	0.20	0.20	0.04	0.86	0.86	XXX
76886	TC	A	Echo exam, infant hips	0.00	1.00	1.00	0.09	1.09	1.09	XXX
76930	.....	A	Echo guide for heart sac tap	0.67	1.31	1.31	0.15	2.13	2.13	XXX
76930	26	A	Echo guide for heart sac tap	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76930	TC	A	Echo guide for heart sac tap	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76932	.....	A	Echo guide for heart biopsy	0.67	1.31	1.31	0.15	2.13	2.13	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76934	.....	A	Echo guide for chest tap	0.67	1.31	1.31	0.15	2.13	2.13	XXX
76934	26	A	Echo guide for chest tap	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76934	TC	A	Echo guide for chest tap	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76936	.....	A	Echo guide for artery repair	1.99	5.39	5.39	0.48	7.86	7.86	XXX
76936	26	A	Echo guide for artery repair	1.99	0.92	0.92	0.10	3.01	3.01	XXX
76936	TC	A	Echo guide for artery repair	0.00	4.47	4.47	0.38	4.85	4.85	XXX
76938	.....	A	Echo exam for drainage	0.67	1.31	1.31	0.15	2.13	2.13	XXX
76938	26	A	Echo exam for drainage	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76938	TC	A	Echo exam for drainage	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76941	.....	A	Echo guide for transfusion	1.34	1.54	1.54	0.19	3.07	3.07	XXX
76941	26	A	Echo guide for transfusion	1.34	0.45	0.45	0.10	1.89	1.89	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.09	1.09	0.09	1.18	1.18	XXX
76942	.....	A	Echo guide for biopsy	0.67	1.31	1.31	0.15	2.13	2.13	XXX
76942	26	A	Echo guide for biopsy	0.67	0.23	0.23	0.05	0.95	0.95	XXX
76942	TC	A	Echo guide for biopsy	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76945	.....	A	Echo guide, villus sampling	0.67	1.54	1.54	0.19	2.40	2.40	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.45	0.45	0.10	1.22	1.22	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.09	1.09	0.09	1.18	1.18	XXX
76946	.....	A	Echo guide for amniocentesis	0.38	1.21	1.21	0.13	1.72	1.72	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.13	0.13	0.03	0.54	0.54	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76948	.....	A	Echo guide, ova aspiration	0.38	1.21	1.21	0.13	1.72	1.72	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.03	0.54	0.54	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76950	.....	A	Echo guidance radiotherapy	0.58	1.12	1.12	0.12	1.82	1.82	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76960	.....	A	Echo guidance radiotherapy	0.58	1.12	1.12	0.12	1.82	1.82	XXX
76960	26	A	Echo guidance radiotherapy	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76960	TC	A	Echo guidance radiotherapy	0.00	0.92	0.92	0.08	1.00	1.00	XXX
76965	.....	A	Echo guidance radiotherapy	1.34	5.05	5.05	0.52	6.91	6.91	XXX
76965	26	A	Echo guidance radiotherapy	1.34	1.09	1.09	0.19	2.62	2.62	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	3.95	3.95	0.33	4.28	4.28	XXX
76970	.....	A	Ultrasound exam follow-up	0.40	0.88	0.88	0.10	1.38	1.38	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.03	0.56	0.56	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	0.74	0.74	0.07	0.81	0.81	XXX
76975	.....	A	GI endoscopic ultrasound	0.81	1.33	1.33	0.15	2.29	2.29	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.25	0.25	0.05	1.11	1.11	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.08	1.08	0.10	1.18	1.18	XXX
76986	.....	A	Echo exam at surgery	1.20	2.26	2.26	0.25	3.71	3.71	XXX
76986	26	A	Echo exam at surgery	1.20	0.39	0.39	0.08	1.67	1.67	XXX
76986	TC	A	Echo exam at surgery	0.00	1.86	1.86	0.17	2.03	2.03	XXX
77261	.....	A	Radiation therapy planning	1.39	0.46	0.46	0.09	1.94	1.94	XXX
77262	.....	A	Radiation therapy planning	2.11	0.70	0.70	0.14	2.95	2.95	XXX
77263	.....	A	Radiation therapy planning	3.14	1.04	1.04	0.20	4.38	4.38	XXX
77280	.....	A	Set radiation therapy field	0.70	2.70	2.70	0.26	3.66	3.66	XXX
77280	26	A	Set radiation therapy field	0.70	0.24	0.24	0.05	0.99	0.99	XXX
77280	TC	A	Set radiation therapy field	0.00	2.46	2.46	0.21	2.67	2.67	XXX
77285	.....	A	Set radiation therapy field	1.05	4.29	4.29	0.41	5.75	5.75	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.07	1.46	1.46	XXX
77285	TC	A	Set radiation therapy field	0.00	3.95	3.95	0.34	4.29	4.29	XXX
77290	.....	A	Set radiation therapy field	1.56	5.14	5.14	0.50	7.20	7.20	XXX
77290	26	A	Set radiation therapy field	1.56	0.52	0.52	0.11	2.19	2.19	XXX
77290	TC	A	Set radiation therapy field	0.00	4.61	4.61	0.39	5.00	5.00	XXX
77295	.....	A	Set radiation therapy field	4.57	21.35	21.35	1.93	27.85	27.85	XXX
77295	26	A	Set radiation therapy field	4.57	1.53	1.53	0.23	6.33	6.33	XXX
77295	TC	A	Set radiation therapy field	0.00	19.81	19.81	1.70	21.51	21.51	XXX
77300	.....	A	Radiation therapy dose plan	0.62	1.16	1.16	0.12	1.90	1.90	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.21	0.21	0.04	0.87	0.87	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.95	0.95	0.08	1.03	1.03	XXX
77305	.....	A	Radiation therapy dose plan	0.70	1.56	1.56	0.17	2.43	2.43	XXX
77305	26	A	Radiation therapy dose plan	0.70	0.24	0.24	0.05	0.99	0.99	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
77305	TC	A	Radiation therapy dose plan	0.00	1.32	1.32	0.12	1.44	1.44	XXX
77310		A	Radiation therapy dose plan	1.05	1.99	1.99	0.22	3.26	3.26	XXX
77310	26	A	Radiation therapy dose plan	1.05	0.34	0.34	0.07	1.46	1.46	XXX
77310	TC	A	Radiation therapy dose plan	0.00	1.65	1.65	0.15	1.80	1.80	XXX
77315		A	Radiation therapy dose plan	1.56	2.40	2.40	0.28	4.24	4.24	XXX
77315	26	A	Radiation therapy dose plan	1.56	0.52	0.52	0.11	2.19	2.19	XXX
77315	TC	A	Radiation therapy dose plan	0.00	1.88	1.88	0.17	2.05	2.05	XXX
77321		A	Radiation therapy port plan	0.95	3.19	3.19	0.30	4.44	4.44	XXX
77321	26	A	Radiation therapy port plan	0.95	0.32	0.32	0.06	1.33	1.33	XXX
77321	TC	A	Radiation therapy port plan	0.00	2.87	2.87	0.24	3.11	3.11	XXX
77326		A	Radiation therapy dose plan	0.93	1.99	1.99	0.21	3.13	3.13	XXX
77326	26	A	Radiation therapy dose plan	0.93	0.31	0.31	0.06	1.30	1.30	XXX
77326	TC	A	Radiation therapy dose plan	0.00	1.67	1.67	0.15	1.82	1.82	XXX
77327		A	Radiation therapy dose plan	1.39	2.93	2.93	0.30	4.62	4.62	XXX
77327	26	A	Radiation therapy dose plan	1.39	0.46	0.46	0.09	1.94	1.94	XXX
77327	TC	A	Radiation therapy dose plan	0.00	2.46	2.46	0.21	2.67	2.67	XXX
77328		A	Radiation therapy dose plan	2.09	4.21	4.21	0.44	6.74	6.74	XXX
77328	26	A	Radiation therapy dose plan	2.09	0.69	0.69	0.14	2.92	2.92	XXX
77328	TC	A	Radiation therapy dose plan	0.00	3.52	3.52	0.30	3.82	3.82	XXX
77331		A	Special radiation dosimetry	0.87	0.65	0.65	0.09	1.61	1.61	XXX
77331	26	A	Special radiation dosimetry	0.87	0.29	0.29	0.06	1.22	1.22	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.36	0.36	0.03	0.39	0.39	XXX
77332		A	Radiation treatment aid(s)	0.54	1.14	1.14	0.12	1.80	1.80	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.19	0.19	0.04	0.77	0.77	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	0.95	0.95	0.08	1.03	1.03	XXX
77333		A	Radiation treatment aid(s)	0.84	1.63	1.63	0.18	2.65	2.65	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.28	0.28	0.06	1.18	1.18	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.35	1.35	0.12	1.47	1.47	XXX
77334		A	Radiation treatment aid(s)	1.24	2.71	2.71	0.27	4.22	4.22	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.08	1.72	1.72	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.31	2.31	0.19	2.50	2.50	XXX
77336		A	Radiation physics consu	0.00	2.11	2.11	0.18	2.29	2.29	XXX
77370		A	Radiation physics consult	0.00	2.48	2.48	0.21	2.69	2.69	XXX
77401		A	Radiation treatment delivery	0.00	1.26	1.26	0.11	1.37	1.37	XXX
77402		A	Radiation treatment delivery	0.00	1.26	1.26	0.11	1.37	1.37	XXX
77403		A	Radiation treatment delivery	0.00	1.26	1.26	0.11	1.37	1.37	XXX
77404		A	Radiation treatment delivery	0.00	1.26	1.26	0.11	1.37	1.37	XXX
77406		A	Radiation treatment delivery	0.00	1.26	1.26	0.11	1.37	1.37	XXX
77407		A	Radiation treatment delivery	0.00	1.48	1.48	0.13	1.61	1.61	XXX
77408		A	Radiation treatment delivery	0.00	1.48	1.48	0.13	1.61	1.61	XXX
77409		A	Radiation treatment delivery	0.00	1.48	1.48	0.13	1.61	1.61	XXX
77411		A	Radiation treatment delivery	0.00	1.48	1.48	0.13	1.61	1.61	XXX
77412		A	Radiation treatment delivery	0.00	1.65	1.65	0.15	1.80	1.80	XXX
77413		A	Radiation treatment delivery	0.00	1.65	1.65	0.15	1.80	1.80	XXX
77414		A	Radiation treatment delivery	0.00	1.65	1.65	0.15	1.80	1.80	XXX
77416		A	Radiation treatment delivery	0.00	1.65	1.65	0.15	1.80	1.80	XXX
77417		A	Radiology port film(s)	0.00	0.42	0.42	0.04	0.46	0.46	XXX
77419		A	Weekly radiation therapy	3.60	1.20	1.20	0.23	5.03	5.03	XXX
77420		A	Weekly radiation therapy	1.61	0.54	0.54	0.11	2.26	2.26	XXX
77425		A	Weekly radiation therapy	2.44	0.82	0.82	0.17	3.43	3.43	XXX
77430		A	Weekly radiation therapy	3.60	1.20	1.20	0.23	5.03	5.03	XXX
77431		A	Radiation therapy management	1.81	0.60	0.60	0.12	2.53	2.53	XXX
77432		A	Stereotactic radiation trmt	7.93	3.68	3.68	0.40	12.01	12.01	XXX
77470		A	Special radiation treatment	2.09	8.60	8.60	0.80	11.49	11.49	XXX
77470	26	A	Special radiation treatment	2.09	0.69	0.69	0.14	2.92	2.92	XXX
77470	TC	A	Special radiation treatment	0.00	7.90	7.90	0.66	8.56	8.56	XXX
77600		R	Hyperthermia treatment	1.56	2.68	2.68	0.29	4.53	4.53	ZZZ
77600	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.11	2.19	2.19	ZZZ
77600	TC	R	Hyperthermia treatment	0.00	2.16	2.16	0.18	2.34	2.34	ZZZ
77605		R	Hyperthermia treatment	2.09	3.57	3.57	0.39	6.05	6.05	ZZZ
77605	26	R	Hyperthermia treatment	2.09	0.69	0.69	0.14	2.92	2.92	ZZZ
77605	TC	R	Hyperthermia treatment	0.00	2.88	2.88	0.25	3.13	3.13	ZZZ
77610		R	Hyperthermia treatment	1.56	2.68	2.68	0.29	4.53	4.53	ZZZ
77610	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.11	2.19	2.19	ZZZ
77610	TC	R	Hyperthermia treatment	0.00	2.16	2.16	0.18	2.34	2.34	ZZZ
77615		R	Hyperthermia treatment	2.09	3.57	3.57	0.39	6.05	6.05	ZZZ
77615	26	R	Hyperthermia treatment	2.09	0.69	0.69	0.14	2.92	2.92	ZZZ
77615	TC	R	Hyperthermia treatment	0.00	2.88	2.88	0.25	3.13	3.13	ZZZ
77620		R	Hyperthermia treatment	1.56	2.68	2.68	0.29	4.53	4.53	ZZZ
77620	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.11	2.19	2.19	ZZZ
77620	TC	R	Hyperthermia treatment	0.00	2.16	2.16	0.18	2.34	2.34	ZZZ
77750		A	Infuse radioactive materials	4.91	2.47	2.47	0.38	7.76	7.76	090
77750	26	A	Infuse radioactive materials	4.91	1.53	1.53	0.30	6.74	6.74	090
77750	TC	A	Infuse radioactive materials	0.00	0.95	0.95	0.08	1.03	1.03	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
77761	.....	A	Radioelement application	3.81	2.96	2.96	0.39	7.16	7.16	090
77761	26	A	Radioelement application	3.81	1.18	1.18	0.23	5.22	5.22	090
77761	TC	A	Radioelement application	0.00	1.78	1.78	0.16	1.94	1.94	090
77762	.....	A	Radioelement application	5.72	4.34	4.34	0.57	10.63	10.63	090
77762	26	A	Radioelement application	5.72	1.78	1.78	0.35	7.85	7.85	090
77762	TC	A	Radioelement application	0.00	2.56	2.56	0.22	2.78	2.78	090
77763	.....	A	Radioelement application	8.57	5.85	5.85	0.77	15.19	15.19	090
77763	26	A	Radioelement application	8.57	2.66	2.66	0.50	11.73	11.73	090
77763	TC	A	Radioelement application	0.00	3.19	3.19	0.27	3.46	3.46	090
77776	.....	A	Radioelement application	4.66	3.10	3.10	0.45	8.21	8.21	XXX
77776	26	A	Radioelement application	4.66	1.56	1.56	0.31	6.53	6.53	XXX
77776	TC	A	Radioelement application	0.00	1.54	1.54	0.14	1.68	1.68	XXX
77777	.....	A	Radioelement application	7.48	5.34	5.34	0.71	13.53	13.53	090
77777	26	A	Radioelement application	7.48	2.33	2.33	0.45	10.26	10.26	090
77777	TC	A	Radioelement application	0.00	3.01	3.01	0.26	3.27	3.27	090
77778	.....	A	Radioelement application	11.19	7.13	7.13	0.98	19.30	19.30	090
77778	26	A	Radioelement application	11.19	3.49	3.49	0.67	15.35	15.35	090
77778	TC	A	Radioelement application	0.00	3.64	3.64	0.31	3.95	3.95	090
77781	.....	A	High intensity brachytherapy	1.66	14.92	14.92	1.32	17.90	17.90	090
77781	26	A	High intensity brachytherapy	1.66	0.51	0.51	0.11	2.28	2.28	090
77781	TC	A	High intensity brachytherapy	0.00	14.40	14.40	1.21	15.61	15.61	090
77782	.....	A	High intensity brachytherapy	2.49	15.18	15.18	1.37	19.04	19.04	090
77782	26	A	High intensity brachytherapy	2.49	0.78	0.78	0.16	3.43	3.43	090
77782	TC	A	High intensity brachytherapy	0.00	14.40	14.40	1.21	15.61	15.61	090
77783	.....	A	High intensity brachytherapy	3.73	15.56	15.56	1.44	20.73	20.73	090
77783	26	A	High intensity brachytherapy	3.73	1.15	1.15	0.23	5.11	5.11	090
77783	TC	A	High intensity brachytherapy	0.00	14.40	14.40	1.21	15.61	15.61	090
77784	.....	A	High intensity brachytherapy	5.61	16.14	16.14	1.56	23.31	23.31	090
77784	26	A	High intensity brachytherapy	5.61	1.74	1.74	0.35	7.70	7.70	090
77784	TC	A	High intensity brachytherapy	0.00	14.40	14.40	1.21	15.61	15.61	090
77789	.....	A	Radioelement application	1.12	0.66	0.66	0.10	1.88	1.88	090
77789	26	A	Radioelement application	1.12	0.34	0.34	0.07	1.53	1.53	090
77789	TC	A	Radioelement application	0.00	0.32	0.32	0.03	0.35	0.35	090
77790	.....	A	Radioelement handling	1.05	0.70	0.70	0.10	1.85	1.85	XXX
77790	26	A	Radioelement handling	1.05	0.34	0.34	0.07	1.46	1.46	XXX
77790	TC	A	Radioelement handling	0.00	0.36	0.36	0.03	0.39	0.39	XXX
78000	.....	A	Thyroid, single uptake	0.19	0.75	0.75	0.07	1.01	1.01	XXX
78000	26	A	Thyroid, single uptake	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.68	0.68	0.06	0.74	0.74	XXX
78001	.....	A	Thyroid, multiple uptakes	0.26	1.01	1.01	0.10	1.37	1.37	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.02	0.37	0.37	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	0.92	0.92	0.08	1.00	1.00	XXX
78003	.....	A	Thyroid suppress/stimul	0.33	0.80	0.80	0.08	1.21	1.21	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.02	0.46	0.46	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.68	0.68	0.06	0.74	0.74	XXX
78006	.....	A	Thyroid,imaging with uptake	0.49	1.85	1.85	0.18	2.52	2.52	XXX
78006	26	A	Thyroid,imaging with uptake	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78006	TC	A	Thyroid,imaging with uptake	0.00	1.69	1.69	0.15	1.84	1.84	XXX
78007	.....	A	Thyroid, image, mult uptakes	0.50	1.99	1.99	0.19	2.68	2.68	XXX
78007	26	A	Thyroid, image, mult uptakes	0.50	0.17	0.17	0.03	0.70	0.70	XXX
78007	TC	A	Thyroid, image, mult uptakes	0.00	1.82	1.82	0.16	1.98	1.98	XXX
78010	.....	A	Thyroid imaging	0.39	1.41	1.41	0.14	1.94	1.94	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.03	0.55	0.55	XXX
78010	TC	A	Thyroid imaging	0.00	1.29	1.29	0.11	1.40	1.40	XXX
78011	.....	A	Thyroid imaging with flow	0.45	1.86	1.86	0.18	2.49	2.49	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.16	0.16	0.03	0.64	0.64	XXX
78011	TC	A	Thyroid imaging with flow	0.00	1.70	1.70	0.15	1.85	1.85	XXX
78015	.....	A	Thyroid met imaging	0.67	2.05	2.05	0.21	2.93	2.93	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.05	0.95	0.95	XXX
78015	TC	A	Thyroid met imaging	0.00	1.82	1.82	0.16	1.98	1.98	XXX
78016	.....	A	Thyroid met imaging/studies	0.82	2.75	2.75	0.27	3.84	3.84	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.28	0.28	0.06	1.16	1.16	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	2.47	2.47	0.21	2.68	2.68	XXX
78017	.....	A	Thyroid met imaging, mult	0.87	2.93	2.93	0.28	4.08	4.08	XXX
78017	26	A	Thyroid met imaging, mult	0.87	0.29	0.29	0.06	1.22	1.22	XXX
78017	TC	A	Thyroid met imaging, mult	0.00	2.64	2.64	0.22	2.86	2.86	XXX
78018	.....	A	Thyroid, met imaging, body	0.95	4.17	4.17	0.39	5.51	5.51	XXX
78018	26	A	Thyroid, met imaging, body	0.95	0.32	0.32	0.06	1.33	1.33	XXX
78018	TC	A	Thyroid, met imaging, body	0.00	3.85	3.85	0.33	4.18	4.18	XXX
78070	.....	A	Parathyroid nuclear imaging	0.82	1.46	1.46	0.15	2.43	2.43	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.17	0.17	0.04	1.03	1.03	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	1.29	1.29	0.11	1.40	1.40	XXX
78075	.....	A	Adrenal nuclear imaging	0.74	4.10	4.10	0.38	5.22	5.22	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.25	0.25	0.05	1.04	1.04	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
78075	TC	A	Adrenal nuclear imaging	0.00	3.85	3.85	0.33	4.18	4.18	XXX
78102		A	Bone marrow imaging, ltd	0.55	1.63	1.63	0.17	2.35	2.35	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.04	0.78	0.78	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	1.44	1.44	0.13	1.57	1.57	XXX
78103		A	Bone marrow imaging, mult	0.75	2.50	2.50	0.24	3.49	3.49	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.25	0.25	0.05	1.05	1.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	2.25	2.25	0.19	2.44	2.44	XXX
78104		A	Bone marrow imaging, body	0.80	3.16	3.16	0.30	4.26	4.26	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.28	0.28	0.05	1.13	1.13	XXX
78104	TC	A	Bone marrow imaging, body	0.00	2.89	2.89	0.25	3.14	3.14	XXX
78110		A	Plasma volume, single	0.19	0.74	0.74	0.07	1.00	1.00	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.67	0.67	0.06	0.73	0.73	XXX
78111		A	Plasma volume, multiple	0.22	1.90	1.90	0.18	2.30	2.30	XXX
78111	26	A	Plasma volume, multiple	0.22	0.07	0.07	0.02	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.82	1.82	0.16	1.98	1.98	XXX
78120		A	Red cell mass, single	0.23	1.31	1.31	0.13	1.67	1.67	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.02	0.33	0.33	XXX
78120	TC	A	Red cell mass, single	0.00	1.23	1.23	0.11	1.34	1.34	XXX
78121		A	Red cell mass, multiple	0.32	2.17	2.17	0.19	2.68	2.68	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.02	0.45	0.45	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.06	2.06	0.17	2.23	2.23	XXX
78122		A	Blood volume	0.45	3.42	3.42	0.31	4.18	4.18	XXX
78122	26	A	Blood volume	0.45	0.15	0.15	0.03	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	3.27	3.27	0.28	3.55	3.55	XXX
78130		A	Red cell survival study	0.61	2.23	2.23	0.21	3.05	3.05	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78130	TC	A	Red cell survival study	0.00	2.02	2.02	0.17	2.19	2.19	XXX
78135		A	Red cell survival kinetics	0.64	3.67	3.67	0.34	4.65	4.65	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.04	0.90	0.90	XXX
78135	TC	A	Red cell survival kinetics	0.00	3.45	3.45	0.30	3.75	3.75	XXX
78140		A	Red cell sequestration	0.61	3.00	3.00	0.28	3.89	3.89	XXX
78140	26	A	Red cell sequestration	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78140	TC	A	Red cell sequestration	0.00	2.79	2.79	0.24	3.03	3.03	XXX
78160		A	Plasma iron turnover	0.33	2.71	2.71	0.24	3.28	3.28	XXX
78160	26	A	Plasma iron turnover	0.33	0.11	0.11	0.02	0.46	0.46	XXX
78160	TC	A	Plasma iron turnover	0.00	2.60	2.60	0.22	2.82	2.82	XXX
78162		A	Iron absorption exam	0.45	2.42	2.42	0.22	3.09	3.09	XXX
78162	26	A	Iron absorption exam	0.45	0.15	0.15	0.03	0.63	0.63	XXX
78162	TC	A	Iron absorption exam	0.00	2.27	2.27	0.19	2.46	2.46	XXX
78170		A	Red cell iron utilization	0.41	3.90	3.90	0.35	4.66	4.66	XXX
78170	26	A	Red cell iron utilization	0.41	0.13	0.13	0.03	0.57	0.57	XXX
78170	TC	A	Red cell iron utilization	0.00	3.77	3.77	0.32	4.09	4.09	XXX
78172	26	A	Total body iron estimation	0.53	0.19	0.19	0.04	0.76	0.76	XXX
78185		A	Spleen imaging	0.40	1.81	1.81	0.18	2.39	2.39	XXX
78185	26	A	Spleen imaging	0.40	0.13	0.13	0.03	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	1.67	1.67	0.15	1.82	1.82	XXX
78190		A	Platelet survival, kinetics	1.09	4.41	4.41	0.42	5.92	5.92	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.36	0.36	0.07	1.52	1.52	XXX
78190	TC	A	Platelet survival, kinetics	0.00	4.06	4.06	0.35	4.41	4.41	XXX
78191		A	Platelet survival	0.61	5.41	5.41	0.48	6.50	6.50	XXX
78191	26	A	Platelet survival	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78191	TC	A	Platelet survival	0.00	5.20	5.20	0.44	5.64	5.64	XXX
78195		A	Lymph system imaging	1.20	3.13	3.13	0.30	4.63	4.63	XXX
78195	26	A	Lymph system imaging	1.20	0.24	0.24	0.05	1.49	1.49	XXX
78195	TC	A	Lymph system imaging	0.00	2.89	2.89	0.25	3.14	3.14	XXX
78201		A	Liver imaging	0.44	1.82	1.82	0.18	2.44	2.44	XXX
78201	26	A	Liver imaging	0.44	0.14	0.14	0.03	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	1.67	1.67	0.15	1.82	1.82	XXX
78202		A	Liver imaging with flow	0.51	2.22	2.22	0.21	2.94	2.94	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.04	0.72	0.72	XXX
78202	TC	A	Liver imaging with flow	0.00	2.05	2.05	0.17	2.22	2.22	XXX
78205		A	Liver imaging (3D)	0.71	4.44	4.44	0.41	5.56	5.56	XXX
78205	26	A	Liver imaging (3D)	0.71	0.25	0.25	0.05	1.01	1.01	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.19	4.19	0.36	4.55	4.55	XXX
78215		A	Liver and spleen imaging	0.49	2.25	2.25	0.20	2.94	2.94	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.08	2.08	0.17	2.25	2.25	XXX
78216		A	Liver & spleen image, flow	0.57	2.66	2.66	0.25	3.48	3.48	XXX
78216	26	A	Liver & spleen image, flow	0.57	0.19	0.19	0.04	0.80	0.80	XXX
78216	TC	A	Liver & spleen image, flow	0.00	2.47	2.47	0.21	2.68	2.68	XXX
78220		A	Liver function study	0.49	2.81	2.81	0.25	3.55	3.55	XXX
78220	26	A	Liver function study	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78220	TC	A	Liver function study	0.00	2.64	2.64	0.22	2.86	2.86	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
78223	.....	A	Hepatobiliary imaging	0.84	2.88	2.88	0.28	4.00	4.00	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.06	1.18	1.18	XXX
78223	TC	A	Hepatobiliary imaging	0.00	2.60	2.60	0.22	2.82	2.82	XXX
78230	.....	A	Salivary gland imaging	0.45	1.70	1.70	0.17	2.32	2.32	XXX
78230	26	A	Salivary gland imaging	0.45	0.16	0.16	0.03	0.64	0.64	XXX
78230	TC	A	Salivary gland imaging	0.00	1.54	1.54	0.14	1.68	1.68	XXX
78231	.....	A	Serial salivary imaging	0.52	2.43	2.43	0.23	3.18	3.18	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.04	0.74	0.74	XXX
78231	TC	A	Serial salivary imaging	0.00	2.25	2.25	0.19	2.44	2.44	XXX
78232	.....	A	Salivary gland function exam	0.47	2.67	2.67	0.24	3.38	3.38	XXX
78232	26	A	Salivary gland function exam	0.47	0.16	0.16	0.03	0.66	0.66	XXX
78232	TC	A	Salivary gland function exam	0.00	2.51	2.51	0.21	2.72	2.72	XXX
78258	.....	A	Esophageal motility study	0.74	2.30	2.30	0.22	3.26	3.26	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.05	1.04	1.04	XXX
78258	TC	A	Esophageal motility study	0.00	2.05	2.05	0.17	2.22	2.22	XXX
78261	.....	A	Gastric mucosa imaging	0.69	3.15	3.15	0.30	4.14	4.14	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.05	0.98	0.98	XXX
78261	TC	A	Gastric mucosa imaging	0.00	2.91	2.91	0.25	3.16	3.16	XXX
78262	.....	A	Gastroesophageal reflux exam	0.68	3.25	3.25	0.31	4.24	4.24	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.05	0.96	0.96	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	3.01	3.01	0.26	3.27	3.27	XXX
78264	.....	A	Gastric emptying study	0.78	3.19	3.19	0.30	4.27	4.27	XXX
78264	26	A	Gastric emptying study	0.78	0.27	0.27	0.05	1.10	1.10	XXX
78264	TC	A	Gastric emptying study	0.00	2.93	2.93	0.25	3.18	3.18	XXX
78270	.....	A	Vit B–12 absorption exam	0.20	1.17	1.17	0.11	1.48	1.48	XXX
78270	26	A	Vit B–12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B–12 absorption exam	0.00	1.09	1.09	0.10	1.19	1.19	XXX
78271	.....	A	Vit B–12 absorp exam, IF	0.20	1.24	1.24	0.11	1.55	1.55	XXX
78271	26	A	Vit B–12 absorp exam, IF	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit B–12 absorp exam, IF	0.00	1.17	1.17	0.10	1.27	1.27	XXX
78272	.....	A	Vit B–12 absorp, combined	0.27	1.74	1.74	0.17	2.18	2.18	XXX
78272	26	A	Vit B–12 absorp, combined	0.27	0.10	0.10	0.02	0.39	0.39	XXX
78272	TC	A	Vit B–12 absorp, combined	0.00	1.64	1.64	0.15	1.79	1.79	XXX
78278	.....	A	Acute GI blood loss imaging	0.99	3.79	3.79	0.37	5.15	5.15	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.33	0.33	0.07	1.39	1.39	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	3.45	3.45	0.30	3.75	3.75	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.03	0.54	0.54	XXX
78290	.....	A	Meckel's divert exam	0.68	2.39	2.39	0.23	3.30	3.30	XXX
78290	26	A	Meckel's divert exam	0.68	0.23	0.23	0.05	0.96	0.96	XXX
78290	TC	A	Meckel's divert exam	0.00	2.16	2.16	0.18	2.34	2.34	XXX
78291	.....	A	Leveen/shunt patency exam	0.88	2.46	2.46	0.24	3.58	3.58	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.29	0.29	0.06	1.23	1.23	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	2.17	2.17	0.18	2.35	2.35	XXX
78300	.....	A	Bone imaging, limited area	0.62	1.98	1.98	0.20	2.80	2.80	XXX
78300	26	A	Bone imaging, limited area	0.62	0.22	0.22	0.04	0.88	0.88	XXX
78300	TC	A	Bone imaging, limited area	0.00	1.76	1.76	0.16	1.92	1.92	XXX
78305	.....	A	Bone imaging, multiple areas	0.83	2.88	2.88	0.28	3.99	3.99	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.06	1.17	1.17	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	2.60	2.60	0.22	2.82	2.82	XXX
78306	.....	A	Bone imaging, whole body	0.86	3.32	3.32	0.32	4.50	4.50	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.06	1.21	1.21	XXX
78306	TC	A	Bone imaging, whole body	0.00	3.03	3.03	0.26	3.29	3.29	XXX
78315	.....	A	Bone imaging, 3 phase	1.02	3.72	3.72	0.36	5.10	5.10	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.33	0.33	0.07	1.42	1.42	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	3.39	3.39	0.29	3.68	3.68	XXX
78320	.....	A	Bone imaging (3D)	1.04	4.53	4.53	0.43	6.00	6.00	XXX
78320	26	A	Bone imaging (3D)	1.04	0.34	0.34	0.07	1.45	1.45	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.19	4.19	0.36	4.55	4.55	XXX
78350	.....	A	Bone mineral, single photon	0.22	0.61	0.61	0.07	0.90	0.90	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.02	0.31	0.31	XXX
78350	TC	A	Bone mineral, single photon	0.00	0.54	0.54	0.05	0.59	0.59	XXX
78351	.....	N	Bone mineral, dual photon	+0.30	0.14	0.14	0.02	0.46	0.46	XXX
78414	26	A	Non-imaging heart function	0.45	0.15	0.15	0.03	0.63	0.63	XXX
78428	.....	A	Cardiac shunt imaging	0.78	1.87	1.87	0.19	2.84	2.84	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.27	0.27	0.05	1.10	1.10	XXX
78428	TC	A	Cardiac shunt imaging	0.00	1.60	1.60	0.14	1.74	1.74	XXX
78445	.....	A	Vascular flow imaging	0.49	1.50	1.50	0.15	2.14	2.14	XXX
78445	26	A	Vascular flow imaging	0.49	0.18	0.18	0.04	0.71	0.71	XXX
78445	TC	A	Vascular flow imaging	0.00	1.32	1.32	0.11	1.43	1.43	XXX
78455	.....	A	Venous thrombosis study	0.73	3.07	3.07	0.29	4.09	4.09	XXX
78455	26	A	Venous thrombosis study	0.73	0.25	0.25	0.05	1.03	1.03	XXX
78455	TC	A	Venous thrombosis study	0.00	2.83	2.83	0.24	3.07	3.07	XXX
78457	.....	A	Venous thrombosis imaging	0.77	2.14	2.14	0.22	3.13	3.13	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.26	0.26	0.05	1.08	1.08	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
78457	TC	A	Venous thrombosis imaging	0.00	1.88	1.88	0.17	2.05	2.05	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.15	3.15	0.30	4.35	4.35	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.30	0.30	0.06	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	2.85	2.85	0.24	3.09	3.09	XXX
78459	26	I	Heart muscle imaging (PET)	+1.88	1.00	1.00	0.10	2.98	2.98	XXX
78460		A	Heart muscle blood single	0.86	1.96	1.96	0.21	3.03	3.03	XXX
78460	26	A	Heart muscle blood single	0.86	0.29	0.29	0.06	1.21	1.21	XXX
78460	TC	A	Heart muscle blood single	0.00	1.67	1.67	0.15	1.82	1.82	XXX
78461		A	Heart muscle blood multiple	1.23	3.75	3.75	0.37	5.35	5.35	XXX
78461	26	A	Heart muscle blood multiple	1.23	0.40	0.40	0.08	1.71	1.71	XXX
78461	TC	A	Heart muscle blood multiple	0.00	3.35	3.35	0.29	3.64	3.64	XXX
78464		A	Heart image (3D) single	1.09	5.37	5.37	0.50	6.96	6.96	XXX
78464	26	A	Heart image (3D) single	1.09	0.36	0.36	0.07	1.52	1.52	XXX
78464	TC	A	Heart image (3D) single	0.00	5.02	5.02	0.43	5.45	5.45	XXX
78465		A	Heart image (3D) multiple	1.46	8.85	8.85	0.80	11.11	11.11	XXX
78465	26	A	Heart image (3D) multiple	1.46	0.48	0.48	0.10	2.04	2.04	XXX
78465	TC	A	Heart image (3D) multiple	0.00	8.37	8.37	0.70	9.07	9.07	XXX
78466		A	Heart infarct image	0.69	2.10	2.10	0.22	3.01	3.01	XXX
78466	26	A	Heart infarct image	0.69	0.24	0.24	0.05	0.98	0.98	XXX
78466	TC	A	Heart infarct image	0.00	1.86	1.86	0.17	2.03	2.03	XXX
78468		A	Heart infarct image, EF	0.80	2.87	2.87	0.27	3.94	3.94	XXX
78468	26	A	Heart infarct image, EF	0.80	0.27	0.27	0.05	1.12	1.12	XXX
78468	TC	A	Heart infarct image, EF	0.00	2.60	2.60	0.22	2.82	2.82	XXX
78469		A	Heart infarct image (3D)	0.92	4.01	4.01	0.38	5.31	5.31	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.06	1.29	1.29	XXX
78469	TC	A	Heart infarct image (3D)	0.00	3.71	3.71	0.32	4.03	4.03	XXX
78472		A	Gated heart, resting	0.98	4.23	4.23	0.41	5.62	5.62	XXX
78472	26	A	Gated heart, resting	0.98	0.33	0.33	0.07	1.38	1.38	XXX
78472	TC	A	Gated heart, resting	0.00	3.91	3.91	0.34	4.25	4.25	XXX
78473		A	Gated heart, multiple	1.47	6.34	6.34	0.59	8.40	8.40	XXX
78473	26	A	Gated heart, multiple	1.47	0.48	0.48	0.10	2.05	2.05	XXX
78473	TC	A	Gated heart, multiple	0.00	5.86	5.86	0.49	6.35	6.35	XXX
78478		A	Heart wall motion (add-on)	0.62	1.31	1.31	0.14	2.07	2.07	XXX
78478	26	A	Heart wall motion (add-on)	0.62	0.21	0.21	0.04	0.87	0.87	XXX
78478	TC	A	Heart wall motion (add-on)	0.00	1.10	1.10	0.10	1.20	1.20	XXX
78480		A	Heart function, (add-on)	0.62	1.31	1.31	0.14	2.07	2.07	XXX
78480	26	A	Heart function, (add-on)	0.62	0.21	0.21	0.04	0.87	0.87	XXX
78480	TC	A	Heart function, (add-on)	0.00	1.10	1.10	0.10	1.20	1.20	XXX
78481		A	Heart first pass single	0.98	4.03	4.03	0.39	5.40	5.40	XXX
78481	26	A	Heart first pass single	0.98	0.33	0.33	0.07	1.38	1.38	XXX
78481	TC	A	Heart first pass single	0.00	3.71	3.71	0.32	4.03	4.03	XXX
78483		A	Heart first pass multiple	1.47	6.07	6.07	0.57	8.11	8.11	XXX
78483	26	A	Heart first pass multiple	1.47	0.48	0.48	0.10	2.05	2.05	XXX
78483	TC	A	Heart first pass multiple	0.00	5.58	5.58	0.47	6.05	6.05	XXX
78491	26	I	Heart image (pet) single	+1.50	1.00	1.00	0.10	2.60	2.60	XXX
78492	26	I	Heart image (pet) multiple	+1.87	1.00	1.00	0.10	2.97	2.97	XXX
78580		A	Lung perfusion imaging	0.74	2.69	2.69	0.26	3.69	3.69	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.05	1.04	1.04	XXX
78580	TC	A	Lung perfusion imaging	0.00	2.43	2.43	0.21	2.64	2.64	XXX
78584		A	Lung V/Q image single breath	0.99	2.60	2.60	0.26	3.85	3.85	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.33	0.33	0.07	1.39	1.39	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.27	2.27	0.19	2.46	2.46	XXX
78585		A	Lung V/Q imaging	1.09	4.35	4.35	0.41	5.85	5.85	XXX
78585	26	A	Lung V/Q imaging	1.09	0.36	0.36	0.07	1.52	1.52	XXX
78585	TC	A	Lung V/Q imaging	0.00	4.00	4.00	0.34	4.34	4.34	XXX
78586		A	Aerosol lung image, single	0.40	1.97	1.97	0.19	2.56	2.56	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.03	0.56	0.56	XXX
78586	TC	A	Aerosol lung image, single	0.00	1.84	1.84	0.16	2.00	2.00	XXX
78587		A	Aerosol lung image, multiple	0.49	2.15	2.15	0.20	2.84	2.84	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	1.99	1.99	0.17	2.16	2.16	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	2.16	2.16	0.20	2.76	2.76	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.13	0.13	0.03	0.56	0.56	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.02	2.02	0.17	2.19	2.19	XXX
78593		A	Vent image, 1 proj, gas	0.49	2.61	2.61	0.24	3.34	3.34	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	2.45	2.45	0.21	2.66	2.66	XXX
78594		A	Vent image, mult proj, gas	0.53	3.72	3.72	0.34	4.59	4.59	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.19	0.19	0.04	0.76	0.76	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	3.54	3.54	0.30	3.84	3.84	XXX
78596		A	Lung differential function	1.27	5.43	5.43	0.52	7.22	7.22	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.09	1.78	1.78	XXX
78596	TC	A	Lung differential function	0.00	5.02	5.02	0.43	5.45	5.45	XXX
78600		A	Brain imaging, ltd static	0.44	2.20	2.20	0.20	2.84	2.84	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.03	0.62	0.62	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.05	2.05	0.17	2.22	2.22	XXX
78601		A	Brain ltd imaging & flow	0.51	2.59	2.59	0.24	3.34	3.34	XXX
78601	26	A	Brain ltd imaging & flow	0.51	0.18	0.18	0.04	0.73	0.73	XXX
78601	TC	A	Brain ltd imaging & flow	0.00	2.41	2.41	0.20	2.61	2.61	XXX
78605		A	Brain imaging, complete	0.53	2.60	2.60	0.24	3.37	3.37	XXX
78605	26	A	Brain imaging, complete	0.53	0.19	0.19	0.04	0.76	0.76	XXX
78605	TC	A	Brain imaging, complete	0.00	2.41	2.41	0.20	2.61	2.61	XXX
78606		A	Brain imaging comp & flow	0.64	2.96	2.96	0.27	3.87	3.87	XXX
78606	26	A	Brain imaging comp & flow	0.64	0.22	0.22	0.04	0.90	0.90	XXX
78606	TC	A	Brain imaging comp & flow	0.00	2.75	2.75	0.23	2.98	2.98	XXX
78607		A	Brain imaging (3D)	1.23	5.05	5.05	0.47	6.75	6.75	XXX
78607	26	A	Brain imaging (3D)	1.23	0.40	0.40	0.08	1.71	1.71	XXX
78607	TC	A	Brain imaging (3D)	0.00	4.65	4.65	0.39	5.04	5.04	XXX
78610		A	Brain flow imaging only	0.30	1.22	1.22	0.12	1.64	1.64	XXX
78610	26	A	Brain flow imaging only	0.30	0.10	0.10	0.02	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.12	1.12	0.10	1.22	1.22	XXX
78615		A	Cerebral blood flow imaging	0.42	2.87	2.87	0.26	3.55	3.55	XXX
78615	26	A	Cerebral blood flow imaging	0.42	0.14	0.14	0.03	0.59	0.59	XXX
78615	TC	A	Cerebral blood flow imaging	0.00	2.73	2.73	0.23	2.96	2.96	XXX
78630		A	Cerebrospinal fluid scan	0.68	3.80	3.80	0.36	4.84	4.84	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.05	0.96	0.96	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	3.57	3.57	0.31	3.88	3.88	XXX
78635		A	CSF ventriculography	0.61	2.01	2.01	0.20	2.82	2.82	XXX
78635	26	A	CSF ventriculography	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78635	TC	A	CSF ventriculography	0.00	1.80	1.80	0.16	1.96	1.96	XXX
78645		A	CSF shunt evaluation	0.57	2.63	2.63	0.25	3.45	3.45	XXX
78645	26	A	CSF shunt evaluation	0.57	0.19	0.19	0.04	0.80	0.80	XXX
78645	TC	A	CSF shunt evaluation	0.00	2.43	2.43	0.21	2.64	2.64	XXX
78647		A	Cerebrospinal fluid scan	0.90	4.50	4.50	0.42	5.82	5.82	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.31	0.31	0.06	1.27	1.27	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	4.19	4.19	0.36	4.55	4.55	XXX
78650		A	CSF leakage imaging	0.61	3.50	3.50	0.32	4.43	4.43	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78650	TC	A	CSF leakage imaging	0.00	3.29	3.29	0.28	3.57	3.57	XXX
78660		A	Nuclear exam of tear flow	0.53	1.69	1.69	0.17	2.39	2.39	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.19	0.19	0.04	0.76	0.76	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	1.50	1.50	0.13	1.63	1.63	XXX
78700		A	Kidney imaging, static	0.45	2.31	2.31	0.21	2.97	2.97	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.03	0.63	0.63	XXX
78700	TC	A	Kidney imaging, static	0.00	2.16	2.16	0.18	2.34	2.34	XXX
78701		A	Kidney imaging with flow	0.49	2.69	2.69	0.24	3.42	3.42	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.16	0.03	0.68	0.68	XXX
78701	TC	A	Kidney imaging with flow	0.00	2.52	2.52	0.21	2.73	2.73	XXX
78704		A	Imaging renogram	0.74	3.06	3.06	0.29	4.09	4.09	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.05	1.04	1.04	XXX
78704	TC	A	Imaging renogram	0.00	2.81	2.81	0.24	3.05	3.05	XXX
78707		A	Kidney flow & function image	0.96	3.48	3.48	0.33	4.77	4.77	XXX
78707	26	A	Kidney flow & function image	0.96	0.31	0.31	0.06	1.33	1.33	XXX
78707	TC	A	Kidney flow & function image	0.00	3.17	3.17	0.27	3.44	3.44	XXX
78708		A	Kidney flow & function image	1.21	3.48	3.48	0.33	5.02	5.02	XXX
78708	26	A	Kidney flow & function image	1.21	0.31	0.31	0.06	1.58	1.58	XXX
78708	TC	A	Kidney flow & function image	0.00	3.17	3.17	0.27	3.44	3.44	XXX
78709		A	Kidney flow & function image	1.41	3.48	3.48	0.33	5.22	5.22	XXX
78709	26	A	Kidney flow & function image	1.41	0.31	0.31	0.06	1.78	1.78	XXX
78709	TC	A	Kidney flow & function image	0.00	3.17	3.17	0.27	3.44	3.44	XXX
78710		A	Kidney imaging (3D)	0.66	4.41	4.41	0.41	5.48	5.48	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.05	0.93	0.93	XXX
78710	TC	A	Kidney imaging (3D)	0.00	4.19	4.19	0.36	4.55	4.55	XXX
78715		A	Renal vascular flow exam	0.30	1.22	1.22	0.12	1.64	1.64	XXX
78715	26	A	Renal vascular flow exam	0.30	0.10	0.10	0.02	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.12	1.12	0.10	1.22	1.22	XXX
78725		A	Kidney function study	0.38	1.39	1.39	0.14	1.91	1.91	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.03	0.54	0.54	XXX
78725	TC	A	Kidney function study	0.00	1.27	1.27	0.11	1.38	1.38	XXX
78730		A	Urinary bladder retention	0.36	1.15	1.15	0.11	1.62	1.62	XXX
78730	26	A	Urinary bladder retention	0.36	0.12	0.12	0.02	0.50	0.50	XXX
78730	TC	A	Urinary bladder retention	0.00	1.03	1.03	0.09	1.12	1.12	XXX
78740		A	Ureteral reflux study	0.57	1.70	1.70	0.17	2.44	2.44	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.04	0.80	0.80	XXX
78740	TC	A	Ureteral reflux study	0.00	1.50	1.50	0.13	1.63	1.63	XXX
78760		A	Testicular imaging	0.66	2.12	2.12	0.21	2.99	2.99	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78760	TC	A	Testicular imaging	0.00	1.90	1.90	0.17	2.07	2.07	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
78761	.....	A	Testicular imaging & flow	0.71	2.52	2.52	0.24	3.47	3.47	XXX
78761	26	A	Testicular imaging & flow	0.71	0.25	0.25	0.05	1.01	1.01	XXX
78761	TC	A	Testicular imaging & flow	0.00	2.27	2.27	0.19	2.46	2.46	XXX
78800	.....	A	Tumor imaging, limited area	0.66	2.63	2.63	0.24	3.53	3.53	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	2.41	2.41	0.20	2.61	2.61	XXX
78801	.....	A	Tumor imaging, mult areas	0.79	3.27	3.27	0.31	4.37	4.37	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.05	1.11	1.11	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	3.00	3.00	0.26	3.26	3.26	XXX
78802	.....	A	Tumor imaging, whole body	0.86	4.21	4.21	0.40	5.47	5.47	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.29	0.29	0.06	1.21	1.21	XXX
78802	TC	A	Tumor imaging, whole body	0.00	3.92	3.92	0.34	4.26	4.26	XXX
78803	.....	A	Tumor imaging (3D)	1.09	5.01	5.01	0.46	6.56	6.56	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.36	0.36	0.07	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	4.65	4.65	0.39	5.04	5.04	XXX
78805	.....	A	Abscess imaging, ltd area	0.73	2.66	2.66	0.25	3.64	3.64	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.05	1.03	1.03	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	2.41	2.41	0.20	2.61	2.61	XXX
78806	.....	A	Abscess imaging, whole body	0.86	4.85	4.85	0.45	6.16	6.16	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.28	0.28	0.06	1.20	1.20	XXX
78806	TC	A	Abscess imaging, whole body	0.00	4.56	4.56	0.39	4.95	4.95	XXX
78807	.....	A	Nuclear localization/abscess	1.09	5.01	5.01	0.46	6.56	6.56	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.36	0.36	0.07	1.52	1.52	XXX
78807	TC	A	Nuclear localization/abscess	0.00	4.65	4.65	0.39	5.04	5.04	XXX
78810	26	N	Tumor imaging (PET)	+1.93	1.02	1.02	0.10	3.05	3.05	XXX
78890	.....	B	Nuclear medicine data proc	+0.05	0.94	0.94	0.08	1.07	1.07	XXX
78890	26	B	Nuclear medicine data proc	+0.05	0.01	0.01	0.00	0.06	0.06	XXX
78890	TC	B	Nuclear medicine data proc	+0.00	0.92	0.92	0.08	1.00	1.00	XXX
78891	.....	B	Nuclear med data proc	+0.10	1.90	1.90	0.18	2.18	2.18	XXX
78891	26	B	Nuclear med data proc	+0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	+0.00	1.86	1.86	0.17	2.03	2.03	XXX
79000	.....	A	Intial hyperthyroid therapy	1.80	2.46	2.46	0.29	4.55	4.55	XXX
79000	26	A	Intial hyperthyroid therapy	1.80	0.60	0.60	0.12	2.52	2.52	XXX
79000	TC	A	Intial hyperthyroid therapy	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79001	.....	A	Repeat hyperthyroid therapy	1.05	1.27	1.27	0.15	2.47	2.47	XXX
79001	26	A	Repeat hyperthyroid therapy	1.05	0.34	0.34	0.07	1.46	1.46	XXX
79001	TC	A	Repeat hyperthyroid therapy	0.00	0.92	0.92	0.08	1.00	1.00	XXX
79020	.....	A	Thyroid ablation	1.81	2.46	2.46	0.29	4.56	4.56	XXX
79020	26	A	Thyroid ablation	1.81	0.60	0.60	0.12	2.53	2.53	XXX
79020	TC	A	Thyroid ablation	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79030	.....	A	Thyroid ablation, carcinoma	2.10	2.56	2.56	0.31	4.97	4.97	XXX
79030	26	A	Thyroid ablation, carcinoma	2.10	0.70	0.70	0.14	2.94	2.94	XXX
79030	TC	A	Thyroid ablation, carcinoma	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79035	.....	A	Thyroid metastatic therapy	2.52	2.70	2.70	0.34	5.56	5.56	XXX
79035	26	A	Thyroid metastatic therapy	2.52	0.84	0.84	0.17	3.53	3.53	XXX
79035	TC	A	Thyroid metastatic therapy	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79100	.....	A	Hematopoetic nuclear therapy	1.32	2.29	2.29	0.26	3.87	3.87	XXX
79100	26	A	Hematopoetic nuclear therapy	1.32	0.43	0.43	0.09	1.84	1.84	XXX
79100	TC	A	Hematopoetic nuclear therapy	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79200	.....	A	Intracavitary nuc treatment	1.99	2.52	2.52	0.31	4.82	4.82	XXX
79200	26	A	Intracavitary nuc treatment	1.99	0.66	0.66	0.14	2.79	2.79	XXX
79200	TC	A	Intracavitary nuc treatment	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79300	26	A	Interstitial nuclear therapy	1.60	0.53	0.53	0.11	2.24	2.24	XXX
79400	.....	A	Nonhemato nuclear therapy	1.96	2.51	2.51	0.30	4.77	4.77	XXX
79400	26	A	Nonhemato nuclear therapy	1.96	0.65	0.65	0.13	2.74	2.74	XXX
79400	TC	A	Nonhemato nuclear therapy	0.00	1.86	1.86	0.17	2.03	2.03	XXX
79420	26	A	Intravascular nuc therapy	1.51	0.50	0.50	0.10	2.11	2.11	XXX
79440	.....	A	Nuclear joint therapy	1.99	2.52	2.52	0.31	4.82	4.82	XXX
79440	26	A	Nuclear joint therapy	1.99	0.66	0.66	0.14	2.79	2.79	XXX
79440	TC	A	Nuclear joint therapy	0.00	1.86	1.86	0.17	2.03	2.03	XXX
80500	.....	A	Lab pathology consultation	0.37	0.20	0.18	0.01	0.58	0.56	XXX
80502	.....	A	Lab pathology consultation	1.33	0.59	0.49	0.02	1.94	1.84	XXX
83020	26	A	Assay hemoglobin	0.37	0.24	0.23	0.01	0.62	0.61	XXX
83912	26	A	Genetic examination	0.37	0.20	0.23	0.01	0.58	0.61	XXX
84165	26	A	Assay serum proteins	0.37	0.24	0.23	0.01	0.62	0.61	XXX
84181	26	A	Western blot test	0.37	0.25	0.23	0.01	0.63	0.61	XXX
84182	26	A	Protein, western blot test	0.37	0.30	0.22	0.01	0.68	0.60	XXX
85060	.....	A	Blood smear interpretation	0.45	0.42	0.17	0.02	0.89	0.64	XXX
85095	.....	A	Bone marrow aspiration	1.08	1.74	0.48	0.05	2.87	1.61	XXX
85097	.....	A	Bone marrow interpretation	0.94	1.41	0.35	0.04	2.39	1.33	XXX
85102	.....	A	Bone marrow biopsy	1.37	1.86	0.59	0.05	3.28	2.01	XXX
85390	26	A	Fibrinolysins screen	0.37	0.31	0.22	0.01	0.69	0.60	XXX
85576	26	A	Blood platelet aggregation	0.37	0.32	0.23	0.01	0.70	0.61	XXX
86077	.....	A	Physician blood bank service	0.94	0.44	0.35	0.02	1.40	1.31	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
86078	.....	A	Physician blood bank service	0.94	0.44	0.35	0.02	1.40	1.31	XXX
86079	.....	A	Physician blood bank service	0.94	0.44	0.34	0.02	1.40	1.30	XXX
86255	26	A	Fluorescent antibody; screen	0.37	0.33	0.25	0.01	0.71	0.63	XXX
86256	26	A	Fluorescent antibody; titer	0.37	0.35	0.25	0.01	0.73	0.63	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.29	0.23	0.01	0.67	0.61	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.27	0.23	0.01	0.65	0.61	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.35	0.25	0.01	0.78	0.68	XXX
86334	26	A	Immunofixation procedure	0.37	0.28	0.23	0.01	0.66	0.61	XXX
86490	.....	A	Coccidioidomycosis skin test	0.00	0.10	0.10	0.02	0.12	0.12	XXX
86510	.....	A	Histoplasmosis skin test	0.00	0.12	0.12	0.02	0.14	0.14	XXX
86580	.....	A	TB intradermal test	0.00	0.12	0.12	0.02	0.14	0.14	XXX
86585	.....	A	TB tine test	0.00	0.14	0.14	0.01	0.15	0.15	XXX
87164	26	A	Dark field examination	0.37	0.21	0.22	0.01	0.59	0.60	XXX
87207	26	A	Smear, stain & interpret	0.37	0.30	0.27	0.01	0.68	0.65	XXX
88104	.....	A	Cytopathology, fluids	0.56	0.66	0.66	0.04	1.26	1.26	XXX
88104	26	A	Cytopathology, fluids	0.56	0.20	0.20	0.02	0.78	0.78	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.45	0.45	0.02	0.47	0.47	XXX
88106	.....	A	Cytopathology, fluids	0.56	0.62	0.62	0.03	1.21	1.21	XXX
88106	26	A	Cytopathology, fluids	0.56	0.26	0.26	0.01	0.83	0.83	XXX
88106	TC	A	Cytopathology, fluids	0.00	0.36	0.36	0.02	0.38	0.38	XXX
88107	.....	A	Cytopathology, fluids	0.76	0.64	0.64	0.04	1.44	1.44	XXX
88107	26	A	Cytopathology, fluids	0.76	0.32	0.32	0.02	1.10	1.10	XXX
88107	TC	A	Cytopathology, fluids	0.00	0.32	0.32	0.02	0.34	0.34	XXX
88108	.....	A	Cytopath, concentrate tech	0.56	0.64	0.64	0.04	1.24	1.24	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.23	0.23	0.02	0.81	0.81	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.41	0.41	0.02	0.43	0.43	XXX
88125	.....	A	Forensic cytopathology	0.26	0.30	0.30	0.00	0.56	0.56	XXX
88125	26	A	Forensic cytopathology	0.26	0.07	0.07	0.00	0.33	0.33	XXX
88125	TC	A	Forensic cytopathology	0.00	0.23	0.23	0.00	0.23	0.23	XXX
88141	.....	A	Cytopath cerv/vag interpret	0.42	0.89	0.15	0.04	1.35	0.61	XXX
88160	.....	A	Cytopath smear, other source	0.50	0.73	0.73	0.03	1.26	1.26	XXX
88160	26	A	Cytopath smear, other source	0.50	0.15	0.15	0.01	0.66	0.66	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.59	0.59	0.02	0.61	0.61	XXX
88161	.....	A	Cytopath smear, other source	0.50	0.69	0.69	0.03	1.22	1.22	XXX
88161	26	A	Cytopath smear, other source	0.50	0.18	0.18	0.01	0.69	0.69	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.51	0.51	0.02	0.53	0.53	XXX
88162	.....	A	Cytopath smear, other source	0.76	0.66	0.66	0.05	1.47	1.47	XXX
88162	26	A	Cytopath smear, other source	0.76	0.31	0.31	0.03	1.10	1.10	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.35	0.35	0.02	0.37	0.37	XXX
88170	.....	A	Fine needle aspiration	1.27	0.77	0.77	0.09	2.13	2.13	XXX
88170	26	A	Fine needle aspiration	1.27	0.57	0.57	0.05	1.89	1.89	XXX
88170	TC	A	Fine needle aspiration	0.00	0.20	0.20	0.04	0.24	0.24	XXX
88171	.....	A	Fine needle aspiration	1.27	0.63	0.63	0.09	1.99	1.99	XXX
88171	26	A	Fine needle aspiration	1.27	0.49	0.49	0.05	1.81	1.81	XXX
88171	TC	A	Fine needle aspiration	0.00	0.15	0.15	0.04	0.19	0.19	XXX
88172	.....	A	Evaluation of smear	0.60	0.72	0.72	0.05	1.37	1.37	XXX
88172	26	A	Evaluation of smear	0.60	0.24	0.24	0.03	0.87	0.87	XXX
88172	TC	A	Evaluation of smear	0.00	0.48	0.48	0.02	0.50	0.50	XXX
88173	.....	A	Interpretation of smear	1.39	1.17	1.17	0.05	2.61	2.61	XXX
88173	26	A	Interpretation of smear	1.39	0.52	0.52	0.03	1.94	1.94	XXX
88173	TC	A	Interpretation of smear	0.00	0.64	0.64	0.02	0.66	0.66	XXX
88180	.....	A	Cell marker study	0.36	0.38	0.38	0.03	0.77	0.77	XXX
88180	26	A	Cell marker study	0.36	0.13	0.13	0.01	0.50	0.50	XXX
88180	TC	A	Cell marker study	0.00	0.25	0.25	0.02	0.27	0.27	XXX
88182	.....	A	Cell marker study	0.77	0.89	0.89	0.07	1.73	1.73	XXX
88182	26	A	Cell marker study	0.77	0.26	0.26	0.03	1.06	1.06	XXX
88182	TC	A	Cell marker study	0.00	0.63	0.63	0.04	0.67	0.67	XXX
88300	.....	A	Surg path, gross	0.08	0.36	0.36	0.01	0.45	0.45	XXX
88300	26	A	Surg path, gross	0.08	0.03	0.03	0.01	0.12	0.12	XXX
88300	TC	A	Surg path, gross	0.00	0.33	0.33	0.00	0.33	0.33	XXX
88302	.....	A	Tissue exam by pathologist	0.13	0.63	0.63	0.04	0.80	0.80	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.02	0.21	0.21	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.58	0.58	0.02	0.60	0.60	XXX
88304	.....	A	Tissue exam by pathologist	0.22	0.72	0.72	0.04	0.98	0.98	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.09	0.09	0.02	0.33	0.33	XXX
88304	TC	A	Tissue exam by pathologist	0.00	0.62	0.62	0.02	0.64	0.64	XXX
88305	.....	A	Tissue exam by pathologist	0.75	1.06	1.06	0.08	1.89	1.89	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.31	0.31	0.04	1.10	1.10	XXX
88305	TC	A	Tissue exam by pathologist	0.00	0.75	0.75	0.04	0.79	0.79	XXX
88307	.....	A	Tissue exam by pathologist	1.59	1.71	1.71	0.12	3.42	3.42	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.61	0.61	0.06	2.26	2.26	XXX
88307	TC	A	Tissue exam by pathologist	0.00	1.10	1.10	0.06	1.16	1.16	XXX
88309	.....	A	Tissue exam by pathologist	2.28	2.49	2.49	0.13	4.90	4.90	XXX
88309	26	A	Tissue exam by pathologist	2.28	0.89	0.89	0.07	3.24	3.24	XXX

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CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
88309	TC	A	Tissue exam by pathologist	0.00	1.60	1.60	0.06	1.66	1.66	XXX
88311		A	Decalcify tissue	0.24	0.15	0.15	0.01	0.40	0.40	XXX
88311	26	A	Decalcify tissue	0.24	0.09	0.09	0.01	0.34	0.34	XXX
88311	TC	A	Decalcify tissue	0.00	0.06	0.06	0.00	0.06	0.06	XXX
88312		A	Special stains	0.54	1.11	1.11	0.01	1.66	1.66	XXX
88312	26	A	Special stains	0.54	0.20	0.20	0.01	0.75	0.75	XXX
88312	TC	A	Special stains	0.00	0.91	0.91	0.00	0.91	0.91	XXX
88313		A	Special stains	0.24	0.73	0.73	0.01	0.98	0.98	XXX
88313	26	A	Special stains	0.24	0.09	0.09	0.01	0.34	0.34	XXX
88313	TC	A	Special stains	0.00	0.65	0.65	0.00	0.65	0.65	XXX
88314		A	Histochemical stain	0.45	1.30	1.30	0.04	1.79	1.79	XXX
88314	26	A	Histochemical stain	0.45	0.35	0.35	0.02	0.82	0.82	XXX
88314	TC	A	Histochemical stain	0.00	0.95	0.95	0.02	0.97	0.97	XXX
88318		A	Chemical histochemistry	0.42	0.58	0.58	0.01	1.01	1.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.18	0.01	0.61	0.61	XXX
88318	TC	A	Chemical histochemistry	0.00	0.39	0.39	0.00	0.39	0.39	XXX
88319		A	Enzyme histochemistry	0.53	2.53	2.53	0.04	3.10	3.10	XXX
88319	26	A	Enzyme histochemistry	0.53	0.31	0.31	0.02	0.86	0.86	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.21	2.21	0.02	2.23	2.23	XXX
88321		A	Microslide consultation	1.30	0.81	0.48	0.03	2.14	1.81	XXX
88323		A	Microslide consultation	1.35	1.20	1.20	0.05	2.60	2.60	XXX
88323	26	A	Microslide consultation	1.35	0.68	0.68	0.03	2.06	2.06	XXX
88323	TC	A	Microslide consultation	0.00	0.52	0.52	0.02	0.54	0.54	XXX
88325		A	Comprehensive review of data	2.22	1.10	0.82	0.04	3.36	3.08	XXX
88329		A	Pathology consult in surgery	0.67	0.34	0.25	0.03	1.04	0.95	XXX
88331		A	Pathology consult in surgery	1.19	0.68	0.68	0.08	1.95	1.95	XXX
88331	26	A	Pathology consult in surgery	1.19	0.45	0.45	0.04	1.68	1.68	XXX
88331	TC	A	Pathology consult in surgery	0.00	0.23	0.23	0.04	0.27	0.27	XXX
88332		A	Pathology consult in surgery	0.59	0.32	0.32	0.04	0.95	0.95	XXX
88332	26	A	Pathology consult in surgery	0.59	0.22	0.22	0.02	0.83	0.83	XXX
88332	TC	A	Pathology consult in surgery	0.00	0.10	0.10	0.02	0.12	0.12	XXX
88342		A	Immunocytochemistry	0.85	0.98	0.98	0.04	1.87	1.87	XXX
88342	26	A	Immunocytochemistry	0.85	0.31	0.31	0.02	1.18	1.18	XXX
88342	TC	A	Immunocytochemistry	0.00	0.67	0.67	0.02	0.69	0.69	XXX
88346		A	Immunofluorescent study	0.86	1.00	1.00	0.04	1.90	1.90	XXX
88346	26	A	Immunofluorescent study	0.86	0.30	0.30	0.02	1.18	1.18	XXX
88346	TC	A	Immunofluorescent study	0.00	0.70	0.70	0.02	0.72	0.72	XXX
88347		A	Immunofluorescent study	0.86	0.78	0.78	0.04	1.68	1.68	XXX
88347	26	A	Immunofluorescent study	0.86	0.42	0.42	0.02	1.30	1.30	XXX
88347	TC	A	Immunofluorescent study	0.00	0.35	0.35	0.02	0.37	0.37	XXX
88348		A	Electron microscopy	1.51	3.80	3.80	0.16	5.47	5.47	XXX
88348	26	A	Electron microscopy	1.51	0.34	0.34	0.08	1.93	1.93	XXX
88348	TC	A	Electron microscopy	0.00	3.46	3.46	0.08	3.54	3.54	XXX
88349		A	Scanning electron microscopy	0.76	8.14	8.14	0.12	9.02	9.02	XXX
88349	26	A	Scanning electron microscopy	0.76	0.17	0.17	0.06	0.99	0.99	XXX
88349	TC	A	Scanning electron microscopy	0.00	7.97	7.97	0.06	8.03	8.03	XXX
88355		A	Analysis, skeletal muscle	1.85	3.00	3.00	0.13	4.98	4.98	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.81	0.81	0.07	2.73	2.73	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.19	2.19	0.06	2.25	2.25	XXX
88356		A	Analysis, nerve	3.02	4.19	4.19	0.18	7.39	7.39	XXX
88356	26	A	Analysis, nerve	3.02	0.84	0.84	0.10	3.96	3.96	XXX
88356	TC	A	Analysis, nerve	0.00	3.35	3.35	0.08	3.43	3.43	XXX
88358		A	Analysis, tumor	2.82	1.74	1.74	0.16	4.72	4.72	XXX
88358	26	A	Analysis, tumor	2.82	1.26	1.26	0.08	4.16	4.16	XXX
88358	TC	A	Analysis, tumor	0.00	0.48	0.48	0.08	0.56	0.56	XXX
88362		A	Nerve teasing preparations	2.17	3.27	3.27	0.13	5.57	5.57	XXX
88362	26	A	Nerve teasing preparations	2.17	0.50	0.50	0.07	2.74	2.74	XXX
88362	TC	A	Nerve teasing preparations	0.00	2.77	2.77	0.06	2.83	2.83	XXX
88365		A	Tissue hybridization	0.93	1.82	1.82	0.05	2.80	2.80	XXX
88365	26	A	Tissue hybridization	0.93	0.39	0.39	0.03	1.35	1.35	XXX
88365	TC	A	Tissue hybridization	0.00	1.43	1.43	0.02	1.45	1.45	XXX
88371	26	A	Protein, western blot tissue	0.37	0.33	0.23	0.01	0.71	0.61	XXX
88372	26	A	Protein analysis w/probe	0.37	0.33	0.23	0.01	0.71	0.61	XXX
89060	26	A	Exam, synovial fluid crystals	0.37	0.31	0.24	0.01	0.69	0.62	XXX
89100		A	Sample intestinal contents	0.60	0.90	0.27	0.03	1.53	0.90	XXX
89105		A	Sample intestinal contents	0.50	1.93	0.23	0.03	2.46	0.76	XXX
89130		A	Sample stomach contents	0.45	0.93	0.17	0.03	1.41	0.65	XXX
89132		A	Sample stomach contents	0.19	1.21	0.11	0.02	1.42	0.32	XXX
89135		A	Sample stomach contents	0.79	1.31	0.31	0.04	2.14	1.14	XXX
89136		A	Sample stomach contents	0.21	0.51	0.14	0.02	0.74	0.37	XXX
89140		A	Sample stomach contents	0.94	0.98	0.29	0.07	1.99	1.30	XXX
89141		A	Sample stomach contents	0.85	1.59	0.28	0.06	2.50	1.19	XXX
89350		A	Sputum specimen collection	0.00	0.13	0.13	0.03	0.16	0.16	XXX
89360		A	Collect sweat for test	0.00	0.03	0.03	0.03	0.06	0.06	XXX

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
90780	.....	A	IV infusion therapy, 1 hour	0.00	0.90	0.06	0.08	0.98	0.14	XXX
90781	.....	A	IV infusion, additional hour	0.00	0.64	0.18	0.04	0.68	0.22	XXX
90782	.....	T	Injection (SC)/(IM)	0.00	0.12	0.03	0.01	0.13	0.04	XXX
90783	.....	T	Injection (IA)	0.00	0.21	0.06	0.03	0.24	0.09	XXX
90784	.....	T	Injection (IV)	0.00	0.22	0.06	0.04	0.26	0.10	XXX
90788	.....	T	Injection of antibiotic	0.00	0.11	0.03	0.01	0.12	0.04	XXX
90801	.....	A	Psy dx interview	2.80	1.09	1.05	0.09	3.98	3.94	XXX
90802	.....	A	Intac psy dx interview	3.01	1.24	1.15	0.05	4.30	4.21	XXX
90804	.....	A	Psytx, office (20-30)	1.11	0.45	0.40	0.05	1.61	1.56	XXX
90805	.....	A	Psytx, office (20–30) w/e&m	1.47	0.58	0.52	0.05	2.10	2.04	XXX
90806	.....	A	Psytx, office (45–50)	1.73	0.71	0.61	0.08	2.52	2.42	XXX
90807	.....	A	Psytx, office (45–50) w/e&m	2.00	0.81	0.70	0.08	2.89	2.78	XXX
90808	.....	A	Psytx, office (75–80)	2.76	1.11	1.06	0.15	4.02	3.97	XXX
90809	.....	A	Psytx, office (75–80) w/e&m	3.15	1.26	1.20	0.15	4.56	4.50	XXX
90810	.....	A	Intac psytx, office (20–30)	1.19	0.47	0.40	0.09	1.75	1.68	XXX
90811	.....	A	Intac psytx, off 20–30 w/e&m	1.58	0.68	0.58	0.09	2.35	2.25	XXX
90812	.....	A	Intac psytx, office (45–50)	1.86	0.69	0.61	0.09	2.64	2.56	XXX
90813	.....	A	Intac psytx, off 45–50 w/e&m	2.15	0.87	0.75	0.09	3.11	2.99	XXX
90814	.....	A	Intac psytx, office (75–80)	2.97	1.08	0.96	0.09	4.14	4.02	XXX
90815	.....	A	Intac psytx, off 75–80 w/e&m	3.39	1.31	1.15	0.09	4.79	4.63	XXX
90816	.....	A	Psytx, hosp (20–30)	1.24	0.50	0.44	0.05	1.79	1.73	XXX
90817	.....	A	Psytx, hosp (20–30) w/e&m	1.65	0.71	0.63	0.05	2.41	2.33	XXX
90818	.....	A	Psytx, hosp (45–50)	1.94	0.79	0.68	0.08	2.81	2.70	XXX
90819	.....	A	Psytx, hosp (45–50) w/e&m	2.24	0.98	0.83	0.08	3.30	3.15	XXX
90821	.....	A	Psytx, hosp (75–80)	3.09	1.24	1.18	0.15	4.48	4.42	XXX
90822	.....	A	Psytx, hosp (75–80) w/e&m	3.53	1.48	1.43	0.15	5.16	5.11	XXX
90823	.....	A	Intac psytx, hosp (20–30)	1.33	0.51	0.44	0.09	1.93	1.86	XXX
90824	.....	A	Intac psytx, hsp 20–30 w/e&m	1.77	0.74	0.63	0.09	2.60	2.49	XXX
90826	.....	A	Intac psytx, hosp (45–50)	2.08	0.77	0.67	0.09	2.94	2.84	XXX
90827	.....	A	Intac psytx, hsp 45–50 w/e&m	2.41	0.95	0.82	0.09	3.45	3.32	XXX
90828	.....	A	Intac psytx, hosp (75–80)	3.32	1.20	1.07	0.09	4.61	4.48	XXX
90829	.....	A	Intac psytx, hsp 75–80 w/e&m	3.80	1.44	1.27	0.09	5.33	5.16	XXX
90845	.....	A	Psychoanalysis	1.79	0.64	0.58	0.05	2.48	2.42	XXX
90846	.....	R	Family psytx w/o patient	1.83	0.76	0.67	0.08	2.67	2.58	XXX
90847	.....	R	Family psytx w/patient	2.21	0.86	0.79	0.08	3.15	3.08	XXX
90849	.....	R	Multiple family group psytx	0.59	0.31	0.30	0.03	0.93	0.92	XXX
90853	.....	A	Group psychotherapy	0.59	0.31	0.29	0.03	0.93	0.91	XXX
90857	.....	A	Intac group psytx	0.63	0.34	0.31	0.02	0.99	0.96	XXX
90862	.....	A	Medication management	0.95	0.36	0.35	0.05	1.36	1.35	XXX
90865	.....	A	Narcosynthesis	2.84	5.14	0.88	0.07	8.05	3.79	XXX
90870	.....	A	Electroconvulsive therapy	1.88	0.64	0.71	0.08	2.60	2.67	000
90871	.....	A	Electroconvulsive therapy	2.72	NA	0.89	0.13	NA	3.74	000
90880	.....	A	Hypnotherapy	2.19	0.88	0.80	0.07	3.14	3.06	XXX
90885	.....	B	Psy evaluation of records	+0.97	0.97	0.97	0.04	1.98	1.98	XXX
90887	.....	B	Consultation with family	+1.48	1.82	1.73	0.04	3.34	3.25	XXX
90901	.....	A	Biofeedback, any method	0.41	0.43	0.33	0.07	0.91	0.81	000
90911	.....	A	Biofeedback peri/uro/rectal	0.89	0.60	0.59	0.27	1.76	1.75	000
90918	.....	A	ESRD related services, month	11.18	4.46	4.46	0.14	15.78	15.78	XXX
90919	.....	A	ESRD related services, month	8.54	3.59	3.59	0.14	12.27	12.27	XXX
90920	.....	A	ESRD related services, month	7.27	2.98	2.98	0.14	10.39	10.39	XXX
90921	.....	A	ESRD related services, month	4.47	2.02	2.02	0.14	6.63	6.63	XXX
90922	.....	A	ESRD related services, day	0.37	0.13	0.13	0.01	0.51	0.51	XXX
90923	.....	A	Esrd related services, day	0.28	0.12	0.12	0.01	0.41	0.41	XXX
90924	.....	A	Esrd related services, day	0.24	0.10	0.10	0.01	0.35	0.35	XXX
90925	.....	A	Esrd related services, day	0.15	0.07	0.07	0.01	0.23	0.23	XXX
90935	.....	A	Hemodialysis, one evaluation	1.22	NA	0.58	0.10	NA	1.90	000
90937	.....	A	Hemodialysis, repeated eval.	2.11	NA	0.86	0.18	NA	3.15	000
90945	.....	A	Dialysis, one evaluation	1.28	NA	0.60	0.08	NA	1.96	000
90947	.....	A	Dialysis, repeated eval.	2.16	NA	0.88	0.14	NA	3.18	000
90997	.....	A	Hemoperfusion	1.84	NA	0.77	0.16	NA	2.77	000
91000	.....	A	Esophageal intubation	0.73	1.47	1.47	0.06	2.26	2.26	000
91000	26	A	Esophageal intubation	0.73	0.15	0.15	0.05	0.93	0.93	000
91000	TC	A	Esophageal intubation	0.00	1.33	1.33	0.01	1.34	1.34	000
91010	.....	A	Esophagus motility study	1.25	1.38	1.38	0.17	2.80	2.80	000
91010	26	A	Esophagus motility study	1.25	0.45	0.45	0.11	1.81	1.81	000
91010	TC	A	Esophagus motility study	0.00	0.94	0.94	0.06	1.00	1.00	000
91011	.....	A	Esophagus motility study	1.50	2.81	2.81	0.18	4.49	4.49	000
91011	26	A	Esophagus motility study	1.50	0.41	0.41	0.11	2.02	2.02	000
91011	TC	A	Esophagus motility study	0.00	2.40	2.40	0.07	2.47	2.47	000
91012	.....	A	Esophagus motility study	1.46	2.29	2.29	0.23	3.98	3.98	000
91012	26	A	Esophagus motility study	1.46	0.46	0.46	0.15	2.07	2.07	000
91012	TC	A	Esophagus motility study	0.00	1.83	1.83	0.08	1.91	1.91	000
91020	.....	A	Gastric motility	1.44	2.01	2.01	0.18	3.63	3.63	000
91020	26	A	Gastric motility	1.44	0.44	0.44	0.12	2.00	2.00	000

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
91020	TC	A	Gastric motility	0.00	1.57	1.57	0.06	1.63	1.63	000
91030		A	Acid perfusion of esophagus	0.91	2.27	2.27	0.05	3.23	3.23	000
91030	26	A	Acid perfusion of esophagus	0.91	0.26	0.26	0.03	1.20	1.20	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.01	2.01	0.02	2.03	2.03	000
91032		A	Esophagus, acid reflux test	1.21	2.08	2.08	0.16	3.45	3.45	000
91032	26	A	Esophagus, acid reflux test	1.21	0.30	0.30	0.10	1.61	1.61	000
91032	TC	A	Esophagus, acid reflux test	0.00	1.78	1.78	0.06	1.84	1.84	000
91033		A	Prolonged acid reflux test	1.30	1.39	1.39	0.25	2.94	2.94	000
91033	26	A	Prolonged acid reflux test	1.30	0.45	0.45	0.14	1.89	1.89	000
91033	TC	A	Prolonged acid reflux test	0.00	0.94	0.94	0.11	1.05	1.05	000
91052		A	Gastric analysis test	0.79	1.68	1.68	0.07	2.54	2.54	000
91052	26	A	Gastric analysis test	0.79	0.16	0.16	0.04	0.99	0.99	000
91052	TC	A	Gastric analysis test	0.00	1.52	1.52	0.03	1.55	1.55	000
91055		A	Gastric intubation for smear	0.94	2.06	2.06	0.06	3.06	3.06	000
91055	26	A	Gastric intubation for smear	0.94	0.21	0.21	0.04	1.19	1.19	000
91055	TC	A	Gastric intubation for smear	0.00	1.85	1.85	0.02	1.87	1.87	000
91060		A	Gastric saline load test	0.45	0.25	0.25	0.06	0.76	0.76	000
91060	26	A	Gastric saline load test	0.45	0.11	0.11	0.04	0.60	0.60	000
91060	TC	A	Gastric saline load test	0.00	0.14	0.14	0.02	0.16	0.16	000
91065		A	Breath hydrogen test	0.20	1.59	1.59	0.05	1.84	1.84	000
91065	26	A	Breath hydrogen test	0.20	0.08	0.08	0.03	0.31	0.31	000
91065	TC	A	Breath hydrogen test	0.00	1.51	1.51	0.02	1.53	1.53	000
91100		A	Pass intestine bleeding tube	1.08	NA	0.26	0.05	NA	1.39	000
91105		A	Gastric intubation treatment	0.37	NA	0.11	0.04	NA	0.52	000
91122		A	Anal pressure record	1.77	2.21	2.21	0.22	4.20	4.20	000
91122	26	A	Anal pressure record	1.77	0.80	0.80	0.13	2.70	2.70	000
91122	TC	A	Anal pressure record	0.00	1.41	1.41	0.09	1.50	1.50	000
92002		A	Eye exam, new patient	0.88	0.96	0.36	0.02	1.86	1.26	XXX
92004		A	Eye exam, new patient	1.67	1.58	0.87	0.02	3.27	2.56	XXX
92012		A	Eye exam established pt	0.67	1.26	0.35	0.02	1.95	1.04	XXX
92014		A	Eye exam & treatment	1.10	1.25	0.58	0.02	2.37	1.70	XXX
92015		N	Refraction	+0.38	1.93	0.38	0.02	2.33	0.78	XXX
92018		A	New eye exam & treatment	1.51	NA	1.11	0.03	NA	2.65	XXX
92019		A	Eye exam & treatment	1.31	NA	0.85	0.03	NA	2.19	XXX
92020		A	Special eye evaluation	0.37	0.51	0.20	0.01	0.89	0.58	XXX
92060		A	Special eye evaluation	0.69	1.34	1.34	0.02	2.05	2.05	XXX
92060	26	A	Special eye evaluation	0.69	0.32	0.32	0.01	1.02	1.02	XXX
92060	TC	A	Special eye evaluation	0.00	1.02	1.02	0.01	1.03	1.03	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.62	0.62	0.01	1.00	1.00	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.06	0.06	0.01	0.44	0.44	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.56	0.56	0.00	0.56	0.56	XXX
92070		A	Fitting of contact lens	0.70	0.87	0.40	0.06	1.63	1.16	XXX
92081		A	Visual field examination(s)	0.36	0.80	0.80	0.01	1.17	1.17	XXX
92081	26	A	Visual field examination(s)	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92081	TC	A	Visual field examination(s)	0.00	0.64	0.64	0.00	0.64	0.64	XXX
92082		A	Visual field examination(s)	0.44	1.05	1.05	0.02	1.51	1.51	XXX
92082	26	A	Visual field examination(s)	0.44	0.23	0.23	0.01	0.68	0.68	XXX
92082	TC	A	Visual field examination(s)	0.00	0.82	0.82	0.01	0.83	0.83	XXX
92083		A	Visual field examination(s)	0.50	1.33	1.33	0.04	1.87	1.87	XXX
92083	26	A	Visual field examination(s)	0.50	0.28	0.28	0.03	0.81	0.81	XXX
92083	TC	A	Visual field examination(s)	0.00	1.05	1.05	0.01	1.06	1.06	XXX
92100		A	Serial tonometry exam(s)	0.92	0.73	0.26	0.01	1.66	1.19	XXX
92120		A	Tonography & eye evaluation	0.81	0.72	0.30	0.02	1.55	1.13	XXX
92130		A	Water provocation tonography	0.81	0.80	0.26	0.02	1.63	1.09	XXX
92140		A	Glaucoma provocative tests	0.50	0.77	0.27	0.01	1.28	0.78	XXX
92225		A	Special eye exam, initial	0.38	0.96	0.21	0.02	1.36	0.61	XXX
92226		A	Special eye exam, subsequent	0.33	1.01	0.19	0.02	1.36	0.54	XXX
92230		A	Eye exam with photos	0.60	1.74	0.18	0.04	2.38	0.82	XXX
92235		A	Eye exam with photos	0.81	2.67	2.67	0.09	3.57	3.57	XXX
92235	26	A	Eye exam with photos	0.81	0.49	0.49	0.03	1.33	1.33	XXX
92235	TC	A	Eye exam with photos	0.00	2.18	2.18	0.06	2.24	2.24	XXX
92240		A	Icg angiography	1.10	2.84	2.84	0.09	4.03	4.03	XXX
92240	26	A	Icg angiography	1.10	0.66	0.66	0.03	1.79	1.79	XXX
92240	TC	A	Icg angiography	0.00	2.17	2.17	0.06	2.23	2.23	XXX
92250		A	Eye exam with photos	0.44	1.38	1.38	0.02	1.84	1.84	XXX
92250	26	A	Eye exam with photos	0.44	0.24	0.24	0.01	0.69	0.69	XXX
92250	TC	A	Eye exam with photos	0.00	1.14	1.14	0.01	1.15	1.15	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.18	0.09	0.03	0.41	0.32	XXX
92265		A	Eye muscle evaluation	0.81	1.10	1.10	0.02	1.93	1.93	XXX
92265	26	A	Eye muscle evaluation	0.81	0.21	0.21	0.00	1.02	1.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.89	0.89	0.02	0.91	0.91	XXX
92270		A	Electro-oculography	0.81	1.19	1.19	0.05	2.05	2.05	XXX
92270	26	A	Electro-oculography	0.81	0.41	0.41	0.03	1.25	1.25	XXX
92270	TC	A	Electro-oculography	0.00	0.79	0.79	0.02	0.81	0.81	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
92275	.....	A	Electroretinography	1.01	1.89	1.89	0.05	2.95	2.95	XXX
92275	26	A	Electroretinography	1.01	0.38	0.38	0.03	1.42	1.42	XXX
92275	TC	A	Electroretinography	0.00	1.51	1.51	0.02	1.53	1.53	XXX
92283	.....	A	Color vision examination	0.17	0.63	0.63	0.01	0.81	0.81	XXX
92283	26	A	Color vision examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
92283	TC	A	Color vision examination	0.00	0.59	0.59	0.00	0.59	0.59	XXX
92284	.....	A	Dark adaptation eye exam	0.24	1.66	1.66	0.02	1.92	1.92	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.09	0.09	0.01	0.34	0.34	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.57	1.57	0.01	1.58	1.58	XXX
92285	.....	A	Eye photography	0.20	1.26	1.26	0.01	1.47	1.47	XXX
92285	26	A	Eye photography	0.20	0.10	0.10	0.01	0.31	0.31	XXX
92285	TC	A	Eye photography	0.00	1.16	1.16	0.00	1.16	1.16	XXX
92286	.....	A	Internal eye photography	0.66	1.56	1.56	0.07	2.29	2.29	XXX
92286	26	A	Internal eye photography	0.66	0.34	0.34	0.05	1.05	1.05	XXX
92286	TC	A	Internal eye photography	0.00	1.21	1.21	0.02	1.23	1.23	XXX
92287	.....	A	Internal eye photography	0.81	2.65	0.38	0.08	3.54	1.27	XXX
92310	.....	N	Contact lens fitting	+1.17	1.99	1.17	0.00	3.16	2.34	XXX
92311	.....	A	Contact lens fitting	1.08	0.93	0.41	0.03	2.04	1.52	XXX
92312	.....	A	Contact lens fitting	1.26	0.93	0.51	0.03	2.22	1.80	XXX
92313	.....	A	Contact lens fitting	0.92	0.86	0.40	0.03	1.81	1.35	XXX
92314	.....	N	Prescription of contact lens	+0.69	1.51	0.69	0.00	2.20	1.38	XXX
92315	.....	A	Prescription of contact lens	0.45	0.60	0.07	0.03	1.08	0.55	XXX
92316	.....	A	Prescription of contact lens	0.68	0.61	0.27	0.04	1.33	0.99	XXX
92317	.....	A	Prescription of contact lens	0.45	0.76	0.25	0.02	1.23	0.72	XXX
92325	.....	A	Modification of contact lens	0.00	0.33	0.12	0.01	0.34	0.13	XXX
92326	.....	A	Replacement of contact lens	0.00	0.26	0.09	0.06	0.32	0.15	XXX
92330	.....	A	Fitting of artificial eye	1.08	0.83	0.33	0.09	2.00	1.50	XXX
92335	.....	A	Fitting of artificial eye	0.45	0.66	0.19	0.11	1.22	0.75	XXX
92340	.....	N	Fitting of spectacles	+0.37	1.05	0.37	0.00	1.42	0.74	XXX
92341	.....	N	Fitting of spectacles	+0.47	1.15	0.47	0.00	1.62	0.94	XXX
92342	.....	N	Fitting of spectacles	+0.53	1.21	0.53	0.00	1.74	1.06	XXX
92352	.....	B	Special spectacles fitting	+0.37	1.05	0.37	0.01	1.43	0.75	XXX
92353	.....	B	Special spectacles fitting	+0.50	1.18	0.50	0.01	1.69	1.01	XXX
92354	.....	B	Special spectacles fitting	+0.00	0.81	0.41	0.10	0.91	0.51	XXX
92355	.....	B	Special spectacles fitting	+0.00	0.81	0.41	0.01	0.82	0.42	XXX
92358	.....	B	Eye prosthesis service	+0.00	0.47	0.24	0.05	0.52	0.29	XXX
92370	.....	N	Repair & adjust spectacles	+0.32	0.79	0.32	0.00	1.11	0.64	XXX
92371	.....	B	Repair & adjust spectacles	+0.00	0.47	0.24	0.02	0.49	0.26	XXX
92392	.....	I	Supply of low vision aids	+0.00	0.47	0.24	0.02	0.49	0.26	XXX
92393	.....	I	Supply of artificial eye	+0.00	0.47	0.24	0.67	1.14	0.91	XXX
92395	.....	I	Supply of spectacles	+0.00	0.47	0.24	0.10	0.57	0.34	XXX
92396	.....	I	Supply of contact lenses	+0.00	0.47	0.24	0.08	0.55	0.32	XXX
92502	.....	A	Ear and throat examination	1.51	NA	1.11	0.12	NA	2.74	000
92504	.....	A	Ear microscopy examination	0.18	0.49	0.11	0.02	0.69	0.31	XXX
92506	.....	A	Speech & hearing evaluation	0.86	0.89	0.86	0.05	1.80	1.77	XXX
92507	.....	A	Speech/hearing therapy	0.52	0.73	0.65	0.03	1.28	1.20	XXX
92508	.....	A	Speech/hearing therapy	0.26	0.70	0.56	0.02	0.98	0.84	XXX
92510	.....	A	Rehab for ear implant	1.50	1.35	1.35	0.15	3.00	3.00	XXX
92511	.....	A	Nasopharyngoscopy	0.84	0.79	0.49	0.09	1.72	1.42	000
92512	.....	A	Nasal function studies	0.55	0.62	0.20	0.05	1.22	0.80	XXX
92516	.....	A	Facial nerve function test	0.43	0.54	0.21	0.04	1.01	0.68	XXX
92520	.....	A	Laryngeal function studies	0.76	0.57	0.54	0.05	1.38	1.35	XXX
92525	.....	A	Oral function evaluation	1.50	1.23	1.20	0.11	2.84	2.81	XXX
92526	.....	A	Oral function therapy	0.55	0.69	0.70	0.05	1.29	1.30	XXX
92541	.....	A	Spontaneous nystagmus test	0.40	0.75	0.75	0.07	1.22	1.22	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.21	0.21	0.05	0.66	0.66	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.54	0.54	0.02	0.56	0.56	XXX
92542	.....	A	Positional nystagmus test	0.33	0.71	0.71	0.07	1.11	1.11	XXX
92542	26	A	Positional nystagmus test	0.33	0.18	0.18	0.04	0.55	0.55	XXX
92542	TC	A	Positional nystagmus test	0.00	0.54	0.54	0.03	0.57	0.57	XXX
92543	.....	A	Caloric vestibular test	0.10	0.57	0.57	0.02	0.69	0.69	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	XXX
92543	TC	A	Caloric vestibular test	0.00	0.52	0.52	0.01	0.53	0.53	XXX
92544	.....	A	Optokinetic nystagmus test	0.26	0.67	0.67	0.05	0.98	0.98	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.13	0.13	0.03	0.42	0.42	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.53	0.53	0.02	0.55	0.55	XXX
92545	.....	A	Oscillating tracking test	0.23	0.65	0.65	0.04	0.92	0.92	XXX
92545	26	A	Oscillating tracking test	0.23	0.12	0.12	0.02	0.37	0.37	XXX
92545	TC	A	Oscillating tracking test	0.00	0.53	0.53	0.02	0.55	0.55	XXX
92546	.....	A	Sinusoidal rotational test	0.29	1.17	1.17	0.05	1.51	1.51	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.15	0.15	0.03	0.47	0.47	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.02	1.02	0.02	1.04	1.04	XXX
92547	.....	A	Supplemental electrical test	0.00	0.50	0.50	0.06	0.56	0.56	XXX
92548	.....	A	Posturography	0.50	1.41	1.41	0.19	2.10	2.10	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
92548	26	A	Posturography	0.50	0.22	0.22	0.05	0.77	0.77	XXX
92548	TC	A	Posturography	0.00	1.19	1.19	0.14	1.33	1.33	XXX
92552	.....	A	Pure tone audiometry, air	0.00	0.50	0.50	0.04	0.54	0.54	XXX
92553	.....	A	Audiometry, air & bone	0.00	0.51	0.51	0.07	0.58	0.58	XXX
92555	.....	A	Speech threshold audiometry	0.00	0.51	0.51	0.04	0.55	0.55	XXX
92556	.....	A	Speech audiometry, complete	0.00	0.51	0.51	0.06	0.57	0.57	XXX
92557	.....	A	Comprehensive hearing test	0.00	0.51	0.51	0.13	0.64	0.64	XXX
92561	.....	A	Bekesy audiometry, diagnosis	0.00	0.45	0.45	0.07	0.52	0.52	XXX
92562	.....	A	Loudness balance test	0.00	0.53	0.53	0.04	0.57	0.57	XXX
92563	.....	A	Tone decay hearing test	0.00	0.51	0.51	0.04	0.55	0.55	XXX
92564	.....	A	Sisi hearing test	0.00	0.51	0.51	0.05	0.56	0.56	XXX
92565	.....	A	Stenger test, pure tone	0.00	0.50	0.50	0.04	0.54	0.54	XXX
92567	.....	A	Tympanometry	0.00	0.44	0.44	0.06	0.50	0.50	XXX
92568	.....	A	Acoustic reflex testing	0.00	0.44	0.44	0.04	0.48	0.48	XXX
92569	.....	A	Acoustic reflex decay test	0.00	0.44	0.44	0.04	0.48	0.48	XXX
92571	.....	A	Filtered speech hearing test	0.00	0.51	0.51	0.04	0.55	0.55	XXX
92572	.....	A	Staggered spondaic word test	0.00	0.51	0.51	0.01	0.52	0.52	XXX
92573	.....	A	Lombard test	0.00	0.51	0.51	0.04	0.55	0.55	XXX
92575	.....	A	Sensorineural acuity test	0.00	0.39	0.39	0.03	0.42	0.42	XXX
92576	.....	A	Synthetic sentence test	0.00	0.51	0.51	0.05	0.56	0.56	XXX
92577	.....	A	Stenger test, speech	0.00	0.51	0.51	0.08	0.59	0.59	XXX
92579	.....	A	Visual audiometry (vra)	0.00	1.00	1.00	0.07	1.07	1.07	XXX
92582	.....	A	Conditioning play audiometry	0.00	0.99	0.99	0.07	1.06	1.06	XXX
92583	.....	A	Select picture audiometry	0.00	1.23	1.23	0.09	1.32	1.32	XXX
92584	.....	A	Electrocochleography	0.00	0.72	0.72	0.25	0.97	0.97	XXX
92585	.....	A	Auditory evoked potential	0.50	1.82	1.82	0.31	2.63	2.63	XXX
92585	26	A	Auditory evoked potential	0.50	0.21	0.21	0.14	0.85	0.85	XXX
92585	TC	A	Auditory evoked potential	0.00	1.60	1.60	0.17	1.77	1.77	XXX
92587	.....	A	Evoked auditory test	0.13	0.54	0.54	0.13	0.80	0.80	XXX
92587	26	A	Evoked auditory test	0.13	0.07	0.07	0.01	0.21	0.21	XXX
92587	TC	A	Evoked auditory test	0.00	0.48	0.48	0.12	0.60	0.60	XXX
92588	.....	A	Evoked auditory test	0.36	0.68	0.68	0.16	1.20	1.20	XXX
92588	26	A	Evoked auditory test	0.36	0.23	0.23	0.02	0.61	0.61	XXX
92588	TC	A	Evoked auditory test	0.00	0.45	0.45	0.14	0.59	0.59	XXX
92589	.....	A	Auditory function test(s)	0.00	0.76	0.76	0.06	0.82	0.82	XXX
92596	.....	A	Ear protector evaluation	0.00	0.51	0.51	0.06	0.57	0.57	XXX
92597	.....	A	Oral speech device eval	1.35	1.20	1.10	0.11	2.66	2.56	XXX
92598	.....	A	Modify oral speech device	0.99	0.85	0.64	0.07	1.91	1.70	XXX
92950	.....	A	Heart/lung resuscitation (CPR)	3.80	1.37	0.91	0.17	5.34	4.88	000
92953	.....	A	Temporary external pacing	0.23	NA	0.18	0.15	NA	0.56	000
92960	.....	A	Heart electroconversion	2.25	1.54	2.11	0.16	3.95	4.52	000
92970	.....	A	Cardioassist, internal	3.52	NA	2.95	0.41	NA	6.88	000
92971	.....	A	Cardioassist, external	1.77	NA	0.82	0.08	NA	2.67	000
92975	.....	A	Dissolve clot, heart vessel	7.25	NA	7.60	0.42	NA	15.27	000
92977	.....	A	Dissolve clot, heart vessel	0.00	NA	0.05	0.54	NA	0.59	XXX
92978	.....	A	Intravas us, heart (add-on)	1.80	NA	3.53	0.36	NA	5.69	ZZZ
92978	26	A	Intravas us, heart (add-on)	1.80	NA	1.80	0.08	NA	3.68	ZZZ
92978	TC	A	Intravas us, heart (add-on)	0.00	NA	1.73	0.28	NA	2.01	ZZZ
92979	.....	A	Intravas us, heart (add-on)	1.44	NA	1.78	0.20	NA	3.42	ZZZ
92979	26	A	Intravas us, heart (add-on)	1.44	NA	1.44	0.06	NA	2.94	ZZZ
92979	TC	A	Intravas us, heart (add-on)	0.00	NA	0.34	0.14	NA	0.48	ZZZ
92980	.....	A	Insert intracoronary stent	14.84	NA	10.01	1.22	NA	26.07	000
92981	.....	A	Insert intracoronary stent	4.17	NA	2.05	0.44	NA	6.66	ZZZ
92982	.....	A	Coronary artery dilation	10.98	NA	7.50	1.22	NA	19.70	000
92984	.....	A	Coronary artery dilation	2.97	NA	1.51	0.44	NA	4.92	ZZZ
92986	.....	A	Revision of aortic valve	21.80	NA	11.60	0.90	NA	34.30	090
92987	.....	A	Revision of mitral valve	22.70	NA	12.14	0.91	NA	35.75	090
92990	.....	A	Revision of pulmonary valve	17.34	NA	9.28	0.71	NA	27.33	090
92995	.....	A	Coronary atherectomy	12.09	NA	8.11	1.22	NA	21.42	000
92996	.....	A	Coronary atherectomy	3.26	NA	1.55	0.44	NA	5.25	ZZZ
92997	.....	A	Pul art balloon repair, perc	12.00	NA	17.22	1.22	NA	30.44	000
92998	.....	A	Pul art balloon repair, perc	6.00	NA	6.16	0.44	NA	12.60	ZZZ
93000	.....	A	Electrocardiogram, complete	0.17	0.24	0.24	0.04	0.45	0.45	XXX
93005	.....	A	Electrocardiogram, tracing	0.00	0.16	0.16	0.03	0.19	0.19	XXX
93010	.....	A	Electrocardiogram report	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93012	.....	A	Transmission of ecg	0.00	0.27	0.27	0.22	0.49	0.49	XXX
93014	.....	A	Report on transmitted ecg	0.52	0.24	0.24	0.05	0.81	0.81	XXX
93015	.....	A	Cardiovascular stress test	0.75	1.86	1.86	0.18	2.79	2.79	XXX
93016	.....	A	Cardiovascular stress test	0.45	0.19	0.19	0.03	0.67	0.67	XXX
93017	.....	A	Cardiovascular stress test	0.00	1.40	1.40	0.12	1.52	1.52	XXX
93018	.....	A	Cardiovascular stress test	0.30	0.13	0.13	0.03	0.46	0.46	XXX
93024	.....	A	Cardiac drug stress test	1.17	1.38	1.38	0.23	2.78	2.78	XXX
93024	26	A	Cardiac drug stress test	1.17	0.58	0.58	0.14	1.89	1.89	XXX
93024	TC	A	Cardiac drug stress test	0.00	0.80	0.80	0.09	0.89	0.89	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
93040	.....	A	Rhythm ECG with report	0.16	0.25	0.25	0.02	0.43	0.43	XXX
93041	.....	A	Rhythm ECG, tracing	0.00	0.04	0.04	0.01	0.05	0.05	XXX
93042	.....	A	Rhythm ECG, report	0.16	0.04	0.04	0.01	0.21	0.21	XXX
93224	.....	A	ECG monitor/report, 24 hrs	0.52	0.54	0.54	0.31	1.37	1.37	XXX
93225	.....	A	ECG monitor/record, 24 hrs	0.00	0.09	0.09	0.09	0.18	0.18	XXX
93226	.....	A	ECG monitor/report, 24 hrs	0.00	0.25	0.25	0.16	0.41	0.41	XXX
93227	.....	A	ECG monitor/review, 24 hrs	0.52	0.22	0.22	0.06	0.80	0.80	XXX
93230	.....	A	ECG monitor/report, 24 hrs	0.52	0.51	0.51	0.34	1.37	1.37	XXX
93231	.....	A	Ecg monitor/record, 24 hrs	0.00	0.09	0.09	0.11	0.20	0.20	XXX
93232	.....	A	ECG monitor/report, 24 hrs	0.00	0.25	0.25	0.15	0.40	0.40	XXX
93233	.....	A	ECG monitor/review, 24 hrs	0.52	0.22	0.22	0.08	0.82	0.82	XXX
93235	.....	A	ECG monitor/report, 24 hrs	0.45	0.41	0.41	0.23	1.09	1.09	XXX
93236	.....	A	ECG monitor/report, 24 hrs	0.00	0.26	0.26	0.17	0.43	0.43	XXX
93237	.....	A	ECG monitor/review, 24 hrs	0.45	0.18	0.18	0.06	0.69	0.69	XXX
93268	.....	A	ECG record/review	0.52	0.66	0.66	0.36	1.54	1.54	XXX
93270	.....	A	ECG recording	0.00	0.14	0.14	0.09	0.23	0.23	XXX
93271	.....	A	Ecg/monitoring and anaylysis	0.00	0.27	0.27	0.22	0.49	0.49	XXX
93272	.....	A	Ecg/review, interpret only	0.52	0.23	0.23	0.05	0.80	0.80	XXX
93278	.....	A	ECG/signal-averaged	0.25	0.37	0.37	0.18	0.80	0.80	XXX
93278	26	A	ECG/signal-averaged	0.25	0.12	0.12	0.06	0.43	0.43	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.24	0.24	0.12	0.36	0.36	XXX
93303	.....	A	Echo transthoracic	1.30	2.23	2.23	0.36	3.89	3.89	XXX
93303	26	A	Echo transthoracic	1.30	0.63	0.63	0.09	2.02	2.02	XXX
93303	TC	A	Echo transthoracic	0.00	1.60	1.60	0.27	1.87	1.87	XXX
93304	.....	A	Echo transthoracic	0.75	1.83	1.83	0.19	2.77	2.77	XXX
93304	26	A	Echo transthoracic	0.75	0.33	0.33	0.05	1.13	1.13	XXX
93304	TC	A	Echo transthoracic	0.00	1.50	1.50	0.14	1.64	1.64	XXX
93307	.....	A	Echo exam of heart	0.92	1.65	1.65	0.36	2.93	2.93	XXX
93307	26	A	Echo exam of heart	0.92	0.47	0.47	0.09	1.48	1.48	XXX
93307	TC	A	Echo exam of heart	0.00	1.18	1.18	0.27	1.45	1.45	XXX
93308	.....	A	Echo exam of heart	0.53	1.53	1.53	0.19	2.25	2.25	XXX
93308	26	A	Echo exam of heart	0.53	0.22	0.22	0.05	0.80	0.80	XXX
93308	TC	A	Echo exam of heart	0.00	1.31	1.31	0.14	1.45	1.45	XXX
93312	.....	A	Echo transesophageal	2.20	6.02	6.02	0.45	8.67	8.67	XXX
93312	26	A	Echo transesophageal	2.20	0.84	0.84	0.12	3.16	3.16	XXX
93312	TC	A	Echo transesophageal	0.00	5.18	5.18	0.33	5.51	5.51	XXX
93313	.....	A	Echo transesophageal	0.95	4.58	0.45	0.06	5.59	1.46	XXX
93314	.....	A	Echo transesophageal	1.25	4.32	4.32	0.39	5.96	5.96	XXX
93314	26	A	Echo transesophageal	1.25	0.60	0.60	0.06	1.91	1.91	XXX
93314	TC	A	Echo transesophageal	0.00	3.72	3.72	0.33	4.05	4.05	XXX
93315	.....	A	Echo transesophageal	2.78	7.36	7.36	0.45	10.59	10.59	XXX
93315	26	A	Echo transesophageal	2.78	1.30	1.30	0.12	4.20	4.20	XXX
93315	TC	A	Echo transesophageal	0.00	6.06	6.06	0.33	6.39	6.39	XXX
93316	.....	A	Echo transesophageal	0.95	0.79	0.46	0.06	1.80	1.47	XXX
93317	.....	A	Echo transesophageal	1.83	1.64	1.64	0.39	3.86	3.86	XXX
93317	26	A	Echo transesophageal	1.83	0.68	0.68	0.06	2.57	2.57	XXX
93317	TC	A	Echo transesophageal	0.00	0.96	0.96	0.33	1.29	1.29	XXX
93320	.....	A	Doppler echo exam, heart	0.38	0.81	0.81	0.18	1.37	1.37	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.21	0.21	0.05	0.64	0.64	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	0.60	0.60	0.13	0.73	0.73	ZZZ
93321	.....	A	Doppler echo exam, heart	0.15	0.58	0.58	0.11	0.84	0.84	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.08	0.08	0.02	0.25	0.25	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.50	0.50	0.09	0.59	0.59	ZZZ
93325	.....	A	Doppler color flow	0.07	0.39	0.39	0.25	0.71	0.71	ZZZ
93325	26	A	Doppler color flow	0.07	0.04	0.04	0.01	0.12	0.12	ZZZ
93325	TC	A	Doppler color flow	0.00	0.35	0.35	0.24	0.59	0.59	ZZZ
93350	.....	A	Echo transthoracic	0.78	7.46	7.46	0.24	8.48	8.48	XXX
93350	26	A	Echo transthoracic	0.78	0.43	0.43	0.10	1.31	1.31	XXX
93350	TC	A	Echo transthoracic	0.00	7.04	7.04	0.14	7.18	7.18	XXX
93501	.....	A	Right heart catheterization	3.02	17.41	17.41	1.54	21.97	21.97	000
93501	26	A	Right heart catheterization	3.02	1.27	1.27	0.34	4.63	4.63	000
93501	TC	A	Right heart catheterization	0.00	16.13	16.13	1.20	17.33	17.33	000
93503	.....	A	Insert/place heart catheter	2.91	1.14	0.72	0.36	4.41	3.99	000
93505	.....	A	Biopsy of heart lining	4.38	3.83	3.83	0.46	8.67	8.67	000
93505	26	A	Biopsy of heart lining	4.38	1.94	1.94	0.28	6.60	6.60	000
93505	TC	A	Biopsy of heart lining	0.00	1.89	1.89	0.18	2.07	2.07	000
93508	.....	A	Cath placement, angiography	4.10	16.13	16.13	0.98	21.21	21.21	000
93508	26	A	Cath placement, angiography	4.10	4.11	4.11	0.23	8.44	8.44	000
93508	TC	A	Cath placement, angiography	0.00	12.03	12.03	0.75	12.78	12.78	000
93510	.....	A	Left heart catheterization	4.33	37.21	37.21	2.86	44.40	44.40	000
93510	26	A	Left heart catheterization	4.33	1.94	1.94	0.23	6.50	6.50	000
93510	TC	A	Left heart catheterization	0.00	35.27	35.27	2.63	37.90	37.90	000
93511	.....	A	Left heart catheterization	5.03	36.62	36.62	2.76	44.41	44.41	000
93511	26	A	Left heart catheterization	5.03	2.28	2.28	0.20	7.51	7.51	000

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[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
93511	TC	A	Left heart catheterization	0.00	34.34	34.34	2.56	36.90	36.90	000
93514		A	Left heart catheterization	7.05	37.51	37.51	2.94	47.50	47.50	000
93514	26	A	Left heart catheterization	7.05	3.17	3.17	0.38	10.60	10.60	000
93514	TC	A	Left heart catheterization	0.00	34.34	34.34	2.56	36.90	36.90	000
93524		A	Left heart catheterization	6.95	48.01	48.01	3.69	58.65	58.65	000
93524	26	A	Left heart catheterization	6.95	3.15	3.15	0.34	10.44	10.44	000
93524	TC	A	Left heart catheterization	0.00	44.86	44.86	3.35	48.21	48.21	000
93526		A	Rt & Lt heart catheters	5.99	48.77	48.77	3.83	58.59	58.59	000
93526	26	A	Rt & Lt heart catheters	5.99	2.67	2.67	0.39	9.05	9.05	000
93526	TC	A	Rt & Lt heart catheters	0.00	46.10	46.10	3.44	49.54	49.54	000
93527		A	Rt & Lt heart catheters	7.28	48.10	48.10	3.85	59.23	59.23	000
93527	26	A	Rt & Lt heart catheters	7.28	3.23	3.23	0.50	11.01	11.01	000
93527	TC	A	Rt & Lt heart catheters	0.00	44.86	44.86	3.35	48.21	48.21	000
93528		A	Rt & Lt heart catheters	9.00	48.89	48.89	3.68	61.57	61.57	000
93528	26	A	Rt & Lt heart catheters	9.00	4.02	4.02	0.33	13.35	13.35	000
93528	TC	A	Rt & Lt heart catheters	0.00	44.86	44.86	3.35	48.21	48.21	000
93529		A	Rt, Lt heart catheterization	4.80	46.95	46.95	3.57	55.32	55.32	000
93529	26	A	Rt, Lt heart catheterization	4.80	2.09	2.09	0.22	7.11	7.11	000
93529	TC	A	Rt, Lt heart catheterization	0.00	44.86	44.86	3.35	48.21	48.21	000
93530		A	Rt heart cath, congenital	4.23	17.84	17.84	1.54	23.61	23.61	000
93530	26	A	Rt heart cath, congenital	4.23	1.70	1.70	0.34	6.27	6.27	000
93530	TC	A	Rt heart cath, congenital	0.00	16.13	16.13	1.20	17.33	17.33	000
93531		A	R & l heart cath, congenital	8.35	49.83	49.83	3.83	62.01	62.01	000
93531	26	A	R & l heart cath, congenital	8.35	3.73	3.73	0.39	12.47	12.47	000
93531	TC	A	R & l heart cath, congenital	0.00	46.10	46.10	3.44	49.54	49.54	000
93532		A	R & l heart cath, congenital	10.00	49.02	49.02	3.85	62.87	62.87	000
93532	26	A	R & l heart cath, congenital	10.00	4.15	4.15	0.50	14.65	14.65	000
93532	TC	A	R & l heart cath, congenital	0.00	44.86	44.86	3.35	48.21	48.21	000
93533		A	R & l heart cath, congenital	6.70	47.27	47.27	3.57	57.54	57.54	000
93533	26	A	R & l heart cath, congenital	6.70	2.40	2.40	0.22	9.32	9.32	000
93533	TC	A	R & l heart cath, congenital	0.00	44.86	44.86	3.35	48.21	48.21	000
93536		A	Insert circulation assi	4.85	NA	3.18	0.71	NA	8.74	000
93539		A	Injection, cardiac cath	0.40	0.19	0.52	0.20	0.79	1.12	000
93540		A	Injection, cardiac cath	0.43	0.20	0.53	0.20	0.83	1.16	000
93541		A	Injection for lung angiogram	0.29	NA	0.21	0.16	NA	0.66	000
93542		A	Injection for heart x-rays	0.29	NA	0.34	0.16	NA	0.79	000
93543		A	Injection for heart x-rays	0.29	0.35	0.55	0.11	0.75	0.95	000
93544		A	Injection for aortography	0.25	0.11	0.32	0.11	0.47	0.68	000
93545		A	Injection for coronary xrays	0.40	0.53	0.85	0.24	1.17	1.49	000
93555		A	Imaging, cardiac cath	0.81	6.35	6.35	0.42	7.58	7.58	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.36	0.36	0.04	1.21	1.21	XXX
93555	TC	A	Imaging, cardiac cath	0.00	5.99	5.99	0.38	6.37	6.37	XXX
93556		A	Imaging, cardiac cath	0.83	9.81	9.81	0.65	11.29	11.29	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.37	0.37	0.07	1.27	1.27	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.44	9.44	0.58	10.02	10.02	XXX
93561		A	Cardiac output measurement	0.50	0.64	0.64	0.16	1.30	1.30	000
93561	26	A	Cardiac output measurement	0.50	0.14	0.14	0.09	0.73	0.73	000
93561	TC	A	Cardiac output measurement	0.00	0.50	0.50	0.07	0.57	0.57	000
93562		A	Cardiac output measurement	0.16	0.35	0.35	0.10	0.61	0.61	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.06	0.27	0.27	000
93562	TC	A	Cardiac output measurement	0.00	0.30	0.30	0.04	0.34	0.34	000
93600		A	Bundle of His recording	2.12	2.18	2.18	0.38	4.68	4.68	000
93600	26	A	Bundle of His recording	2.12	0.86	0.86	0.24	3.22	3.22	000
93600	TC	A	Bundle of His recording	0.00	1.32	1.32	0.14	1.46	1.46	000
93602		A	Intra-atrial recording	2.12	2.39	2.39	0.22	4.73	4.73	000
93602	26	A	Intra-atrial recording	2.12	0.94	0.94	0.14	3.20	3.20	000
93602	TC	A	Intra-atrial recording	0.00	1.45	1.45	0.08	1.53	1.53	000
93603		A	Right ventricular recording	2.12	1.75	1.75	0.28	4.15	4.15	000
93603	26	A	Right ventricular recording	2.12	0.68	0.68	0.16	2.96	2.96	000
93603	TC	A	Right ventricular recording	0.00	1.07	1.07	0.12	1.19	1.19	000
93607		A	Right ventricular recording	3.26	2.86	2.86	0.28	6.40	6.40	000
93607	26	A	Right ventricular recording	3.26	1.42	1.42	0.17	4.85	4.85	000
93607	TC	A	Right ventricular recording	0.00	1.44	1.44	0.11	1.55	1.55	000
93609		A	Mapping of tachycardia	10.07	8.41	8.41	0.47	18.95	18.95	000
93609	26	A	Mapping of tachycardia	10.07	4.37	4.37	0.28	14.72	14.72	000
93609	TC	A	Mapping of tachycardia	0.00	4.04	4.04	0.19	4.23	4.23	000
93610		A	Intra-atrial pacing	3.02	3.91	3.91	0.27	7.20	7.20	000
93610	26	A	Intra-atrial pacing	3.02	1.31	1.31	0.17	4.50	4.50	000
93610	TC	A	Intra-atrial pacing	0.00	2.60	2.60	0.10	2.70	2.70	000
93612		A	Intraventricular pacing	3.02	4.00	4.00	0.29	7.31	7.31	000
93612	26	A	Intraventricular pacing	3.02	1.35	1.35	0.17	4.54	4.54	000
93612	TC	A	Intraventricular pacing	0.00	2.65	2.65	0.12	2.77	2.77	000
93615		A	Esophageal recording	0.99	0.98	0.98	0.04	2.01	2.01	000
93615	26	A	Esophageal recording	0.99	0.20	0.20	0.02	1.21	1.21	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
93615	TC	A	Esophageal recording	0.00	0.78	0.78	0.02	0.80	0.80	000
93616		A	Esophageal recording	1.49	1.25	1.25	0.10	2.84	2.84	000
93616	26	A	Esophageal recording	1.49	0.43	0.43	0.08	2.00	2.00	000
93616	TC	A	Esophageal recording	0.00	0.82	0.82	0.02	0.84	0.84	000
93618		A	Heart rhythm pacing	4.26	3.90	3.90	0.72	8.88	8.88	000
93618	26	A	Heart rhythm pacing	4.26	1.87	1.87	0.44	6.57	6.57	000
93618	TC	A	Heart rhythm pacing	0.00	2.03	2.03	0.28	2.31	2.31	000
93619		A	Electrophysiology evaluation	7.32	6.28	6.28	1.40	15.00	15.00	000
93619	26	A	Electrophysiology evaluation	7.32	3.24	3.24	0.86	11.42	11.42	000
93619	TC	A	Electrophysiology evaluation	0.00	3.05	3.05	0.54	3.59	3.59	000
93620		A	Electrophysiology evaluation	11.59	6.65	6.65	1.55	19.79	19.79	000
93620	26	A	Electrophysiology evaluation	11.59	5.10	5.10	0.95	17.64	17.64	000
93620	TC	A	Electrophysiology evaluation	0.00	1.55	1.55	0.60	2.15	2.15	000
93621	26	A	Electrophysiology evaluation	12.66	5.66	5.66	1.11	19.43	19.43	000
93622	26	A	Electrophysiology evaluation	12.74	5.71	5.71	1.07	19.52	19.52	000
93623	26	A	Stimulation, pacing heart	2.85	1.27	1.27	0.20	4.32	4.32	000
93624		A	Electrophysiologic study	4.81	4.05	4.05	0.35	9.21	9.21	000
93624	26	A	Electrophysiologic study	4.81	2.06	2.06	0.21	7.08	7.08	000
93624	TC	A	Electrophysiologic study	0.00	1.99	1.99	0.14	2.13	2.13	000
93631		A	Heart pacing, mapping	7.60	4.14	4.14	1.37	13.11	13.11	000
93631	26	A	Heart pacing, mapping	7.60	3.35	3.35	0.67	11.62	11.62	000
93631	TC	A	Heart pacing, mapping	0.00	0.78	0.78	0.70	1.48	1.48	000
93640		A	Evaluation heart device	3.52	3.38	3.38	1.09	7.99	7.99	000
93640	26	A	Evaluation heart device	3.52	1.58	1.58	0.61	5.71	5.71	000
93640	TC	A	Evaluation heart device	0.00	1.80	1.80	0.48	2.28	2.28	000
93641		A	Electrophysiology evaluation	5.93	5.93	5.93	1.09	12.95	12.95	000
93641	26	A	Electrophysiology evaluation	5.93	2.64	2.64	0.61	9.18	9.18	000
93641	TC	A	Electrophysiology evaluation	0.00	3.30	3.30	0.48	3.78	3.78	000
93642		A	Electrophysiology evaluation	4.89	3.97	3.97	1.09	9.95	9.95	000
93642	26	A	Electrophysiology evaluation	4.89	2.17	2.17	0.61	7.67	7.67	000
93642	TC	A	Electrophysiology evaluation	0.00	1.80	1.80	0.48	2.28	2.28	000
93650		A	Ablate heart dysrhythm focus	10.51	NA	6.17	1.34	NA	18.02	000
93651		A	Ablate heart dysrhythm focus	16.25	NA	10.49	1.34	NA	28.08	000
93652		A	Ablate heart dysrhythm focus	17.68	NA	10.98	1.34	NA	30.00	000
93660	26	A	Tilt table evaluation	1.89	0.84	0.84	0.17	2.90	2.90	000
93720		A	Total body plethysmography	0.17	0.55	0.55	0.10	0.82	0.82	XXX
93721		A	Plethysmography tracing	0.00	0.55	0.55	0.07	0.62	0.62	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.03	0.25	0.25	XXX
93724		A	Analyze pacemaker system	4.89	2.85	2.85	0.50	8.24	8.24	000
93724	26	A	Analyze pacemaker system	4.89	2.14	2.14	0.22	7.25	7.25	000
93724	TC	A	Analyze pacemaker system	0.00	0.71	0.71	0.28	0.99	0.99	000
93731		A	Analyze pacemaker system	0.45	0.59	0.59	0.07	1.11	1.11	XXX
93731	26	A	Analyze pacemaker system	0.45	0.21	0.21	0.03	0.69	0.69	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.38	0.38	0.04	0.42	0.42	XXX
93732		A	Analyze pacemaker system	0.92	0.85	0.85	0.08	1.85	1.85	XXX
93732	26	A	Analyze pacemaker system	0.92	0.42	0.42	0.04	1.38	1.38	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.44	0.44	0.04	0.48	0.48	XXX
93733		A	Telephone analysis, pacemaker	0.17	0.21	0.21	0.08	0.46	0.46	XXX
93733	26	A	Telephone analysis, pacemaker	0.17	0.09	0.09	0.02	0.28	0.28	XXX
93733	TC	A	Telephone analysis, pacemaker	0.00	0.11	0.11	0.06	0.17	0.17	XXX
93734		A	Analyze pacemaker system	0.38	0.50	0.50	0.06	0.94	0.94	XXX
93734	26	A	Analyze pacemaker system	0.38	0.18	0.18	0.03	0.59	0.59	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.32	0.32	0.03	0.35	0.35	XXX
93735		A	Analyze pacemaker system	0.74	0.68	0.68	0.08	1.50	1.50	XXX
93735	26	A	Analyze pacemaker system	0.74	0.33	0.33	0.04	1.11	1.11	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.35	0.35	0.04	0.39	0.39	XXX
93736		A	Telephone analysis, pacemaker	0.15	0.20	0.20	0.09	0.44	0.44	XXX
93736	26	A	Telephone analysis, pacemaker	0.15	0.09	0.09	0.03	0.27	0.27	XXX
93736	TC	A	Telephone analysis, pacemaker	0.00	0.11	0.11	0.06	0.17	0.17	XXX
93737		A	Analyze cardio/defibrillator	0.45	0.60	0.60	0.06	1.11	1.11	XXX
93737	26	A	Analyze cardio/defibrillator	0.45	0.21	0.21	0.02	0.68	0.68	XXX
93737	TC	A	Analyze cardio/defibrillator	0.00	0.39	0.39	0.04	0.43	0.43	XXX
93738		A	Analyze cardio/defibrillator	0.92	0.86	0.86	0.07	1.85	1.85	XXX
93738	26	A	Analyze cardio/defibrillator	0.92	0.43	0.43	0.03	1.38	1.38	XXX
93738	TC	A	Analyze cardio/defibrillator	0.00	0.43	0.43	0.04	0.47	0.47	XXX
93740		A	Temperature gradient studies	0.16	0.49	0.49	0.04	0.69	0.69	XXX
93740	26	A	Temperature gradient studies	0.16	0.03	0.03	0.03	0.22	0.22	XXX
93740	TC	A	Temperature gradient studies	0.00	0.46	0.46	0.01	0.47	0.47	XXX
93770		A	Measure venous pressure	0.16	0.52	0.52	0.02	0.70	0.70	XXX
93770	26	A	Measure venous pressure	0.16	0.09	0.09	0.02	0.27	0.27	XXX
93770	TC	A	Measure venous pressure	0.00	0.43	0.43	0.00	0.43	0.43	XXX
93797		A	Cardiac rehab	0.18	0.27	0.08	0.02	0.47	0.28	000
93798		A	Cardiac rehab/monitor	0.28	0.41	0.12	0.04	0.73	0.44	000
93875		A	Extracranial study	0.22	0.95	0.95	0.18	1.35	1.35	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
93875	26	A	Extracranial study	0.22	0.11	0.11	0.06	0.39	0.39	XXX
93875	TC	A	Extracranial study	0.00	0.84	0.84	0.12	0.96	0.96	XXX
93880		A	Extracranial study	0.60	2.31	2.31	0.44	3.35	3.35	XXX
93880	26	A	Extracranial study	0.60	0.26	0.26	0.04	0.90	0.90	XXX
93880	TC	A	Extracranial study	0.00	2.05	2.05	0.40	2.45	2.45	XXX
93882		A	Extracranial study	0.40	2.02	2.02	0.29	2.71	2.71	XXX
93882	26	A	Extracranial study	0.40	0.20	0.20	0.03	0.63	0.63	XXX
93882	TC	A	Extracranial study	0.00	1.82	1.82	0.26	2.08	2.08	XXX
93886		A	Intracranial study	0.94	2.55	2.55	0.50	3.99	3.99	XXX
93886	26	A	Intracranial study	0.94	0.45	0.45	0.05	1.44	1.44	XXX
93886	TC	A	Intracranial study	0.00	2.10	2.10	0.45	2.55	2.55	XXX
93888		A	Intracranial study	0.62	1.85	1.85	0.34	2.81	2.81	XXX
93888	26	A	Intracranial study	0.62	0.26	0.26	0.03	0.91	0.91	XXX
93888	TC	A	Intracranial study	0.00	1.60	1.60	0.31	1.91	1.91	XXX
93922		A	Extremity study	0.25	1.22	1.22	0.19	1.66	1.66	XXX
93922	26	A	Extremity study	0.25	0.12	0.12	0.05	0.42	0.42	XXX
93922	TC	A	Extremity study	0.00	1.10	1.10	0.14	1.24	1.24	XXX
93923		A	Extremity study	0.45	1.50	1.50	0.35	2.30	2.30	XXX
93923	26	A	Extremity study	0.45	0.25	0.25	0.09	0.79	0.79	XXX
93923	TC	A	Extremity study	0.00	1.25	1.25	0.26	1.51	1.51	XXX
93924		A	Extremity study	0.50	2.30	2.30	0.39	3.19	3.19	XXX
93924	26	A	Extremity study	0.50	0.20	0.20	0.10	0.80	0.80	XXX
93924	TC	A	Extremity study	0.00	2.10	2.10	0.29	2.39	2.39	XXX
93925		A	Lower extremity study	0.58	2.47	2.47	0.44	3.49	3.49	XXX
93925	26	A	Lower extremity study	0.58	0.29	0.29	0.04	0.91	0.91	XXX
93925	TC	A	Lower extremity study	0.00	2.18	2.18	0.40	2.58	2.58	XXX
93926		A	Lower extremity study	0.39	1.86	1.86	0.30	2.55	2.55	XXX
93926	26	A	Lower extremity study	0.39	0.15	0.15	0.03	0.57	0.57	XXX
93926	TC	A	Lower extremity study	0.00	1.72	1.72	0.27	1.99	1.99	XXX
93930		A	Upper extremity study	0.46	2.31	2.31	0.47	3.24	3.24	XXX
93930	26	A	Upper extremity study	0.46	0.24	0.24	0.05	0.75	0.75	XXX
93930	TC	A	Upper extremity study	0.00	2.07	2.07	0.42	2.49	2.49	XXX
93931		A	Upper extremity study	0.31	1.56	1.56	0.31	2.18	2.18	XXX
93931	26	A	Upper extremity study	0.31	0.16	0.16	0.03	0.50	0.50	XXX
93931	TC	A	Upper extremity study	0.00	1.40	1.40	0.28	1.68	1.68	XXX
93965		A	Extremity study	0.35	1.05	1.05	0.19	1.59	1.59	XXX
93965	26	A	Extremity study	0.35	0.16	0.16	0.06	0.57	0.57	XXX
93965	TC	A	Extremity study	0.00	0.88	0.88	0.13	1.01	1.01	XXX
93970		A	Extremity study	0.68	2.30	2.30	0.51	3.49	3.49	XXX
93970	26	A	Extremity study	0.68	0.30	0.30	0.05	1.03	1.03	XXX
93970	TC	A	Extremity study	0.00	2.01	2.01	0.46	2.47	2.47	XXX
93971		A	Extremity study	0.45	1.57	1.57	0.34	2.36	2.36	XXX
93971	26	A	Extremity study	0.45	0.18	0.18	0.03	0.66	0.66	XXX
93971	TC	A	Extremity study	0.00	1.39	1.39	0.31	1.70	1.70	XXX
93975		A	Vascular study	1.80	3.03	3.03	0.55	5.38	5.38	XXX
93975	26	A	Vascular study	1.80	0.69	0.69	0.05	2.54	2.54	XXX
93975	TC	A	Vascular study	0.00	2.34	2.34	0.50	2.84	2.84	XXX
93976		A	Vascular study	1.21	1.94	1.94	0.37	3.52	3.52	XXX
93976	26	A	Vascular study	1.21	0.43	0.43	0.03	1.67	1.67	XXX
93976	TC	A	Vascular study	0.00	1.52	1.52	0.34	1.86	1.86	XXX
93978		A	Vascular study	0.65	2.62	2.62	0.47	3.74	3.74	XXX
93978	26	A	Vascular study	0.65	0.35	0.35	0.05	1.05	1.05	XXX
93978	TC	A	Vascular study	0.00	2.28	2.28	0.42	2.70	2.70	XXX
93979		A	Vascular study	0.44	1.69	1.69	0.31	2.44	2.44	XXX
93979	26	A	Vascular study	0.44	0.25	0.25	0.03	0.72	0.72	XXX
93979	TC	A	Vascular study	0.00	1.44	1.44	0.28	1.72	1.72	XXX
93980		A	Penile vascular study	1.25	2.84	2.84	0.45	4.54	4.54	XXX
93980	26	A	Penile vascular study	1.25	0.67	0.67	0.07	1.99	1.99	XXX
93980	TC	A	Penile vascular study	0.00	2.17	2.17	0.38	2.55	2.55	XXX
93981		A	Penile vascular study	0.44	2.27	2.27	0.39	3.10	3.10	XXX
93981	26	A	Penile vascular study	0.44	0.15	0.15	0.03	0.62	0.62	XXX
93981	TC	A	Penile vascular study	0.00	2.12	2.12	0.36	2.48	2.48	XXX
93990		A	Doppler flow testing	0.25	1.60	1.60	0.29	2.14	2.14	XXX
93990	26	A	Doppler flow testing	0.25	0.15	0.15	0.02	0.42	0.42	XXX
93990	TC	A	Doppler flow testing	0.00	1.45	1.45	0.27	1.72	1.72	XXX
94010		A	Breathing capacity test	0.17	0.45	0.45	0.05	0.67	0.67	XXX
94010	26	A	Breathing capacity test	0.17	0.06	0.06	0.02	0.25	0.25	XXX
94010	TC	A	Breathing capacity test	0.00	0.39	0.39	0.03	0.42	0.42	XXX
94060		A	Evaluation of wheezing	0.31	0.58	0.58	0.09	0.98	0.98	XXX
94060	26	A	Evaluation of wheezing	0.31	0.09	0.09	0.03	0.43	0.43	XXX
94060	TC	A	Evaluation of wheezing	0.00	0.49	0.49	0.06	0.55	0.55	XXX
94070		A	Evaluation of wheezing	0.60	2.56	2.56	0.13	3.29	3.29	XXX
94070	26	A	Evaluation of wheezing	0.60	0.18	0.18	0.03	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	2.38	2.38	0.10	2.48	2.48	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
94150		B	Vital capacity test	+0.07	0.88	0.88	0.02	0.97	0.97	XXX
94150	26	B	Vital capacity test	+0.07	0.07	0.07	0.01	0.15	0.15	XXX
94150	TC	B	Vital capacity test	+0.00	0.81	0.81	0.01	0.82	0.82	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.40	0.40	0.03	0.54	0.54	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.37	0.37	0.02	0.39	0.39	XXX
94240		A	Residual lung capacity	0.26	1.31	1.31	0.07	1.64	1.64	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.02	0.36	0.36	XXX
94240	TC	A	Residual lung capacity	0.00	1.23	1.23	0.05	1.28	1.28	XXX
94250		A	Expired gas collection	0.11	0.41	0.41	0.02	0.54	0.54	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.37	0.37	0.01	0.38	0.38	XXX
94260		A	Thoracic gas volume	0.13	0.31	0.31	0.06	0.50	0.50	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.02	0.19	0.19	XXX
94260	TC	A	Thoracic gas volume	0.00	0.28	0.28	0.04	0.32	0.32	XXX
94350		A	Lung nitrogen washout curve	0.26	1.37	1.37	0.05	1.68	1.68	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	1.29	1.29	0.04	1.33	1.33	XXX
94360		A	Measure airflow resistance	0.26	0.39	0.39	0.07	0.72	0.72	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.31	0.31	0.06	0.37	0.37	XXX
94370		A	Breath airway closing volume	0.26	1.58	1.58	0.03	1.87	1.87	XXX
94370	26	A	Breath airway closing volume	0.26	0.09	0.09	0.01	0.36	0.36	XXX
94370	TC	A	Breath airway closing volume	0.00	1.49	1.49	0.02	1.51	1.51	XXX
94375		A	Respiratory flow volume loop	0.31	0.48	0.48	0.04	0.83	0.83	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.10	0.10	0.01	0.42	0.42	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.38	0.38	0.03	0.41	0.41	XXX
94400		A	CO2 breathing response curve	0.40	0.62	0.62	0.19	1.21	1.21	XXX
94400	26	A	CO2 breathing response curve	0.40	0.13	0.13	0.13	0.66	0.66	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.49	0.49	0.06	0.55	0.55	XXX
94450		A	Hypoxia response curve	0.40	0.91	0.91	0.05	1.36	1.36	XXX
94450	26	A	Hypoxia response curve	0.40	0.42	0.42	0.02	0.84	0.84	XXX
94450	TC	A	Hypoxia response curve	0.00	0.49	0.49	0.03	0.52	0.52	XXX
94620		A	Pulmonary stress testing	0.88	2.00	2.00	0.15	3.03	3.03	XXX
94620	26	A	Pulmonary stress testing	0.88	0.30	0.30	0.05	1.23	1.23	XXX
94620	TC	A	Pulmonary stress testing	0.00	1.70	1.70	0.10	1.80	1.80	XXX
94640		A	Airway inhalation treatment	0.00	0.35	0.02	0.03	0.38	0.05	XXX
94650		A	Pressure breathing (IPPB)	0.00	0.36	0.02	0.03	0.39	0.05	XXX
94651		A	Pressure breathing (IPPB)	0.00	0.36	0.02	0.03	0.39	0.05	XXX
94652		A	Pressure breathing (IPPB)	0.00	NA	0.02	0.08	NA	0.10	XXX
94656		A	Initial ventilator mgmt	1.22	NA	0.37	0.12	NA	1.71	XXX
94657		A	Cont. ventilator	0.83	NA	0.29	0.05	NA	1.17	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.48	0.28	0.06	1.30	1.10	XXX
94662		A	Neg pressure ventilation,cnp	0.76	NA	0.30	0.02	NA	1.08	XXX
94664		A	Aerosol or vapor inhalations	0.00	0.27	0.02	0.04	0.31	0.06	XXX
94665		A	Aerosol or vapor inhalations	0.00	0.31	0.02	0.05	0.36	0.07	XXX
94667		A	Chest wall manipulation	0.00	0.43	0.02	0.05	0.48	0.07	XXX
94668		A	Chest wall manipulation	0.00	0.43	0.02	0.03	0.46	0.05	XXX
94680		A	Exhaled air analysis: O2	0.26	1.12	1.12	0.10	1.48	1.48	XXX
94680	26	A	Exhaled air analysis: O2	0.26	0.06	0.06	0.03	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis: O2	0.00	1.05	1.05	0.07	1.12	1.12	XXX
94681		A	Exhaled air analysis: O2,CO2	0.20	1.74	1.74	0.17	2.11	2.11	XXX
94681	26	A	Exhaled air analysis: O2,CO2	0.20	0.08	0.08	0.04	0.32	0.32	XXX
94681	TC	A	Exhaled air analysis: O2,CO2	0.00	1.66	1.66	0.13	1.79	1.79	XXX
94690		A	Exhaled air analysis	0.07	1.30	1.30	0.04	1.41	1.41	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.00	0.10	0.10	XXX
94690	TC	A	Exhaled air analysis	0.00	1.26	1.26	0.04	1.30	1.30	XXX
94720		A	Monoxide diffusing capacity	0.26	1.04	1.04	0.08	1.38	1.38	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.07	0.07	0.02	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.97	0.97	0.06	1.03	1.03	XXX
94725		A	Membrane diffusion capacity	0.26	1.88	1.88	0.14	2.28	2.28	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.09	0.09	0.01	0.36	0.36	XXX
94725	TC	A	Membrane diffusion capacity	0.00	1.79	1.79	0.13	1.92	1.92	XXX
94750		A	Pulmonary compliance study	0.23	2.78	2.78	0.06	3.07	3.07	XXX
94750	26	A	Pulmonary compliance study	0.23	0.15	0.15	0.02	0.40	0.40	XXX
94750	TC	A	Pulmonary compliance study	0.00	2.63	2.63	0.04	2.67	2.67	XXX
94760		A	Measure blood oxygen level	0.00	0.04	0.04	0.02	0.06	0.06	XXX
94761		A	Measure blood oxygen level	0.00	0.09	0.09	0.06	0.15	0.15	XXX
94762		A	Measure blood oxygen level	0.00	0.11	0.11	0.10	0.21	0.21	XXX
94770		A	Exhaled carbon dioxide test	0.15	1.23	1.23	0.11	1.49	1.49	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.03	0.03	0.03	0.21	0.21	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	1.20	1.20	0.08	1.28	1.28	XXX
95004		A	Allergy skin tests	0.00	0.11	0.04	0.01	0.12	0.05	XXX
95010		A	Sensitivity skin tests	0.15	0.22	0.08	0.01	0.38	0.24	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
95015		A	Sensitivity skin tests	0.15	0.25	0.07	0.01	0.41	0.23	XXX
95024		A	Allergy skin tests	0.00	0.13	0.05	0.01	0.14	0.06	XXX
95027		A	Skin end point titration	0.00	0.17	0.17	0.01	0.18	0.18	XXX
95028		A	Allergy skin tests	0.00	0.21	0.21	0.01	0.22	0.22	XXX
95044		A	Allergy patch tests	0.00	0.11	0.04	0.01	0.12	0.05	XXX
95052		A	Photo patch test	0.00	0.11	0.04	0.01	0.12	0.05	XXX
95056		A	Photosensitivity tests	0.00	0.12	0.04	0.01	0.13	0.05	XXX
95060		A	Eye allergy tests	0.00	0.48	0.48	0.02	0.50	0.50	XXX
95065		A	Nose allergy test	0.00	0.33	0.33	0.01	0.34	0.34	XXX
95070		A	Bronchial allergy tests	0.00	0.06	0.06	0.02	0.08	0.08	XXX
95071		A	Bronchial allergy tests	0.00	0.13	0.13	0.02	0.15	0.15	XXX
95075		A	Ingestion challenge test	0.95	0.72	0.45	0.02	1.69	1.42	XXX
95078		A	Provocative testing	0.00	0.10	0.10	0.02	0.12	0.12	XXX
95115		A	Immunotherapy, one injection	0.00	0.28	0.09	0.02	0.30	0.11	000
95117		A	Immunotherapy injections	0.00	0.25	0.08	0.02	0.27	0.10	000
95144		A	Antigen therapy services	0.06	0.12	0.03	0.01	0.19	0.10	000
95145		A	Antigen therapy services	0.06	0.20	0.03	0.03	0.29	0.12	000
95146		A	Antigen therapy services	0.06	0.14	0.02	0.03	0.23	0.11	000
95147		A	Antigen therapy services	0.06	0.15	0.04	0.03	0.24	0.13	000
95148		A	Antigen therapy services	0.06	0.16	0.04	0.03	0.25	0.13	000
95149		A	Antigen therapy services	0.06	0.21	0.04	0.03	0.30	0.13	000
95165		A	Antigen therapy services	0.06	0.13	0.03	0.01	0.20	0.10	000
95170		A	Antigen therapy services	0.06	0.14	0.03	0.03	0.23	0.12	000
95180		A	Rapid desensitization	2.01	1.37	1.06	0.01	3.39	3.08	000
95805		A	Multiple sleep latency test	1.88	6.89	6.89	0.45	9.22	9.22	XXX
95805	26	A	Multiple sleep latency test	1.88	0.71	0.71	0.07	2.66	2.66	XXX
95805	TC	A	Multiple sleep latency test	0.00	6.18	6.18	0.38	6.56	6.56	XXX
95806		A	Sleep study, unattended	1.66	2.84	2.84	0.55	5.05	5.05	XXX
95806	26	A	Sleep study, unattended	1.66	0.75	0.75	0.19	2.60	2.60	XXX
95806	TC	A	Sleep study, unattended	0.00	2.10	2.10	0.36	2.46	2.46	XXX
95807		A	Sleep study, attended	1.66	10.24	10.24	0.67	12.57	12.57	XXX
95807	26	A	Sleep study, attended	1.66	0.59	0.59	0.19	2.44	2.44	XXX
95807	TC	A	Sleep study, attended	0.00	9.65	9.65	0.48	10.13	10.13	XXX
95808		A	Polysomnography, 1–3	2.65	10.49	10.49	0.67	13.81	13.81	XXX
95808	26	A	Polysomnography, 1–3	2.65	0.85	0.85	0.19	3.69	3.69	XXX
95808	TC	A	Polysomnography, 1–3	0.00	9.64	9.64	0.48	10.12	10.12	XXX
95810		A	Polysomnography, 4 or more	3.53	14.22	14.22	0.67	18.42	18.42	XXX
95810	26	A	Polysomnography, 4 or more	3.53	1.39	1.39	0.19	5.11	5.11	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	12.83	12.83	0.48	13.31	13.31	XXX
95811		A	Polysomnography w/cpap	3.80	14.68	14.68	0.70	19.18	19.18	XXX
95811	26	A	Polysomnography w/cpap	3.80	1.53	1.53	0.20	5.53	5.53	XXX
95811	TC	A	Polysomnography w/cpap	0.00	13.15	13.15	0.50	13.65	13.65	XXX
95812		A	Electroencephalogram (EEG)	1.08	2.58	2.58	0.15	3.81	3.81	XXX
95812	26	A	Electroencephalogram (EEG)	1.08	0.46	0.46	0.04	1.58	1.58	XXX
95812	TC	A	Electroencephalogram (EEG)	0.00	2.12	2.12	0.11	2.23	2.23	XXX
95813		A	Electroencephalogram (EEG)	1.73	3.93	3.93	0.15	5.81	5.81	XXX
95813	26	A	Electroencephalogram (EEG)	1.73	0.79	0.79	0.04	2.56	2.56	XXX
95813	TC	A	Electroencephalogram (EEG)	0.00	3.14	3.14	0.11	3.25	3.25	XXX
95816		A	Electroencephalogram (EEG)	1.08	2.34	2.34	0.13	3.55	3.55	XXX
95816	26	A	Electroencephalogram (EEG)	1.08	0.46	0.46	0.03	1.57	1.57	XXX
95816	TC	A	Electroencephalogram (EEG)	0.00	1.88	1.88	0.10	1.98	1.98	XXX
95819		A	Electroencephalogram (EEG)	1.08	2.42	2.42	0.14	3.64	3.64	XXX
95819	26	A	Electroencephalogram (EEG)	1.08	0.46	0.46	0.04	1.58	1.58	XXX
95819	TC	A	Electroencephalogram (EEG)	0.00	1.97	1.97	0.10	2.07	2.07	XXX
95822		A	Sleep electroencephalogram	1.08	2.52	2.52	0.18	3.78	3.78	XXX
95822	26	A	Sleep electroencephalogram	1.08	0.49	0.49	0.04	1.61	1.61	XXX
95822	TC	A	Sleep electroencephalogram	0.00	2.04	2.04	0.14	2.18	2.18	XXX
95824		A	Electroencephalography	0.74	0.42	0.42	0.07	1.23	1.23	XXX
95824	26	A	Electroencephalography	0.74	0.31	0.31	0.04	1.09	1.09	XXX
95824	TC	A	Electroencephalography	0.00	0.11	0.11	0.03	0.14	0.14	XXX
95827		A	Night electroencephalogram	1.08	6.64	6.64	0.24	7.96	7.96	XXX
95827	26	A	Night electroencephalogram	1.08	0.42	0.42	0.07	1.57	1.57	XXX
95827	TC	A	Night electroencephalogram	0.00	6.22	6.22	0.17	6.39	6.39	XXX
95829		A	Surgery electrocorticogram	6.21	10.17	10.17	0.05	16.43	16.43	XXX
95829	26	A	Surgery electrocorticogram	6.21	2.53	2.53	0.03	8.77	8.77	XXX
95829	TC	A	Surgery electrocorticogram	0.00	7.64	7.64	0.02	7.66	7.66	XXX
95830		A	Insert electrodes for EEG	1.70	2.27	0.70	0.07	4.04	2.47	XXX
95831		A	Limb muscle testing, manual	0.28	0.33	0.14	0.03	0.64	0.45	XXX
95832		A	Hand muscle testing, manual	0.29	0.27	0.12	0.02	0.58	0.43	XXX
95833		A	Body muscle testing, manual	0.47	0.41	0.22	0.05	0.93	0.74	XXX
95834		A	Body muscle testing, manual	0.60	0.51	0.30	0.06	1.17	0.96	XXX
95851		A	Range of motion measurements	0.16	0.27	0.08	0.02	0.45	0.26	XXX
95852		A	Range of motion measurements	0.11	0.25	0.06	0.02	0.38	0.19	XXX
95857		A	Tensilon test	0.53	0.50	0.23	0.04	1.07	0.80	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
95858	.....	A	Tensilon test & myogram	1.56	0.76	0.76	0.09	2.41	2.41	XXX
95858	26	A	Tensilon test & myogram	1.56	0.43	0.43	0.05	2.04	2.04	XXX
95858	TC	A	Tensilon test & myogram	0.00	0.33	0.33	0.04	0.37	0.37	XXX
95860	.....	A	Muscle test, one limb	0.96	0.77	0.77	0.09	1.82	1.82	XXX
95860	26	A	Muscle test, one limb	0.96	0.46	0.46	0.06	1.48	1.48	XXX
95860	TC	A	Muscle test, one limb	0.00	0.31	0.31	0.03	0.34	0.34	XXX
95861	.....	A	Muscle test, two limbs	1.54	1.11	1.11	0.16	2.81	2.81	XXX
95861	26	A	Muscle test, two limbs	1.54	0.72	0.72	0.10	2.36	2.36	XXX
95861	TC	A	Muscle test, two limbs	0.00	0.39	0.39	0.06	0.45	0.45	XXX
95863	.....	A	Muscle test, 3 limbs	1.87	1.25	1.25	0.18	3.30	3.30	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.76	0.76	0.11	2.74	2.74	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.49	0.49	0.07	0.56	0.56	XXX
95864	.....	A	Muscle test, 4 limbs	1.99	1.27	1.27	0.27	3.53	3.53	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.92	0.92	0.14	3.05	3.05	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	0.35	0.35	0.13	0.48	0.48	XXX
95867	.....	A	Muscle test, head or neck	0.79	0.71	0.71	0.09	1.59	1.59	XXX
95867	26	A	Muscle test, head or neck	0.79	0.26	0.26	0.05	1.10	1.10	XXX
95867	TC	A	Muscle test, head or neck	0.00	0.46	0.46	0.04	0.50	0.50	XXX
95868	.....	A	Muscle test, head or neck	1.18	0.93	0.93	0.15	2.26	2.26	XXX
95868	26	A	Muscle test, head or neck	1.18	0.54	0.54	0.10	1.82	1.82	XXX
95868	TC	A	Muscle test, head or neck	0.00	0.39	0.39	0.05	0.44	0.44	XXX
95869	.....	A	Muscle test, thor paraspinal	0.37	0.40	0.40	0.05	0.82	0.82	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.19	0.19	0.03	0.59	0.59	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	0.21	0.02	0.23	0.23	XXX
95870	.....	A	Muscle test, non-paraspinal	0.37	0.87	0.87	0.05	1.29	1.29	XXX
95870	26	A	Muscle test, non-paraspinal	0.37	0.37	0.37	0.03	0.77	0.77	XXX
95870	TC	A	Muscle test, non-paraspinal	0.00	0.50	0.50	0.02	0.52	0.52	XXX
95872	.....	A	Muscle test, one fiber	1.50	1.39	1.39	0.11	3.00	3.00	XXX
95872	26	A	Muscle test, one fiber	1.50	0.56	0.56	0.06	2.12	2.12	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.83	0.83	0.05	0.88	0.88	XXX
95875	.....	A	Limb exercise test	1.34	1.50	1.50	0.10	2.94	2.94	XXX
95875	26	A	Limb exercise test	1.34	0.49	0.49	0.04	1.87	1.87	XXX
95875	TC	A	Limb exercise test	0.00	1.01	1.01	0.06	1.07	1.07	XXX
95900	.....	A	Motor nerve conduction test	0.42	0.39	0.39	0.05	0.86	0.86	XXX
95900	26	A	Motor nerve conduction test	0.42	0.20	0.20	0.03	0.65	0.65	XXX
95900	TC	A	Motor nerve conduction test	0.00	0.19	0.19	0.02	0.21	0.21	XXX
95903	.....	A	Motor nerve conduction test	0.60	0.54	0.54	0.05	1.19	1.19	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.03	0.89	0.89	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.27	0.27	0.02	0.29	0.29	XXX
95904	.....	A	Sense nerve conduction test	0.34	0.34	0.34	0.05	0.73	0.73	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.03	0.52	0.52	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.19	0.19	0.02	0.21	0.21	XXX
95920	.....	A	Intraoperative nerve testing	2.11	NA	5.56	0.20	NA	7.87	XXX
95920	26	A	Intraoperative nerve testing	2.11	NA	0.98	0.12	NA	3.21	XXX
95920	TC	A	Intraoperative nerve testing	0.00	NA	4.58	0.08	NA	4.66	XXX
95921	.....	A	Autonomic nervous func test	0.90	5.48	5.48	0.05	6.43	6.43	XXX
95921	26	A	Autonomic nervous func test	0.90	0.90	0.90	0.02	1.82	1.82	XXX
95921	TC	A	Autonomic nervous func test	0.00	4.58	4.58	0.03	4.61	4.61	XXX
95922	.....	A	Autonomic nervous func test	0.96	5.54	5.54	0.06	6.56	6.56	XXX
95922	26	A	Autonomic nervous func test	0.96	0.96	0.96	0.03	1.95	1.95	XXX
95922	TC	A	Autonomic nervous func test	0.00	4.58	4.58	0.03	4.61	4.61	XXX
95923	.....	A	Autonomic nervous func test	0.90	5.48	5.48	0.05	6.43	6.43	XXX
95923	26	A	Autonomic nervous func test	0.90	0.90	0.90	0.02	1.82	1.82	XXX
95923	TC	A	Autonomic nervous func test	0.00	4.58	4.58	0.03	4.61	4.61	XXX
95925	.....	A	Somatosensory testing	0.54	2.65	2.65	0.12	3.31	3.31	XXX
95925	26	A	Somatosensory testing	0.54	0.28	0.28	0.05	0.87	0.87	XXX
95925	TC	A	Somatosensory testing	0.00	2.37	2.37	0.07	2.44	2.44	XXX
95926	.....	A	Somatosensory testing	0.54	2.57	2.57	0.12	3.23	3.23	XXX
95926	26	A	Somatosensory testing	0.54	0.28	0.28	0.05	0.87	0.87	XXX
95926	TC	A	Somatosensory testing	0.00	2.29	2.29	0.07	2.36	2.36	XXX
95927	.....	A	Somatosensory testing	0.54	2.40	2.40	0.12	3.06	3.06	XXX
95927	26	A	Somatosensory testing	0.54	0.27	0.27	0.05	0.86	0.86	XXX
95927	TC	A	Somatosensory testing	0.00	2.13	2.13	0.07	2.20	2.20	XXX
95930	.....	A	Visual evoked potential test	0.35	1.34	1.34	0.05	1.74	1.74	XXX
95930	26	A	Visual evoked potential test	0.35	0.16	0.16	0.04	0.55	0.55	XXX
95930	TC	A	Visual evoked potential test	0.00	1.18	1.18	0.01	1.19	1.19	XXX
95933	.....	A	Blink reflex test	0.59	0.44	0.44	0.10	1.13	1.13	XXX
95933	26	A	Blink reflex test	0.59	0.21	0.21	0.04	0.84	0.84	XXX
95933	TC	A	Blink reflex test	0.00	0.24	0.24	0.06	0.30	0.30	XXX
95934	.....	A	'h' reflex test	0.51	0.50	0.50	0.05	1.06	1.06	XXX
95934	26	A	'h' reflex test	0.51	0.23	0.23	0.03	0.77	0.77	XXX
95934	TC	A	'h' reflex test	0.00	0.27	0.27	0.02	0.29	0.29	XXX
95936	.....	A	'h' reflex test	0.55	0.50	0.50	0.05	1.10	1.10	XXX
95936	26	A	'h' reflex test	0.55	0.26	0.26	0.03	0.84	0.84	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
95936	TC	A	'h' reflex test	0.00	0.24	0.24	0.02	0.26	0.26	XXX
95937		A	Neuromuscular junction test	0.65	0.52	0.52	0.07	1.24	1.24	XXX
95937	26	A	Neuromuscular junction test	0.65	0.24	0.24	0.04	0.93	0.93	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.28	0.28	0.03	0.31	0.31	XXX
95950		A	Ambulatory eeg monitoring	1.51	4.32	4.32	0.60	6.43	6.43	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.66	0.66	0.10	2.27	2.27	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	3.65	3.65	0.50	4.15	4.15	XXX
95951		A	EEG monitoring/videorecord	6.00	18.23	18.23	0.64	24.87	24.87	XXX
95951	26	A	EEG monitoring/videorecord	6.00	2.53	2.53	0.11	8.64	8.64	XXX
95951	TC	A	EEG monitoring/videorecord	0.00	15.70	15.70	0.53	16.23	16.23	XXX
95953		A	EEG monitoring/computer	3.08	3.79	3.79	0.60	7.47	7.47	XXX
95953	26	A	EEG monitoring/computer	3.08	1.46	1.46	0.10	4.64	4.64	XXX
95953	TC	A	EEG monitoring/computer	0.00	2.33	2.33	0.50	2.83	2.83	XXX
95954		A	EEG monitoring/giving drugs	2.45	3.26	3.26	0.28	5.99	5.99	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.98	0.98	0.22	3.65	3.65	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	2.27	2.27	0.06	2.33	2.33	XXX
95955		A	EEG during surgery	1.01	3.88	3.88	0.30	5.19	5.19	XXX
95955	26	A	EEG during surgery	1.01	0.35	0.35	0.11	1.47	1.47	XXX
95955	TC	A	EEG during surgery	0.00	3.53	3.53	0.19	3.72	3.72	XXX
95956		A	EEG monitoring/cable/radio	3.08	44.02	44.02	0.61	47.71	47.71	XXX
95956	26	A	EEG monitoring/cable/radio	3.08	1.08	1.08	0.11	4.27	4.27	XXX
95956	TC	A	EEG monitoring/cable/radio	0.00	42.94	42.94	0.50	43.44	43.44	XXX
95957		A	EEG digital analysis	1.98	2.51	2.51	0.18	4.67	4.67	XXX
95957	26	A	EEG digital analysis	1.98	0.95	0.95	0.05	2.98	2.98	XXX
95957	TC	A	EEG digital analysis	0.00	1.56	1.56	0.13	1.69	1.69	XXX
95958		A	EEG monitoring/function test	4.25	8.40	8.40	0.52	13.17	13.17	XXX
95958	26	A	EEG monitoring/function test	4.25	1.63	1.63	0.38	6.26	6.26	XXX
95958	TC	A	EEG monitoring/function test	0.00	6.77	6.77	0.14	6.91	6.91	XXX
95961		A	Electrode stimulation, brain	2.97	4.99	4.99	0.20	8.16	8.16	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.17	1.17	0.12	4.26	4.26	XXX
95961	TC	A	Electrode stimulation, brain	0.00	3.82	3.82	0.08	3.90	3.90	XXX
95962		A	Electrode stimulation, brain	3.21	3.87	3.87	0.20	7.28	7.28	XXX
95962	26	A	Electrode stimulation, brain	3.21	1.42	1.42	0.12	4.75	4.75	XXX
95962	TC	A	Electrode stimulation, brain	0.00	2.45	2.45	0.08	2.53	2.53	XXX
96100		A	Psychological testing	0.00	0.40	0.37	0.20	0.60	0.57	XXX
96105		A	Assessment of aphasia	0.00	0.49	0.38	0.20	0.69	0.58	XXX
96111		A	Developmental test, extend	0.00	0.54	0.41	0.20	0.74	0.61	XXX
96115		A	Neurobehavior status exam	0.00	0.70	0.54	0.20	0.90	0.74	XXX
96117		A	Neuropsych test battery	0.00	0.54	0.49	0.20	0.74	0.69	XXX
96400		A	Chemotherapy, (SC)/(IM)	0.00	1.06	0.29	0.01	1.07	0.30	XXX
96405		A	Intralesional chemo admin	0.52	0.95	0.25	0.03	1.50	0.80	000
96406		A	Intralesional chemo admin	0.80	1.10	0.30	0.04	1.94	1.14	000
96408		A	Chemotherapy, push technique	0.00	1.04	0.31	0.06	1.10	0.37	XXX
96410		A	Chemotherapy, infusion method	0.00	1.16	0.34	0.09	1.25	0.43	XXX
96412		A	Chemotherapy, infusion method	0.00	0.52	0.15	0.08	0.60	0.23	XXX
96414		A	Chemotherapy, infusion method	0.00	1.16	0.35	0.09	1.25	0.44	XXX
96420		A	Chemotherapy, push technique	0.00	1.15	0.34	0.09	1.24	0.43	XXX
96422		A	Chemotherapy, infusion method	0.00	1.16	0.35	0.09	1.25	0.44	XXX
96423		A	Chemotherapy, infusion method	0.00	0.94	0.27	0.03	0.97	0.30	XXX
96425		A	Chemotherapy, infusion method	0.00	1.24	0.36	0.09	1.33	0.45	XXX
96440		A	Chemotherapy, intracavitary	2.37	2.83	1.03	0.06	5.26	3.46	000
96445		A	Chemotherapy, intracavitary	2.20	2.79	1.01	0.09	5.08	3.30	000
96450		A	Chemotherapy, into CNS	1.89	2.42	0.84	0.06	4.37	2.79	000
96520		A	Pump refilling, maintenance	0.00	0.85	0.25	0.06	0.91	0.31	XXX
96530		A	Pump refilling, maintenance	0.00	0.93	0.27	0.07	1.00	0.34	XXX
96542		A	Chemotherapy injection	1.42	1.76	0.67	0.13	3.31	2.22	XXX
96900		A	Ultraviolet light therapy	0.00	0.17	0.06	0.03	0.20	0.09	XXX
96902		B	Trichogram	+0.41	0.54	0.54	0.02	0.97	0.97	XXX
96910		A	Photochemotherapy with UV–B	0.00	0.17	0.06	0.04	0.21	0.10	XXX
96912		A	Photochemotherapy with UV–A	0.00	0.23	0.08	0.05	0.28	0.13	XXX
96913		A	Photochemotherapy, UV–A or B	0.00	0.40	0.14	0.10	0.50	0.24	XXX
97001		A	Pt evaluation	1.20	0.34	0.47	0.11	1.65	1.78	XXX
97002		A	Pt re-evaluation	0.60	0.25	0.23	0.01	0.86	0.84	XXX
97003		A	Ot evaluation	1.20	0.54	0.54	0.11	1.85	1.85	XXX
97004		A	Ot re-evaluation	0.60	0.21	0.14	0.01	0.82	0.75	XXX
97010		B	Hot or cold packs therapy	+0.06	0.13	0.02	0.02	0.21	0.10	XXX
97012		A	Mechanical traction therapy	0.25	0.14	0.03	0.02	0.41	0.30	XXX
97014		A	Electric stimulation therapy	0.18	0.13	0.02	0.02	0.33	0.22	XXX
97016		A	Vasopneumatic device therapy	0.18	0.13	0.02	0.02	0.33	0.22	XXX
97018		A	Paraffin bath therapy	0.06	0.11	0.01	0.03	0.20	0.10	XXX
97020		A	Microwave therapy	0.06	0.12	0.01	0.02	0.20	0.09	XXX
97022		A	Whirlpool therapy	0.17	0.13	0.02	0.02	0.32	0.21	XXX
97024		A	Diathermy treatment	0.06	0.12	0.01	0.02	0.20	0.09	XXX
97026		A	Infrared therapy	0.06	0.11	0.01	0.02	0.19	0.09	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
97028		A	Ultraviolet therapy	0.08	0.11	0.01	0.01	0.20	0.10	XXX
97032		A	Electrical stimulation	0.25	0.15	0.03	0.01	0.41	0.29	XXX
97033		A	Electric current therapy	0.26	0.16	0.03	0.02	0.44	0.31	XXX
97034		A	Contrast bath therapy	0.21	0.14	0.02	0.01	0.36	0.24	XXX
97035		A	Ultrasound therapy	0.21	0.14	0.02	0.01	0.36	0.24	XXX
97036		A	Hydrotherapy	0.28	0.17	0.03	0.02	0.47	0.33	XXX
97039		A	Physical therapy treatment	0.20	0.14	0.02	0.03	0.37	0.25	XXX
97110		A	Therapeutic exercises	0.45	0.18	0.05	0.02	0.65	0.52	XXX
97112		A	Neuromuscular reeducation	0.45	0.16	0.05	0.01	0.62	0.51	XXX
97113		A	Aquatic therapy/exercises	0.44	0.16	0.05	0.02	0.62	0.51	XXX
97116		A	Gait training therapy	0.40	0.15	0.04	0.01	0.56	0.45	XXX
97122		A	Manual traction therapy	0.42	0.15	0.04	0.01	0.58	0.47	XXX
97124		A	Massage therapy	0.35	0.15	0.04	0.01	0.51	0.40	XXX
97139		A	Physical medicine procedure	0.21	0.13	0.02	0.02	0.36	0.25	XXX
97150		A	Group therapeutic procedures	0.27	0.14	0.03	0.02	0.43	0.32	XXX
97250		A	Myofascial release	0.45	0.17	0.05	0.04	0.66	0.54	000
97260		A	Regional manipulation	0.19	0.13	0.02	0.02	0.34	0.23	000
97261		A	Supplemental manipulations	0.12	0.15	0.01	0.01	0.28	0.14	000
97265		A	Joint mobilization	0.45	0.16	0.05	0.04	0.65	0.54	XXX
97504		A	Orthotic training	0.45	0.14	0.05	0.02	0.61	0.52	XXX
97520		A	Prosthetic training	0.45	0.16	0.05	0.02	0.63	0.52	XXX
97530		A	Therapeutic activities	0.44	0.16	0.05	0.02	0.62	0.51	XXX
97535		A	Self care mngment training	0.45	0.16	0.05	0.02	0.63	0.52	XXX
97537		A	Community/work reintegration	0.45	0.16	0.05	0.02	0.63	0.52	XXX
97542		A	Wheelchair mngement training	0.25	0.14	0.03	0.02	0.41	0.30	XXX
97703		A	Prosthetic checkout	0.25	0.06	0.03	0.03	0.34	0.31	XXX
97750		A	Physical performance test	0.45	0.15	0.05	0.03	0.63	0.53	XXX
97770		A	Cognitive skills development	0.44	0.14	0.05	0.03	0.61	0.52	XXX
98925		A	Osteopathic manipulation	0.45	0.29	0.17	0.02	0.76	0.64	000
98926		A	Osteopathic manipulation	0.65	0.38	0.28	0.03	1.06	0.96	000
98927		A	Osteopathic manipulation	0.87	0.44	0.32	0.03	1.34	1.22	000
98928		A	Osteopathic manipulation	1.03	0.52	0.36	0.04	1.59	1.43	000
98929		A	Osteopathic manipulation	1.19	0.56	0.40	0.03	1.78	1.62	000
98940		A	Chiropractic manipulation	0.45	0.24	0.12	0.01	0.70	0.58	000
98941		A	Chiropractic manipulation	0.65	0.29	0.17	0.01	0.95	0.83	000
98942		A	Chiropractic manipulation	0.87	0.35	0.23	0.01	1.23	1.11	000
98943		N	Chiropractic manipulation	+0.40	0.72	0.40	0.01	1.13	0.81	XXX
99141		B	Sedation, iv/im or inhalant	+0.80	2.82	0.97	0.05	3.67	1.82	XXX
99142		B	Sedation, oral/rectal/nasal	+0.60	2.62	0.77	0.04	3.26	1.41	XXX
99175		A	Induction of vomiting	0.00	0.28	0.07	0.10	0.38	0.17	XXX
99183		A	Hyperbaric oxygen therapy	2.34	0.75	0.73	0.11	3.20	3.18	XXX
99185		A	Regional hypothermia	0.00	NA	0.05	0.04	NA	0.09	XXX
99186		A	Total body hypothermia	0.00	NA	0.05	0.52	NA	0.57	XXX
99195		A	Phlebotomy	0.00	1.26	0.11	0.03	1.29	0.14	XXX
99201		A	Office/outpatient visit, new	0.45	0.83	0.32	0.04	1.32	0.81	XXX
99202		A	Office/outpatient visit, new	0.88	1.11	0.50	0.05	2.04	1.43	XXX
99203		A	Office/outpatient visit, new	1.34	1.49	0.73	0.06	2.89	2.13	XXX
99204		A	Office/outpatient visit, new	2.00	2.00	1.00	0.08	4.08	3.08	XXX
99205		A	Office/outpatient visit, new	2.67	2.24	1.21	0.09	5.00	3.97	XXX
99211		A	Office/outpatient visit, est	0.17	0.32	0.16	0.02	0.51	0.35	XXX
99212		A	Office/outpatient visit, est	0.45	0.45	0.28	0.02	0.92	0.75	XXX
99213		A	Office/outpatient visit, est	0.67	0.55	0.35	0.03	1.25	1.05	XXX
99214		A	Office/outpatient visit, est	1.10	0.84	0.55	0.04	1.98	1.69	XXX
99215		A	Office/outpatient visit, est	1.77	1.12	0.80	0.07	2.96	2.64	XXX
99217		A	Observation care discharge	1.28	NA	0.55	0.04	NA	1.87	XXX
99218		A	Observation care	1.28	NA	0.62	0.06	NA	1.96	XXX
99219		A	Observation care	2.14	NA	0.92	0.09	NA	3.15	XXX
99220		A	Observation care	2.99	NA	1.27	0.09	NA	4.35	XXX
99221		A	Initial hospital care	1.28	NA	0.64	0.06	NA	1.98	XXX
99222		A	Initial hospital care	2.14	NA	0.94	0.09	NA	3.17	XXX
99223		A	Initial hospital care	2.99	NA	1.26	0.08	NA	4.33	XXX
99231		A	Subsequent hospital care	0.64	NA	0.28	0.03	NA	0.95	XXX
99232		A	Subsequent hospital care	1.06	NA	0.43	0.04	NA	1.53	XXX
99233		A	Subsequent hospital care	1.51	NA	0.60	0.05	NA	2.16	XXX
99234		A	Observ/hosp same date	2.56	NA	1.09	0.06	NA	3.71	XXX
99235		A	Observ/hosp same date	3.42	NA	1.38	0.09	NA	4.89	XXX
99236		A	Observ/hosp same date	4.27	NA	1.72	0.09	NA	6.08	XXX
99238		A	Hospital discharge day	1.28	NA	0.57	0.04	NA	1.89	XXX
99239		A	Hospital discharge day	1.75	NA	0.73	0.04	NA	2.52	XXX
99241		A	Office consultation	0.64	0.72	0.40	0.08	1.44	1.12	XXX
99242		A	Office consultation	1.29	1.12	0.66	0.09	2.50	2.04	XXX
99243		A	Office consultation	1.72	1.41	0.87	0.10	3.23	2.69	XXX
99244		A	Office consultation	2.58	1.80	1.19	0.11	4.49	3.88	XXX
99245		A	Office consultation	3.43	2.12	1.52	0.16	5.71	5.11	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
99251		A	Initial inpatient consult	0.66	NA	0.40	0.08	NA	1.14	XXX
99252		A	Initial inpatient consult	1.32	NA	0.71	0.09	NA	2.12	XXX
99253		A	Initial inpatient consult	1.82	NA	0.94	0.10	NA	2.86	XXX
99254		A	Initial inpatient consult	2.64	NA	1.26	0.11	NA	4.01	XXX
99255		A	Initial inpatient consult	3.65	NA	1.66	0.14	NA	5.45	XXX
99261		A	Follow-up inpatient consult	0.42	NA	0.30	0.03	NA	0.75	XXX
99262		A	Follow-up inpatient consult	0.85	NA	0.48	0.04	NA	1.37	XXX
99263		A	Follow-up inpatient consult	1.27	NA	0.65	0.04	NA	1.96	XXX
99271		A	Confirmatory consultation	0.45	0.46	0.32	0.07	0.98	0.84	XXX
99272		A	Confirmatory consultation	0.84	0.65	0.50	0.09	1.58	1.43	XXX
99273		A	Confirmatory consultation	1.19	0.90	0.65	0.11	2.20	1.95	XXX
99274		A	Confirmatory consultation	1.73	1.19	0.85	0.11	3.03	2.69	XXX
99275		A	Confirmatory consultation	2.31	1.34	1.05	0.17	3.82	3.53	XXX
99281		A	Emergency dept visit	0.33	NA	0.11	0.01	NA	0.45	XXX
99282		A	Emergency dept visit	0.55	NA	0.15	0.03	NA	0.73	XXX
99283		A	Emergency dept visit	1.24	NA	0.27	0.04	NA	1.55	XXX
99284		A	Emergency dept visit	1.95	NA	0.39	0.06	NA	2.40	XXX
99285		A	Emergency dept visit	3.06	NA	0.57	0.08	NA	3.71	XXX
99291		A	Critical care, first hour	4.00	1.45	1.50	0.11	5.56	5.61	XXX
99292		A	Critical care, addl 30 min	2.00	0.78	0.79	0.04	2.82	2.83	XXX
99295		A	Neonatal critical care	16.00	NA	5.32	1.55	NA	22.87	XXX
99296		A	Neonatal critical care	8.00	NA	4.60	0.77	NA	13.37	XXX
99297		A	Neonatal critical care	4.00	NA	3.54	0.38	NA	7.92	XXX
99301		A	Nursing facility care	1.20	NA	0.69	0.03	NA	1.92	XXX
99302		A	Nursing facility care	1.61	NA	0.89	0.04	NA	2.54	XXX
99303		A	Nursing facility care	2.01	NA	1.05	0.07	NA	3.13	XXX
99311		A	Nursing facility care, subseq	0.60	NA	0.38	0.03	NA	1.01	XXX
99312		A	Nursing facility care, subseq	1.00	NA	0.52	0.03	NA	1.55	XXX
99313		A	Nursing facility care, subseq	1.42	NA	0.68	0.04	NA	2.14	XXX
99315		A	Nursing fac discharge day	1.13	NA	1.48	0.04	NA	2.65	XXX
99316		A	Nursing fac discharge day	1.50	NA	1.85	0.04	NA	3.39	XXX
99321		A	Rest home visit, new patient	0.71	0.36	0.61	0.03	1.10	1.35	XXX
99322		A	Rest home visit, new patient	1.01	0.55	0.89	0.05	1.61	1.95	XXX
99323		A	Rest home visit, new patient	1.28	0.70	0.97	0.06	2.04	2.31	XXX
99331		A	Rest home visit, estab pat	0.60	0.35	0.53	0.02	0.97	1.15	XXX
99332		A	Rest home visit, estab pat	0.80	0.45	0.60	0.03	1.28	1.43	XXX
99333		A	Rest home visit, estab pat	1.00	0.54	1.06	0.02	1.56	2.08	XXX
99341		A	Home visit, new patient	1.01	0.48	0.60	0.05	1.54	1.66	XXX
99342		A	Home visit, new patient	1.52	0.73	1.02	0.05	2.30	2.59	XXX
99343		A	Home visit, new patient	2.27	1.07	1.45	0.06	3.40	3.78	XXX
99344		A	Home visit, new patient	3.03	1.34	1.74	0.09	4.46	4.86	XXX
99345		A	Home visit, new patient	3.79	1.61	2.04	0.09	5.49	5.92	XXX
99347		A	Home visit, estab patient	0.76	0.39	0.68	0.04	1.19	1.48	XXX
99348		A	Home visit, estab patient	1.26	0.61	0.86	0.04	1.91	2.16	XXX
99349		A	Home visit, estab patient	2.02	0.90	0.83	0.05	2.97	2.90	XXX
99350		A	Home visit, estab patient	3.03	1.24	1.06	0.07	4.34	4.16	XXX
99354		A	Prolonged service, office	1.77	1.03	0.73	0.07	2.87	2.57	XXX
99355		A	Prolonged service, office	1.77	0.92	0.66	0.07	2.76	2.50	XXX
99356		A	Prolonged service, inpatient	1.71	NA	0.63	0.08	NA	2.42	XXX
99357		A	Prolonged service, inpatient	1.71	NA	0.67	0.08	NA	2.46	XXX
99374		B	Home health care supervision	+1.10	2.51	1.99	0.04	3.65	3.13	XXX
99375		A	Home health care supervision	1.73	1.03	0.87	0.04	2.80	2.64	XXX
99377		B	Hospice care supervision	+1.10	2.51	1.99	0.04	3.65	3.13	XXX
99378		A	Hospice care supervision	1.73	1.03	0.87	0.04	2.80	2.64	XXX
99379		B	Nursing fac care supervision	+1.10	2.51	1.99	0.04	3.65	3.13	XXX
99380		B	Nursing fac care supervision	+1.73	3.14	2.62	0.04	4.91	4.39	XXX
99381		N	Preventive visit, new, infant	+1.19	2.61	1.19	0.08	3.88	2.46	XXX
99382		N	Preventive visit, new, age 1–4	+1.36	2.74	1.36	0.09	4.19	2.81	XXX
99383		N	Preventive visit, new, age 5–11	+1.36	2.66	1.36	0.09	4.11	2.81	XXX
99384		N	Preventive visit, new, 12–17	+1.53	2.83	1.53	0.10	4.46	3.16	XXX
99385		N	Preventive visit, new, 18–39	+1.53	2.83	1.53	0.09	4.45	3.15	XXX
99386		N	Preventive visit, new, 40–64	+1.88	3.25	1.88	0.10	5.23	3.86	XXX
99387		N	Preventive visit, new, 65 & over	+2.06	3.51	2.06	0.11	5.68	4.23	XXX
99391		N	Preventive visit, est, infant	+1.02	1.86	1.02	0.07	2.95	2.11	XXX
99392		N	Preventive visit, est, age 1–4	+1.19	2.03	1.19	0.08	3.30	2.46	XXX
99393		N	Preventive visit, est, age 5–11	+1.19	1.99	1.19	0.08	3.26	2.46	XXX
99394		N	Preventive visit, est, 12–17	+1.36	2.18	1.36	0.09	3.63	2.81	XXX
99395		N	Preventive visit, est, 18–39	+1.36	2.23	1.98	0.08	3.67	3.42	XXX
99396		N	Preventive visit, est, 40–64	+1.53	2.43	2.15	0.09	4.05	3.77	XXX
99397		N	Preventive visit, est, 65 & over	+1.71	2.65	2.33	0.10	4.46	4.14	XXX
99401		N	Preventive counseling, indiv	+0.48	1.06	0.87	0.03	1.57	1.38	XXX
99402		N	Preventive counseling, indiv	+0.98	1.63	1.37	0.05	2.66	2.40	XXX
99403		N	Preventive counseling, indiv	+1.46	2.18	1.85	0.08	3.72	3.39	XXX
99404		N	Preventive counseling, indiv	+1.95	2.73	2.34	0.11	4.79	4.40	XXX

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
99411		N	Preventive counseling, group	+0.15	0.31	0.25	0.01	0.47	0.41	XXX
99412		N	Preventive counseling, group	+0.25	0.45	0.35	0.01	0.71	0.61	XXX
99431		A	Initial care, normal newborn	1.17	NA	0.55	0.08	NA	1.80	XXX
99432		A	Newborn care not in hospital	1.26	0.93	0.42	0.08	2.27	1.76	XXX
99433		A	Normal newborn care, hospital	0.62	NA	0.33	0.04	NA	0.99	XXX
99435		A	Hospital NB discharge day	1.50	NA	0.64	0.10	NA	2.24	XXX
99436		A	Attendance, birth	1.50	2.89	2.55	0.10	4.49	4.15	XXX
99440		A	Newborn resuscitation	2.93	NA	3.10	0.19	NA	6.22	XXX
A4263		A	Permanent tear duct plug	0.00	2.60	0.90	0.00	2.60	0.90	XXX
A4300		A	Cath impl vasc access portal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4550		A	Surgical trays	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0002		A	Temporary urinary catheter	0.50	2.34	0.19	0.02	2.86	0.71	000
G0004		A	ECG transm phys review & int	0.52	0.63	0.63	0.65	1.80	1.80	XXX
G0005		A	ECG 24 hour recording	0.00	0.12	0.12	0.09	0.21	0.21	XXX
G0006		A	ECG transmission & analysis	0.00	0.32	0.32	0.51	0.83	0.83	XXX
G0007		A	ECG phy review & interpret	0.52	0.26	0.26	0.05	0.83	0.83	XXX
G0015		A	Post symptom ECG tracing	0.00	0.32	0.32	0.51	0.83	0.83	XXX
G0016		A	Post symptom ECG md review	0.52	0.48	0.48	0.05	1.05	1.05	XXX
G0025		A	Collagen skin test kit	0.00	1.17	0.32	0.00	1.17	0.32	XXX
G0030	26	A	PET imaging prev PET single	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0031	26	A	PET imaging prev PET multple	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0032	26	A	PET follow SPECT 78464 singl	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0033	26	A	PET follow SPECT 78464 mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0034	26	A	PET follow SPECT 76865 singl	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0035	26	A	PET follow SPECT 78465 mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0036	26	A	PET follow cornry angio sing	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0037	26	A	PET follow cornry angio mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0038	26	A	PET follow myocard perf sing	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0039	26	A	PET follow myocard perf mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0040	26	A	PET follow stress echo singl	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0041	26	A	PET follow stress echo mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0042	26	A	PET follow ventriculogm sing	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0043	26	A	PET follow ventriculogm mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0044	26	A	PET following rest ECG singl	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0045	26	A	PET following rest ECG mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0046	26	A	PET follow stress ECG singl	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0047	26	A	PET follow stress ECG mult	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0050		A	Residual urine by ultrasound	0.00	0.60	0.60	0.05	0.65	0.65	XXX
G0101		A	CA screen; pelvic/breast exam	0.45	1.17	0.81	0.02	1.64	1.28	XXX
G0104		A	CA screen; flexi sigmoidscope	0.96	6.84	1.15	0.12	7.92	2.23	000
G0105		A	Colorectal scrn; hi risk ind	3.70	12.28	5.01	0.39	16.37	9.10	000
G0106		A	Colon CA screen; barium enema	0.99	1.92	1.92	0.21	3.12	3.12	XXX
G0106	26	A	Colon CA screen; barium enema	0.99	0.33	0.33	0.07	1.39	1.39	XXX
G0106	TC	A	Colon CA screen; barium enema	0.00	1.59	1.59	0.14	1.73	1.73	XXX
G0110		R	Nett pulm-rehab educ; ind	0.90	1.70	0.90	0.04	2.64	1.84	XXX
G0111		R	Nett pulm-rehab educ; group	0.27	0.59	0.27	0.02	0.88	0.56	XXX
G0112		R	Nett; nutrition guid, initial	1.72	3.32	2.36	0.10	5.14	4.18	XXX
G0113		R	Nett; nutrition guid, subseqnt	1.29	2.77	1.86	0.09	4.15	3.24	XXX
G0114		R	Nett; psychosocial consult	1.20	1.36	1.20	0.11	2.67	2.51	XXX
G0115		R	Nett; psychological testing	1.20	1.53	1.20	0.11	2.84	2.51	XXX
G0116		R	Nett; psychosocial counsel	1.11	1.70	1.52	0.05	2.86	2.68	XXX
G0120		A	Colon ca scrn; barium enema	0.99	1.92	1.92	0.21	3.12	3.12	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.33	0.33	0.07	1.39	1.39	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	1.59	1.59	0.14	1.73	1.73	XXX
G0121		N	Colon ca scrn; barium enema	+3.70	12.28	5.01	0.39	16.37	9.10	XXX
G0122		N	Colon ca scrn; barium enema	+0.99	1.92	1.92	0.21	3.12	3.12	XXX
G0122	26	N	Colon ca scrn; barium enema	+0.99	0.33	0.33	0.07	1.39	1.39	XXX
G0122	TC	N	Colon ca scrn; barium enema	+0.00	1.59	1.59	0.14	1.73	1.73	XXX
G0124	26	A	Screen c/v thin layer by MD	0.42	1.70	0.42	0.04	2.16	0.88	XXX
G0125	26	A	Lung image (PET)	1.50	0.36	0.36	0.07	1.93	1.93	XXX
G0126	26	A	Lung image (PET), staging	1.87	0.48	0.48	0.10	2.45	2.45	XXX
G0127		R	Trim nail(s)	0.11	1.59	0.11	0.02	1.72	0.24	000
M0064		A	Visit for drug monitoring	0.37	0.19	0.23	0.03	0.59	0.63	XXX
M0101		G	Foot care hygienic/pm	0.43	1.91	0.43	0.03	2.37	0.89	XXX
P3001	26	A	Screening pap smear by phys	0.42	1.00	0.15	0.04	1.46	0.61	XXX
Q0035		A	Cardiokymography	0.17	0.32	0.32	0.04	0.53	0.53	XXX
Q0035	26	A	Cardiokymography	0.17	0.10	0.10	0.01	0.28	0.28	XXX
Q0035	TC	A	Cardiokymography	0.00	0.22	0.22	0.03	0.25	0.25	XXX
Q0068		A	Extracorpeal plasmapheresis	1.67	3.38	0.68	0.16	5.21	2.51	000
Q0091		A	Obtaining screen pap smear	0.37	0.58	0.14	0.03	0.98	0.54	XXX
Q0092		A	Set up port xray equipment	0.00	0.22	0.22	0.01	0.23	0.23	XXX
R0070		A	Transport portable x-ray	0.00	0.77	0.77	0.01	0.78	0.78	XXX
R0075		A	Transport port x-ray multipl	0.00	0.19	0.19	0.01	0.20	0.20	XXX

ADDENDUM D.—PHYSICIAN CODES ALWAYS SUBJECT TO THE OUTPATIENT REHABILITATION FINANCIAL LIMITATION

CPT[1] code	Description
29126	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); DYNAMIC
29131	APPLICATION OF FINGER SPLINT; DYNAMIC
64550	APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR
90901	BIOFEEDBACK TRAINING BY ANY MODALITY
90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AUDITORY PROCESSING, AND/OR AURAL REHABILITATION STATUS
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); INDIVIDUAL
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); GROUP, TWO OR MORE INDIVIDUALS
92510	AURAL REHABILITATION FOLLOWING COCHLEAR IMPLANT (INCLUDES EVALUATION OF AURAL REHABILITATION STATUS AND HEARING, THERAPEUTIC SERVICES) WITH OR WITHOUT SPEECH PROCESSOR PROGRAMMING
92525	EVALUATION OF SWALLOWING AND ORAL FUNCTION FOR FEEDING
92526	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC OR AUGMENTATIVE/ ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH
92598	MODIFICATION OF VOICE PROSTHETIC OR AUGMENTATIVE/ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH
95831	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); EXTREMITY (EXCLUDING HAND) OR TRUNK, WITH REPORT
95832	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
95833	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); TOTAL EVALUATION OF BODY, EXCLUDING HANDS
95834	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); TOTAL EVALUATION OF BODY, INCLUDING HANDS
95851	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); EACH EXTREMITY (EXCLUDING HAND) OR EACH TRUNK SECTION (SPINE)
95852	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPOR
97001	PHYSICAL THERAPY EVALUATION
97002	PHYSICAL THERAPY RE-EVALUATION
97003	OCCUPATIONAL THERAPY EVALUATION
97004	OCCUPATIONAL THERAPY RE-EVALUATION
97010	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR COLD PACKS
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL
97014	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH
97020	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; MICROWAVE
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97036	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND PROPRIOCEPTION
97113	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97122	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; TRACTION, MANUAL
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)
97139	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97250	MYOFASCIAL RELEASE/SOFT TISSUE MOBILIZATION, ONE OR MORE REGIONS
97260	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; ONE AREA

ADDENDUM D.—PHYSICIAN CODES ALWAYS SUBJECT TO THE OUTPATIENT REHABILITATION FINANCIAL LIMITATION—Continued

CPT[1] code	Description
97261	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; EACH ADDITIONAL AREA
97265	JOINT MOBILIZATION, ONE OR MORE AREAS (PERIPHERAL OR SPINAL)
97504	ORTHOTICS FITTING AND TRAINING, UPPER AND/OR LOWER EXTREMITIES, EACH 15 MINUTES
97520	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITIES, EACH 15 MINUTES
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE ON ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES
97535	SELF CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (ADL) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ADAPTIVE EQUIPMENT) DIRECT ONE ON ONE CONTACT BY PROVIDER, EACH 15 MINUTES
97537	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, MONEY MANAGEMENT, AVOCATIONAL ACTIVITIES AND/OR WORK ENVIRONMENT/MODIFICATION ANALYSIS, WORK TASK ANALYSIS), DIRECT ONE ON ONE CONTACT BY PROVIDER, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT/PROPULSION TRAINING, EACH 15 MINUTES
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR
97703	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE, ESTABLISHED PATIENT, EACH 15 MINUTES
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES
97770	DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING, INCLUDES COMPENSATORY TRAINING AND/OR SENSORY INTEGRATIVE ACTIVITIES, DIRECT (ONE ON ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES
97780	ACUPUNCTURE, ONE OR MORE NEEDLES; WITHOUT ELECTRICAL STIMULATION
97781	ACUPUNCTURE, ONE OR MORE NEEDLES; WITH ELECTRICAL STIMULATION
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE

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[2] Not all listed services are covered by the Medicare program.

ADDENDUM E.—PHYSICIAN CODES POTENTIALLY SUBJECT TO THE OUTPATIENT REHABILITATION FINANCIAL LIMITATION

CPT[1] code	Description
29065	APPLICATION; SHOULDER TO HAND (LONG ARM)
29075	APPLICATION; ELBOW TO FINGER (SHORT ARM)
29085	APPLICATION; HAND AND LOWER FOREARM (GAUNTLET)
29105	APPLICATION OF LONG ARM SPLINT (SHOULDER TO HAND)
29125	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); STATIC
29130	APPLICATION OF FINGER SPLINT; STATIC
29200	STRAPPING; THORAX
29220	STRAPPING; LOW BACK
29240	STRAPPING; SHOULDER (EG, VELPEAU)
29260	STRAPPING; ELBOW OR WRIST
29280	STRAPPING; HAND OR FINGER
29345	APPLICATION OF LONG LEG CAST (THIGH TO TOES);
29355	APPLICATION OF LONG LEG CAST (THIGH TO TOES); WALKER OR AMBULATORY TYPE
29358	APPLICATION OF LONG LEG CAST BRACE
29365	APPLICATION OF CYLINDER CAST (THIGH TO ANKLE)
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);
29425	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES); WALKING OR AMBULATORY TYPE
29435	APPLICATION OF PATELLAR TENDON BEARING (PTB) CAST
29445	APPLICATION OF RIGID TOTAL CONTACT LEG CAST
29505	APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES)
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)
29520	STRAPPING; HIP
29530	STRAPPING; KNEE
29540	STRAPPING; ANKLE
29550	STRAPPING; TOES
29580	STRAPPING; UNNA BOOT
29590	DENIS-BROWNE SPLINT STRAPPING

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[2] Not all listed services are covered by the Medicare program.

ADDENDUM F.—OUTPATIENT REHABILITATION THERAPY CODES

CPT1/ code	Description
11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS
11041	DEBRIDEMENT; SKIN, FULL THICKNESS
11042	DEBRIDEMENT; SKIN, AND SUBCUTANEOUS TISSUE
11043	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE
11044	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, MUSCLE, AND BONE
29065	APPLICATION; SHOULDER TO HAND (LONG ARM)
29075	APPLICATION; ELBOW TO FINGER (SHORT ARM)
29085	APPLICATION; HAND AND LOWER FOREARM (GAUNTLET)
29345	APPLICATION OF LONG LEG CAST (THIGH TO TOES);
29365	APPLICATION OF CYLINDER CAST (THIGH TO ANKLE)
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);
29445	APPLICATION OF RIGID TOTAL CONTACT LEG CAST
29105	APPLICATION OF LONG ARM SPLINT (SHOULDER TO HAND)
29125	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); STATIC
29126	APPLICATION OF SHORT ARM SPLINT (FOREARM TO HAND); DYNAMIC
29130	APPLICATION OF FINGER SPLINT; STATIC
29131	APPLICATION OF FINGER SPLINT; DYNAMIC
29200	STRAPPING; THORAX
29220	STRAPPING; LOW BACK
29240	STRAPPING; SHOULDER (EG, VELPEAU)
29260	STRAPPING; ELBOW OR WRIST
29280	STRAPPING; HAND OR FINGER
29505	APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES)
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)
29520	STRAPPING; HIP
29530	STRAPPING; KNEE
29540	STRAPPING; ANKLE
29550	STRAPPING; TOES
29580	STRAPPING; UNNA BOOT
29590	DENIS-BROWNE SPLINT STRAPPING
64550	APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR
90724	IMMUNIZATION, ACTIVE; INFLUENZA VIRUS VACCINE
90732	IMMUNIZATION, ACTIVE; PNEUMOCOCCAL VACCINE, POLYVALENT
90744	IMMUNIZATION, ACTIVE; HEPATITIS B VACCINE; NEWBORN TO 11 YEARS
90745	IMMUNIZATION, ACTIVE; HEPATITIS B VACCINE; 11–19 YEARS
90746	IMMUNIZATION, ACTIVE; HEPATITIS B VACCINE; 20 YEARS AND ABOVE
90747	IMMUNIZATION, ACTIVE; HEPATITIS B VACCINE; DIALYSIS OR IMMUNOSUPPRESSED PATIENT, ANY AGE
90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACT-TO-FACE WITH THE PATIENT
90901	BIOFEEDBACK TRAINING BY ANY MODALITY
90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AUDITORY PROCESSING, AND/OR AURAL REHABILITATION STATUS
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); INDIVIDUAL
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); GROUP, TWO OR MORE INDIVIDUALS
92510	AURAL REHABILITATION FOLLOWING COCHLEAR IMPLANT (INCLUDES EVALUATION OF AURAL REHABILITATION STATUS AND HEARING, THERAPEUTIC SERVICES) WITH OR WITHOUT SPEECH PROCESSOR PROGRAMMING
92525	EVALUATION OF SWALLOWING AND ORAL FUNCTION FOR FEEDING
92526	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC OR AUGMENTATIVE/ ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH
92598	MODIFICATION OF VOICE PROSTHETIC OR AUGMENTATIVE/ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH
94664	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; INITIAL DEMONSTRATION AND/OR EVALUATION
94665	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; SUBSEQUENT
94667	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; INITIAL DEMONSTRATION AND/OR EVALUATION
94668	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; SUBSEQUENT
95831	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); EXTREMITY (EXCLUDING HAND) OR TRUNK, WITH REPORT
95832	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
95833	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); TOTAL EVALUATION OF BODY, EXCLUDING HANDS
95834	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE); TOTAL EVALUATION OF BODY, INCLUDING HANDS

ADDENDUM F.—OUTPATIENT REHABILITATION THERAPY CODES—Continued

CPT1/ code	Description
95851	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); EACH EXTREMITY (EXCLUDING HAND) OR EACH TRUNK SECTION (SPINE)
95852	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPOR
96110	DEVELOPMENT TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN), WITH INTERPRETATION AND REPORT
96111	DEVELOPMENTAL TESTING; EXTENDED (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS, EG, BAYLEY SCALES OF INFANT DEVELOPMENT) WITH INTERPRETATION AND REPORT, PER HOUR
96115	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION,MEMORY, VISUAL SPATIAL ABILITIES, LANGUAGE FUNCTIONS, PLANNING) WITH INTERPRETATION AND REPORT, PER HOUR
97001	PHYSICAL THERAPY EVALUATION
97002	PHYSICAL THERAPY RE-EVALUATION
97003	OCCUPATIONAL THERAPY EVALUATION
97004	OCCUPATIONAL THERAPY RE-EVALUATION
97010	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR COLD PACKS
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL
97014	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH
97020	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; MICROWAVE
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97036	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND PROPRIOCEPTION
97113	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97122	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; TRACTION, MANUAL
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)
97139	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)
97250	MYOFASCIAL RELEASE/SOFT TISSUE MOBILIZATION, ONE OR MORE REGIONS
97260	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; ONE AREA
97261	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; EACH ADDITIONAL AREA
97265	JOINT MOBILIZATION, ONE OR MORE AREAS (PERIPHERAL OR SPINAL)
97504	ORTHOTICS FITTING AND TRAINING, UPPER AND/OR LOWER EXTREMITIES, EACH 15 MINUTES
97520	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITIES, EACH 15 MINUTES
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE ON ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES
97535	SELF CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (ADL) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ADAPTIVE EQUIPMENT) DIRECT ONE ON ONE CONTACT BY PROVIDER, EACH 15 MINUTES
97537	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, MONEY MANAGEMENT, AVOCATIONAL ACTIVITIES AND/OR WORK ENVIRONMENT/ MODIFICATION ANALYSIS, WORK TASK ANALYSIS), DIRECT ONE ON ONE CONTACT BY PROVIDER, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT/PROPULSION TRAINING, EACH 15 MINUTES
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR
97703	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE, ESTABLISHED PATIENT, EACH 15 MINUTES

ADDENDUM F.—OUTPATIENT REHABILITATION THERAPY CODES—Continued

CPT1/ code	Description
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES
97770	DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING, INCLUDES COMPENSATORY TRAINING AND/OR SENSORY INTEGRATIVE ACTIVITIES, DIRECT (ONE ON ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES
97780	ACUPUNCTURE, ONE OR MORE NEEDLES; WITHOUT ELECTRICAL STIMULATION
97781	ACUPUNCTURE, ONE OR MORE NEEDLES; WITH ELECTRICAL STIMULATION
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE DESCRIPTION
V5362	SPEECH SCREENING
V5363	LANGUAGE SCREENING
V5364	DYSPHAGIA SCREENING

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