Federal Register

Friday,
March 1, 2002

Part V

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 419, and 489

Medicare Program; Correction of Certain Calendar Year 2002 Payment Rates Under the Hospital Outpatient Prospective Payment System and the Pro Rata Reduction on Transitional Pass-Through Payments; Correction of Technical and Typographical Errors; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 419, and 489

[CMS–1159–F4]

RIN 0938–AK54

Medicare Program; Correction of Certain Calendar Year 2002 Payment Rates Under the Hospital Outpatient Prospective Payment System and the Pro Rata Reduction on Transitional Pass-Through Payments; Correction of Technical and Typographical Errors

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

ACTION: Final rule.

SUMMARY: This final rule corrects inadvertent technical errors that affect the amounts and factors used to determine the payment rates for services paid under the Medicare hospital outpatient prospective payment system as published in the November 30, 2001 final rule entitled ''Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002.'' In addition, this final rule corrects the amount of the uniform reduction to be applied to transitional pass-through payments for CY 2002. This final rule also corrects other technical and typographical errors that appeared in the November 30, 2001 final rule.

EFFECTIVE DATE: This final rule is effective on April 1, 2002. The effective date for § 419.32(b)(1)(iii), revised at 66 FR 59856, published on November 30, 2001 and § 419.62(d), added at 66 FR 55865, published on November 2, 2001, is April 1, 2002.

FOR FURTHER INFORMATION CONTACT: Robert Braver, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

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I. Background

On November 30, 2001, we published a final rule announcing the final ambulatory payment classification (APC) groups, relative weights, and payment rates under the hospital outpatient prospective payment system (OPPS) for calendar year (CY) 2002 (66 FR 59856). As discussed in detail in that final rule, in setting the APC relative weights, we incorporated 75 percent of the estimated transitional pass-through costs for devices eligible for transitional pass-through payments in CY 2002 into the costs of the APC groups associated with the use of the devices (66 FR 59906).

After publication of the November 30, 2001 final rule, we discovered that the final rule reflected several inadvertent technical errors in which we incorrectly associated specific devices approved for transitional pass-through payments with particular procedures. The magnitude of these errors was significant enough to affect not only the estimate of total transitional pass-through payments and the uniform reduction percentage to be applied to transitional pass-through payments in 2002, but also the payment rates for all procedure-related APCs. (Procedure-related APCs are those other than the APCs for pass-through drugs and devices, new technology, and partial hospitalization.) Using rates that reflected these errors would have inappropriately affected payments to hospitals. Thus, we determined that it would be inappropriate to allow the payment rates published on November 30, 2001 to become effective without further changes. In order to ensure that there were no other errors that might also have significant implications for OPPS payments, we decided to undertake an intensive review of the relevant data files. Because of the time needed for this review, we were unable to complete it and recalculate the rates before the previously published effective date of January 1, 2002 announced in the November 30, 2001 final rule. We therefore decided to continue to pay for services covered under the OPPS after January 1, 2002 and until no later than April 1, 2002 under the rates in effect on December 31, 2001. In addition, we decided to make transitional pass-through payments during that period without applying the uniform reduction announced on November 30, 2001.

Therefore, on December 31, 2001, we published a final rule, entitled ''Prospective Payment System for Hospital Outpatient Services; Delay in Effective Date of Calendar Year 2002 Payment Rates and the Pro Rata Reduction on Transitional Pass-Through Payments' (66 FR 67494), that announced we would indefinitely delay the effective date for §§ 419.32(b)(1)(iii) and 419.62(d) of the regulations. We also announced that we were delaying until no later than April 1, 2002, the effective date of the updated OPPS payment rates and the uniform reduction of transitional pass-through payments that we published in the preamble and addenda of the November 30, 2001 final rule.

We did not delay the following provisions of the November 30, 2001 final rule:

- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 coinsurance limit.
- Limitation of copayment amount to inpatient hospital deductible amount.
- Changes in services covered within the scope of OPPS.
- Categories of hospitals subject to, and excluded from, the OPPS.
- Criteria for new technology APCs.
- Provider-based issues.
- Change to the definition of ''single-use devices'' for transitional pass-through payments.

We have also discovered typographical and other technical errors in the preamble and addenda to the November 30, 2001 final rule. These errors involve the incorrect assignment of status indicators (SIs) to certain Physicians' Current Procedural Terminology (CPT) codes, inconsistencies between the preamble and addenda in the assignment of codes to APC groups, and similar matters. Correction of these typographical and technical errors does not involve any changes in the policies announced in the November 30, 2001 final rule. Corrections to the preamble text are listed below. The appropriate corrections are incorporated into the new addenda A, B, C, and D. The corrected addenda A and D are printed at the end of this rule. Addenda B and C are available on our Web site: *http://www.cms.hhs.gov.* Tables 2 and 3 below summarize the corrections to the errors in addenda A and B.

II. Correction of Errors

In the FR Doc. 01–29621 published November 30, 2001 (66 FR 59856), we are making the corrections described below.

A. Corrections of Device Cost Assignments to APCs

Since publication of the December 31, 2001 final rule, we have conducted an intensive internal review of device costs associated with specific CPT codes. We have also considered information concerning the use of devices brought to our attention from hospitals, manufacturers, and other such sources. As a result of this review, we determined that we had inadvertently associated device(s) with certain procedures for which no devices are used, incorrectly identified device(s) used with certain other procedures, or failed to associate one or more devices with procedures requiring the use of those devices. The following APCs were affected:

- APC 0084 Level I Electrophysiologic Evaluation
- APC 0085 Level II Electrophysiologic Evaluation
- APC 0090 Insertion/Replacement of Pacemaker/Pulse Generator
- APC 0091 Level I Vascular Ligation
- APC 0104 Transcatheter Placement of Intracoronary Stents
- APC 0229 Transcatheter Placement of Intravascular Shunts
- APC 0237 Level III Posterior Segment Eye Procedures
- APC 0241 Level IV Repair and Plastic Eye Procedures
- APC 0242 Level V Repair and Plastic Eye Procedures
- APC 0246 Cataract Procedures with IOL Insert
- APC 0248 Laser Retinal Procedures
- APC 0312 Radioelement Applications
- APC 0313 Brachytherapy

The changes in the assignment of device costs associated with these 13 APCs resulted in a net reduction in the estimate of total transitional pass-through payments for CY 2002.

In addition, the changes in the assignment of device costs associated with these 13 APCs have caused changes to the median costs for these APCs. (Median costs are used to set the relative weights of each APC. The relative weight of each APC is the ratio of its median cost to the median cost of APC 601, Mid-level clinic visit, adjusted by the ''scalar'' that is discussed below.) We found that the changes in the assignment of device costs and the resulting changes in the median costs of the 13 associated APC groups affected the relative payment weights for all procedure-related APCs as well as the estimate of aggregate CY 2002 payments.

The changes in relative payment weights resulting from revisions in the assignment of device costs associated with the 13 APCs identified above required that we recalculate the ''scalar,'' which is the factor that we use to ensure compliance with section 1833(t)(9)(B) of the Social Security Act (the Act). That section of the Act provides that APC reclassification and recalibration changes (and wage index changes) must be made in a manner so that the estimated aggregate payments under the OPPS for a particular year are neither greater nor less than the estimated aggregate payments would have been without these changes. The corrections, as well as appropriate adjustments made under the authority of section 1833(t)(2)(E) of the Act, have the overall effect of revising the scalar from 0.945, which we announced in the November 30, 2001 final rule (66 FR 59886), to 0.951. This revised scalar has the effect of slightly increasing the relative weights of the procedure-related APCs (except for those for which we revised the device-associated costs).

We are also revising the target that we set for outlier payments in the November 30, 2001 final rule from 2.0 percent to 1.5 percent, and thus we are revising the threshold for outlier payments from 3 times the applicable APC payment for a service to 3.5 times the applicable payment amount for a service. These adjustments ensure that the payment rate for every procedure-related APC is at least equal to and in no case lower than the rate published in the November 30, 2001 final rule (except for those APCs for which we revised the device-associated costs). The conversion factor is reduced by 1.5 percent (rather than 2.0 percent) to reflect the revised outlier target and 0.5 percent for the adjustments described above that are due to changes in relative payment weights resulting from revisions in the assignment of device costs. The overall effect of these adjustments does not change the conversion factor announced in the November 2, 2001 final rule. The conversion factor remains $50.904.

Recalculation of the scalar changes the offset amounts that we published in Table 5 in the November 30, 2001 final rule. Certain APC rates increased as a result of the incorporation of 75 percent of the pass-through costs of devices eligible for pass-through payments. Those amounts were deducted from the pass-through payments for those devices, so that the increases to the APC rates were offset by the simultaneous reduction of the associated pass-through costs, as described in the November 30, 2001 final rule (66 FR 59904–59906). The recalculated offset amounts are listed in Table 1 below, which parallels Table 5 of the November 30, 2001 final rule (66 FR 59907). Column 3 shows the device costs already included in the rates for 25 APCs before we incorporated 75 percent of the pass-through device costs into the rates. The label ''NA'' in column 3 means that there were no device costs associated with the APC before incorporating 75 percent of pass-through device costs into the rates. In Table 1, the amounts in column 3 have not changed since the November 30, 2001 final rule. In Table 1, the amounts in column 5, which are the sum of columns 3 and 4, have changed to account for the corrections in column 4.

TABLE 1.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	Device costs (before fold-in) reflected in APC rate	Additional device costs folded into APC rate	Total offset for device costs
1	2	3	4	5
0032	Insertion of Central Venous/Arterial Catheter	$73.79	$279.97	$353.76
0046	Open/Percutaneous Treatment Fracture or Dislocation	NA	100.29	100.29
0048	Arthroplasty with Prosthesis	NA	514.64	514.64
0057	Bunion Procedures	NA	162.89	162.89
0070	Thoracentesis/Lavage Procedures	NA	26.47	26.47
0080	Diagnostic Cardiac Catheterization	164.27	134.39	298.66

TABLE 1.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS—Continued

APC	Description	Device costs (before fold-in) reflected in APC rate	Additional device costs folded into APC rate	Total offset for device costs
1	2	3	4	5
0081	Non-Coronary Angioplasty or Atherectomy	307.06	362.95	670.01
0082	Coronary Atherectomy	242.95	1,214.06	1,457.01
0083	Coronary Angioplasty	528.64	383.31	911.95
0085	Level II Electrophysiologic Evaluation	NA	1,578.03	1,578.03
0086	Ablate Heart Dysrhythm Focus	NA	1,320.96	1,320.96
0087	Cardiac Electrophysiologic Recording/Mapping	NA	1,980.16	1,980.16
0088	Thrombectomy	162.72	261.14	423.86
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	3,175.70	3,286.36	6,462.06
0090	Insertion/Replacement of Pacemaker Pulse Generator	2,921.06	2,123.20	5,044.26
0094	Resuscitation and Cardioversion	NA	19.34	19.34
0103	Miscellaneous Vascular Procedures	NA	207.18	207.18
0104	Transcatheter Placement of Intracoronary Stents	428.16	1,256.31	1,684.47
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	657.59	1,049.13	1,706.72
0107	Insertion of Cardioverter-Defibrillator	6,803.85	11,099.62	17,903.47
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	6,940.27	19,607.20	26,547.47
0111	Blood Product Exchange	NA	209.72	209.72
0115	Cannula/Access Device Procedures	NA	127.26	127.26
0117	Chemotherapy Administration by Infusion Only	NA	30.03	30.03
0118	Chemotherapy Administration by Both Infusion and Other Technique	NA	28.50	28.50
0119	Implantation of Devices	NA	3,348.98	3,348.98
0120	Infusion Therapy Except Chemotherapy	NA	35.12	35.12
0121	Level I Tube Changes and Repositioning	NA	6.10	6.10
0122	Level II Tube Changes and Repositioning	72.55	214.82	287.37
0124	Revision of Implanted Infusion Pump	NA	3,308.76	3,308.76
0144	Diagnostic Anoscopy	NA	128.28	128.28
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	60.92	0.00	60.92
0152	Percutaneous Biliary Endoscopic Procedures	107.61	0.00	107.61
0153	Peritoneal and Abdominal Procedures	NA	41.23	41.23
0154	Hernia/Hydrocele Procedures	108.11	378.73	486.84
0161	Level II Cystourethroscopy and other Genitourinary Procedures	NA	11.20	11.20
0162	Level III Cystourethroscopy and other Genitourinary Procedures	NA	319.68	319.68
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	NA	901.51	901.51
0179	Urinary Incontinence Procedures	NA	3,400.90	3,400.90
0182	Insertion of Penile Prosthesis	2,238.90	569.11	2,808.14
0202	Level VIII Female Reproductive Proc	505.32	1,233.41	1,738.73
0203	Level V Nerve Injections	NA	420.98	420.98
0207	Level IV Nerve Injections	NA	63.63	63.63
0222	Implantation of Neurological Device	4,458.57	9,599.99	14,058.56
0223	Implantation of Pain Management Device	421.33	3,330.14	3,751.47
0225	Implantation of Neurostimulator Electrodes	1,182.00	11,941.06	13,123.06
0226	Implantation of Drug Infusion Reservoir	NA	3,363.74	3,363.74
0227	Implantation of Drug Infusion Device	3,810.46	2,395.55	6,206.01
0229	Transcatherter Placement of Intravascular Shunts	1,074.41	842.97	1,917.38
0246	Cataract Procedures with IOL Insert	146.82	0.00	146.82
0259	Level VI ENT Procedures	12,407.52	3,836.13	16,243.65
0264	Level II Miscellaneous Radiology Procedures	NA	61.59	61.59
0312	Radioelement Applications	NA	5,897.22	5,897.22
0313	Brachytherapy	NA	998.23	998.23
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	NA	210.75	210.75
0686	Level V Skin Repair	NA	465.77	465.77
0687	Revision/Removal of Neurostimulator Electrodes	NA	1,444.65	1,444.65
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	NA	6,238.79	6,238.79
0692	Electronic Analysis of Neurostimulator Pulse Generators	NA	644.44	644.44

As noted above, the estimates of transitional pass-through payments for devices, and of total pass-through payments for all eligible items, have decreased because of the corrections of device costs associated with specific procedures. After we incorporated 75 percent of the estimated pass-through device costs into the APCs, the remaining estimate of total pass-through payments for CY 2002 is 1.20 billion, which results in a uniform reduction in pass-through payments for 2002 of 63.6 percent.

During the first quarter of CY 2002, payments to hospitals for outpatient services are based on the rates and Healthcare Common Procedure Coding System (HCPCS) codes that were in effect for CY 2001, and a uniform reduction of transitional pass-through payments does not apply. Hospitals have thus received the advantage of much higher pass-through payments during the first quarter of CY 2002 than they would have, had we proceeded with implementation of the revised CY 2002 rates and the requisite uniform reduction for services furnished on or after January 1, 2002.

We are making four revised addenda available. Revised Addendum A and Addendum D are printed at the end of this preamble. Addendum A shows the corrected relative weights and payment rates, as well as the national unadjusted copayment and minimum unadjusted copayment amounts that are effective April 1, 2002. Addendum D incorporates several corrections to the payment status indicator addendum that was published on November 30, 2001.

Revised Addendum B and Addendum C are available on our Web site at *http://www.cms.hhs.gov.* Addendum B shows payment rates, weights, APC assignment, and payment status by HCPCS code. Addendum C lists the HCPCS codes in each APC group.

On December 31, 2001, we published a final rule that delayed the effective date of the payment rates and the uniform reduction to the transitional pass-through payments under the OPPS announced in the November 30, 2001 final rule until no later than April 1, 2002. We also announced that payment under the OPPS would continue to be made under the payment rates in effect on December 31, 2001, and that we would not apply a uniform reduction to payments for transitional pass-through items. This final rule implements the revised payment rates in Addendum A effective for services furnished on or after April 1, 2002. Also, effective for services furnished on or after April 1, 2002, a uniform reduction of 63.6 percent applies to transitional pass-through payments made under the OPPS. In addition, effective for services furnished on or after April 1, 2002, the threshold for determining outlier payments is when service costs are 3.5 times greater than the applicable APC payment amount. Also, effective for services furnished on or after April 1, 2002, payment will be made for new 2002 HCPCS codes and modifiers that are payable under the OPPS.

B. Correction of Technical and Typographical Errors in the Preamble and the Regulations Text of the November 30, 2001 Final Rule

We are correcting the following typographical and technical errors in the preamble and regulations text of the November 30, 2001 final rule. As we have stated previously, these corrections do not involve any changes in the policies announced in that rule.

1. On page 59863, in column two, the heading ''Level I Nerve Injections (to include Trigger Point, Joint, Other Injections, and Lower Complexity Nerve Blocks)'' is corrected to read ''Level VI Nerve Injections (APC 204) (to include Trigger Point, Joint, Other Injections, and Lower Complexity Nerve Blocks).''

2. On page 59863, in column two, the chart that will be under the revised heading (see item 1 above) ''Level VI Nerve Injections (APC 204) (to include Trigger Point, Joint, Other Injections, and Lower Complexity Nerve Blocks)'' is revised to read:

	Reassigned CPT Code from APC
27096	(1)
62270	0210
62272	0210
62273	0212
62310–62319	0212

[1] Currently packaged.

3. On page 59863, in column two, the heading ''Level II Nerve Injections (to include Moderate Complexity Nerve Blocks and Epidurals):'' is corrected to read ''Level III Nerve Injections (APC 206) (to include Moderate Complexity Nerve Blocks and Epidurals):''.

4. On page 59863, in column two and continuing to the top of column three, the heading ''Level III Nerve Injections (to include Moderately High Complexity Epidurals, Facet Blocks, and Disk Injections):'' is corrected to read ''Level IV Nerve Injections (APC 207) (to include Moderately High Complexity Epidurals, Facet Blocks, and Disk Injections):''.

5. On page 59863, in column three, the heading ''Level IV Nerve Injections (to include High Complexity Lysis of Adhesions, Neurolytic Procedures, Removal of Implantable Pumps and Stimulators):'' is corrected to read ''Level V Nerve Injections (APC 203) (to include High Complexity Lysis of Adhesions, Neurolytic Procedures, Removal of Implantable Pumps and Stimulators):''.

6. On page 59868, in column two, the first and second complete sentences beginning at line five from the top of the page are corrected to read ''We would note that payment for IMRT planning includes payment for the following CPT codes: 77300, 77336, 77370, 77280–77295, 77305–77321. The only CPT codes that may be billed in addition to 77301 (IMRT planning) are the CPT codes 77332–77334.''

7. On page 59870, in column one, the last sentence is corrected to read ''According to our methodology for pricing new technology services, these services will be reassigned to APC 0714, New Technology—Level IX ($1250–$1500), which results in a payment rate of $1,375 with a status indicator of 'S,' indicating that the multiple procedure discount is not applied.''

8. On page 59883, in column two, on line 17 from the top of the page, ''G0224,'' is corrected to read ''G0244.''

9. On page 59883, in column two, beginning at the bottom of the page and continuing to the top of column three, the list of acceptable diagnosis codes for chest pain is corrected to read as follows:

For Chest Pain:

411.1 Intermediate coronary syndrome
411.81 Coronary occlusion without myocardial infarction
411.0 Postmyocardial infarction syndrome
411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

10. On page 59883, in column three, the list of acceptable diagnosis codes for congestive heart failure is corrected to read as follows:

For Congestive Heart Failure:

391.8 Other acute rheumatic heart disease
398.91 Rheumatic heart failure (congestive)
402.01 Malignant hypertensive heart disease with congestive heart failure
402.11 Benign hypertensive heart disease with congestive heart failure
402.91 Unspecified hypertensive heart disease with congestive heart failure
404.01 Malignant hypertensive heart and renal disease with congestive heart failure
404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11 Benign hypertensive heart and renal disease with congestive heart failure
404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91 Unspecified hypertensive heart and renal disease with congestive heart failure
404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0 Congestive heart failure
428.1 Left heart failure
428.9 Heart failure, unspecified

11. On page 59883, in column three, the second-to-last sentence is corrected to read ''For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010), or pulse oximetry (CPT codes 94760 or 94761).''

12. We are also making revisions to our regulations under 42 CFR Part 419, specifically § 419.32 ''Calculation of prospective payment rates for hospital outpatient services,'' and § 419.62 ''Transitional pass-through payments: General rules.'' At §§ 419.32(b)(1)(iii) and 419.62(d), we are revising our language to specify that the provisions

under these sections are applicable to a portion of CY 2002 and not necessarily the entire year for 2002.

C. Correction of Technical and Typographical Errors in Addenda A, B, C, and D

Addenda A, B, and D as published in the November 30, 2001 final rule contain a number of typographical and technical errors that do not involve any changes in the policies announced in that rule. Addenda A and D at the end of this document reflect the corrections of these errors. Corrected addenda B and C are available on our Web site at http://www.cms.hhs.gov.

1. Corrections to Addendum A

Table 2, Corrections to Addendum A of the November 30, 2001 final rule, shows the APC listings for which corrections are required. It provides the data as published in that final rule and the additions and corrections to these data.

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TABLE 2--CORRECTIONS TO ADDENDUM A OF THE NOVEMBER 30, 2001 FINAL RULE

CORRECTIONS TO THE LIST OF AMBULATORY CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS													
As Published in the November 30, 2001 Final Rule							Corrections to the November 30, 2001 Final Rule						
APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0097	Cardiac monitoring for 30 days	X	0.84	$42.76	$23.52	$8.55	------	Cardiac and ambulatory blood pressure monitoring	------	------	------	------	------
0339	Observation	X	6.85	$348.69	------	$69.74	------	------	S	------	------	------	------
0352	Level II Injections	X	0.41	$20.87	------	$4.17	------	Level I Injections	------	------	------	------	------
------	------	------		------	------	------	0843	Pegaspargase, singl dose vial	G	-------	$1,225.57	------	$179.74
0903	Cytomegalovirus imm IV/vial	G	------	$370.50	------	$47.58	------	------	------	-------	$638.48	------	$91.40
0931	Factor IX non-recombinant, per iu	G	------	$26.13	------	$3.74	------	------			$0.71	------	$0.09
------	-------	------		------	------	------	1002	Cochlear implant system	H				
-------	----------	----------	----------	----------	----------	----------	1616	Histrelin acatate, 10 mgs	G	----------	14.16	----------	2.03
1624	Sodium Phosphate P32	G	------	$54.34	------	$7.78	------	------	------	------	$81.10	------	------
	-------	------		------	------	------	7047	Droperidol/fentanyl inj	G	------	$6.67	------	$0.95
------	------	------		------	------	------	7052	Somatrem injection	G	------	$41.90	------	$6.00
7315	Sodium hyaluronate injection, 5mg	G	------	$26.13	------	$3.74	------	Sodium hyaluronate injection, 20mg	------	------	$130.63	------	$18.70
	------	------		------	------	------	7316	Sodium hyaluron	G	------	$26.13	------	$3.74

CORRECTIONS TO THE LIST OF AMBULATORY CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS													
As Published in the November 30, 2001 Final Rule							Corrections to the November 30, 2001 Final Rule						
APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
								ate injection 5mg					
	------	------		------	------	------	0734	Darbepoetin alfa, 1 mcg	G	------	$4.74	------	$0.68
	------	------		------	------	------	1775	FDG per dose (4-40 mCi/ml)	G	------	$475.00		$68.00

2. Corrections to Addendum B of the November 30, 2001 Final Rule

Table 3, Corrections to Addendum B of the November 30, 2001 final rule shows the APC assignments for which corrections are required. It provides the data as published in that final rule and the additions and corrections to these data.

Table 3—CORRECTIONS TO ADDENDUM B OF THE NOVEMBER 30, 2001 FINAL RULE

TABLE 3 -- CORRECTIONS TO ADDENDUM B.—PAYMENT BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2002													
As Published in the in the November 30, 2001 Final Rule							Corrections to the November 30, 2001 Final Rule						
CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47382	T	Percut ablate liver rf	0152	$821.08	$207.38	$164.22	------	T	------	0980	$1,875.00	------	$375.00
48511	S	Drain pancreatic pseudocyst	0005	$205.14	------	$41.03	------	T	------	0005	------	------	------
50021	S	Renal abscess, percut drain	0005	$205.14	------	$41.03	------	T	------	------	------	------	------
61793	S	Focus radiation beam	0302	$568.09	------	$113.62	------	E	------	------	------	------	------
62355	T	Remove spinal canal catheter	0105	$751.34	------	$150.27	------	------	------	0203	------	------	------
62365	T	Remove spine infusion device	0105	$751.34	------	$150.27	------	------	------	0203	------	------	------
64614	T	Destroy nerve, extrem musc	0206	$182.75	------	$36.55	------	------	------	0204	------	------	------
76873	N	Echograp trans r, pros study	------	------	------	------	------	S	------	0266	------	------	------
93786	E	Ambulatory BP recording	------	------	------	------	------	X	------	097	------	------	------
96000	T	Motion analysis, video/3d	0972	$150.00	------	$30.00	------	S	------	0708	------	------	------
96001	T	Motion test w/ft press meas	0972	$150.00	------	$30.00	------	S	------	0708	------	------	------
96002	T	Dynamic surface emg	0972	$150.00	------	$30.00	------	S	------	0708	------	------	------
96003	T	Dynamic fine wire emg	0972	$150.00	------	$30.00	------	S	------	0708	------	------	------
C1300	T	Hyperbaric oxygen	0971	$75.00	------	$15.00	------	S	------	0707	$75.00	------	$15.00
------	------	------	------	------	------	------	C1774	G	Non esrd darbepoetin alfa	0734	$4.74	------	$0.68
							C1775	G	FDG, per dose (4-40 mCi/ml)	1775	$475.00	------	$68.00
G0210	S	PET img wholebody dx lung ca	0712	$875.00	------	$175.00	------		PET img WhBD ring dxlung ca	0714	$1,375.00	------	$275.00
G0211	S	PET img wholebody init lung	0712	$875.00	------	$175.00	------		PET img WhBD ring init lung	0714	$1,375.00	------	$275.00
G0212	S	PET img wholebod restag lung	0712	$875.00	------	$175.00	------		PET img WhBD ring restag lun	0714	$1,375.00	------	$275.00
G0213	S	PET img wholebody dx colorec	0712	$875.00	------	$175.00	------		PET img WhBD ring dx colorec	0714	$1,375.00	------	$275.00
G0214	S	PET img wholebod init colore	0712	$875.00	------	$175.00	------		PET img WhBD ring init colore	0714	$1,375.00	------	$275.00
G0215	S	PETimg wholebod restag colre	0712	$875.00	------	$175.00	------		PET img whbd restag col	0714	$1,375.00	------	$275.00
G0216	S	PET img wholebod dx melanoma	0712	$875.00	------	$175.00	------		PET img WhBD ring dx melanom	0714	$1,375.00	------	$275.00

TABLE 3 -- CORRECTIONS TO ADDENDUM B.—PAYMENT BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2002

As Published in the in the November 30, 2001 Final Rule							Corrections to the November 30, 2001 Final Rule						
CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0217	S	PET img wholebod init melano	0712	$875.00	------	$175.00	------		PET img WhBD ring init melan	0714	$1,375.00	------	$275.00
G0218	S	PET img wholebod restag mela	0712	$875.00	------	$175.00	------		PET img WhBD ring restag mel	0714	$1,375.00	------	$275.00
G0219	S	PET img wholbod melano nonco	0712	$875.00	------	$175.00	------	E	PET img WhBD ring noncov ind	------	------	------	------
G0220	S	PET img wholebod dx lymphoma	0712	$875.00	------	$175.00	------		PET img WhBD ring dx lymphom	0714	$1,375.00	------	$275.00
G0221	S	PET imag wholbod init lympho	0712	$875.00	------	$175.00	------		PET img WhBD ring init lymph	0714	$1,375.00	------	$275.00
G0222	S	PET imag wholbod resta lymph	0712	$875.00	------	$175.00	------		PET img WhBD ring resta lymp	0714	$1,375.00	------	$275.00
G0223	S	PET imag wholbod reg dx head	0712	$875.00	------	$175.00	------		PET imag WhBD reg ring dx head	0714	$1,375.00	------	$275.00
G0224	S	PET imag wholbod reg ini hea	0712	$875.00	------	$175.00	------		PET img WhBD reg ring ini hea	0714	$1,375.00	------	$275.00
G0225	S	PET whol restag headneck onl	0712	$875.00	------	$175.00	------		PET img WhBD ring restag hea	0714	$1,375.00	------	$275.00
G0226	S	PET img wholbody dx esophagl	0712	$875.00	------	$175.00	------		PET img WhBD dx esophag	0714	$1,375.00	------	$275.00
G0227	S	PET img wholbod ini esophage	0712	$875.00	------	$175.00	------		PET img whbd ini esopha	0714	$1,375.00	------	275.00
G0228	S	PET img wholbod restg esopha	0712	$875.00	------	$175.00	------		Pet img WhBD ring restg esop	0714	$1,375.00	------	$275.00
G0229	S	PET img metabolic brain pres	0712	$875.00	------	$175.00	------		PET img metabolic brain ring	0714	$1,375.00	------	$275.00
G0230	S	PET myocard viability post s	0712	$875.00	------	$175.00	------		Pet myocard viability ring	0714	$1,375.00	------	$275.00
G0231	S	PET WhBD colorec; gamma cam	0712	$875.00	------	$175.00	------		------	0714	$1,375.00	------	$275.00
G0232	S	PET WhBD lymphoma; gamma cam	0712	$875.00	------	$175.00	------		------	0714	$1,375.00	------	$275.00
G0233	S	PET WhBD melanoma; gamma cam	0712	$875.00	------	$175.00	------		------	0714	$1,375.00	------	$275.00
G0234	S	PET WhBD pulm nod; gamma cam	0712	$875.00	------	$175.00	------		------	0714	$1,375.00	------	$275.00
G0244	X	Observ care by facility topt	0339	$348.69	------	$69.74	------	S	------	------	------	------	------
J0850	G	Cytomegalovirus imm IV /vial	0903	$370.50	------	$47.58	------		------	------	$638.48	------	$91.40
J1810	E	Droperidol/fentanyl inj, up to 2 ml	------	------	------	------	------	G	------	7047	$6.67	------	$0.95
J2940	G	Somatrem injection	7033	$209.48	------	$29.99	------	G	------	7052	$41.90		$6.00

TABLE 3 -- CORRECTIONS TO ADDENDUM B.—PAYMENT BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2002

As Published in the in the November 30, 2001 Final Rule							Corrections to the November 30, 2001 Final Rule						
CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	CPT/ HCPCS	Status Indicator	Description	APC	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7193	G	Factor IX non-recombinant	0931	$26.13	------	$3.74	------		------	------	$0.71		$0.09
J7315	D	Sodium hyaluronate injection	7315	$26.13	------	$3.74	------		------	------	$130.63		$18.70
J7316	G	Sodium hyaluronate injection	7315	$26.13	------	$3.74	------		------	7316	$26.13		$3.74
J9266	E	Pegaspargase/singl dose vial	------	------	------	------	------	G	------	0843	$1,225.57	------	$179.74
L2102	A	Afo tibial fx cast plstr mol	------	------	------	------	------	E	------	------	------	------	------
L2104	A	Afo tib fx cast synthetic mo	------	------	------	------	------	E	------	------	------	------	------
L2122	A	Kafo fem fx cast plaster mol	------	------	------	------	------	E	------	------	------	------	------
L2124	A	Kafo fem fx cast synthet mol	------	------	------	------	------	E	------	------	------	------	------
L3760	E	EO withjoint, Prefabricated	------	------	------	------	------	A	------	------	------	------	------
L8614	E	Cochlear device/system	------	------	------	------	------	H	------	1002	------	------	------
Q0081	D	Infusion ther other than che	0120	$156.78	------	$31.36	------	T	------	------	------	------	------
Q0086	D	Physical therapy evaluation/	------	------	$42.67	------	------	A	------	------	------	------	------
Q0160	D	Factor IX non-recombinant	0931	$26.13	------	$3.74	------		------	------	$0.71		$0.09
Q2020	E	Histrelin acetate, 10 mg	------	------	------	------	------	G	------	1616	$14.16	------	$2.03
Q3007	G	Sodium Phosphate P32	1624	$54.34	------	$7.78	------		------	------	$81.10	------	$11.61
Q3017	A	Ambsrv, ALS assmt, no other a/s	------	------	------	------	------	E	------	------	------	------	------
------	------	------	------	------	------	------	Q3019	A	ALS emer trans no ALS service	------	------	------	------
------	------	------	------	------	------	------	Q3020	A	ALS nonemer trans no als service	------	------	------	------

BILLING CODE 4120–01–C

3. Corrections to Addendum D of the November 30, 2001 Final Rule

On page 60091, there are two corrections to Addendum D as published in the November 30, 2001 final rule.

a. Under the status column for Screening Mammography, ''Lower of Charges or National Rate'' is revised to read ''Physician Fee Schedule.''

b. We are adding a status indicator that was inadvertently omitted. In the indicator column we are adding, where it should appear alphabetically, status indicator ''D'', ''Deleted Code'' under the service column, and ''Codes Are Deleted Effective with the Beginning of the Calendar Year'' under the status column.

III. Waiver of Notice of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. The rates in this final rule incorporate the correction of errors that were identified in connection with the rates published in the November 30, 2001 final rule.

We find that it is in the general public interest to proceed with implementing the corrected rates without proposed rulemaking and public comment. The delay in implementing the 2002 rates was necessary to correct identified inadvertent technical errors and to allow us to review our data files to ensure that other errors could also be identified and corrected. As a matter of good public policy, we do not believe that the necessary delay in implementing the CY 2002 OPPS rates should result in continued uncertainty among hospitals, beneficiaries, and others regarding CY 2002 payment rates for OPPS services. The public is expecting the corrected OPPS update for CY 2002 to be made effective no later than April 1, 2002. Thus, there is an urgent need, effective for services furnished on or after April 1, 2002, to implement the corrected rate update and new 2002 HCPCS codes for Medicare payments under the OPPS. There is not sufficient time to provide notice of proposed rulemaking without further delaying the effective date of the rates. Therefore, we find that it is contrary to the public interest to continue to delay the effective date of the rates.

IV. Collection of Information Requirements

This document does not impose information collection and record-keeping requirements. Consequently, the Office of Management and Budget need not review it under the authority of the Paperwork Reduction Act of 1995.

V. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

As discussed above in this preamble, this final rule corrects inadvertent technical errors in the November 30, 2001 final rule that implemented the CY 2002 payments for the hospital OPPS. We note that the November 30, 2001 final rule was not a major rule. As we also discussed above in the preamble, this final rule corrects the estimate of the transitional pass-through payments for CY 2002 and the resulting uniform reduction that is required for that year, the median costs for several APCs, the scalar used to adjust the relative payment weights for the effects of recalibration, and device cost assignment to device-related APCs. We also note that on November 2, 2001, we published a final rule that announced the updated conversion factor for payments under the OPPS (66 FR 55857).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues between $5 million and $25 million (for details see the Small Business Administration's final rule that set forth size standards for health care industries at 65 FR 69432). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with not more than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the PPS, we classify these hospitals as urban hospitals. See the November 30, 2001 final rule for the regulatory impact analysis related to the updated CY 2002 hospital OPPS payments.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not have a significant economic effect on these governments or the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule will not have a substantial effect on States or local governments.

Because the November 30, 2001 final rule includes the relevant impact analysis for the changes to the hospital OPPS, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

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 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR part 419 is corrected

by making the following correcting amendments:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

1. The authority citation continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

§ 419.32 [Corrected]

2. In § 419.32, paragraph (b)(1)(iii) is corrected by removing the phrase ''For calendar year 2002,'' and adding in its place the phrase ''For the portion of calendar year 2002 that is affected by these rules,''.

§ 419.62 [Corrected]

In § 419.62, paragraph (d) is corrected by removing the phrase ''For CY 2002'' and adding in its place ''For the portion of CY 2002 affected by these rules,''.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: February 27, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 27, 2002.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Photochemotherapy	S	0.43	$21.89	$7.88	$4.38
0002	Fine needle Biopsy/Aspiration	T	0.42	$21.38	$11.76	$4.28
0003	Bone Marrow Biopsy/Aspiration	T	1.04	$52.94	$27.08	$10.59
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	2.48	$126.24	$32.57	$25.25
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	4.05	$206.16	$90.71	$41.23
0006	Level I Incision & Drainage	T	2.19	$111.48	$33.95	$22.30
0007	Level II Incision & Drainage	T	6.79	$345.64	$72.03	$69.13
0008	Level III Incision and Drainage	T	10.99	$559.43	$113.67	$111.89
0009	Nail Procedures	T	0.63	$32.07	$8.34	$6.41
0010	Level I Destruction of Lesion	T	0.66	$33.60	$9.86	$6.72
0011	Level II Destruction of Lesion	T	1.48	$75.34	$27.88	$15.07
0012	Level I Debridement & Destruction	T	0.66	$33.60	$9.18	$6.72
0013	Level II Debridement & Destruction	T	1.37	$69.74	$17.66	$13.95
0015	Level IV Debridement & Destruction	T	2.08	$105.88	$31.20	$21.18
0016	Level V Debridement & Destruction	T	3.04	$154.75	$65.00	$30.95
0017	Level VI Debridement & Destruction	T	9.73	$495.30	$227.84	$99.06
0018	Biopsy of Skin/Puncture of Lesion	T	1.06	$53.96	$17.66	$10.79
0019	Level I Excision/ Biopsy	T	4.24	$215.83	$78.91	$43.17
0020	Level II Excision/ Biopsy	T	8.49	$432.17	$130.53	$86.43
0021	Level IV Excision/ Biopsy	T	11.89	$605.25	$236.51	$121.05
0022	Level V Excision/ Biopsy	T	13.99	$712.15	$292.94	$142.43
0023	Exploration Penetrating Wound	T	2.09	$106.39	$40.37	$21.28
0024	Level I Skin Repair	T	2.29	$116.57	$41.97	$23.31
0025	Level II Skin Repair	T	3.41	$173.58	$65.57	$34.72
0026	Level III Skin Repair	T	12.69	$645.97	$277.92	$129.19
0027	Level IV Skin Repair	T	18.12	$922.38	$383.10	$184.48
0028	Level I Breast Surgery	T	14.08	$716.73	$303.74	$143.35
0029	Level II Breast Surgery	T	23.90	$1,216.61	$632.64	$243.32
0030	Level III Breast Surgery	T	34.40	$1,751.10	$763.55	$350.22
0032	Insertion of Central Venous/Arterial Catheter	T	12.71	$646.99	.....	$129.40
0033	Partial Hospitalization	P	4.17	$212.27	$48.17	$42.45
0035	Placement of Arterial or Central Venous Catheter	T	0.13	$6.62	$2.91	$1.32
0041	Level I Arthroscopy	T	23.74	$1,208.46	$580.06	$241.69
0042	Level II Arthroscopy	T	35.97	$1,831.02	$804.74	$366.20
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	4.07	$207.18	.....	$41.44
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/ Trunk.	T	2.54	$129.30	$38.08	$25.86
0045	Bone/Joint Manipulation Under Anesthesia	T	11.74	$597.61	$277.12	$119.52
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	27.86	$1,418.19	$535.76	$283.64
0047	Arthroplasty without Prosthesis	T	26.51	$1,349.47	$537.03	$269.89
0048	Arthroplasty with Prosthesis	T	43.44	$2,211.27	$725.94	$442.25
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.93	$810.90	$356.95	$162.18
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	20.75	$1,056.26	$507.15	$211.25
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	28.73	$1,462.47	$675.24	$292.49
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	36.15	$1,840.18	$930.91	$368.04
0053	Level I Hand Musculoskeletal Procedures	T	11.76	$598.63	$253.49	$119.73
0054	Level II Hand Musculoskeletal Procedures	T	19.95	$1,015.53	$472.33	$203.11
0055	Level I Foot Musculoskeletal Procedures	T	15.52	$790.03	$355.34	$158.01
0056	Level II Foot Musculoskeletal Procedures	T	18.95	$964.63	$405.81	$192.93
0057	Bunion Procedures	T	24.49	$1,246.64	$496.65	$249.33
0058	Level I Strapping and Cast Application	S	1.28	$65.16	$19.27	$13.03
0059	Level II Strapping and Cast Application	S	2.23	$113.52	$29.59	$22.70
0060	Manipulation Therapy	S	0.23	$11.71	.....	$2.34
0068	CPAP Initiation	S	3.04	$154.75	$85.11	$30.95

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0069	Thoracoscopy	T	23.72	$1,207.44	$591.64	$241.49
0070	Thoracentesis/Lavage Procedures	T	4.61	$234.67	$79.60	$46.93
0071	Level I Endoscopy Upper Airway	T	1.04	$52.94	$14.22	$10.59
0072	Level II Endoscopy Upper Airway	T	1.22	$62.10	$34.16	$12.42
0073	Level III Endoscopy Upper Airway	T	3.31	$168.49	$74.14	$33.70
0074	Level IV Endoscopy Upper Airway	T	11.39	$579.80	$295.70	$115.96
0075	Level V Endoscopy Upper Airway	T	17.52	$891.84	$445.92	$178.37
0076	Endoscopy Lower Airway	T	7.61	$387.38	$189.82	$77.48
0077	Level I Pulmonary Treatment	S	0.39	$19.85	$10.92	$3.97
0078	Level II Pulmonary Treatment	S	0.87	$44.29	$19.04	$8.86
0079	Ventilation Initiation and Management	S	0.60	$30.54	$16.80	$6.11
0080	Diagnostic Cardiac Catheterization	T	34.93	$1,778.08	$838.92	$355.62
0081	Non-Coronary Angioplasty or Atherectomy	T	29.42	$1,497.60	$710.91	$299.52
0082	Coronary Atherectomy	T	92.53	$4,710.15	$1,351.74	$942.03
0083	Coronary Angioplasty	T	59.84	$3,046.10	$794.30	$609.22
0084	Level I Electrophysiologic Evaluation	S	6.90	$351.24	$115.91	$70.25
0085	Level II Electrophysiologic Evaluation	T	58.28	$2,966.69	$654.48	$593.34
0086	Ablate Heart Dysrhythm Focus	T	73.14	$3,723.12	$1,265.37	$744.62
0087	Cardiac Electrophysiologic Recording/Mapping	T	52.77	$2,686.20	.....	$537.24
0088	Thrombectomy	T	34.57	$1,759.75	$678.68	$351.95
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	150.39	$7,655.45	$2,246.59	$1,531.09
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	116.11	$5,910.46	$2,133.88	$1,182.09
0091	Level I Vascular Ligation	T	21.15	$1,076.62	$348.23	$215.32
0092	Level II Vascular Ligation	T	20.02	$1,019.10	$505.37	$203.82
0093	Vascular Repair/Fistula Construction	T	14.24	$724.87	$277.34	$144.97
0094	Resuscitation and Cardioversion	S	6.12	$311.53	$105.29	$62.31
0095	Cardiac Rehabilitation	S	0.62	$31.56	$16.73	$6.31
0096	Non-Invasive Vascular Studies	S	1.72	$87.55	$48.15	$17.51
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	0.85	$43.27	$23.80	$8.65
0098	Injection of Sclerosing Solution	T	1.25	$63.63	$20.88	$12.73
0099	Electrocardiograms	S	0.36	$18.33	$10.08	$3.67
0100	Stress Tests and Continuous ECG	X	1.48	$75.34	$41.44	$15.07
0101	Tilt Table Evaluation	S	3.76	$191.40	$105.27	$38.28
0103	Miscellaneous Vascular Procedures	T	16.04	$816.50	$295.70	$163.30
0104	Transcatheter Placement of Intracoronary Stents	T	96.97	$4,936.16	.....	$987.23
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	14.85	$755.92	$370.40	$151.18
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	36.85	$1,875.81	$503.07	$375.16
0107	Insertion of Cardioverter-Defibrillator	T	381.66	$19,428.02	$4,224.27	$3,885.60
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	576.78	$29,360.41	.....	$5,872.08
0109	Removal of Implanted Devices	T	6.30	$320.70	$131.49	$64.14
0110	Transfusion	S	5.34	$271.83	$114.17	$54.37
0111	Blood Product Exchange	S	21.21	$1,079.67	$300.74	$215.93
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.46	$1,855.96	$612.47	$371.19
0113	Excision Lymphatic System	T	15.62	$795.12	$326.55	$159.02
0114	Thyroid/Lymphadenectomy Procedures	T	29.46	$1,499.63	$493.78	$299.93
0115	Cannula/Access Device Procedures	T	21.47	$1,092.91	$506.74	$218.58
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	0.91	$46.32	.....	$9.26
0117	Chemotherapy Administration by Infusion Only	S	4.03	$205.14	$52.69	$41.03
0118	Chemotherapy Administration by Both Infusion and Other Technique.	S	4.22	$214.81	$72.03	$42.96
0119	Implantation of Devices	T	80.14	$4,079.45	.....	$815.89
0120	Infusion Therapy Except Chemotherapy	T	3.10	$157.80	$42.67	$31.56
0121	Level I Tube changes and Repositioning	T	2.56	$130.31	$52.53	$26.06
0122	Level II Tube changes and Repositioning	T	9.94	$505.99	$114.93	$101.20
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	8.62	$438.79	.....	$87.76
0124	Revision of Implanted Infusion Pump	T	89.58	$4,559.98	.....	$912.00
0125	Refilling of Infusion Pump	T	3.01	$153.22	.....	$30.64
0130	Level I Laparoscopy	T	26.06	$1,326.56	$659.53	$265.31
0131	Level II Laparoscopy	T	37.85	$1,926.72	$1,001.89	$385.34
0132	Level III Laparoscopy	T	56.38	$2,869.97	$1,239.22	$573.99
0140	Esophageal Dilation without Endoscopy	T	5.68	$289.13	$107.24	$57.83
0141	Upper GI Procedures	T	7.25	$369.05	$184.67	$73.81
0142	Small Intestine Endoscopy	T	6.98	$355.31	$152.78	$71.06
0143	Lower GI Endoscopy	T	7.31	$372.11	$186.06	$74.42
0144	Diagnostic Anoscopy	T	4.46	$227.03	$49.32	$45.41

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0145	Therapeutic Anoscopy	T	10.88	$553.84	$179.39	$110.77
0146	Level I Sigmoidoscopy	T	2.75	$139.99	$64.40	$28.00
0147	Level II Sigmoidoscopy	T	5.74	$292.19	$137.33	$58.44
0148	Level I Anal/Rectal Procedure	T	2.41	$122.68	$43.59	$24.54
0149	Level III Anal/Rectal Procedure	T	13.61	$692.80	$293.06	$138.56
0150	Level IV Anal/Rectal Procedure	T	18.19	$925.94	$437.12	$185.19
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	15.39	$783.41	$245.46	$156.68
0152	Percutaneous Biliary Endoscopic Procedures	T	16.23	$826.17	$207.38	$165.23
0153	Peritoneal and Abdominal Procedures	T	23.70	$1,206.42	$496.31	$241.28
0154	Hernia/Hydrocele Procedures	T	31.58	$1,607.55	$556.98	$321.51
0155	Level II Anal/Rectal Procedure	T	5.30	$269.79	$99.82	$53.96
0156	Level II Urinary and Anal Procedures	T	2.46	$125.22	$37.57	$25.04
0157	Colorectal Cancer Screening: Barium Enema	S	1.99	$101.30	$22.19	$20.26
0158	Colorectal Cancer Screening: Colonoscopy	T	6.59	$335.46	$83.87	$67.09
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.34	$119.12	$29.78	$23.82
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.16	$262.66	$105.06	$52.53
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	13.80	$702.48	$249.36	$140.50
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	25.23	$1,284.31	$427.49	$256.86
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	40.63	$2,068.23	$792.58	$413.65
0164	Level I Urinary and Anal Procedures	T	1.02	$51.92	$15.58	$10.38
0165	Level III Urinary and Anal Procedures	T	5.25	$267.25	$91.76	$53.45
0166	Level I Urethral Procedures	T	12.27	$624.59	$218.73	$124.92
0167	Level II Urethral Procedures	T	22.41	$1,140.76	$555.84	$228.15
0168	Level III Urethral Procedures	T	18.53	$943.25	$405.60	$188.65
0169	Lithotripsy	T	39.85	$2,028.52	$1,115.69	$405.70
0170	Dialysis for Other Than ESRD Patients	S	0.29	$14.76	$3.25	$2.95
0179	Urinary Incontinence Procedures	T	140.14	$7,133.69	$3,067.48	$1,426.74
0180	Circumcision	T	15.11	$769.16	$304.87	$153.83
0181	Penile Procedures	T	22.21	$1,130.58	$621.82	$226.12
0182	Insertion of Penile Prosthesis	T	88.04	$4,481.59	$1,492.28	$896.32
0183	Testes/Epididymis Procedures	T	18.97	$965.65	$448.94	$193.13
0184	Prostate Biopsy	T	4.86	$247.39	$123.70	$49.48
0187	Miscellaneous Placement/Repositioning	X	4.24	$215.83	$94.96	$43.17
0188	Level II Female Reproductive Proc	T	0.81	$41.23	$11.95	$8.25
0189	Level III Female Reproductive Proc	T	1.26	$64.14	$18.60	$12.83
0190	Surgical Hysteroscopy	T	17.01	$865.88	$424.28	$173.18
0191	Level I Female Reproductive Proc	T	0.23	$11.71	$3.40	$2.34
0192	Level IV Female Reproductive Proc	T	2.52	$128.28	$35.33	$25.66
0193	Level V Female Reproductive Proc	T	11.23	$571.65	$171.13	$114.33
0194	Level VI Female Reproductive Proc	T	15.95	$811.92	$397.84	$162.38
0195	Level VII Female Reproductive Proc	T	20.74	$1,055.75	$483.80	$211.15
0196	Dilation and Curettage	T	13.56	$690.26	$338.23	$138.05
0197	Infertility Procedures	T	2.41	$122.68	$49.55	$24.54
0198	Pregnancy and Neonatal Care Procedures	T	1.32	$67.19	$32.92	$13.44
0199	Vaginal Delivery	T	5.12	$260.63	$72.98	$52.13
0200	Therapeutic Abortion	T	11.41	$580.81	$307.83	$116.16
0201	Spontaneous Abortion	T	14.42	$734.04	$329.65	$146.81
0202	Level VIII Female Reproductive Proc	T	63.90	$3,252.77	$1,593.85	$650.55
0203	Level V Nerve Injections	T	15.88	$808.36	$363.78	$161.67
0204	Level VI Nerve Injections	T	2.25	$114.53	$43.52	$22.91
0206	Level III Nerve Injections	T	3.62	$184.27	$75.55	$36.85
0207	Level IV Nerve Injections	T	5.40	$274.88	$123.69	$54.98
0208	Laminotomies and Laminectomies	T	29.29	$1,490.98	.....	$298.20
0209	Extended EEG Studies and Sleep Studies, Level II	S	10.60	$539.58	$280.58	$107.92
0212	Level II Nervous System Injections	T	3.79	$192.93	$88.78	$38.59
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.66	$135.40	$70.41	$27.08
0214	Electroencephalogram	S	2.11	$107.41	$53.71	$21.48
0215	Level I Nerve and Muscle Tests	S	0.66	$33.60	$17.47	$6.72
0216	Level III Nerve and Muscle Tests	S	2.63	$133.88	$60.25	$26.78
0218	Level II Nerve and Muscle Tests	S	1.04	$52.94	$23.82	$10.59
0220	Level I Nerve Procedures	T	13.68	$696.37	$327.29	$139.27
0221	Level II Nerve Procedures	T	21.55	$1,096.98	$463.62	$219.40
0222	Implantation of Neurological Device	T	304.29	$15,489.58	.....	$3,097.92
0223	Implantation of Pain Management Device	T	75.83	$3,860.05	.....	$772.01
0224	Implantation of Reservoir/Pump/Shunt	T	28.65	$1,458.40	$453.41	$291.68
0225	Implantation of Neurostimulator Electrodes	T	269.11	$13,698.78	.....	$2,739.76
0226	Implantation of Drug Infusion Reservoir	T	76.24	$3,880.92	.....	$776.18

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0227	Implantation of Drug Infusion Device	T	140.36	$7,144.89	.....	$1,428.98
0228	Creation of Lumbar Subarachnoid Shunt	T	54.08	$2,752.89	$696.46	$550.58
0229	Transcatherter Placement of Intravascular Shunts	T	76.09	$3,873.29	$996.86	$774.66
0230	Level I Eye Tests & Treatments	S	0.62	$31.56	$14.52	$6.31
0231	Level III Eye Tests & Treatments	S	2.05	$104.35	$46.96	$20.87
0232	Level I Anterior Segment Eye Procedures	T	3.52	$179.18	$78.84	$35.84
0233	Level II Anterior Segment Eye Procedures	T	10.90	$554.85	$266.33	$110.97
0234	Level III Anterior Segment Eye Procedures	T	19.20	$977.36	$469.13	$195.47
0235	Level I Posterior Segment Eye Procedures	T	5.60	$285.06	$78.91	$57.01
0236	Level II Posterior Segment Eye Procedures	T	16.30	$829.74	.....	$165.95
0237	Level III Posterior Segment Eye Procedures	T	32.16	$1,637.07	$818.54	$327.41
0238	Level I Repair and Plastic Eye Procedures	T	3.02	$153.73	$58.96	$30.75
0239	Level II Repair and Plastic Eye Procedures	T	5.84	$297.28	$115.94	$59.46
0240	Level III Repair and Plastic Eye Procedures	T	13.91	$708.07	$315.31	$141.61
0241	Level IV Repair and Plastic Eye Procedures	T	17.84	$908.13	$384.47	$181.63
0242	Level V Repair and Plastic Eye Procedures	T	24.26	$1,234.93	$597.36	$246.99
0243	Strabismus/Muscle Procedures	T	17.81	$906.60	$431.39	$181.32
0244	Corneal Transplant	T	38.69	$1,969.48	$851.42	$393.90
0245	Level I Cataract Procedures without IOL Insert	T	10.50	$534.49	$251.21	$106.90
0246	Cataract Procedures with IOL Insert	T	20.73	$1,055.24	$495.96	$211.05
0247	Laser Eye Procedures Except Retinal	T	4.05	$206.16	$94.83	$41.23
0248	Laser Retinal Procedures	T	4.35	$221.43	$94.05	$44.29
0249	Level II Cataract Procedures without IOL Insert	T	21.93	$1,116.32	$524.67	$223.26
0250	Nasal Cauterization/Packing	T	2.11	$107.41	$37.59	$21.48
0251	Level I ENT Procedures	T	2.44	$124.21	$27.99	$24.84
0252	Level II ENT Procedures	T	5.99	$304.91	$114.24	$60.98
0253	Level III ENT Procedures	T	12.40	$631.21	$284.00	$126.24
0254	Level IV ENT Procedures	T	17.47	$889.29	$272.41	$177.86
0256	Level V ENT Procedures	T	26.76	$1,362.19	$623.05	$272.44
0258	Tonsil and Adenoid Procedures	T	17.53	$892.35	$437.25	$178.47
0259	Level VI ENT Procedures	T	378.75	$19,279.89	$9,447.14	$3,855.98
0260	Level I Plain Film Except Teeth	X	0.70	$35.63	$19.60	$7.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.22	$62.10	$34.15	$12.42
0262	Plain Film of Teeth	X	0.65	$33.09	$10.90	$6.62
0263	Level I Miscellaneous Radiology Procedures	X	1.62	$82.46	$44.53	$16.49
0264	Level II Miscellaneous Radiology Procedures	X	3.74	$190.38	$104.71	$38.08
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.95	$48.36	$26.60	$9.67
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.55	$78.90	$43.40	$15.78
0267	Vascular Ultrasound	S	2.34	$119.12	$65.52	$23.82
0269	Level I Echocardiogram Except Transesophageal	S	3.87	$197.00	$102.44	$39.40
0270	Transesophageal Echocardiogram	S	5.34	$271.83	$146.79	$54.37
0271	Mammography	S	0.60	$30.54	$16.80	$6.11
0272	Level I Fluoroscopy	X	1.38	$70.25	$38.64	$14.05
0274	Myelography	S	5.27	$268.26	$128.12	$53.65
0275	Arthrography	S	2.61	$132.86	$69.09	$26.57
0276	Level I Digestive Radiology	S	1.49	$75.85	$41.72	$15.17
0277	Level II Digestive Radiology	S	2.16	$109.95	$60.47	$21.99
0278	Diagnostic Urography	S	2.36	$120.13	$66.07	$24.03
0279	Level I Angiography and Venography except Extremity	S	7.77	$395.52	$174.57	$79.10
0280	Level II Angiography and Venography except Extremity	S	13.63	$693.82	$353.85	$138.76
0281	Venography of Extremity	S	4.35	$221.43	$115.16	$44.29
0282	Miscellaneous Computerized Axial Tomography	S	1.59	$80.94	$44.51	$16.19
0283	Computerized Axial Tomography with Contrast Material	S	4.51	$229.58	$126.27	$45.92
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.18	$365.49	$201.02	$73.10
0285	Positron Emission Tomography (PET)	S	18.83	$958.52	$415.21	$191.70
0286	Myocardial Scans	S	5.43	$276.41	$152.03	$55.28
0287	Complex Venography	S	4.09	$208.20	$114.51	$41.64
0288	CT, Bone Density	S	1.18	$60.07	$33.03	$12.01
0289	Needle Localization for Breast Biopsy	X	1.63	$82.97	$44.80	$16.59
0290	Standard Non-Imaging Nuclear Medicine	S	1.76	$89.59	$49.27	$17.92
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans.	S	3.52	$179.18	$90.20	$35.84
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans.	S	4.22	$214.81	$118.15	$42.96
0294	Level I Therapeutic Nuclear Medicine	S	5.04	$256.56	$141.11	$51.31
0295	Level II Therapeutic Nuclear Medicine	S	12.17	$619.50	$340.73	$123.90
0296	Level I Therapeutic Radiologic Procedures	S	3.41	$173.58	$95.47	$34.72

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0297	Level II Therapeutic Radiologic Procedures	S	7.11	$361.93	$172.51	$72.39
0299	Miscellaneous Radiation Treatment	S	0.21	$10.69	$5.66	$2.14
0300	Level I Radiation Therapy	S	2.08	$105.88	$47.72	$21.18
0301	Level II Radiation Therapy	S	5.18	$263.68	.....	$52.74
0302	Level III Radiation Therapy	S	11.23	$571.65	$216.55	$114.33
0303	Treatment Device Construction	X	3.01	$153.22	$69.28	$30.64
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.63	$82.97	$41.52	$16.59
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.74	$190.38	$91.38	$38.08
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.59	$742.69	$339.05	$148.54
0312	Radioelement Applications	S	124.64	$6,344.67	.....	$1,268.93
0313	Brachytherapy	S	35.74	$1,819.31	.....	$363.86
0314	Hyperthermic Therapies	S	3.92	$199.54	$101.77	$39.91
0320	Electroconvulsive Therapy	S	3.90	$198.53	$80.06	$39.71
0321	Biofeedback and Other Training	S	0.93	$47.34	$21.78	$9.47
0322	Brief Individual Psychotherapy	S	1.16	$59.05	$12.40	$11.81
0323	Extended Individual Psychotherapy	S	1.74	$88.57	$21.26	$17.71
0324	Family Psychotherapy	S	2.71	$137.95	.....	$27.59
0325	Group Psychotherapy	S	1.38	$70.25	$18.27	$14.05
0330	Dental Procedures	S	11.04	$561.98	.....	$112.40
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.26	$165.95	$91.27	$33.19
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.25	$267.25	$146.98	$53.45
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.41	$275.39	$151.46	$55.08
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.32	$321.71	$176.94	$64.34
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	8.60	$437.77	$240.77	$87.55
0339	Observation	S	6.90	$351.24	.....	$70.25
0340	Minor Ancillary Procedures	X	0.85	$43.27	$10.82	$8.65
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.11	$5.60	$3.08	$1.12
0342	Level I Pathology	X	0.21	$10.69	$5.88	$2.14
0343	Level II Pathology	X	0.39	$19.85	$10.72	$3.97
0344	Level III Pathology	X	0.56	$28.51	$15.68	$5.70
0345	Level I Transfusion Laboratory Procedures	X	0.27	$13.74	$5.37	$2.75
0346	Level II Transfusion Laboratory Procedures	X	0.77	$39.20	$12.03	$7.84
0347	Level III Transfusion Laboratory Procedures	X	1.57	$79.92	$20.13	$15.98
0348	Fertility Laboratory Procedures	X	0.77	$39.20	.....	$7.84
0352	Level I Injections	X	0.41	$20.87	.....	$4.17
0353	Level II Allergy Injections	X	0.25	$12.73	$2.92	$2.55
0354	Administration of Influenza/Pneumonia Vaccine	K	0.11	$5.60	.....	.....
0355	Level I Immunizations	K	0.19	$9.67	$5.05	$1.93
0356	Level II Immunizations	K	1.12	$57.01	.....	$11.40
0359	Level II Injections	X	1.80	$91.63	.....	$18.33
0360	Level I Alimentary Tests	X	1.36	$69.23	$34.62	$13.85
0361	Level II Alimentary Tests	X	3.27	$166.46	$83.23	$33.29
0362	Fitting of Vision Aids	X	0.87	$44.29	$9.63	$8.86
0363	Otorhinolaryngologic Function Tests	X	1.74	$88.57	$32.77	$17.71
0364	Level I Audiometry	X	0.58	$29.52	$11.51	$5.90
0365	Level II Audiometry	X	1.32	$67.19	$20.16	$13.44
0367	Level I Pulmonary Test	X	0.70	$35.63	$17.82	$7.13
0368	Level II Pulmonary Tests	X	1.48	$75.34	$38.42	$15.07
0369	Level III Pulmonary Tests	X	3.51	$178.67	$58.50	$35.73
0370	Allergy Tests	X	0.81	$41.23	$11.81	$8.25
0371	Level I Allergy Injections	X	0.70	$35.63	.....	$7.13
0372	Therapeutic Phlebotomy	X	0.53	$26.98	$10.09	$5.40
0373	Neuropsychological Testing	X	1.01	$51.41	$14.39	$10.28
0374	Monitoring Psychiatric Drugs	X	0.89	$45.30	$9.97	$9.06
0600	Low Level Clinic Visits	V	0.87	$44.29	.....	$8.86
0601	Mid Level Clinic Visits	V	0.95	$48.36	.....	$9.67
0602	High Level Clinic Visits	V	1.38	$70.25	.....	$14.05
0610	Low Level Emergency Visits	V	1.24	$63.12	$19.57	$12.62
0611	Mid Level Emergency Visits	V	2.16	$109.95	$36.47	$21.99
0612	High Level Emergency Visits	V	3.51	$178.67	$54.14	$35.73
0620	Critical Care	S	8.45	$430.14	$150.55	$86.03
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.21	$468.83	$206.28	$93.77
0686	Level V Skin Repair	T	24.15	$1,229.33	$565.49	$245.87
0687	Revision/Removal of Neurostimulator Electrodes	T	42.58	$2,167.49	$997.05	$433.50

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	146.12	$7,438.09	$3,644.66	$1,487.62
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.43	$21.89	$12.03	$4.38
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.38	$19.34	$10.63	$3.87
0691	Electronic Analysis of Programmable Shunts/Pumps	S	3.18	$161.87	$89.02	$32.37
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	14.43	$734.54	$403.99	$146.91
0693	Level II Breast Reconstruction	T	32.00	$1,628.93	$798.17	$325.79
0694	Level III Excision/Biopsy	T	4.01	$204.13	$81.65	$40.83
0695	Level VII Debridement & Destruction	T	15.87	$807.85	$266.59	$161.57
0697	Level II Echocardiogram Except Transesophageal	S	2.09	$106.39	$55.32	$21.28
0698	Level II Eye Tests & Treatments	S	1.04	$52.94	$20.64	$10.59
0699	Level IV Eye Tests & Treatment	T	6.49	$330.37	$148.66	$66.07
0701	SR 89 chloride, per mCi	G		$963.42		$137.92
0702	SM 153 lexidronam, 50 mCi	G		$1,020.00		$146.02
0704	IN 111 Satumomab pendetide per dose	G		$1,591.25		$227.80
0705	TC 99M tetrofosmin, per dose	G		$114.00		$16.32
0706	New Technology—Level I ($0–$50)	S		$25.00		$5.00
0707	New Technology—Level II ($50–$100)	S		$75.00		$15.00
0708	New Technology—Level III ($100–$200)	S		$150.00		$30.00
0709	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
0710	New Technology—Level V ($300–$500)	S		$400.00		$80.00
0711	New Technology—Level VI ($500–$750)	S		$625.00		$125.00
0712	New Technology—Level VII ($750–$1000)	S		$875.00		$175.00
0713	New Technology—Level VIII ($1000–$1250)	S		$1,125.00		$225.00
0714	New Technology—Level IX ($1250–$1500)	S		$1,375.00		$275.00
0715	New Technology—Level X ($1500–$1750)	S		$1,625.00		$325.00
0716	New Technology—Level XI ($1750–$2000)	S		$1,875.00		$375.00
0717	New Technology—Level XII ($2000–$2500)	S		$2,250.00		$450.00
0718	New Technology—Level XIII ($2500–$3000)	S		$2,750.00		$550.00
0719	New Technology—Level XIV ($3000–$3500)	S		$3,250.00		$650.00
0720	New Technology—Level XV ($3500–$5000)	S		$4,250.00		$850.00
0721	New Technology—Level XVI ($5000–$6000)	S		$5,500.00		$1,100.00
0725	Leucovorin calcium inj, 50 mg	G		$4.15		$0.38
0726	Dexrazoxane hcl injection, 250 mg	G		$194.52		$24.98
0727	Etidronate disodium inj 300 mg	G		$63.65		$9.11
0728	Filgrastim 300 mcg injection	G		$179.08		$23.00
0730	Pamidronate disodium , 30 mg	G		$265.87		$38.06
0731	Sargramostim injection 50 mcg	G		$29.06		$4.16
0732	Mesna injection 200 mg	G		$36.48		$3.30
0733	Non esrd epoetin alpha inj, 1000 u	G		$12.26		$1.57
0734	Darepoetin alfa, 1 MCG	G		$4.74		$0.68
0750	Dolasetron mesylate, 10 mg	G		$16.45		$2.11
0754	Metoclopramide hcl injection up to 10 mg	G		$1.17		$0.11
0755	Thiethylperazine maleate inj up to 10 mg	G		$4.60		$0.66
0762	Dronabinol 2.5mg oral	G		$3.28		$0.42
0763	Dolasetron mesylate oral, 100 mg	G		$69.64		$8.94
0764	Granisetron hcl injection 10 mcg	G		$18.54		$2.65
0765	Granisetron hcl 1 mg oral	G		$44.69		$6.40
0768	Ondansetron hcl injection 1 mg	G		$6.09		$0.78
0769	Ondansetron hcl 8mg oral	G		$26.41		$3.39
0800	Leuprolide acetate, 3.75 mg	G		$93.47		$12.00
0801	Cyclophosphamide oral 25 mg	G		$2.03		$0.18
0802	Etoposide oral 50 mg	G		$52.43		$6.73
0803	Melphalan oral 2 mg	G		$2.29		$0.33
0807	Aldesleukin/single use vial	G		$672.60		$96.29
0809	Bcg live intravesical vac	G		$166.49		$21.38
0810	Goserelin acetate implant 3.6 mg	G		$446.49		$63.92
0811	Carboplatin injection 50 mg	G		$114.46		$16.39
0812	Carmus bischl nitro inj 100 mg	G		$117.84		$16.87
0813	Cisplatin 10 mg injection	G		$42.18		$3.82
0814	Asparaginase injection 10,000 u	G		$62.61		$8.96
0815	Cyclophosphamide 100 mg inj	G		$5.82		$0.75
0816	Cyclophosphamide lyophilized 100 mg	G		$4.89		$0.63
0817	Cytarabine hcl 100 mg inj	G		$6.10		$0.55
0818	Dactinomycin 0.5 mg	G		$13.87		$1.99
0819	Dacarbazine 100 mg inj	G		$12.68		$1.15
0820	Daunorubicin 10 mg	G		$76.62		$6.94
0821	Daunorubicin citrate liposom 10 mg	G		$64.60		$9.25
0822	Diethylstilbestrol injection 250 mg	G		$14.41		$1.30

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0823	Docetaxel, 20 mg	G		$297.83		$42.64
0824	Etoposide 10 mg inj	G		$10.45		$0.95
0826	Methotrexate Oral 2.5 mg	G		$3.45		$0.31
0827	Floxuridine injection 500 mg	G		$129.56		$16.64
0828	Gemcitabine HCL 200 mg	G		$106.72		$15.28
0830	Irinotecan injection 20 mg	G		$134.25		$19.22
0831	Ifosfomide injection 1 gm	G		$156.64		$22.42
0832	Idarubicin hcl injection 5 mg	G		$412.21		$59.01
0833	Interferon alfacon-1, 1 mcg	G		$4.10		$0.59
0834	Interferon alfa-2a inj recombinant 3 million u	G		$34.86		$4.99
0836	Interferon alfa-2b inj recombinant, 1 million	G		$11.28		$1.45
0838	Interferon gamma 1-b inj, 3 million u	G		$285.65		$40.89
0839	Mechlorethamine hcl inj 10 mg	G		$12.01		$1.72
0840	Melphalan hydrochl 50 mg	G		$400.74		$57.37
0841	Methotrexate sodium inj 5 mg	G		$0.45		$0.04
0842	Fludarabine phosphate inj 50 mg	G		$271.82		$38.91
0843	Pegaspargase, singl dose vial	G		$1,225.57		$179.74
0844	Pentostatin injection, 10 mg	G		$1,654.14		$236.80
0847	Doxorubicin hcl 10 mg vl chemo	G		$37.46		$4.81
0849	Rituximab, 100 mg	G		$454.55		$65.07
0850	Streptozocin injection, 1 gm	G		$117.64		$16.84
0851	Thiotepa injection, 15 mg	G		$116.97		$10.59
0852	Topotecan, 4 mg	G		$664.19		$95.08
0853	Vinblastine sulfate inj, 1 mg	G		$4.11		$0.37
0854	Vincristine sulfate 1 mg inj	G		$30.16		$3.87
0855	Vinorelbine tartrate, 10 mg	G		$88.83		$12.72
0856	Porfimer sodium, 75 mg	G		$2,603.66		$372.74
0857	Bleomycin sulfate injection 15 u	G		$289.37		$37.16
0858	Cladribine, 1mg	G		$53.39		$4.83
0859	Fluorouracil injection 500 mg	G		$2.73		$0.25
0860	Plicamycin (mithramycin) inj 2.5 mg	G		$93.80		$13.43
0861	Leuprolide acetate injection 1 mg	G		$69.79		$6.32
0862	Mitomycin 5 mg inj	G		$121.65		$11.01
0863	Paclitaxel injection, 30 mg	G		$173.50		$22.28
0864	Mitoxantrone hcl, 5 mg	G		$244.21		$34.96
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	G		$7.86		$1.12
0884	Rho d immune globulin inj, 1 dose pkg	G		$34.11		$4.38
0886	Azathioprine oral 50mg	G		$1.25		$0.11
0887	Azathioprine parenteral 100 mg	G		$1.06		$0.10
0888	Cyclosporine oral 100 mg	G		$5.22		$0.67
0889	Cyclosporin parenteral 250mg	G		$25.08		$3.22
0890	Lymphocyte immune globulin 250 mg	G		$269.06		$38.52
0891	Tacrolimus oral per 1 mg	G		$2.91		$0.42
0900	Alglucerase injection, per 10 u	G		$37.53		$5.37
0901	Alpha 1 proteinase inhibitor, 10 mg	G		$2.09		$0.30
0902	Botulinum toxin a, per unit	G		$4.39		$0.63
0903	Cytomegalovirus imm IV/vial	G		$638.48		$91.40
0905	Immune globulin 500 mg	G		$35.63		$3.23
0906	RSV-ivig, 50 mg	G		$15.51		$1.99
0907	Ganciclovir Sodium 500 mg injection	K	0.42	$21.38		$4.28
0908	Tetanus immune globulin inj up to 250 u	G		$102.60		$13.18
0909	Interferon beta-1a, 33 mcg	G		$225.22		$32.24
0910	Interferon beta-1b/0.25 mg	G		$68.40		$9.79
0911	Streptokinase per 250,000 iu	K	1.67	$85.01		$17.00
0913	Ganciclovir long act implant 4.5 mg	G		$4,750.00		$680.00
0916	Injection imiglucerase/unit	G		$3.75		$0.54
0917	Pharmacologic stressors	K	0.35	$17.82		$3.56
0925	Factor viii per iu	G		$0.87		$0.08
0926	Factor VIII (porcine) per iu	G		$2.09		$0.30
0927	Factor viii recombinant per iu	G		$1.12		$0.14
0928	Factor ix complex per iu	G		$0.48		$0.04
0929	Anti-inhibitor per iu	G		$1.43		$0.18
0930	Antithrombin iii injection per iu	G		$1.05		$0.15
0931	Factor IX non-recombinant, per iu	G		$0.71		$0.09
0932	Factor IX recombinant, per iu	G		$1.12		$0.16
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.80	$142.53		$28.51
0950	Blood (Whole) For Transfusion	K	1.98	$100.79		$20.16
0952	Cryoprecipitate	K	0.66	$33.60		$6.72
0954	RBC leukocytes reduced	K	2.69	$136.93		$27.39

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0955	Plasma, Fresh Frozen	K	2.14	$108.93		$21.79
0956	Plasma Protein Fraction	K	1.20	$61.08		$12.22
0957	Platelet Concentrate	K	0.93	$47.34		$9.47
0958	Platelet Rich Plasma	K	1.11	$56.50		$11.30
0959	Red Blood Cells	K	1.95	$99.26		$19.85
0960	Washed Red Blood Cells	K	3.62	$184.27		$36.85
0961	Infusion, Albumin (Human) 5%, 50 ml	K	2.08	$105.88		$21.18
0962	Infusion, Albumin (Human) 25%, 50 ml	K	1.05	$53.45		$10.69
0963	Albumin (human), 5%, 250 ml	K	10.35	$526.86		$105.37
0964	Albumin (human), 25%, 20 ml	K	2.08	$105.88		$21.18
0965	Albumin (human), 25%, 50ml	K	5.20	$264.70		$52.94
0966	Plasmaprotein fract, 5%, 250ml	K	5.95	$302.88		$60.58
0970	New Technology—Level I ($0–$50)	T		$25.00		$5.00
0971	New Technology—Level II ($50–$100)	T		$75.00		$15.00
0972	New Technology—Level III ($100–$200)	T		$150.00		$30.00
0973	New Technology—Level IV ($200–$300)	T		$250.00		$50.00
0974	New Technology—Level V ($300–$500)	T		$400.00		$80.00
0975	New Technology—Level VI ($500–$750)	T		$625.00		$125.00
0976	New Technology—Level VII ($750–$1000)	T		$875.00		$175.00
0977	New Technology—Level VIII ($1000–$1250)	T		$1,125.00		$225.00
0978	New Technology—Level IX ($1250–$1500)	T		$1,375.00		$275.00
0979	New Technology—Level X ($1500–$1750)	T		$1,625.00		$325.00
0980	New Technology—Level XI ($1750–$2000)	T		$1,875.00		$375.00
0981	New Technology—Level XII ($2000–$2500)	T		$2,250.00		$450.00
0982	New Technology—Level XIII ($2500–$3000)	T		$2,750.00		$550.00
0983	New Technology—Level XIV ($3000@ndash;$3500)	T		$3,250.00		$650.00
0984	New Technology—Level XV ($3500–$5000)	T		$4,250.00		$850.00
0985	New Technology—Level XVI ($5000–$6000)	T		$5,500.00		$1,100.00
1002	Cochlear implant system	H				
1009	Cryoprecip reduced plasma	K	0.82	$41.74		$8.35
1010	Blood, L/R, CMV-neg	K	2.74	$139.48		$27.90
1011	Platelets, HLA-m, L/R, unit	K	11.27	$573.69		$114.74
1012	Platelet concentrate, L/R, irradiated, unit	K	1.83	$93.15		$18.63
1013	Platelet concentrate, L/R, unit	K	1.12	$57.01		$11.40
1014	Platelets, aph/pher, L/R, unit	K	8.50	$432.68		$86.54
1016	Blood, L/R, froz/deglycerol/washed	K	6.80	$346.15		$69.23
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.86	$451.01		$90.20
1018	Blood, L/R, irradiated	K	2.98	$151.69		$30.34
1019	Platelets, aph/pher, L/R, irradiated, unit	K	9.16	$466.28		$93.26
1024	Quinupristin/dalfopristin 500 mg (150/350)	G		$102.05		$13.11
1045	Iobenguane sulfate I–131	G		$495.65		$70.96
1058	TC 99M oxidronate, per vial	G		$36.74		$5.26
1059	Cultured chondrocytes implnt	G		$14,250.00		$2,040.00
1064	I-131 cap, each add mCi	G		$5.86		$0.75
1065	I-131 sol, each add mCi	G		$15.81		$2.03
1066	IN 111 satumomab pendetide	G		$1,591.25		$227.80
1079	CO 57/58 0.5 mCi	G		$253.84		$36.34
1084	Denileukin diftitox, 300 MCG	G		$999.88		$143.14
1086	Temozolomide, oral 5 mg	G		$6.05		$0.87
1087	I-123 per 100 uci	G		$0.65		$0.06
1089	Coo 57, 0.5 Mci	G		$81.10		$10.41
1091	IN 111 Oxyquinoline, per .5 mCi	G		$427.50		$61.20
1092	IN 111 Pentetate, per 0.5 mCi	G		$256.50		$23.22
1094	TC 99M Albumin aggr,1.0 cmCi	G		$33.09		$4.25
1095	Technetium TC 99M Depreotide	G		$38.00		$5.44
1096	TC 99M Exametazime, per dose	G		$445.31		$63.75
1097	TC 99M Mebrofenin, per vial	G		$51.44		$7.36
1098	TC 99M Pentetate, per vial	G		$22.43		$2.88
1099	TC 99M Pyrophosphate, per vial	G		$39.11		$5.60
1122	TC 99M arcitumomab, per vial	G		$1,235.00		$176.80
1166	Cytarabine liposomal, 10 mg	G		$371.45		$53.18
1167	Epirubicin hcl, 2 mg	G		$24.94		$3.57
1178	Busulfan IV, 6 mg	G		$26.48		$3.79
1188	I-131 cap, per 1-5 mCi	G		$117.25		$15.06
1200	TC 99M Sodium Glucoheptonate	G		$22.61		$3.24
1201	TC 99M succimer, per vial	G		$135.66		$19.42
1202	TC 99M Sulfur Colloid, per dose	G		$76.00		$9.76
1203	Verteporfin for injection	G		$1,458.25		$208.76
1205	Technetium Tc 99m disofenin	G		$79.17		$11.33

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1207	Octreotide acetate depot 1mg	G		$138.08		$19.77
1305	Apligraf	G		$1,157.81		$165.75
1348	I-131 sol, per 1–6 mCi	G		$146.57		$18.82
1400	Diphenhydramine hcl 50mg	G		$0.23		$0.02
1401	Prochlorperazine maleate 5mg	G		$0.65		$0.06
1402	Promethazine hcl 12.5mg oral	G		$0.01		
1403	Chlorpromazine hcl 10mg oral	G		$0.27		$0.02
1404	Trimethobenzamide hcl 250mg	G		$0.38		$0.03
1405	Thiethylperazine maleate10mg	G		$0.56		$0.08
1406	Perphenazine 4mg oral	G		$0.62		$0.06
1407	Hydroxyzine pamoate 25mg	G		$0.28		$0.03
1409	Factor viia recombinant, per 1.2 mg	G		$1,596.00		$228.48
1600	Technetium TC 99M sestamibi	G		$121.70		$17.42
1601	Technetium TC 99M medronate	G		$42.18		$5.42
1602	Technetium TC 99M apcitide	G		$475.00		$68.00
1603	Thallous chloride TL 201, per mCi	G		$78.16		$7.08
1604	IN 111 capromab pendetide, per dose	G		$2,192.13		$313.82
1605	Abciximab injection, 10 mg	G		$513.02		$73.44
1606	Anistreplase, 30 u	G		$2,693.80		$385.64
1607	Eptifibatide injection, 5 mg	G		$11.31		$1.45
1608	Etanercept injection, 25 mg	G		$141.01		$20.19
1609	Rho(D) immune globulin h, sd, 100 iu	G		$20.55		$2.64
1611	Hylan G–F 20 injection, 16 mg	G		$213.87		$27.47
1612	Daclizumab, parenteral, 25 mg	G		$397.29		$56.88
1613	Trastuzumab, 10 mg	G		$52.83		$7.56
1614	Valrubicin, 200 mg	G		$423.22		$60.59
1615	Basiliximab, 20 mg	G		$1,437.78		$205.83
1616	Histrelin acetate, 10 mgs	G		$14.16		$2.03
1617	Lepirudin	G		$131.96		$18.89
1618	Vonwillebrandfactrcmplx, per iu	G		$0.95		$0.14
1619	Ga 67, per mCi	G		$25.62		$2.32
1620	Technetium tc99m bicisate	G		$403.99		$57.83
1621	Xenin xe 133	G		$29.93		$2.71
1622	Technetium tc99m mertiatide	G		$137.75		$19.72
1623	Technetium tc99m glucepatate	G		$22.61		$3.24
1624	Sodium phosphate p32	G		$81.10		$7.78
1625	Indium 111-in pentetreotide	G		$935.75		$133.96
1626	Technetium tc99m oxidronate	G		$1.47		$0.21
1627	Technetium tc99mlabeled rbcs	G		$40.90		$5.85
1628	Chromic phosphate p32	G		$150.86		$21.60
1713	Anchor/screw bn/bn,tis/bn	H				
1714	Cath, trans atherectomy, dir	H				
1715	Brachytherapy needle	H				
1716	Brachytx seed, Gold 198	H				
1717	Brachytx seed, HDR Ir-192	H				
1718	Brachytx seed, Iodine 125	H				
1719	Brachytxseed, Non-HDR Ir-192	H				
1720	Brachytx seed, Palladium 103	H				
1721	AICD, dual chamber	H				
1722	AICD, single chamber	H				
1724	Cath, trans atherec,rotation	H				
1725	Cath, translumin non-laser	H				
1726	Cath, bal dil, non-vascular	H				
1727	Cath, bal tis dis, non-vas	H				
1728	Cath, brachytx seed adm	H				
1729	Cath, drainage	H				
1730	Cath, EP, 19 or fewer elect	H				
1731	Cath, EP, 20 or more elec	H				
1732	Cath, EP, diag/abl, 3D/vect	H				
1733	Cath, EP, othr than cool-tip	H				
1750	Cath, hemodialysis,long-term	H				
1751	Cath, inf, per/cent/midline	H				
1752	Cath, hemodialysis,short-term	H				
1753	Cath, intravas ultrasound	H				
1754	Catheter, intradiscal	H				
1755	Catheter, intraspinal	H				
1756	Cath, pacing, transesoph	H				
1757	Cath, thrombectomy/embolect	H				
1758	Cath, ureteral	H				

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1759	Cath, intra echocardiography	H				
1760	Closure dev, vasc, imp/insert	H				
1762	Conn tiss, human (inc fascia)	H				
1763	Conn tiss, non-human	H				
1764	Event recorder, cardiac	H				
1765	Adhesion barrier	H				
1766	Intro/sheath, strble, non-peel	H				
1767	Generator, neurostim, imp	H				
1768	Graft, vascular	H				
1769	Guide wire	H				
1770	Imaging coil, MR, insertable	H				
1771	Rep dev, urinary, w/sling	H				
1772	Infusion pump, programmable	H				
1773	Retrieval dev, insert	H				
1775	FDG, per dose (4–40 mCi/ml)	G		$475.00		$68.00
1776	Joint device (implantable)	H				
1777	Lead, AICD, endo single coil	H				
1778	Lead, neurostimulator	H				
1779	Lead, pmkr, transvenous VDD	H				
1780	Lens, intraocular	H				
1781	Mesh (implantable)	H				
1782	Morcellator	H				
1784	Ocular dev, intraop, det ret	H				
1785	Pmkr, dual, rate-resp	H				
1786	Pmkr, single, rate-resp	H				
1787	Patient progr, neurostim	H				
1788	Port, indwelling, imp	H				
1789	Prosthesis, breast, imp	H				
1813	Prosthesis, penile, inflatab	H				
1815	Pros, urinary sph, imp	H				
1816	Receiver/transmitter, neuro	H				
1817	Septal defect imp sys	H				
1874	Stent, coated/cov w/del sys	H				
1875	Stent, coated/cov w/o del sy	H				
1876	Stent, non-coa/no-cov w/del	H				
1877	Stent, non-coat/cov w/o del	H				
1878	Matrl for vocal cord	H				
1879	Tissue marker, imp	H				
1880	Vena cava filter	H				
1881	Dialysis access system	H				
1882	AICD, other than sing/dual	H				
1883	Adapt/ext, pacing/neuro lead	H				
1885	Cath, translumin angio laser	H				
1887	Catheter, guiding	H				
1891	Infusion pump, non-prog, perm	H				
1892	Intro/sheath, fixed, peel-away	H				
1893	Intro/sheath, fixed, non-peel	H				
1894	Intro/sheath, non-laser	H				
1895	Lead, AICD, endo dual coil	H				
1896	Lead, AICD, non sing/dual	H				
1897	Lead, neurostim test kit	H				
1898	Lead, pmkr, other than trans	H				
1899	Lead, pmkr/AICD combination	H				
2615	Sealant, pulmonary, liquid	H				
2616	Brachytx seed, Yttrium-90	H				
2617	Stent, non-cor, tem w/o del	H				
2618	Probe, cryoablation	H				
2619	Pmkr, dual, non rate-resp	H				
2620	Pmkr, single, non rate-resp	H				
2621	Pmkr, other than sing/dual	H				
2622	Prosthesis, penile, non-inf	H				
2625	Stent, non-cor, tem w/del sys	H				
2626	Infusion pump, non-prog, temp	H				
2627	Cath, suprapubic/cystoscopic	H				
2628	Catheter, occlusion	H				
2629	Intro/sheath, laser	H				
2630	Cath, EP, cool-tip	H				
2631	Rep dev, urinary, w/o sling	H				
7000	Amifostine, 500 mg	G		$392.06		$56.13

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
7001	Amphotericin B lipid complex, 50 mg	G		$109.25		$15.64
7003	Epoprostenol injection 0.5 mg	G		$12.04		$1.72
7005	Gonadorelin hydroch, 100 mcg	G		$192.37		$27.54
7007	Milrinone lactate, per 5 ml, inj	K	0.44	$22.40		$4.48
7010	Morphine sulfate (preservative free) 10 mg	G		$1.02		$0.09
7011	Oprelvekin injection, 5 mg	G		$245.81		$35.19
7014	Fentanyl citrate injection	G		$1.23		$0.11
7015	Busulfan, oral, 2 mg	G		$1.91		$0.27
7019	Aprotinin, 10,000 kiu	G		$2.16		$0.31
7022	Elliot's B solution, per ml	G		$1.43		$0.20
7023	Bladder calculi irrig sol	G		$24.70		$3.54
7024	Corticorelin ovine triflutat	G		$368.03		$52.69
7025	Digoxin immune FAB (ovine)	G		$551.66		$78.97
7026	Ethanolamine oleate, 100 mg	G		$39.73		$5.69
7027	Fomepizole, 15 mg	G		$10.93		$1.56
7028	Fosphenytoin, 50 mg	G		$5.73		$0.82
7029	Glatiramer acetate, per dose	G		$30.07		$4.30
7030	Hemin, per 1 mg	G		$0.99		$0.14
7031	Octreotide acetate injection	G		$138.08		$19.77
7032	Sermorelin acetate, 0.5 mg	G		$13.60		$1.95
7033	Somatrem, 5mg	G		$209.48		$29.99
7034	Somatropin injection	G		$39.90		$5.12
7035	Teniposide, 50 mg	G		$222.80		$31.90
7036	Urokinase 250,000 iu inj	K	6.44	$327.82		$65.56
7037	Urofollitropin, 75 iu	G		$73.29		$10.49
7038	Muromonab-CD3, 5 mg	G		$269.06		$38.52
7039	Pegademase bovine inj 25 I.U	G		$139.33		$19.95
7040	Pentastarch 10% solution	G		$15.11		$2.16
7041	Tirofiban hydrochloride 12.5 mg	G		$436.41		$62.48
7042	Capecitabine, oral, 150 mg	G		$2.43		$0.35
7043	Infliximab injection 10 mg	G		$63.24		$9.05
7045	Trimetrexate glucoronate	G		$118.75		$17.00
7046	Doxorubicin hcl liposome inj 10 mg	G		$358.95		$51.39
7047	Droperidol/fentanyl inj	G		$6.67		$0.95
7048	Alteplase recombinant	K	0.36	$18.33		$3.67
7049	Filgrastim 480 mcg injection	G		$285.38		$36.65
7050	Prednisone oral	G		$0.07		$0.01
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$773.02
7052	Somatrem injection	G		$41.90		$6.00
7315	Sodium hyaluronate injection, 20mg	G		$130.63		$18.70
7316	Sodium hyaluronate injection, 5mg	G		$26.13		$3.74
9000	Na chromate Cr51, per 0.25mCi	G		$0.52		$0.07
9001	Linezolid inj, 200mg	G		$24.13		$3.45
9002	Tenecteplase, 50mg/vial	G		$2,612.50		$374.00
9003	Palivizumab, per 50mg	G		$664.49		$95.13
9004	Gemtuzumab ozogamicin inj, 5mg	G		$1,929.69		$276.25
9005	Reteplase injection	G		$1,306.25		$187.00
9006	Tacrolimus inj	G		$113.15		$16.20
9007	Baclofen Intrathecal kit-1amp	G		$79.80		$11.42
9008	Baclofen refill kit—per 500 mcg	G		$11.69		$1.67
9009	Baclofen refill kit—per 2000 mcg	G		$49.12		$7.03
9010	Baclofen refill kit—per 4000 mcg	G		$43.08		$6.17
9011	Caffeine Citrate, inj,	G		$3.05		$0.44
9012	Arsenic Trioxide	G		$23.75		$3.40
9013	Co 57 Cobaltous CI	G		$81.10		$10.41
9015	Mycophenolate mofetil oral 250 mg	G		$2.40		$0.34
9016	Echocardiography contrast	G		$118.75		$17.00
9018	Botulinum tox B, per 100 u	G		$8.79		$1.26
9019	Caspofungin acetate, 5 mg	G		$34.20		$4.90
9020	Sirolimus tablet, 1 mg	G		$6.51		$0.93
9100	Iodinated I-131 albumin	G		$10.34		$1.48
9102	51 na chromate, per 50mCi	G		$64.84		$9.28
9103	Na iothalamate I-125, per 10 uci	G		$17.18		$2.46
9104	Anti-thymocycte globulin rabbit	G		$325.09		$46.54
9105	Hep B imm glob, per 1 ml	G		$133.00		$17.08
9106	Sirolimus, 1 mg	G		$6.51		$0.93
9108	Thyrotropin alfa, per 1.1 mg	G		$531.05		$76.02
9109	Tirofliban hcl, per 6.25 mg	G		$207.81		$29.75
9110	Alemtuzumab, per ml	G		$486.88		$69.70

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2002—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9111	Inj, bivalirudin, per 250mg vial	G		$397.81		$56.95
9112	Perflutren lipid micro, per 2ml	G		$148.20		$21.22
9113	Inj pantoprazole sodium, vial	G		$22.80		$3.26
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$62.02
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$58.23
9200	Orcel, per 36 cm2	G		$1,135.25		$162.52
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$82.69
9217	Leuprolide acetate suspnsion, 7.5 mg	G		$592.60		$84.84
9500	Platelets, irradiated	K	1.69	$86.03		$17.21
9501	Platelets, pheresis	K	9.22	$469.33		$93.87
9502	Platelet pheresis irradiated	K	10.00	$509.04		$101.81
9503	Fresh frozen plasma, ea unit	K	1.57	$79.92		$15.98
9504	RBC deglycerolized	K	4.14	$210.74		$42.15
9505	RBC irradiated	K	2.45	$124.71		$24.94
9506	Granulocytes, pheresis	K	28.14	$1,432.44		$286.49

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not Paid Under Outpatient PPS.
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule.
A	Physical, Occupational and Speech Therapy	Physician Fee Schedule.
A	Ambulance	Ambulance Fee Schedule.
A	EPO for ESRD Patients	National Rate.
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule.
A	Physician Services for ESRD Patients	Physician Fee Schedule.
A	Screening Mammography	Physician Fee Schedule.
C	Inpatient Procedures	Admit Patient; Bill as Inpatient.
D	Deleted Code	Codes are deleted effective with the beginning of the calendar year.
E	Non-Covered Items and Services	Not Paid Under Outpatient PPS.
F	Acquisition of Corneal Tissue	Paid at Reasonable Cost.
G	Drug/Biological Pass-Through	Additional Payment.
H	Device Pass-Through	Additional Payment.
K	Non Pass-Through Drug/Biological	Paid Under Outpatient PPS.
N	Incidental Services, packaged into APC Rate	Packaged.
P	Partial Hospitalization	Paid Per Diem APC.
S	Significant Procedure, Not Discounted When Multiple	Paid Under Outpatient PPS.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under Outpatient PPS.
V	Visit to Clinic or Emergency Department	Paid Under Outpatient PPS.
X	Ancillary Service	Paid Under Outpatient PPS.

[FR Doc. 02–5071 Filed 2–28–02; 8:45 am]

BILLING CODE 4120–01–P